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INVESTIGATIONS – REVIEWS – INQUIRIES

An investigation into the care and treatment of Tennyson Obih

A report for
NHS East of England

November 2010

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1. Introduction

1.1 On Monday 11 June 2007 Tennyson Obih (TO) assaulted and burgled his neighbour; attempted to murder a window cleaner, with whom he had got into an altercation in Luton town centre and who he seriously injured; fatally stabbed a police officer, PC Jonathan Henry, who had been called to the disturbance; and wounded another window cleaner working at the scene who intervened to save another police officer. TO was arrested at the scene, remanded in custody and given four life sentences on 24 March 2009.

1.2 At the time of the incident, TO, then aged 27, was under the care of Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust (BLPT). This trust no longer exists and the services are now part of South Essex Partnership University Foundation Trust (SEPT) which took over responsibility in April 2010. Therefore the events to which this report relates all occurred in the period when BLPT was in existence and three years before SEPT took over responsibility for mental health services in the Luton and Bedford areas. In this report all references to *"the trust"* refer to BLPT.

1.3 Under Department of Health guidance HSG (94)27 (amended in 2005), strategic health authorities (SHAs) are required to undertake an independent investigation *"when a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event"*.

1.4 TO's convictions and circumstances meet these criteria and NHS East of England commissioned this independent investigation. This report is the outcome of the investigation.

Methodology

1.5 We have read all TO's records and many other documents provided to us by SEPT. We were greatly helped by Nikki Willmott, assistant risk manager at SEPT and her team for assisting in providing documents, contacts and setting up interview arrangements.

1.6 We have spoken to a number of witnesses from the trust and PCT, all of whom have been helpful and frank. We did not interview past trust employees or board non executives. We were able to interview all those who we determined were necessary to our investigation. We invited all TO's victims and PC Henry's widow to meet with us. We met both window cleaners and PC Henry's widow, Mrs Henry. They all bravely revisited the awful events of 11 June 2007 to help us understand what happened and how they had been affected. We would like to pay tribute to them.

1.7 We wrote to one of TO's sisters as this was the only family address we had. Finally, we spoke to TO, who is presently receiving treatment for his illness in a secure setting, and who tried to help us to the best of his ability. We also asked TO to let his sister, who regularly visits him, know that we would be happy to speak with her if she contacted us.

1.8 We considered the need to appoint medical and care coordinator experts as part of the investigation team. There is very little information about TO's mental state either from the contemporaneous interviews or from the notes. Also the key issues in this investigation were not whether he was ill or how ill was he, but how the services responded to his gradual disengagement and non compliance with medication. From the internal trust investigation and our review of the papers and interviews, it has been acknowledged by almost all that the service TO was offered was below the standard expected, and in some parts not compliant with policies that were in force at the time. Consequently we have not used other experts in this investigation as they would be being asked to point out what has already been accepted.

1.9 We offered interviewees the opportunity to be accompanied and to comment on the factual accuracy of their interview transcripts and if they wish to add to them. A

number of individuals were interviewed by the trust as part of its internal investigations and a transcript of those interviews was taken. We sought permission to use the transcripts of those interviewed by the trust and if necessary to quote from them.

1.10 As consistent with good practice in independent investigations we sent relevant extracts of the report to individuals criticised in the report for factual accuracy checks and comment. The report as a whole was sent to SEPT (as BLPT no longer exists) and Luton PCT for factual accuracy check and comment.

2. Terms of reference

Aim of the investigation

To provide an independent report into the care and treatment provided to TO from his first contact with mental health services up to the time of the offence.

Stage 1

Following the review of clinical notes and other documentary evidence:

- review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan
- review the progress that the trust has made in implementing the action plan
- agree with the SHA any areas (beyond those listed below) that require further consideration.

Stage 2

- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of his offence.
- Compile a comprehensive chronology of events leading up to the homicide and establish the circumstances of the incident itself.
- Review the appropriateness of the treatment, care and supervision of the mental health service user in the light of any identified health and social care needs.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming himself or others.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and his family.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.

- Consider any other matters arising during the course of the investigation which are relevant to the occurrence of the incident or might prevent a recurrence.
- Provide a written report to the SHA that includes measurable and sustainable recommendations.

Method of working

- The panel will examine all appropriate documentation pertaining to the care of TO and seek evidence from those involved in his care, in order to properly carry out its investigation.

- The panel will agree appropriate communication arrangements with family members and give an opportunity to the families of the victim and of TO to contribute to the investigation, as the panel feels necessary.

- The panel will consider, at the investigation chairman/panel's discretion, recommendations from similar independent mental health investigation reports so that any significant common factors can be identified.

- The panel will conduct its work in private.

Output and reporting arrangements

- The panel will provide a report with recommendations to the SHA on its findings.

- The SHA will make the findings and the recommendations of the investigation public.

3. Executive summary and recommendations

3.1 TO first came to the attention of mental health services in 2004. He had been put on probation following a conviction for indecent exposure, and was living in a hostel as a condition of his probation order. The staff were concerned by oddities in his behaviour and conversation, and his GP referred him to specialist mental health services run by BLPT. He was diagnosed with schizophrenia in June 2004. Except for a few months in 2004 when he moved to Milton Keynes, he remained under the care of BLPT until the incident.

3.2 He was a client of the Luton Early Intervention Team (EIT) from February 2005 until September 2006. During this time he was admitted to hospital for treatment of his mental illness on two occasions, and was subject to an emergency admission to hospital after he collapsed and was found to have diabetes. Initially the EIT had difficulty in working successfully with TO. TO had difficulty in understanding and accepting the need both for antipsychotic medication and a strict medication and diet regime to manage his diabetes. However, after an inpatient stay at the London Road recovery unit in Luton from February to July 2006, TO seemed insightful about his health needs and responsive to the support he was offered. He was grateful for the help in community living provided by the EIT through his care coordinator MK. MK also administered his fortnightly depot[1] injection of antipsychotic medication.

3.3 During this time BLPT in agreement with its commissioning primary care trusts (PCTs), closed its early intervention service as a consequence of budget savings. The service consisted of two teams covering Luton and Bedford. As a result TO's care was transferred in September 2006 to Luton South East Community Mental Health Team (CMHT). In closing the early intervention service the trust had developed a satisfactory process for transferring the care of clients safely and effectively to other teams and services. However, this process was not adhered to in TO's case.

[1] A depot injection is a long acting form of medication which, when injected into the muscle creates a store or "depot" of the drug. This is then slowly released over a long time e.g. 1-4 weeks.

3.4 The level of support TO received from his new community mental health team care coordinator was much less than he had received from his EIT care coordinator, MK. Fairly quickly after transfer there were signs of disengagement. TO stopped attending the day care service that he had previously enjoyed, and in December 2006 he was admitted to hospital to treat his diabetes where it was established that he had stopped taking his insulin and his oral antipsychotic medication. However, up until this point he had been compliant with his fortnightly depot injection, administered by JS, the care coordinator for the CMHT.

3.5 Throughout the second half of 2006, TO had been planning a trip to Nigeria to see his family and had been working with his care coordinators to ensure that he would have enough medication to last him for his holiday. He was due to leave at the end of December, and was able to do so, despite his admission to hospital shortly before Christmas.

3.6 TO returned home at the end of January, and immediately informed JS that he would no longer accept his depot injection, or his oral antipsychotic medication, as he was going to take what he said was his father's advice to rely on olive oil and prayer to cure him of his mental illness. He kept to this decision, and took no medication for his mental illness between that date and the date of the incident.

3.7 During this time TO had limited contact with JS, his care coordinator. This was TO's choice rather than JS'. JS kept the rest of the CMHT informed about the difficulties he was having in treating and monitoring TO. The team leader and the consultant psychiatrist agreed that JS should continue to try to keep in contact with TO in the hope that he would be able to pick up any deterioration in his physical or mental health. No other plans were made. The trust's Care Programme Approach (CPA) was not followed during this period.

The incident

3.8 On Monday 11 June 2007 TO assaulted and burgled his neighbour; attempted to murder a window cleaner with whom he had got into an altercation in Luton town centre and who he seriously wounded; fatally stabbed a police officer, PC Henry, who

had been called to the disturbance; and wounded another window cleaner working at the scene who intervened to save another police officer. TO was arrested at the scene and remanded in custody and given four life sentences on 24 March 2009.

3.9 After TO's arrest, the trust carried out three internal investigations: a confidential 72-hour internal management report dated 14 June 2007; a desktop review of clinical records dated 14 November 2007; and a RCA report dated February 2009.

3.10 These reports were all thorough, detailed and substantially accurate in their account of TO's contact with mental health services and of the nature and effectiveness of those services.

3.11 The 72-hour report consists largely of a detailed chronology of TO's contact with services since he was first referred by his GP in April 2004. We have been provided with copies of all the trust's records relating to TO, and, having read these records, we have based our chronology on it.

3.12 We have looked at TO's contact with services between **May 2004 and February 2006**, and have seen the comments made by the internal investigations about the various failures to comply with policy and good practice during this time (these are set out in section 11). We accept in full what is said in the internal investigations, but we do not consider that the failings **during this period** had any bearing at all on the events of 11 June 2007.

3.13 We have identified two discrete periods that are relevant to our terms of reference:

- February to September 2006, when TO underwent rehabilitation as an inpatient and then moved to his own accommodation and was under the care of the Luton EIT.
- 4 September 2006 to the date of the incident (11 June 2007), when TO was living in the community under the care of the Luton South East CMHT (except for the period from 28 December 2006 to 29 January 2007 when he was visiting his family in Nigeria).

Findings and recommendations

3.14 We set out here a list of our findings drawn from the relevant sections of the report. Although clearer to understand if read in context, they are placed here because we feel that they provide a useful overview of our conclusions. We have grouped the findings in this section into various themes. **As a consequence, the numbering of the findings in this section is out of sequence**.

Predictable or preventable?

F1 There is no evidence that TO's violence was predictable.

F2 None of the failures identified in section 7 should have happened. The cumulative effect of these failings meant that TO's illness was untreated and his well being was unmonitored. At his trial the judge accepted that TO's behaviour on 11 June 2007 was affected by his untreated mental illness to some extent. We find therefore that the incident might not have occurred if he had been suitably treated and might therefore have been prevented.

Transfer arrangements

F11 The intended transfer process between the EIT and other services was appropriate and robust.

F13 Senior trust managers failed to ensure that the agreed process for transferring clients from the EIT to the Luton South East CMHT was properly followed. This led to clients being transferred without discussion with, or agreement by, the manager of the CMHT.

F14 The poor compliance with the agreed process for the transfer of clients from the EIT to other services as identified in the trust service user review suggests that there was inadequate senior management supervision of the process.

F12 The Luton South East CMHT manager was not involved at an early stage in agreeing which clients could suitably be transferred to her team.

F3 The transfer arrangements between the EIT and the CMHT that were implemented for TO were not in line with those that had been planned. The EIT and CMHT care coordinators failed to prepare an individual plan that took account of the level and type of care that TO had been receiving from the EIT. The plan should have ensured that TO received a similar type of service from the CMHT or a step-down plan was put in place that would have included options of either reducing or if required increasing his contact levels, or referring him to another team.

F5 We find that there was a failure to record the details of the handover meeting between the two care coordinators and the meeting between them and TO. Therefore we cannot be satisfied that all relevant issues were discussed.

Luton South East CMHT

F4 More could have been done for TO, even within the resources of the CMHT. In particular other members of the team could have provided more support to JS to enable him to take a more active role in following up TO's non compliance with medication.

F8 The CMHT team failed to operate as an effective multidisciplinary team and enquire about the impact of TO's refusal to take his psychiatric medication on his mental state and why he had not attended his outpatient appointment on 13 March 2007.

F15 The CMHT could not offer TO the level of care that he had been receiving from the EIT and which he required to avoid deterioration of his mental health.

F19 The failure to comply with the CPA policy should have been identified by the care coordinator's manager and other members of the Luton South East CMHT.

F20 The inadequacies in care planning and risk assessment and management were not simply technical breaches of detailed trust policy, but evidence of individual and team poor practice within Luton South East CMHT. SS team manager and Dr M team consultant confirm that JS kept them and the rest of the CMHT updated on TO's non-compliance with medication and his elusiveness therefore the poor practice involves the whole team.

Care coordinator

F17 In December 2006 the CMHT care coordinator was aware that TO had stopped attending ACE Enterprises, and was hospitalised for at least nine days with problems caused by non-compliance with his insulin regime. However, neither of these events triggered a risk assessment review, as they should have done.

F7 When the CMHT care coordinator was informed by ACE Enterprises that TO would no longer be attending its services, he failed to ensure that TO's refusal to attend was assessed as part of ongoing mental state assessments.

F6 The CMHT care coordinator failed to assess the significance of TO's admission to hospital for nine days as a result of his failure to manage his diabetes.

F10 The CMHT care coordinator failed to convene a CPA review or a professionals meeting when TO refused his psychiatric medication when he returned from Nigeria or when he failed to attend his outpatient appointment.

F9 The CMHT care coordinator failed to ensure that when TO refused to take his medication he was assessed by the team psychiatrist or one of his team.

F18 The CMHT care coordinator's compliance with the trust's CPA policy including risk assessment, action to be taken on risk of loss of contact, and general care planning was seriously deficient.

Senior management action

F21 The PCT failed to properly consult on the closure of the early intervention service which led to it being closed then reinstated. The decision to close the service despite it being a key part of the National Service Framework was wrong.

F16 We find that one of the managerial priorities at the time was preparing the trust for foundation status, which combined with meeting savings targets, created considerable extra demands on senior managers. As a result this extra pressure may have had an impact on ensuring the transfer of service users from the early intervention service was safely and effectively implemented.

Trust investigations

F22 The 72-hour report was thorough.

F23 The trust's final RCA investigation including its panel membership and terms of reference were robust and appropriate.

F24 The panel undertook a thorough RCA investigation and analysis in line with its terms of reference.

F25 The trust has satisfactorily taken and completed all the necessary actions in response to the recommendations of the RCA investigation report.

Size of CMHT case loads

3.15 Although our findings and recommendations are specific to the case, we consider that some generalisations can and should be made about the context in which these tragedies occurred.

3.16 The starting point was the decision to close an important service to balance the trust's budget in line with its reduced allocation from the PCT. As a result extra burden was put on front-line staff and their managers at a time when supervision systems were not robust enough to provide sufficient support and guidance.

3.17 It is obvious that over the next few years there will be considerable pressure on public service budgets including those in the NHS. It is likely that front-line services will have to become more efficient and that some may have to be reconfigured. Those making decisions on changing front-line services must be required to do so in an open and transparent way, with proper consultation, proper risk assessment and a full audit trail.

3.18 Furthermore, if layers of management are cut to protect front-line workers, ways will have to be found to increase the authority, ability and willingness of front-line staff to make important decisions in consultation with their clients. Consequently decision making by front-line staff may have to be supported by a different structure and form of management and supervision. We consider that trusts having to make these difficult decisions should pay close attention to the way in which EITs and assertive outreach teams (AOTs) carry out their work.

3.19 Engagement, compliance and recovery are the focus of EITs and AOTs, and it was this focus that seemed to result in TO remaining engaged, compliant with medication and developing social contacts while he was under the care of the EIT. It is apparent that he valued the service he received. Engagement was at the heart - and is always at the heart of risk assessment and risk management. Filling out assessment forms and making care plans are important but cannot replace engagement with a client that enables the professional to provide sensitive and insightful ongoing assessment and support.

3.20 It is also clear that the way of team working in EITs and AOTs is for the client to belong to the team not just to the individual professional and therefore support, cover for leave and where appropriate challenge is available. This is a robust system that gives the team as a whole authority and confidence. This did not appear to be the case in the Luton South East CMHT as identified in the review of the team undertaken by ND (external consultant) on behalf of the trust in January 2008. That review also stated that the ways of working in the team was similar to other CMHTs in the trust at the time.

3.21 The levels of caseloads for EITs, AOTs and CMHTs are different and are based on the purposes of each team. It is likely that community teams along with other parts of the NHS will be subject to forthcoming budgetary austerity. If community teams are to be re-configured, decision makers need to consider carefully whether counter-intuitively smaller caseloads for CMHTs might be more efficient and effective.

Recommendations

3.22 It is clear from our findings set out above that we identified a catalogue of failures that may be symptomatic of the reasons why BLPT was subsumed into SEPT in April 2010. We have been informed that this came about in part due to the poor performance of BLPT and the need to ensure that its services were managed by a higher performing trust such as SEPT.

3.23 The three investigations undertaken by the trust and in particular the content of the final RCA report provide a comprehensive set of recommendations. We have reviewed the recommendations of the trust RCA report which we set out below and agree that they are appropriate to the systemic and individual failures the panel identified. We are confident that they are being implemented robustly and we therefore do not feel the need to repeat the recommendations. As a consequence of the range and robustness of the trust recommendation we make very few. We set out below our recommendations and then list the trust recommendations for completeness. SEPT was not responsible for the services at the time of the homicide but as the trust is now responsible for the services the recommendations are directed to SEPT as well as other organisations.

R1 We recommend that the commissioning PCTs and SEPT ensure that all service changes are monitored by senior managers to ensure that agreed processes are followed.

R2 We recommend that SEPT review its non-concordance and disengagement policy within six months. The change should ensure that the policy is clear what action should be taken in circumstances where a community service user is partially engaged as happened in the case of TO.

R3 We recommend that PCTs and SEPT should consider carefully BLPT recommendation 9 and that PCTs and SEPT must not agree to implement service changes unless they have been provided with adequate evidence that the actions set out in the recommendation have been followed and the risks of change have been effectively assessed.

R4 We recommend that the PCT should report to the SHA within six months on the progress that SEPT has made on implementing our recommendations and the continuing progress it has made with the recommendations contained within the final BLPT RCA report as set out below.

The trust's final RCA report recommendations

The report makes the following nine recommendations.

(Trust) Recommendation 1

An audit be undertaken to assure the trust that key staff are aware of the CPA and disengagement policies.

(Trust) Recommendation 2

Review team caseloads annually and ensure team managers review care coordinator workloads on a monthly basis.

(Trust) Recommendation 3

Undertake a review of mandatory training for CPA, practice risk assessment and practice risk management for attendance, capacity and quality.

(Trust) Recommendation 4

Ensure all those with management responsibilities are engaged in appropriate leadership activities which sit within a framework for leadership across the organisation and which are clearly recorded in appraisal and development paperwork.

(Trust) Recommendation 5

Undertake a review and ensure clinical risk assessments and risk management systems are in line with best practice guidance published by the Department of Health in 2007 and other relevant national best practice.

(Trust) Recommendation 6

Review support and supervision arrangements for team managers and ensure existing policy reflects national best practice.

(Trust) Recommendation 7

A standardised pro forma should be introduced for conducting and recording CMHT meetings, which addresses the consideration of issues such as risk, complex cases and handover between teams and care coordinators.

(Trust) Recommendation 8

Develop and implement a plan for the creation of unitary service user clinical records in line with national best practice.

(Trust) Recommendation 9

All service changes likely to impact on the quality of patient care should be risk assessed as part of the broader business case for change, and detailed risk assessment carried out where the risk is significant. Risk assessments must be shared with commissioners where relevant.

4. Predictable or preventable?

4.1 Our terms of reference do not specifically require us to determine whether the murder was preventable or predictable but as we are required to establish the circumstances of the incident and to consider any matters that might prevent a recurrence, we must consider the extent to which legitimate action taken at the time might have reduced the risk of harm.

4.2 Many homicide inquiry findings identify missed or undervalued clues about the dangerousness or volatility of the perpetrator. However it is important to recognise that sometimes there is nothing to suggest a risk of harm being done to another. In these cases there may be evidence of some minor failures in carrying out policy, and the care may not have been at the level of the best in the country but this does not mean that the homicide could have been either predicted or prevented. We have used the following guiding principles to assess whether the homicide could have been predicted or prevented.

- We consider that the homicide would have been predictable if there had been evidence from TO's words, actions or behaviour that should have alerted professionals that there was a real risk of violence, even if this evidence had been un-noticed or misunderstood at the time it occurred.

- We consider that the homicide might have been prevented if there were actions that professionals should have taken which they did not take and if those actions probably should have made a difference to the outcome. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

Predictable

4.3 TO had no convictions of violence, and as far as we know his only conviction was for indecent exposure, which would give no clue that he was capable of homicidal

violence. There were a couple of examples of aggressive behaviour in 2005, but these were not repeated. He did not make threats or talk of wanting to hurt others.

Finding

F1 There is no evidence that TO's violence was predictable.

Preventable

4.4 The events of 11 June 2007 are outlined in the paragraphs below.

4.5 At about 2am a neighbour of TO's, Mr L, answered his door following a knock. TO forced his way in, demanded the keys to Mr L' car, assaulted him and threatened to kill him if he did not comply. TO stole a box set of DVDs from Mr L' flat, told Mr L he could remove what he wanted from the car, allowed Mr L to remove a CD from the car, said that he would return the car by 5am and drove off. He returned about 30 minutes later, spent 30 minutes getting in and out of the car and fiddling with the roof, then locked it and went into his flat.

4.6 At about 7am, in Luton town centre, TO was standing in the road, obstructing Mr C, who was trying to park. There was an altercation, during which TO attacked Mr C's car and stabbed him in the back, before walking slowly off. An onlooker called the police and called for help from some window cleaners nearby.

4.7 One of the window cleaners, Mr K, began following TO, carrying an extendible aluminium pole. TO threatened him and threw a glass bottle at him, which missed him and smashed on the ground.

4.8 The police arrived, but TO ignored their commands to get on his knees. He was sprayed with CS gas to no apparent effect. PC Henry extended his baton, and TO lunged at him, stabbing him twice.

4.9 In the melee another officer fell over and TO went to stab him, so Mr K hit him on the head with his pole. In response, TO swung at Mr K with his knife, catching him on the arm as he lifted it to protect himself.

4.10 More police arrived, including those from the armed response unit, and TO was surrounded and eventually subdued after a baton round and two taser rounds had been fired at him.

4.11 Following his arrest TO was assessed and found not to be detainable under a section of the Mental Health Act.

Comment

Because TO was not found to be sectionable under the Mental Health Act after the incident, this does not provide a determination of his mental state other than to decide whether he was sufficiently ill to be sectioned. Whether a mentally ill person needs to be sectioned depends on their circumstances as well as the nature and degree of their illness. A person who has just killed someone and is being detained for questioning should only be sectioned and moved to a hospital if his safety or the safety of others cannot be provided while he is in custody. Someone who is safe in custody and fit to be questioned should not be sectioned, as this would delay the necessarily urgent investigation of the homicide.

4.12 At his trial, TO did not deny his actions, but denied the charge of murder on the grounds that his responsibility for his actions was so diminished by his mental illness that he should be found guilty of manslaughter instead.

4.13 The jury, after hearing conflicting expert evidence about TO's state of mind at the time of the incident, decided that he was guilty of murder. There was agreement between the expert witnesses that TO was mentally ill at the time, but disagreement as to whether his illness affected his state of mind sufficiently to justify a finding that he was not guilty of murder because his responsibility for his actions was so diminished by reason of his illness.

Comment

The legal test for the defence of diminished responsibility is very precise, and it is not unusual for people suffering from mental illness at the time they commit a homicide to be found guilty of murder. We do not challenge the finding of the court in any way, but, for the reasons given by the judge in paragraph 4.16 below, we consider that TO's mental illness nevertheless played a part in the events of the 11 June.

4.14 The only sentence for murder is life imprisonment, and this is the sentence that was passed on TO. However, when passing a life sentence, the judge also has to decide how many years the convicted person must serve before he can be considered for release on life licence. This period, called the tariff, is intended to reflect the punishment and retribution suitable for the crime. It does not mean that the person is entitled to be released once he has reached his tariff, as he can only be released if the Parole Board considers that it is safe to do so. As a result, many life sentence prisoners remain in prison for years after their tariff has expired, and some are never released.

4.15 There are sentencing guidelines for judges to apply, and where someone has been convicted of the murder of a police officer, the starting point for the tariff is 30 years. However, where the convicted person has a mental illness, even if it is insufficient to establish the defence of diminished responsibility, this can be a mitigating factor which may affect the tariff.

4.16 The judge in TO's case said:

> *"It was the unanimous view of all three psychiatrists who gave evidence at your trial that you have suffered from schizophrenia for the past four years or more. The only issue was whether there was a degree of remission in 2007, and the jury have accepted Dr W's (expert medical witness) evidence that there was; but even he did not suggest that you were wholly unaffected by your illness. I also bear in mind that the killing was not premeditated, although in my view this overlaps to some extent with the mitigating factor of mental illness to which I have referred."*

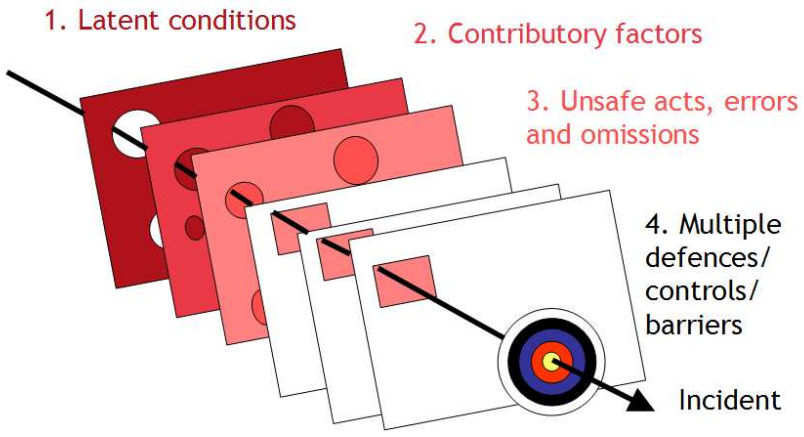
4.17 He then set TO's tariff at 25 years. In effect, the judge recognised that although TO was sufficiently in control of himself to be guilty of murder, nonetheless, to some extent his behaviour had been affected by his illness, so that a reduced tariff was the proper sentence.

Comment

Despite the fact that TO was convicted of murder rather than manslaughter by reason of diminished responsibility, the judge accepted that his illness had affected him. As his illness was undoubtedly affected by his treatment, there is potentially a link between the effectiveness of his care and treatment and his crimes.

With caveats we consider that the evidence in his records suggests that his volatile and unpredictable behaviour was affected by the extent to which his symptoms were under control with medication. We believe that if his illness had been properly treated in the first part of 2007, perhaps the events of 11 June 2007 would not have begun as they did, and if they had not begun as they did they might not have escalated to their tragic conclusion. How the failure to treat his illness came about is described within this report and we have assessed these failures against James Reason's model of incident causation and set out our findings in that regard below.

James Reason's model of incident causation



4.18 We have applied James Reason's model of incident causation, which is used in the risk analysis and risk management of human systems. It was introduced by the British psychologist James Reason in 1990 and has since been adapted to be applied in varying organisations. It likens human systems to multiple slices of Swiss cheese, stacked together side by side. It has gained widespread acceptance and use in healthcare, in the aviation safety industry and in emergency service organisations. It is also known as the cumulative act effect**.** We have used this model as it provides a useful method for analysing the effects of policy decisions (such as service reductions) on clinical practice. This case required such a model as we have concluded that decisions made by senior staff and the trust board impacted on clinical practice.

4.19 The Swiss cheese model explains why things go wrong from an organisational point of view and demonstrates how an incident can occur when defences and barriers are penetrated. According to the model, those investigating the incident must analyse all levels of the system to understand fully the causes of the incident. The model requires investigators to address latent failures in the sequence of events in addition to the unsafe acts directly linked to the incident.

Latent conditions are the things that go wrong as a result of people failing to anticipate the impact of their decisions and the conditions they can create in the workplace (for example, how closing a service will create pressure on staff elsewhere). Such decisions can create weaknesses in an organisation. Latent conditions may lie dormant in a system for many years before they combine with contributory factors and active failures to create the conditions for an incident.

Contributory factors are those that do not necessarily have a direct impact on the incident but play a contributory role. Latent conditions often allow them to occur. For example, if a patient does not speak English and cannot explain that s/he has been given the wrong medication, this can act as a contributory factor.

Unsafe acts, errors and omissions are committed by people in direct contact with the patient or situation. They can take a variety of forms such as slips, lapses, mistakes or violations. Active failures have a direct and usually immediate impact. An example of this might be someone who injects a patient with the wrong medication.

Organisational defences and barriers in place to try to stop incidents or harm taking place are also described in this model. Barriers can be:

- *physical* such as radiator covers or gloves
- *administrative* such as policies and procedures
- *natural* (time, place and distance) such as when a pharmacist makes up a prescription, they complete another task before checking the drug and dispensing it to the patient, therefore using time and distance to reduce the likelihood of human error.

If these barriers fail, and the 'holes' (latent conditions, contributory factors and/or errors) on the Swiss cheese model align, the conditions are right for an adverse incident to take place.

4.20 We conclude that the following latent factors or organisational pre-conditions were present.

- The decision by the Luton PCT and the trust to close the early intervention service due to their need to reduce a large PCT overspend over a very short timeframe, created pressure to assess and transfer a large number of clients in a matter of months.

4.21 We conclude that the following contributory factors to the incident on 11 June 2007 were present.

- Managers failed to ensure that clients were transferred from the EIT to the Luton South East CMHT according to the agreed plan. This led to clients being transferred without discussion or agreement by the manager of the CMHT.

- The EIT and CMHT care coordinators failed to prepare an individual plan that took account of the level and type of care that TO had been receiving from the EIT. The plan should have ensured that TO received a similar type of service from the CMHT or a step-down plan was put in place.

4.22 We conclude that the following unsafe acts, errors and omissions happened.

- The CMHT care coordinator failed to ensure that when ACE Enterprises, a day-care and employment service, told him that TO would no longer be attending their services that this refusal to attend was assessed as part of ongoing mental state assessments.

- The CMHT care coordinator failed to assess the significance of TO's admission to hospital for nine days as a result of his failure to manage his diabetes.

- When TO refused to take his medication he was not assessed by the team psychiatrist or another member of his team.

- The CMHT care coordinator failed to convene a CPA review or a professionals meeting when TO refused his psychiatric medication when he returned from Nigeria or at the latest when he failed to attend his outpatient appointment.

- The CMHT care coordinator's compliance with the trust's CPA policy including risk assessment, action to be taken on risk of loss of contact, and general care planning was seriously deficient.

- The CMHT care coordinator's manager and other members of the Luton South East CMHT should have identified his failure to comply with the CPA policy.

- The CMHT team failed to operate effectively as a multidisciplinary team and enquire about the impact of TO's refusal to take his psychiatric medication on his mental state and why he had not attended his outpatient appointment on 13 March 2007.

4.23 We conclude that the following barriers failed.

- The PCT failed to have consulted properly on the closure of the early intervention service. It is likely that consultation would have led to a decision not to close the EIT service and to seek savings elsewhere. This is evident by the decision to reinstate the service being made while it was being closed down, but which was too late to keep it open.

- The failure of senior managers to adequately supervise the implementation of the transfer process of clients from the EIT to other services.

Finding

F2 None of the failures identified in section 7 should have happened. The cumulative effect of these failings meant that TO's illness was untreated and his well being was unmonitored. At his trial the judge accepted that TO's behaviour on 11 June 2007 was affected by his untreated mental illness to some extent. We find therefore that the incident might not have occurred if he had been suitably treated and might therefore have been prevented.

5. Overview of criminal and social histories

Overview of criminal history

5.1 In September 2004 TO was charged and convicted with the offence of indecent exposure with intent to insult a woman. He was given one year's probation which he served at probation hostels in Luton and Milton Keynes. The police have no record of any reprimand, warnings or cautions.

Overview of social history

5.2 TO was born in Nigeria on 8 March 1980, and came to England to join his siblings in September 2000. He has one brother and two sisters. When he first came to England he lived with his brother and sisters for two years in London, after which they would not let him stay any longer. During his care and treatment with BLPT he was in regular contact with his younger sister, who took an active interest in his welfare and was recorded as his next of kin.

5.3 TO's mother died of diabetes complications when he was 14 years old. His father re-married.

5.4 During past assessments TO stated that his father was a consultant with KLM Dutch Airlines and his mother a military nurse. He passed seven O-levels and wanted to do A-levels but his father encouraged him to go to the UK. When he came to live with his brother and sisters he spent two years doing odd jobs such as working for McDonalds and making deliveries. TO told us he was sacked three or four times for *"not working properly"*.

6. Brief chronology between February 2004 and September 2006

6.1 A more detailed chronology for this period is at Appendix A.

6.2 On 3 February 2004 TO exposed himself to two women in the Elephant & Castle shopping centre in south London. After serving two weeks on remand, he was moved to a bail hostel in Napier Road, Luton, on a year's probation.

6.3 In April 2004 Dr E, who was TO's GP at that time, referred TO to Dr R, a consultant psychiatrist at BLPT. The GP requested an assessment *"as soon as possible"* due to TO's concerning behaviour at Napier Road. Shortly afterwards, TO was transferred to a bail hostel in Milton Keynes. From the records it did not appear that Dr R was informed of this move.

6.4 On 25 May 2004 TO was reviewed in outpatients by Dr M (trust consultant psychiatrist). Another appointment was scheduled for the following week to continue the assessment. TO did not attend.

6.5 On 26 May 2004 Milton Keynes West CMHT (not a BLPT service) received a telephone call from hostel staff in Milton Keynes outlining concerns about TO's behaviour. He was seen by a duty community psychiatric nurse (CPN) in Milton Keynes the following day who suspected that he was showing symptoms of schizophrenia. In a subsequent nursing statement from BLPT's recovery unit at London Road, Luton it is suggested that TO was admitted to an inpatient unit briefly in Milton Keynes though there is no further record of this in the notes.

6.6 In early June 2004 TO's probation officer wrote to Calnwood Court (a BLPT inpatient unit which has since closed), to say that TO had moved temporarily to Milton Keynes due to his fixation on parents collecting children from school. Later that month TO was reviewed by Dr M, who agreed with TO that he would be reviewed again in

three months time. Approximately two months later, his care was transferred to Milton Keynes services.

6.7 In September 2004 Milton Keynes services advised that TO had moved back to Luton. He moved to Mary Seacole House in Luton, his third bail hostel.

6.8 On 17 January 2005 TO was re-referred to Calnwood Court outpatients. Calnwood Court passed the referral to the Luton and Bedfordshire EIT. TO was seen by Dr A (associate specialist) on 25 January 2005 and was subsequently regularly reviewed in conjunction with his care coordinator, locum social worker, LP. Dr A prescribed olanzapine (10mg daily). Over the period to June 2005 the team received reports of non compliance with medication, financial exploitation by other residents and aggression towards others. There was also an incident in which TO was found in a confused state in London. He also failed to attend several review appointments in this period.

6.9 On 21 June 2005 Dr A and LP carried out a joint home visit. TO became aggressive and they withdrew as they felt threatened. They requested a Mental Health Act assessment. TO was assessed by the crisis team and was detained for assessment and treatment under section 2 of the Mental Health Act 1983 at Calnwood Court on the grounds of his risk to others, experience of delusions and expressed intentions to self harm.

6.10 On 18 July 2005 TO's section was rescinded as he was willing to remain in hospital as a voluntary patient, and discharge planning began. Staff at Mary Seacole House refused to take him back as they did not feel they could meet his needs.

6.11 On 4 August 2005 TO was discharged from Calnwood Court to temporary housing. He was prescribed quetiapine (an oral medication) and risperidone contra, a depot medication to be given fortnightly by injection. He was given an injection before discharge, and was due to have another one on 12 August 2005.

6.12 On 8 August 2005 TO was admitted to the Luton & Dunstable Hospital with severe undiagnosed diabetes. It is reported in subsequent documentation that he

required blue light transfer having been found in a semi-conscious state. His depot was administered on 15 August 2005.

6.13 On 17 August 2005 TO discharged himself against medical advice but was subsequently persuaded to return. The team at Luton and Dunstable Hospital was concerned about TO's lack of insight into his diabetes. His care coordinator withheld his depot due to concerns about his physical health. It was difficult to put together a suitable care package due to TO's complex health needs.

6.14 On 24 August 2005 TO's new care coordinator, CV, visited him at the hospital. Difficulties with assembling a care package continued. Dr A suggested intervention by Calnwood Court psychiatrists, with a view to inpatient admission. This was supported by medical staff at the Luton & Dunstable Hospital as they were concerned about TO's lack of insight into the need to take insulin to manage his diabetes. This was put in writing along with a request to admit him to Calnwood Court. However no assessment or admission followed at this time. It was decided not to administer his depot, as he was due to be assessed by a psychiatrist and the medication might interfere with the assessment.

6.15 On 1 September 2005 TO was visited by CV at the Luton & Dunstable Hospital. His depot continued to be withheld. Hospital medical staff were becoming concerned about a lack of assessment from a psychiatrist. TO also could not be registered with a GP as he was required to attend in person to do this.

6.16 On 13 September 2005 Dr M gave permission to administer the depot medication and advised that there were insufficient grounds to admit TO to Calnwood Court. Early intervention team follow up was indicated with district nurse support. A week later TO returned to his flat, having had a depot injection.

Comment

This lack of partnership working between the psychiatrist at Calnwood Court and the medical staff at Luton & Dunstable Hospital falls well below the standard that

would normally be expected of staff working in the NHS. We have not pursued this matter any further as it has no direct bearing on later events.

6.17 On 7 November 2005 TO was admitted to Luton & Dunstable Hospital for the second time due to his GP's concerns about his diabetes but was discharged on the same day. He was followed up but on occasions had not been at home to receive some scheduled visits. TO was in regular receipt of a depot injection from this time onwards until he left to visit Nigeria in 2007.

6.18 On 1 December 2005 records show that TO continued to be non-compliant with his insulin. A professionals meeting was planned with a view to using 'protection of vulnerable adult' procedures. On 12 December 2005 TO was seen for a psychological assessment. It was noted that he could not benefit from individual psychotherapy as he had active symptoms of psychosis and was abusing cannabis. Day treatment was indicated as outpatient care could not provide for the assessed levels of need.

6.19 On 22 December 2005 TO was re-admitted informally to Calnwood Court due to concerns about his ability to look after himself.

6.20 On 29 December 2005 TO was placed on section 3 of the Mental Health Act after he left the ward twice. On one of these occasions police assistance was required to secure his return.

Comment

This period is characterised by problems with diagnosis and compliance with medication, both in relation to TO's schizophrenia and his diabetes. From late February 2005 he was under the care of the early intervention service, but in June 2005 he had a compulsory admission to hospital for treatment of his mental illness. A few days after his discharge in August 2005 he had an emergency admission to hospital for treatment of his untreated and previously undiagnosed diabetes. There was a further brief admission in November 2005 for problems arising from his diabetes, and in December he was admitted informally to hospital for treatment of his psychosis.

TO's contact with the EIT fluctuated in 2005: he had five face-to-face or telephone contacts in the last week of February, four in March, five in April, and only two each in May and June. After he was sectioned in June the frequency of contact went up significantly, with four in July, 10 in August, six in September, six in October, 12 in November, and six in December, before his re-admission to hospital. This suggests that TO presented quite a challenge to the EIT during 2005.

6.21 On 4 January 2006 a professionals meeting was held, at which it was agreed that a forensic referral should be requested, that Calnwood Court should continue to manage TO's diabetes, that Dr M should be invited to the next meeting and that family input should be requested. Dr R (consultant psychologist) wrote to Dr M to request that he referred TO for a forensic opinion. No forensic referral was made then or subsequently.

6.22 On 8 February 2006 TO was discharged from Calnwood Court to the London Road recovery unit in Luton.

Comment

Following discussion with the clinical director (Dr P) and TO's improvement after he went to London Road it was decided by the team that the forensic referral was not needed.

3 February 2006 to 4 September 2006

6.23 TO was admitted to the London Road recovery unit for support in developing independent skills. During this time he lost his temporary housing, as the homeless team was unaware that he was in hospital. The EIT maintained contact during his stay at London Road.

6.24 At London Road, TO was fully compliant with all aspects of his diabetic care, and demonstrated a good level of functioning in all activities of daily living. His records

show that he was seen as having a problem with authority, which he accepted and worked with the team to change. Extended home visits went well.

6.25 On 10 February 2006 an occupational therapy assessment was completed. TO participated well in the programme at London Road during his stay.

6.26 On 11 April 2006 Dr R noted that TO would often try to mask his psychosis but that it was often apparent on further questioning.

6.27 On 19 May he was introduced to MK a new care coordinator who replaced CV who was leaving the EIT.

6.28 On 31 May 2006 TO was referred to ACE Enterprises, a day-care and employment service, by the London Road team to assist him to engage in work and social activities in the community.

6.29 On 7 June 2006 CV referred TO to the AOT. TO was not accepted for treatment as he did not meet the criteria for its service. We attach at Appendix B the referral criteria for the assertive outreach team. It is clear from the criteria that as TO was engaging with the EIT service the decision not to accept him was in line with it.

April/May 2006

6.30 On 16 May 2006 a transfer summary letter from his care coordinator described *"extreme concern about his cognitive abilities in so far as his understanding, logic, assimilation and comprehension of information"* is concerned. This was related to his poor management of his diabetic condition. This letter also refers to the care coordinator's view of the part cultural factors seemed to play in TO's personal expectations, which were high in terms of social and employment success.

6.31 In May 2006 a CPA meeting was held at which it was agreed that independent accommodation would be sought for TO in Luton.

July to August 2006

6.32 TO was discharged on 4 July 2006 to a bedsit in Winsdon Road, Luton. On 5 July 2006 a neuropsychological assessment exploring TO's cognitive ability to manage his diabetic condition, suggested that at certain times he required the support of written prompts or instructions.

6.33 Community support was given by the EIT. On 24 July 2006 his care coordinator noted that TO was coping well.

6.34 On 26 July 2006 a brief risk assessment was completed by MK. The scoring system for the assessment is as follows:

- 0 = no/very low risk
- 1= low risk
- 2= medium (significant) risk
- 3= high risk
- 4=high and imminent risk.

The assessment scored TO's risks as follows:

- risk of violence or harm to others – score of 1
- risk of suicide – score of 1
- risk of deliberate self-harm – score of 0
- risk of accidental self-harm – score of 1
- risk of severe self-neglect – score of 3
- risk to children – score of 0
- risk of abusing others – score of 1
- risk of being exploited – score of 1
- risk of committing an offence – score 1.

6.35 There is a comment on the form that TO:

"Remains at low risk as his psychosis is currently under control. However TO still has residual thoughts that women mean specific things to him when he passes them by on the street and somehow they interfere with him causing him distress. He still believes they are somehow god-like which agitates him, and makes him suspicious of their actions and what they mean to him."

6.36 On 27 July TO attended a discharge CPA meeting with MK, Dr R, Dr P (the consultant psychiatrist treating him at London Road) and other staff from London Road. The meeting agreed that TO's care should be transferred back to the EIT.

6.37 On 28 July 2006 was TO's first day at ACE Enterprises, which happened to be a social trip to Brighton. TO enjoyed himself and interacted well with others. Between this date and 21 August 2006 TO attended the football group and the drop-in computer group and appeared to enjoy them.

6.38 On 3 August 2006 TO was seen by Dr A in the outpatient clinic. It was reported that TO was *"doing very well indeed"*, continuing to see Dr K for his diabetes, and remaining compliant with prescribed medication (depot injection every two weeks). Slight paranoia was noted. MK also attended.

6.39 On 8 August 2006 a CPA plan and risk assessment were completed. The care programme plan stated that TO had now started to attend ACE Enterprises three days a week and his local church on Sundays. The summary of agreed interventions/support states that:

" MK will see TO regularly and will:

- *offer emotional support to TO*
- *offer support with medicine concordance*
- *offer initial support with managing his diabetes regime pending district nurse input*
- *liaise with TO and all the services involved in his care to maintain effective open communications regarding his care*
- *explore occupational activities with TO*

- *monitor TO's mental health well-being*
- *support TO in increasing his level of independence*
- *administer TO's depot injection*
- *offer regular outpatient appointments to monitor TO's mental health and review his medication*
- *support TO in attending ACE Enterprises and review the activities available to him*
- *co-ordinate support for TO's physical health needs."*

6.40 The risk management plan signed and dated by TO and MK on 8 August set out:

> *"1) if mental state begins to deteriorate, then TO should be referred to Dr A for a review of his mental state*
> *2) for discussion within EI team meeting* [sic]
> *3) refer to Crisis Intervention home treatment team if mental state is in crisis and cannot wait for appointments*
> *4) call ambulance if TO is found unconscious and cannot be roused;*
> *5) TO to be referred to his GP Dr P immediately*
> *6) complete vulnerable adult referral within policy within specific timeframe as per BPLT guidelines*
> *7) Discuss with TO the option of A and E department if he has capacity. If not, decide for him depending on his BBM stick test results."*

Comment

The picture here is very different from that of the earlier period of contact; TO is compliant, insightful, appreciative and willing to engage with those seeking to help him.

However, although TO seemed to benefit from his time at London Road, once he moved out to his own accommodation he needed a great deal of input from his care coordinator. He moved to his bedsit on 4 July 2006, and the records show that MK or a colleague saw TO on 20 days between 5 July and 1 September 2006.

In addition, there was substantive telephone contact on 16 days between 3 July and 7 September 2006. This adds up to 36 substantive contacts in 67 days.

Handover to the CMHT

6.41 In 2006 the early intervention service was closed as the commissioning PCT needed to reduce allocations to BLPT due to its large deficit. This is discussed in more detail in section 10. As a result, all clients of the EIT had to be transferred to other teams, or discharged from specialist services altogether. Clients who were assessed as continuing to need specialist services would either be transferred to the AOT or to their catchment area CMHT or back to their GPs. The process to be followed is set out in detail in section 8. The following key steps are extracts from a decommissioning plan prepared on 27 July 2006 by PR who at the time was the associate director for Luton Working Age Mental Health Services.

> *"Develop list of all service users requiring transfer to other teams, including risk details, CPA level and potential transfer destination (EIT assessment only at this stage). Also prioritising highest risk service users and people ready for discharge back to the GP.*
>
> *EIT to hold initial meeting with CMHTs, AOT and forensic team managers and service managers to complete early overall assessment of list of service users whose care requires transfer to other teams.*
>
> *EIT and community services to agree team destination of cases to be transferred to other services.*
>
> *CPA reviews held between EIT and community teams to transfer care for each client."*

6.42 We could find little evidence of this process having occurred in TO's case. MK makes an entry in TO's records on 18 August that *"Transfer CPA provisionally booked for 4/9/06*", but no further mention of the transfer from the EIT to the CMHT is made until 1 September when MK prepares a two-page transfer summary in anticipation of

the transfer to the CMHT. This is mainly a précis of TO's contact with the trust, and as it is not addressed to anyone we assume that it was intended to be kept on the file and read by the next care coordinator.

6.43 The next reference to the transfer is on 4 September, where notes are made by MK and JS that they met TO that day to effect the handover. MK also told the internal investigation that he had had a meeting with JS before going to see TO with him. The notes do not detail any of the matters discussed at either meeting, nor is this information shown elsewhere. There is no evidence that the care plan and risk assessment of 8 August were handed over or discussed.

6.44 At this point TO was in hospital, having been admitted on 31 August with chest pains and breathlessness that proved to be the symptoms of a pulmonary embolism. It may be that this emergency derailed what would otherwise have been a full CPA handover meeting, but we can find no evidence of this in the records, and in any event, a CPA meeting could have been held in TO's absence.

6.45 The CPA plan of 8 August makes no reference to the closure of the EIT or of TO's transfer to another team. There is no evidence in the notes that any written information about the transfer was given to TO at any time. However JK told the internal investigation that he had had discussions with TO about the transfer and the reason for it.

Comment

Whilst meeting with TO at his bedside was a sensible pragmatic response to TO's illness no other meeting was arranged. MK wrote a two-page transfer summary on 1 September but it gave little information about the extent and nature of the care that TO had received after leaving London Road, and did not set out what approach to care should be taken by the receiving CMHT other than saying that TO might need help with budgeting and that sometimes written prompts or instructions could be helpful.

6.46 There is no evidence that Dr A, TO's psychiatrist in the EIT, had a formal handover discussion with DR M, the psychiatrist in the CMHT. However Dr M knew TO well, having treated him during his admissions to Calnwood Court, and both doctors told the internal investigation that they discussed TO from time to time, as they did with other patients who were known to them both.

Finding

F3 The transfer arrangements between the EIT and the CMHT that were implemented for TO were not in line with those that had been planned. The EIT and CMHT care coordinators failed to prepare an individual plan that took account of the level and type of care that TO had been receiving from the EIT. The plan should have ensured that TO received a similar type of service from the CMHT or a step-down plan was put in place that would have included options of either reducing or if required increasing his contact levels, or referring him to another team.

7. Chronology of care and treatment from September 2006 to June 2007 (including key risk issues recorded in the medical records)

7.1 On 4 September 2006 TO was transferred to the Luton South East CMHT at a handover meeting at TO's bedside with MK and JS present. JS agreed to visit TO again on 7 September.

7.2 On 7 September 2006 TO discharged himself against medical advice without any medication. JS contacted TO who refused to return to hospital. JS informed the GP who stated he would discuss the issue with TO as he was due to come in and collect his insulin.

7.3 On 7 September 2006 JS completed a brief risk profile. Identified risks were as follows:

- risk of violence of harm to others – score 1 (low risk)
- risk of severe self-neglect – score 2 (medium/significant risk)
- risk of abusing others – score 1 (low risk)
- risk of committing an offence – score 2 (medium/significant risk).

7.4 JS recorded on the form that *"use of cannabis can bring on psychotic symptoms"*, and that TO was an insulin-dependent diabetic who at times did not manage his diabetes well resulting in re-admission to hospital to stabilise his physical health.

7.5 On 8 September 2006 JS phoned TO. TO declined to return to hospital to collect his warfarin[2] medication.

[2] Warfarin was prescribed for TO following admission to hospital for a possible pulmonary embolism.

7.6 On 15 September 2006 JS made a home visit to TO and administered his fortnightly depot injection. TO was reluctant initially to take the depot complaining of pain at the injection site.

7.7 On 15 September 2006 JS filled out a CPA form. He identified TO's core needs as support with accommodation, budgeting and managing his diabetes. A key intervention was to encourage him to comply with his prescribed medication. JS planned to visit TO every two weeks to discuss his needs, monitor his mental state, and monitor compliance with medication. The consultant (Dr M) planned to see TO as an outpatient in order to monitor his mental state and prescribe appropriate medication. JS noted that at times TO lacks insight into his mental illness and its effect on him achieving his goals.

7.8 On 29 September 2006 JS was unable to contact TO to arrange a home visit to administer his depot medication.

7.9 On 5 October 2006 JS made a home visit to see TO and administered his depot injection. They explored budgeting and spending priorities.

7.10 In October TO attended ACE Enterprises.

7.11 On 19 October 2006 JS visited TO at home to administer the depot. TO was concerned about his finances. Budgeting priorities were explored. TO was advised to contact NOAH Enterprises, a local homeless charity, for support with his meals.

7.12 On 2 November 2006 JS visited TO at home to administer the depot. JS explored budgeting issues with TO who was concerned about his finances. TO told JS he had plans to go to Nigeria for a holiday.

7.13 On 13 November 2006 TO informed ACE Enterprises that he would no longer be attending but gave no reason as to why.

7.14 On 14 November 2006 JS spoke on the telephone to one of TO's sisters regarding TO's intention to visit Nigeria at Christmas. A flight had been booked for 28 December

2006 returning on 23 January 2007. They began planning how the depot medication could best be administered both before and during the holiday.

7.15 On 15 November 2006 JS and TO's sister spoke on the telephone to confirm arrangements for TO's holiday and depot medication. JS had arranged for TO to take the depot medication with him so that his sister, a nurse, could administer it while she was with him in Nigeria.

7.16 On 16 November 2006 JS visited TO at home to administer the depot medication. TO was happy about his holiday arrangements and the plans to manage his medication.

7.17 On 23 November 2006 TO was seen as an outpatient. He expressed concern over his ability to maintain himself in his accommodation. Key issues for him were his inability to cook, and the high cost of his accommodation. He had also recently lost his wallet which contained his gas and electricity cards. JS arranged to meet TO the next day to help him sort out new cards and discuss his concerns.

7.18 On 24 November 2006 JS tried to visit TO at home but there was no answer. JS left a message on TO's mobile. TO returned the call later that day and informed JS that he had ordered a new set of gas/electric cards and that he could collect them in a few days time. JS reminded TO that his depot was due the following week.

7.19 On 29 November 2006 TO telephoned JS to give him his new mobile number. JS returned the call. TO told JS that he had received the new gas/electric cards. JS reminded TO that his depot was due the next day.

7.20 On 30 November 2006 JS made a home visit and administered the depot. Budgeting and cooking issues were discussed. TO did not wish to be referred to another agency that could help with this.

7.21 On 4 December 2006 ACE Enterprises wrote to JS to say that TO had told them he would no longer be attending ACE Enterprises, but that he did not give a reason as to why. His last attendance had been 10 October 2006.

7.22 On 7 December 2006 JS received a phone call from TO's sister who was concerned that TO would need a supply of insulin for his holiday.

7.23 On 8 December 2006, JS contacted TO, who stated he had booked an appointment with his GP to collect a repeat prescription of insulin and would discuss his needs then.

7.24 On 14 December 2006 JS visited TO at home to administer his depot medication.

7.25 On 18 December 2006 TO was admitted to the high dependency unit at the Luton & Dunstable Hospital having stopped his insulin and developed ketoacidosis.[3] JS visited TO and found him to be alert, responsive and keen to leave, but only if he was physically well enough.

7.26 On 28 December 2006 CW (community mental health nurse) visited TO at home whilst JS was on annual leave and administered TO's depot. TO told CW he had been discharged from Luton & Dunstable Hospital the previous day and the doctors had agreed for him to travel. TO was given depot medication with a coolbag and icepack, which his sister, a nurse, would administer in Nigeria for him. The notes show that CW, a woman, was accompanied by a colleague because of the assessed risk that TO posed to women. Male workers visited TO alone as they had never felt threatened or intimidated by TO, and were not considered to be at risk.

7.27 On 5 January 2007 TO's brother phoned JS to tell him that TO only had two weeks' supply of insulin, which was not enough to last his holiday. The brother was given the GP's phone number.

7.28 On 25 January 2007 TO's sister phoned JS to tell him that TO had been detained in Nigeria due to some concerns about the validity of his passport. TO was at the

[3] Diabetic ketoacidosis is a life-threatening acute complication of diabetes mellitus. It manifests clinically as a state of severe uncontrolled diabetes and gross dehydration which inevitably progresses unless it is corrected by rehydration with intravenous fluids and adequate insulin.

British Embassy sorting it out. He was expected back in UK the following day. TO's depot was due on 25 January 2007.

7.29 On 26 January 2007 JS contacted TO's sister who confirmed TO had a flight back the same evening.

7.30 On 29 January 2007 TO left a message to say he had arrived back safely and was at his flat.

7.31 On 30 January 2007 JS made a home visit. TO refused his depot, giving the reason that whilst in Nigeria his father had told him not to take it and that olive oil and prayer would end his mental health problems. JS was unable to persuade him that the depot was a better option. TO stated he would continue with his insulin and warfarin but would no longer take any mental health medication. TO agreed to stay in touch and be visited, but was evasive about setting the next date to meet. TO stated he had last had his depot on 22 January 2007. JS agreed with TO to phone him on 8 February 2007.

7.32 JS carried out a brief risk assessment the same day. Identified risks were as follows:

- risk of violence of harm to others – score 1 (low risk)
- risk of severe self-neglect – score 2 (medium/significant risk)
- risk of abusing others – score 2 (medium/significant risk)
- risk of committing an offence – score 2 (medium/significant risk).

7.33 On 8 February 2007 JS rang TO. There was no response and JS left a message on TO's mobile asking him to make contact.

7.34 On 19 February 2007 JS attempted to contact TO by phone but there was no response. He left a message on TO's mobile.

7.35 On 21 February 2007 JS attempted to contact TO by phone but was unsuccessful.

7.36 On 28 February 2007 JS visited TO at home having not seen or spoken to him for four weeks. TO appeared distracted during the visit but was appropriate in his responses. TO stated he continued to take his warfarin and manage his diabetes. He was concerned about his finances, but appeared to have been spending money on new clothes and trainers. JS attempted to discuss his budgeting but TO did not feel this was appropriate. TO was very vague about the next appointment time.

7.37 On 13 March 2007 TO did not attend a booked outpatient appointment with Dr M.

7.38 On 14 March 2007 JS attempted to visit TO as agreed but there was no response either at his home or by phone.

7.39 On 4 April 2007 JS made a home visit, having not seen or spoken to TO for five weeks. TO appeared vague and distracted at times. He did not wish to discuss medication as he did not feel it was required. TO agreed reluctantly to meet JS in four weeks time.

7.40 On 4 May 2007 JS visited TO at home as agreed, but received no response.

7.41 On 21 May 2007 JS made a home visit to TO, having not seen or spoken to him for over six weeks. Initially TO's behaviour was appropriate, but during the visit he took a number of phone calls which appeared abusive in their tone and to which TO responded with abuse. TO showed JS text messages which were abusive in content but he was vague about who had sent them, and to whom he was speaking. TO stated he was managing his physical health. He agreed to meet JS again on 4 June 2007.

7.42 On 4 June 2007 JS visited TO but received no response. He left a message on TO's mobile to contact him.

The incident leading to TO's arrest

7.43 On 11 June 2007 JS was informed by ZG, social worker, that TO was in police custody in connection with a violent incident that morning. A mental health assessment was completed by the approved social worker and two doctors approved to carry out section 12 Mental Health Act assessments. During this assessment it emerged that TO's GP, Dr P, had left the surgery and TO had not been seen by a GP since January 2007. TO had also not seen his sister since January 2007 when they were in Nigeria.

7.44 During the mental health assessment TO stated that he had not slept the previous night because he went to church in Luton. He stated he felt provoked by one of the preachers and that he felt pain yesterday in his heart and was unhappy and sad about what had gone on. He denied hearing voices, or being controlled by others, or having visual hallucinations. He stated he had a clear mind and knew what he was doing that morning.

7.45 He also stated that he had special powers and he described the events of that morning as a miracle because he had avenged the death of his mother. The connection with the police officer was that his mother's body had been brought to his house by the police. He then stated that what he had done that morning was out of love for his mother and that she was the only person ever to love him. He also stated he felt provoked again that morning. When asked if he felt remorse or regret about that morning's events he stated that he just had love for his mother and he also had one more miracle to do. When asked to explain he just said one more miracle.

7.46 A mini mental state examination was conducted and TO answered all the questions appropriately. He was found not to be detainable under a section of the Mental Health Act.

Chronology analysis

7.47 Having set out in detail our chronology we now provide an analysis of it. We have divided our analysis into two parts: from 4 September 2006, when the CMHT took

over TO's care, until 28 December when TO went to Nigeria; and from 29 January, when TO returned from Nigeria, to the date of the incident on 11 June 2007.

7.48 The chronology of the first period of nearly four months shows that TO was compliant with his psychiatric medication, kept appointments with his care coordinator, attended the outpatient appointment with Dr M in November, and that JS prepared a CPA plan. Superficially, therefore, the pattern of care that had been established with the EIT after TO left London Road continued once he was transferred to the CMHT.

7.49 However, a closer examination shows a different picture. The chronology above details every contact between TO and the CMHT. This is summarised as follows:

- CMHT - 11 meetings and five phone calls from 4 September 2006 to the end of the year (nearly four months)
- EIT - 20 meetings and 16 phone calls from 3 July to 4 September 2006 (two months).

7.50 Furthermore, TO had to be admitted to hospital as an emergency in December 2006 as a result of failing to take his insulin.

7.51 The reduction in meetings was the decision of the CMHT care coordinator, JS. There is nothing in the records to suggest that there was any discussion about this reduction, or the effect that it might have on this rather isolated man. Also during this time TO gave up attending ACE Enterprises in October. There is nothing in the notes to show that JS knew that TO had stopped attending nor that he took any action when he was notified by ACE Enterprises that TO was no longer attending.

7.52 We discussed this with JS:

> *"When we look at the notes we see that up until the point of the handover there was very frequent contact between TO and MK, which is obviously what early intervention is meant to do. But that after the handover it fell off in the*

sense that you were seeing him more or less once a fortnight for his depot injections.

A. *Yes.*

Q. *Which is, presumably, what you thought was appropriate.*
A. *Yes.*

Q. *But it was very striking, the sudden change, from nearly every day to once a fortnight. Can you tell us your thinking about that? Was it clear at the point of handover that that's what it was going to be or was the discussion about some sort of step-down process or anything like that?*

A. *I don't know. I don't think there was a discussion about frequency of contact at the time. From my perspective, I guess, it was around the usual pattern of contact that we would have with people within a generic CMHT rather than try and replicate the level of input that the early intervention were providing.*

Q. *Yes, it would be unreasonable to expect a replication, as you weren't an early intervention team, but it just seems so stark this very sudden reduction. We just wondered whether, with other people, perhaps someone who's coming from AOT, in other situations, whether there's some kind of gradual reduction or whether it's normal for it to go straight from that very high intense level?*
A. *I think it's hard for me to say at the moment, really, in terms of what would be normal.*

Q. *From your experience, from your caseload.*
A. *From my caseload I probably wouldn't have any service users transferring in quite that way before. The main source of referrals would have been through GPs or inpatient admissions. Perhaps any transfers from other teams, and this is an assumption I'm making I must admit, the thinking would be that somebody had got to a point in their journey through mental health services where their level of needs and their level of ongoing support was to be*

met within the pattern of contact the CMHT might provide rather than a more intense level of contact perhaps."

Comment

We were surprised that the handover from EIT to CMHT did not include a discussion of the level of support TO had been receiving and that he might continue to need. This was not a normal transfer arising from a change in a client's need for support, where perhaps an assumption could be made that the typical support of the receiving team would be suitable for the client. This transfer arose from the closure of the EIT, and it is clear that TO was going to the CMHT because there was nowhere else he could go: the AOT had already said that he didn't meet its criteria, he wasn't in crisis and he didn't need to go into hospital, so the CMHT was the only place for him.

In a report commissioned by the trust after its RCA investigation report, we are told:

> **"The generally expected range of service provided by this team is from a minimum of one contact with the client per month to a maximum of three contacts per client per week though this would only be expected to last a maximum of a two-week period at this intensity."**

Finding

F4 More could have been done for TO, even within the resources of the CMHT. In particular other members of the team could have provided more support to JS to enable him to take a more active role in following up TO's non compliance with medication.

7.53 Dr HM, medical director and trust board member, told us of assurances that had been given when the decision to close the EIT was made:

"It was very clear that the service was not closing. It was the team that was closing and the service, the functions would continue under the umbrella of the CMHT.

7.54 We asked Dr HM to comment on the dramatic change in level of support and contact that took place when TO's care was transferred to the CMHT. He had not been involved in TO's care, but he was involved in the desktop review of TO's notes after the incident, and therefore had a good knowledge of the facts. He told us:

"… when I read the daily reports, I found that there is nothing clinical there. What was the reason for the daily contact? …There is not one entry here by the Early Intervention Service which says, 'we are concerned about his mental health, he is having hallucinations or delusions, he is getting increasingly paranoid'. The only time such an entry was made, he was admitted. He was referred to the Crisis Team and admitted through the Crisis Team to the acute unit.

"As a clinician, I ask myself what was the reason for seeing this guy every day."

"I am just making a clinical observation here that from TO's notes and the reports that have been made by the clinicians who saw him on a daily basis when he was in the EI service, there was no clinical need for daily visits. There might have been social needs, housing needs, psychological needs, I don't know, but I am just making that observation."

Comment

Later in this report we quote from a paper prepared by Dr JR, consultant clinical psychologist. The paper*, Proposal for the re-development of early intervention services in Bedfordshire and Luton, *sets out the history of the development of early intervention services and their value. In section 3.4 of the paper Dr JR emphasises the importance of early treatment. (We have included an extract from the paper at appendix C.)

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

Section 6.3.4.2 deals with the standards and outcomes of the EI service which among a list of clinical standards states the following:

- **The client's social needs will be met (wherever possible) e.g. housing, support and benefits**
- **The client will engage in meaningful activity with the community e.g. vocational or educational (where possible)**

In section 3.12 of the paper Dr JR deals with the evidence that EITs lead to high levels of engagement and improved outcomes compared to CMHTs. In her conclusion to this section she states:

"There is NO EVIDENCE that a standard or enhanced CMHT model is capable of matching the outcomes achieved by the specialised EI [early intervention] service model recommended by the DH."

Dr HM's views, drawn from his reading of the clinical notes, concentrate on the evidence of symptoms of mental illness which is an element of the clinical assessment that must be part of any work with a client. The paper referred to above makes it clear that clinical work within early intervention services includes helping clients manage their symptoms and the psychological and social aspects of their illness. This ethos is at the core of the work of the early intervention service. Therefore the transfer to the CMHT of a young man like TO needed a care plan that took proper account of the need to establish a supportive relationship that met all his clinical needs. This was well described by TO when we visited him in Rampton Hospital he told us:

"If people are ill you shouldn't let them go, keep them by your side".

7.55 Dr A, who had been TO's psychiatrist during his time with the EIT, told the internal investigation:

> *"Common sense would suggest that if I, or if people, felt - say our team or any team - felt that somebody should ... be in assertive outreach then they should be; but assertive outreach as we are structured at the moment is a relatively small group of people, so the criteria, shall we say, are very strict. The consequence is that many people who you would have thought it would be really good that they went to an assertive outreach service, would not... There is now quite clear literature - in fact this is a Danish paper - that people were treated in the early intervention service for a couple of years and so they were treated assertively, and then they were transferred to* 'treatment as usual' *in Denmark which would be like our CMHTs.*
>
> *What happened is that they all deteriorated over time, because treatment as usual in CMHTs is much more if you like brokerage case management rather than assertive outreach, it is sort of the opposite; and sadly, you know, you can keep people like TO and so on well, only on condition that you do not take your foot off the pedal.*"

7.56 He went on to say that he would certainly have preferred TO to go to the AOT because he needed constant reminders and encouragement to keep taking his medication.

7.57 MK told the internal investigation that he did not feel that TO's care should have been transferred to the AOT, because he felt that TO was engaging well with him. However, he made it clear that his input had been tailored to meet TO's needs. In particular his level of contact with TO was determined in the light of him having being discharged from the rehabilitation unit and he needed to check TO's capacity to care for himself. For example that he could cook on his own.

7.58 MK also made an interesting point to the internal investigators. He was asked if he had anything to add to his interview to assist with learning lessons from the tragedy, and he said that it might be better if a transfer from one part of the service to another,

as in this case, should be treated as a discharge from the service handing over, rather than simply a transfer between teams, as this would trigger a more rigorous handover.

Comment

At paragraph 6.41 above we summarise the agreed process by which EIT clients would be transferred to other teams, and made the point that the process was not adhered to in TO's case. The process that should have taken place would have met MK's suggestion that it should be as robust as the process for discharging a client from specialist services. However, despite the time constraints caused by the deadline of the EIT closure, and despite the problems caused by TO's hospitalisation with a pulmonary embolism, there was a meeting between MK and JS, and another with both care coordinators and TO.

The lack of detail in the notes makes it impossible for us to establish what was said on handover about the level of TO's needs in the community. There is no record of a multidisciplinary transfer CPA meeting or a clear plan for assisting TO to transfer from the intense and supportive regime in the EIT to the approach taken by the CMHT which places greater reliance on cooperation from the client.

Finding

F5 We find that there was a failure to record the details of the handover meeting between the two care coordinators and the meeting between them and TO. Therefore we cannot be satisfied that all relevant issues were discussed.

7.59 After the handover meeting JS did not see TO again until 15 September, when he made a home visit and gave TO his depot injection. On the same day he signed and dated a care plan review form, which lists the summary of agreed interventions/support as:

- outpatient appointments
- prescription of appropriate medication
- monitoring of mental state

- regular meetings to discuss needs and monitor mental state
- referral to appropriate services if required
- monitoring of compliance with medication.

The form on file is not signed by TO.

Comment

The care plan was far less detailed and personalised than the one drawn up the previous month by MK. Together with the reduction in levels of support, this seems to reflect the differing philosophies of EIT and CMHT, rather than any change in TO's needs. The differing philosophies have the practical consequence of giving CMHT care coordinators two or three times the caseload of EIT care coordinators, and we accept that TO was receiving a standard CMHT service during this time. (The average care coordinator caseload in the EIT was 14 compared with 12 in the AOT and 35 in the CMHTs.)

The problem, it seems to us, is that JS, and presumably the CMHT as a whole, treated TO's transfer from the EIT as if it were caused by his reduced need for services, rather than by the closure of the EIT. His level of need, on an ordinary day-to-day basis without any psychiatric crises, was considerably above that what the CMHT was generally expected to provide. Nonetheless a step-down plan that included regular review should have been put in place.

We believe that the reduction in the level of support to TO must have had an effect on his willingness and ability to engage with his new care coordinator and comply with his treatment. Even though he continued to take his depot injection until he went to Nigeria, his disengagement from ACE Enterprises and the emergency hospital admission arising from his failure to take his insulin should have alerted the CMHT that all was not going as well as had been the case before the handover.

Findings

F6 The CMHT care coordinator failed to assess the significance of TO's admission to hospital for nine days as a result of his failure to manage his diabetes.

F7 When the CMHT care coordinator was informed by ACE Enterprises that TO would no longer be attending its services, he failed to ensure that TO's refusal to attend was assessed as part of ongoing mental state assessments.

January to June 2007

7.60 The chronology for this period details all contacts between TO and JS (there were no contacts with other professionals). During this time TO was known to be non-compliant with his antipsychotic medication, he was increasingly reluctant to see his care coordinator, he was evasive when he was seen and he missed an outpatient appointment. In the course of 19 weeks there were four contacts, by contrast with the 16 in the 16 ½ weeks before TO went to Nigeria, and the 36 in just over nine weeks during which TO was in the community with MK as his care coordinator.

7.61 We asked JS how he had decided to manage TO's decision to stop taking his antipsychotic medication:

> "*I think the primary thing was to maintain contact with TO really to ensure that there were still follow ups and still regular contact. In part that was about monitoring how his mental health was as well as obviously giving him a regular point of contact so that he was aware that if there were any concerns that he had he could raise those concerns. It would be really from my contact with him that if there were any signs of deterioration or concerns about TO that I would take those back to the team, and raise them within the team meeting and really look to the support of the team in terms of what do we do next. What other options might there be? Do we need to take any further actions? Would it be necessary to be looking at an assessment under the Mental Health Act if we were in that sort of scenario? That would be a flexible approach in terms of did I need to see somebody immediately if a concern*

arose? Or was it appropriate to wait until the multidisciplinary team meeting to bring it into that forum to discuss it?"

Comment

As can be seen from the chronologies JS' actual contact with TO was very limited particularly in this period. As a consequence this didn't result in effective monitoring of his mental state or offer sufficient support.

7.62 We asked JS what he had observed in his meetings with TO:

"I couldn't see any deterioration in TO's mental health. Largely that was around observing his persona when I met with him, his responses to questions that I might put to him about how he was spending his time or how he occupied himself. People he was having contact with or was he having contact with people. So it was largely from his responses around that sort of conversation and questioning. He was still maintaining himself in terms of his physical health, his physical appearance and his flat. I didn't find him distracted or responding to any psychotic or hallucinatory experiences or any of those sorts of factors."

7.63 He told us that he discussed TO with colleagues in team meetings, and that TO's psychiatrist, Dr M, was at those meetings.

Comment

In JS' evidence to the trust panel investigation he states that he raised TO's care probably once or maybe twice during 2007 with his colleagues in the CMHT weekly team meeting. Despite an extensive search by the trust we have only been able to locate one set of minutes of the weekly CMHT minutes and that is for 30 January 2007. It states:

"TO refusing medication. Difficult to engage. JS to keep trying."

Twenty three clients were discussed at the meeting and it is reasonable to assume that if they had an average of ten minutes per client that the meeting would have taken at least four hours. There is no record that JS felt the need to escalate his concerns to either requesting an emergency psychiatric assessment or calling a professionals meeting, as the team meeting minutes record for another of the patients discussed on that day. We were told by SS CMHT team manger that the absence of meeting minutes was due on occasions to a lack of administration staff.

7.64 Dr M had known TO since 2004 and had been his doctor during his two psychiatric inpatient stays at Calnwood Court in 2005 and 2006. He told the internal investigation:

> *"On one occasion when the doctor interviewed him he again presented with saying that he did not have any psychotic experiences. But saying that, I have subsequently continued to have contact with him and I found* [TO] *always very difficult to elicit symptoms from him. He will keep symptoms to himself, and I felt he was one of those patients where I find that it is their awkwardness or difficulty in coming across* [that is] *the indication of their psychosis rather than them coming out with florid symptom presentation. There has always been an issue of substance misuse as part of his presentation. He tends to downplay that when directly questioned – sometimes admits to it, sometimes tends to say he has not used – but that had been an ongoing thing right throughout. He then I think was referred to the early intervention team and they took him on. Again they also found it difficult to engage with him, or to get him to comply with medication. I have had dealings with him even during the time he was with the early intervention team, either M – Dr MA – either discussing him or clarifying whether he needed admission for further assessment in an inpatient setting."*

Comment

JS is an experienced psychiatric nurse who knew what to look for and found no overt symptoms of illness. When TO was assessed after his arrest by two psychiatrists and an approved social worker, they could not find evidence that would justify a compulsory admission to hospital for treatment. We accept,

therefore, that any evidence of a deteriorating mental state would probably not have been obvious in the occasional visits in the months prior to the incident. However Dr M's evidence makes it clear that with TO it was the subtle signs of unease and uncommunicativeness that provided evidence of psychosis.

TO's first sign of mental illness was in May 2004. In the time since 2004 he had lived in different areas and been cared for by different teams. He was taken over by Luton & Bedfordshire early intervention service in January 2005 and whilst under its care had a number of admissions to hospital, was detained twice and was identified as someone with complex needs. His psychiatric history was both short and complicated before he transferred to the Luton South East CMHT in September 2006. Consequently it was important that his principal mental health worker (JS) developed a close enough relationship to understand the subtleties of his presenting symptoms.

7.65 In this case, TO had refused his medication on returning from Nigeria, had been unwilling to make another appointment, had failed to respond to three telephone messages from JS, and, when JS finally saw him again a month later on 28 February 2007, he appeared distracted and was vague about making another appointment.

7.66 TO then missed two appointments in March, including an outpatient appointment with Dr M, appeared vague and distracted when seen in early April, missed the appointment arranged for early May, and was seen for the last time before the incident on 21 May, when he was, again, vague.

7.67 We asked JS why there had been no further CPA review after the initial review he carried out in September 2006. He told us that the CPA was being dealt with at outpatient appointments, and that if TO had attended the outpatient appointment on 13 March 2007, he would have been there too, and there would have been a CPA review with the three of them.

7.68 The internal trust investigators discussed this with Dr M.

"Can you tell us what happened if someone did not attend an appointment, either with the team or with the outpatient clinic? Take the outpatient clinic.

A. *I think we usually take it to the team meeting and discuss, but here was a situation where he was still seeing the CPN, there was still contact. If it was a patient who was not seeing the CPN, then we would have had a community risk assessment; but because at that point there was no evidence of him becoming unwell, and when patients feel better they do decide they are well, they do not need the medication, and patients do stop. We try our best and probably* [the] *early intervention team might have done a lot more work on that; but at that point there was not anything I feel I could have done more to make him take the medication. I do not think personally (I might be wrong there) that he was sectionable as such. He was not showing evidence of an illness relapsing at that point in time. I do not know whether we could have done a Mental Health Act assessment to establish whether there were grounds. But I do not think I heard enough or in JS' assessment that that was happening, or even a suggestion that things may not be right."*

Comment

It is clear that TO's consultant psychiatrist was well aware of TO's increasing disengagement from the CMHT.

7.69 DR M has told us in subsequent correspondence that:

"…when TO refused to take his medication following his return from Nigeria, the CMHT agreed on a plan of care which was considered most appropriate at the time…With the benefit of hindsight one could always find deficiencies in any treatment plan, however tight and comprehensive it might have been."

7.70 He described the CMHT treatment plan as follows:

" We did operate as a multi-disciplinary team and TO's care was extensively discussed in the CMHT either initiated by JS or myself during the team

meetings, but it was agreed at that time there was not enough evidence to intervene against his will under the Mental Health Act and therefore, we had to monitor him regularly until his mental health deteriorated to the point that he would become sectionable. Given that TO had no history of violent behaviour this was considered at the time to be the best form of action. He had defaulted and refused outpatient appointments but the team was assured that JS continued to monitor his mental state and bring back to myself or the team any immediate concerns or changes."

Comment

The treatment plan that Dr M describes seems to amount to a wait and see plan. This is a complete contrast to the more active and assertive approach taken by the early intervention team, which from the records and our interviews (including an interview with TO) appears to have managed his care well. The way of working described by Dr M may be suitable for clients who have been assessed as suitable for a CMHT. In TO's case he was being cared for by the CMHT as a result of the closure of the EIT not because he no longer needed an early intervention service.

7.71 We asked SS, CMHT team manager, for her views on this period. She told us:

"I think one of the issues we had at the time was that he would stop his insulin at the same time as he would stop his antipsychotic medication. If I remember rightly, he was still taking his insulin. I think the other issue was that he had disengaged from the outpatient appointments but had not disengaged from JS at that time. To be honest, though, as time went on, he then dictated he only wanted to be seen once a month rather than fortnightly. And there were concerns about that...

Q. *But under the care programme approach, should there... have been some kind of a formal meeting to look at it in the round, do you think?*

A. *Yes. I believe so now. I think now we should have been looking at calling a professionals meeting and looking at a care management plan to try to re-engage him.*

Q. *Can you remember why that did not happen?*

A. *I think we have learned more. We are engaging with much more services now, whereas before I think mental health at the time was working in isolation and should not have been. I just really don't think it was even thought about, whereas now it is. We have the doctors go out on home visits with us if they are not coming to outpatient appointments. So things have changed dramatically from then. But unfortunately, it took this incident to make it change."*

Comment

The concept of a professionals meeting was being practised at that time as one is recorded in notes of a January 2007 team meeting as being recommended for another client. Therefore this is not a case of the team not being aware at the time what they could do, it is that they failed to do what they could have done, for example, call a professionals meeting.

7.72 SS accepted that, even at the time, the case was not handled in accordance with the care programme approach. We asked her:

"Q. *If an auditor had come in a week before the homicide and pulled his file out from the filing cabinet and said, 'Okay, let's look at this and see if it's an example of good care, according what should be going on at the time,' what would the answer have been?*

A. *I would have said it was not adequate. Personally, from my point of view, I would have expected at least weekly visits in the initial period of the handover, to engage TO. In saying that, he was engaging, on a two-weekly*

basis, and he was compliant but I firmly believe that if that holiday to Nigeria had not happened, he might still be in care. But it happened.

Q. *Okay. So that would have been an improvement, during 2006. But then in 2007, after he stopped taking his medication – he did not completely disengage, did he? – but stopped taking the medication and JS knew that he was not taking the medication and was discussing it in the team. But what you are saying there is – do you have any criticism of how that was handled?*

A. *Yes. We did not function like that. We should have increased visits and not allowed him to tell us that he only wanted four weekly visits, even if we had kept in contact by telephone – although he was not always answering his phone at that time, either... Again the CPA process at that time also was six monthly with risk assessments and six monthly reviews. That has now changed. The risk assessment has to be done on a three-month basis even if there is not any change in risk assessment... I think we should have persevered and probably just kept going round there on the spur of the moment even."*

Comment

SS admits that in the case of TO the team should have done more and they didn't apply the CPA process that was in force at that time as they were required to.

Finding

F8 The CMHT team failed to operate as an effective multidisciplinary team and enquire about the impact of TO's refusal to take his psychiatric medication on his mental state and why he had not attended his outpatient appointment on 13 March 2007.

7.73 We asked Dr HM, the medical director of the trust, what should have happened after TO refused his medication.

"I had a very strong view which was here is a chap who is psychotic who has a diagnosis of schizophrenia, who has come back and is not taking medication, he

should have been urgently reviewed by the medical team, the multidisciplinary team. If he is refusing the review, they should have requested a Mental Health Act assessment...

There were little pieces of evidence that things were not going right with him. On 4 April there is a nursing report: 'He appeared vague at times and distracted, did not wish to discuss medication'. On 21 May: 'Appeared appropriate initially, however during my visit he took a number of telephone calls and was abusive'. That should have alerted a further review.

Q. *That should have alerted but the mere fact that he was refusing his medication should have resulted in some formal action, formal meeting, formal review?*

A. *Absolutely..."*

7.74 We then discussed with Dr HM whether TO not taking his medication amounted to disengagement.

*"**Q.** If you are a professional person and someone disengages, there are steps that should be taken under the CPA apart from anything else, is that right?*

A. *Yes. I am not trying to find excuses for the clinical staff but it all depends on how they viewed disengagement. It could be argued that he was engaging because he was opening the door, he was sitting and talking to them. It is just that he refused to take medication. It was non-compliance with medication that he was well known to do and, therefore, is that disengagement? I don't know, it all depends on how JS and the team decided to view that."*

7.75 We then asked Dr HM what action he thought JS and the team should have taken:

*"**Q.** If you had gone in and audited that file then at the beginning of June, would you have thought that is okay, or would you have thought they should have been doing something else?*

A. *I would have expected the monitoring to be a little more detailed and rigorous. I would have expected them to identify what the issues were. I would have expected questions like paranoid thoughts, paranoid delusions, hallucinations to go into that. Is he just refusing to take medication, because that is what he has done all the time, or is he refusing to take medication because he is becoming gradually psychotic? That is the issue here and one would only find that out by going deeper into the issues and deeper into the mental state but, again, I do not see that having happened here."*

7.76 We discussed with SS whether a CPA review would have made any difference.

"Q. *You said that he did not seem ill enough – but presumably, if JS had had a meeting with him and he had been talking in a worrying way or a dangerous way or something like that, that would have triggered a response?*

A. *Yes. Then we would have been looking at the crisis team and also the Mental Health Act if that did not occur.*

Q. *So it was not that he was under the radar, because he was being talked about, but he was under the threshold of being able to take* [any] *sort of any emergency action?*

A. *He did not appear to be in crisis to refer to the crisis team. I think if I remember at the last appointment he was getting some abusive text messages but JS did speak to him about that and he did seem to be coping with that, although* [he] *did not elaborate on what they were. But there was no evidence of him hearing voices, or...*

Q. *You say that what could have happened, if he had been a bit more high profile, if he had gone above the threshold, he could have been referred to AOT or to the crisis team or for a Mental Health Act assessment... Do you think he would have been admitted to hospital? Or do you think he would have been taken on by the crisis team or the assertive outreach team?*

A. *I think there would have been a possibility for the assertive outreach team because he was meeting the criteria of being non-compliant. The issue*

would have been the difficult area of disengagement, because I think they may have viewed it that he was still engaging with JS and that - so they may not have still taken [him]...

Q. *He was non-compliant with the medication but he was still engaged?*

A. *Right.*

Q. *But you don't think the crisis team would have taken him on?*

A. *No, because he did not come across as actually being in crisis. And for a Mental Health Act assessment, he would not have been sectionable."*

Comment

It is impossible for us to assert whether or not a professionals meeting, a home visit by the doctor, a CPA review, a Mental Health Act assessment or a referral to the AOT would have identified that TO was having difficulties and needed more help. An interview with Dr M would have been valuable in assessing what needed to be done. However it seems likely that, if any of these actions had been taken, at the very least TO would have been offered more contact with health care professionals.

Findings

F9 The CMHT care coordinator failed to ensure that when TO refused to take his medication he was assessed by the team psychiatrist or one of his team.

F10 The CMHT care coordinator failed to convene a CPA review or a professionals meeting when TO refused his psychiatric medication when he returned from Nigeria or when he failed to attend his outpatient appointment.

The approach of EIT and AOT

7.77 We asked MK and CW (care coordinators in the EIT), who we interviewed together, to tell us how they would have dealt with the situation if the EIT had taken back TO on his return from Nigeria.

> *"**Q**. How would you have dealt with his non-compliance with medication?*
>
> ***A**. **MK**: Okay I would actually have to try and explore as to why he didn't wish to take it.*
>
> ***Q**. Just use the example that he gave us, it's in the notes, prayer and oil. 'My dad says prayer and oil will do'.*
>
> ***A**. **MK**: This is often a difficult one where you're actually facing the conflict between our western form of treatment and actually traditional cultural forms. Certainly I would get him to reflect on the positives that he'd actually received from receiving the treatment. Then, if he'd continued to insist and say no, I would have had to say can we have a medical review to review this because it's actually prescribed medication and to actually possibly explore whether we could look at a less intrusive manner.*
>
> ***A**. **CW**: I think some of it is about the relationship you have with somebody as well, isn't it? The actual relationship you develop, that trust and things and I think that's really important to remember because I think we've worked very hard in the early intervention service to develop those relationships. So someone quite often would say 'I don't want to take medication' but you will say right, you've got to and they'll go okay, right. So what's the positives and negatives for doing that and getting them to come up and quite often 'okay I probably do need to take it'. I think that's really important for the relationship.*
>
> ***Q**: One refusal fair enough come back again, second refusal.*

A. ***MK:*** *Then you're looking at let's have a review. I think you always have to allow that the person might refuse on that day and then go back, right, I heard what you say what about – do you still have the same wishes? I think it's changed slightly now with CTOs or community treatment orders, but possibly, yes, that's how I would have possibly considered it... You'd have to have a review. We currently face this dilemma even now.*

A. ***CW:*** *It's a constant issue."*

7.78 We asked LL, who was manager for a number of services including the assertive outreach service, whether the AOT might have got involved, and, if so, what would have happened.

"Q *"The fact that he had been referred to AOT in the spring and then turned down in June because it wasn't thought he needed that, would that have prevented the matter from being reconsidered when the early intervention service was closing down. Would you reconsider at any time?*

A. *We would reconsider at any time, because people's lifestyles change, their circumstances change.*

Q: *If we look at TO when he was with the CMHT for a moment, from your experience with the AOT, he comes back from Nigeria and refuses to have his depot injection, he is not engaging very well with the care coordinator community nurse who is visiting him, he is very guarded about talking about his own mental health issues, symptomatology or anything like that. Would he be a suitable client for the CMHT at that point to have re-referred to AOT?*

A. *I think so. Just going through the notes, it was evident to me that, when he returned from Nigeria and was refusing his medication, from some of the things he was saying it appeared that he was unwell, so I would have thought it prudent to refer him to the AOT at that time."*

Comment

After TO's return from Nigeria to June 2007 he was sporadically engaging with JS but not compliant with medication. It is open to question whether the AOT would have accepted him as a client but if a professionals meeting had been called (or some other form of review) then at least advice from AOT could have been sought even if it was decided he was not eligible for the service.

7.79 We asked LL to take us through the process that the care coordinator would have followed to make a referral to AOT.

> *"**A**. The process is a referral form that one completes and sends to the AOT. I was reading up on the operational policy to remind myself, and part of their policy is that they would respond and try to see the person within two weeks of referral.*
>
> ***Q**. Would that have to occur after a CPA review, or could he have done it off his own bat?*
>
> ***A**. I cannot talk for the CMHTs but the first thing that occurred to me when I saw that part when he returned from Nigeria, because he was away for about a month, was that I thought perhaps it would have been a good idea to have a CPA review at that point on his return. That is what I would have expected... to reassess and to do risk assessment at that stage.*
>
> ***Q**. However, if we... think about the six months after he came back from Nigeria, you said it could have been appropriate to make another referral to the assertive outreach team?*
>
> ***A**. Yes.*
>
> ***Q**. On the basis of what you have read, and there is not very much there, do you think that he would have met the criteria for the assertive outreach team? The fact that he was guarded and not taking his medication, but he*

wasn't being violent, dangerous or anything of that nature, do you think they would have thought he was one for them?

A. *It is possible... He probably would have met the criteria to go in but, with hindsight, it is easy to say that now.*

Q. *If I moderate that response slightly in that it sounds to me that you are not saying he was clearly AOT?*

A. *No, he wasn't but he probably would have been considered, that is probably a better way of saying it."*

7.80 LL described for us the different level and type of service that TO may have received if he had been accepted by the AOT.

*"**A.*** *There are occasions when service users who have accessed the AOT service would be visited once, twice, sometimes three times a day because of medication. People who are non-concordant with their medication are visited to be given their medication, so for some people it may be two or three times a day. That would be 365 days a year because even on bank holidays the AOT would visit.*

Q. *If he were unwilling to have his depot having previously taken it, what would the approach of the AOT have been to that?*

A. *An arrangement would have been made for the associate specialist within the AOT to see him right away… The AOT is unique in the way it is run, which is very different from a CMHT in that the case load belongs to the whole team, although a care coordinator would be responsible for a certain number of people within the case load. However, everybody else in the team is aware of the issues around that client and it is because of the way the whole team is set up.*

A. *I suppose the difference with the AOT is that it is not only about treatment but there is this part around social inclusion and getting clients to access things in the community, helping them with their benefits, making sure their housing is secure, because they might be engaging with all sorts of other things such as substance misuse and getting all sorts of people in their flats."*

Interview with TO

7.81 TO agreed to speak to us about his recollections of his contact with services. He told us that he had enjoyed being in London Road, and had had a good relationship with MK. He missed the same level of contact when he was transferred to the CMHT. He agrees that he decided to stop taking his antipsychotic medication when he returned from Nigeria, but recalls that the reason for this was because it hurt, rather than that his father had suggested he stop (the injection has to be given with a big needle, in the buttock, and TO told us that it hurt him to sit down for several days after the injection). However, although the notes made by MK refer to TO complaining about the pain caused by the injection, JS' notes clearly show that, on 29 January 2007, TO said that he was refusing his medication on the advice of his father.

7.82 He told us that during 2007 he knew he was becoming ill again, as he had been several years earlier, but he put this down to the fact that he was smoking cannabis recreationally. He didn't associate this with stopping his medication, nor did he feel able to talk to anyone about how he felt. His recollection, which is not borne out by the notes or the recollection of JS, was that he wanted more contact with the CMHT rather than less. When we asked him if he could think of anything that might have helped him stay well, he said that when someone is not well, the specialist services *"should not let him go, should keep him by their side"*. He said he would have liked to have moved back to London Road when things became difficult, but didn't tell anyone this.

Comment

TO is currently receiving treatment for his mental illness, which affects both his memory and his ability to understand some events. We formed the view that he was answering our questions to the best of his ability, but that sometimes (for instance when he told us the reason he had given for stopping his medication) his recollection was faulty.

However we were convinced by his comment that he would have liked more contact with his CMHT, as this seems to be what he wanted when he was with the EIT.

8. Closure of the early intervention service: how it was planned and how it happened

8.1 We have seen limited documentation about the closure of the Luton early intervention service. We provide here the key dates:

- **26 June 2006:** the associate director for Luton Working Age Mental Health Service met with the Luton EIT to inform staff that a statement of intent to de-commission the team had been made and to issue redundancy letters.

- **September 2006:** the early intervention service closed.

8.2 The trust has supplied us with copies of board level papers which have enabled us to review the level of scrutiny the trust board had over the selection of the early intervention service for closure and the process for its decommissioning. It is clear from the papers that there was considerable discussion and negotiation between the trust and the commissioning PCTs about which services were to be closed.

8.3 We requested copies of board meeting minutes which related to discussions at the board in respect of service user safety as a result of the transfer of EIT clients. Despite an extensive search by SEPT the only minuted board discussion we have seen (which took place on 27 September 2006 after the closure of the service had already happened) is as follows:

> *"LC (a non executive member) asked for assurance that the care that was being given to the transferred Early Intervention patients was at a similar standard and the staff were skilled.* ***PM (chief executive) confirmed that these service users would be receiving safe care but at a lower standard for their specific needs*** *(our emphasis). HM (medical director) confirmed that while a majority of patients were transferred to Community Mental Health Teams (CMHTs), the more difficult patients were transferred to the Assertive Outreach team. With the loss of the Early Intervention service the preventative aspect had been lost."*

Comment

It is of note that the question of what standard of service the clients would be receiving after transfer is only raised after the closure of the service.

8.4 We were supplied with a paper, *De-commissioning plan for the early intervention service,* authored by PR, the associate director for Luton Working Age Mental Health Service and dated 27 July 2006. This document is in tabular form and sets out the key steps that were to be taken in decommissioning the service. We are not aware whether this paper was reviewed by the board, as there is no board minute to reflect that it was discussed.

8.5 The four key actions and dates relevant to this report are quoted in the table below. They are numbered as in the report.

Action	**Timescale**
1. Develop list of all service users requiring transfer to other teams, including risk details, CPA level and potential transfer destination (EIT assessment at this stage only). Also prioritising highest risk service users and people ready for discharge back to the GP.	18.7.06
5. EIT to hold initial meeting with CMHTs, AOT and forensic team managers and service managers to complete early overall assessment of list of service users whose care requires transfer to other teams.	28.7.06
12. EIT and community services to agree destination of cases to be transferred to other services.	16.9.06
15. CPA reviews held between EIT and community teams to transfer care for each client. 47 service users in Luton, and 25 in Bedford. All transfers to be completed.	15.9.06

8.6 The other document we have seen is a BLPT paper entitled *The methodology underpinning the transfer of the former intervention in psychosis caseload to CMHTs, AOT and primary care*. This document was produced by a trust acting associate director (LM) and was dated 16 August 2007, and is a retrospective of the process.

8.7 We include here a substantial part of the paper as it provides a narrative description of the actions that were intended to have taken place.

> *"Team meetings were arranged and all service users were discussed including needs and risk assessments. Present at the team meetings were psychologist, consultant, team manager and care coordinators. These meetings discussed the numbers of service users and the impact this would have on the receiving teams.*
>
> *A list was developed of all service users requiring transfer to other teams including risk details, CPA levels including preferences and wishes and also those service users the EI team had concerns around the service users transfer of care and potential destination.*
>
> *This process also prioritised highest risk service users and service users who were ready for discharge to GP.*
>
> *Transfers to GP were done via letter which included a full summary of the care and interventions during the episode of care with the EI service and the full agreement of the service user, family or carer.*
>
> *All service users' needs and carer's (sic) needs were further discussed in individual supervision on a weekly basis."*

8.8 The quotes above show that the beginning of the process was for the EIT staff to arrive at potential destinations for each of their clients. The next part of the document shows that discussions took place with the possible receiving teams.

> *"At subsequent meeting reviews were done as to which other community teams/GP the users would actually be transferred to with regard to the current policy of GP alignment. However the decision as to which community team the service users would be transferred to was based on service users needs and in discussion with the team manager of the proposed receiving team.*

Early intervention team managers held initial meetings with CMHTs, AOT and forensic team managers and service managers to complete the overall assessment of the list of service users identified for transfer to other community teams.

Early intervention team managers and the community team managers agreed the transfers of service users."

Comment

It appears from these paragraphs that community team managers were to be involved in the decisions about who was being transferred to their team.

8.9 The next quote shows that the care coordinators were involved in the handover CPA meetings/discussions.

"The receiving team managers were then contacted with a list of clients that would to be transferred to their team. Copies of care plans and risk assessments were forwarded to team manager for allocation of care coordinators.

Once care coordinators were appointed, handovers were conducted at CPA reviews and for some service users joint visits between the EI team care coordinator and the care coordinator in the receiving team were undertaken. The process was discussed at all levels in supervision and in team meetings. In some cases there were several contacts between both care coordinators prior to the handover CPA meeting.

The carers were informed of the closure as soon as the initial decision had been taken. This was done by care coordinators meeting with carers and service users. Carers were informed of the changes in service provision initially verbally, at CPA reviews and in some cases by letter."

Comment

The process outlined in the two papers appears to be sensible and safe. It starts with discussion by the team currently looking after the clients, followed by discussion with team managers from the receiving teams. Following the inter-team manager discussions there was to be the completion of care plans and risk assessments and handover CPA reviews with the client and the new CMHT care coordinators.

Finding

F11 The intended transfer process between the EIT and other services was appropriate and robust.

8.10 The decision that the service was going to close was taken in June 2006. The planned date for closure was by September 2006. There were 47 clients (from the Luton team) that had to be reviewed and arrangements made for them to be transferred to other services. This was a short timeframe and a challenging one to meet.

8.11 We discussed the transfer and handover processes with witnesses.

8.12 SS, the CMHT team manager, does not recall being involved in the decisions about which EIT clients would be coming to her team.

> *"**Q**. At what point were you engaged by anybody in decisions around who was coming to you, what their needs were, etc?*
>
> ***A**. There was no point. We were sent a list of who was coming...*
>
> **Q.** *Were you involved in any way in the process deciding how – not just 'so-and-so is coming' – but how those transfers were to be made? In other words, whether somebody needed to step down, whether somebody needed – etc?*

A. *No... There would be the transfer summary that would have handed over files – yes, JS would have received all that and met with the care coordinator, with the service user.*

Q. *So there is a transfer summary, a meeting between care coordinators, but no other professionals – there was not a multidisciplinary meeting? So you would* [not] *have a consultant and other people involved? It was not a mini CPA?*

A. *No."*

8.13 Dr HM, trust medical director, said:

" *I was largely dealing with my clinical directors and telling them to tell the consultants who are responsible for the early intervention service that they need to participate in those meetings, the CPA meetings and so on to effect the transfer safely.*

8.14 He also told us:

"The reason why people focused on the EI service as perhaps the best one to cut was, first, because of the three NSF teams – crisis resolution home treatment, assertive outreach and EI – it was generally felt that EI was not the best service in comparison to the other two. Secondly, it was felt that it is a relatively new service with a small number of patients. There were only 72 patients in the entire EI service, so it was easy to transfer them to a CMHT or other service. ***Thirdly, it was very clear that the service was not closing. It was the team that was closing and the service, the functions would continue under the umbrella of the CMHT (our emphasis).*** *That is a very important point that was made at the executive committee, as I recall it, by PM, that the service is not closing, it is just being transferred, it is the team that is closing. This means that the functions of the service are being transferred to the CMHT.*

Q. *One of the functions of the service was, clearly, to provide a high level of support to someone who has been recently diagnosed. If the function was being transferred,* ***there would be an expectation, would there not, that at***

least the level of service an individual was receiving in the EI ought to be, to some degree, mirrored when they are transferred to the CMHT?

A. ***Yes, I agree*** *and that is the reason why the clinicians had to get involved in the assessment of the 72 patients in the EI service and then decide. You will note that some were discharged to the GP."*

Comment

Following his review of the draft of this investigation report Dr HM has suggested that his response to our questions must be taken in the context of the statement made by PM (the trust chief executive) who confirmed at a board meeting that "… **service users would be receiving safe care but at a lower standard for their specific needs".** ***As service users were going to receive care of a lower standard then it was important that their care was assessed not only ensure that it was safe but also adequate for their needs.***

8.15 We asked SS, the CMHT team manager, what she thought about the reason for transferring clients such as TO.

"I did not think it was appropriate to close the (early intervention) team. I am sure the trust had their reasons for that. I felt it was doing a good service to the service users within that team because they were getting an awful lot of input from people that have smaller caseloads, which is why it was set up in the first place, to actually target that service group and meet their needs. With the CMHT we had far higher caseloads and just could not visit or make contact on a daily or two daily basis which is what was happening in early intervention...

As I say, with the input that early intervention had with those service users, to me it would make more sense to have gone to a team that could provide, perhaps not the same input but certainly a bit more input than community mental health teams could offer. We did not really have a choice. Once another specialist team was refusing to take some of them - not all of them - they had to [go] *somewhere..."*

Comment

The evidence of SS shows that staff of the Luton South East CMHT were not involved in discussions about which clients were to be transferred to them as described in the briefing paper above.

In reality there would have been few alternatives for individuals if they were considered suitable for a CMHT, particularly in the case of TO who had previously been considered by the AOT twice and turned down.

Notwithstanding the lack of alternatives, if a greater partnership approach had happened in practice then it is likely that the needs of TO and others might have been more thoroughly discussed and the resources and approaches taken by the CMHT adapted appropriately.

Finding

F12 The Luton South East CMHT manager was not involved at an early stage in agreeing which clients could suitably be transferred to her team.

8.16 Following these events the trust undertook a review of service-user records related to the transfer of care during late summer 2006 from the Luton and Bedfordshire EITs to CMHTs and AOTs.

8.17 The review was to audit the application of the agreed guidance on transfer. The author of the review, JB, acting deputy director of nursing, chose a sample of 10 clients and examined from the records:

- CPA review and transfer of care
- mental health and needs assessment
- risk assessment and risk management
- care planning
- relapse prevention planning and agreement of an advance directive.

8.18 For the purposes of the review we set out here a selection of the findings related to CPA review and transfer of care and risk assessment and risk management.

- *"A CPA review meeting was held prior to the transfer of care (within three months), as confirmed by a completed CPA review meeting record (CPA6)*
  - *Compliance = 70% (7/10) (4/5 for Luton cases & 3/5 for Bedford cases)*

- *The CPA review meeting that was held prior to the transfer of care incorporated a reassessment of risk, a review of the risk management plan and care plan.*
  - *Compliance = 60% (6/10) for review records; 90% for detailed transfer letters the criterion was otherwise difficult to meaningfully evaluate*

- *A follow-up CPA review meeting was held within six months of the transfer of care (or earlier in the event of an unplanned change in the service or user's circumstances)*
  - *Compliance = 22%*

Risk assessment and risk management

- *A brief risk assessment has been completed within one working day of acceptance by the team*
  - *Compliance = 40% (4/10) (3/5 for Luton cases; 1/5 for Bedford cases)*

- *A full descriptive re-assessment of risk has been completed for all those requiring enhanced CPA care within 10 working days of the transfer of care*
  - *Compliance = 30% (3/10) (2/5 for Luton cases & 1/5 for Bedford cases)*

- *As a supplement to the care plan, a risk management plan has been agreed that highlights actions to be taken in managing risk*
  - *Compliance = 33% 3/9) (a risk management plan was not applicable in one case)"*

8.19 We here extract some of the relevant conclusions of the report.

> *" 5.2 In all areas of the care process, the quality of completed documentation was highly variable with evidence of both excellent practice and poor practice.*
>
> *5.3 … areas of concern included: lengthy periods of time between the transfer of care and the next formal CPA review in most case (> 6 months), where another review occurred…*
>
> *5.4 … this series of reviews raised several key issues: the lack of formal and timely re-assessment of needs in most cases; a lack of comprehensive assessment prior to a care transfer in some case…"*

Comment

As can be seen from the selection of the report we have quoted, a number of the conclusions of the report mirror those in TO's case and show that the failures to comply with the planned transfer arrangements in TO's case and the compliance with CPA and risk assessment (see section 9) was not an isolated incident. Regrettably in this case they had a bearing on the tragic outcome that occurred.

Findings

F13 Senior trust managers failed to ensure that the agreed process for transferring clients from the EIT to the Luton South East CMHT was properly followed. This led to clients being transferred without discussion with, or agreement by, the manager of the CMHT.

F14 The poor compliance with the agreed process for the transfer of clients from the EIT to other services as identified in the trust service user review suggests that there was inadequate senior management supervision of the process.

Recommendation

R1 We recommend that the commissioning PCTs and SEPT ensure that all service changes are monitored by senior managers to ensure that agreed processes are followed.

Luton South East CMHT

8.20 To help put in context the actions taken once TO had been transferred to the Luton South East CMHT, we quote here a description of the team as contained in the trust RCA report into TO's care.

> *"At the time of the incident, Luton South East Community Mental Health Team covered the wards of Dallow, Farley and High Town in Luton. It catered for a population of approximately 13,154 people in Dallow, 10,986 in Farley, and 7,062 in High Town bringing its total population to approximately 31,000 people. Dallow ward is a deprived area with high levels of unemployment and health problems and is a high needs area as indicated by its Jarman score of 46.2 (Jarman scores provide a measure of demand for primary care and serves as a proxy measure of deprivation). All three wards that the team covered had numerous residential homes where service users reside, a homeless hostel and a bail hostel.*
>
> *In terms of function, the team is a specialist secondary service provider offering:*
>
> - *assessment and advice on the management of mental health problems to other professionals within the primary care setting in the previously described catchment area*
> - *care and treatment to those individuals with time limited mental disorders who can benefit from specialist interventions*
> - *care and treatment for those individuals with severe mental illness requiring more complex care than can be managed at the primary care level*

- *a training environment for mental health professionals*
- *health promotion in conjunction with primary care.*

The team establishment was as follows according to its operational policy.

- *a team administrator*
- *a consultant psychiatrist (0.5 WTE) and junior doctors*
- *three community mental health nurses (2.3 WTE)*
- *senior practitioner (0.5 social worker)*
- *two primary care liaison mental health workers."*

8.21 As can be seen from the chronology section of this report, TO was being seen or contacted on an almost daily basis by his EIT care coordinator and during leave the care coordinator arranged for other staff to cover TO's care. The average care coordinator case load for the EIT was 14 to allow for this high level of support for service users.

8.22 CMHTs were not resourced on the same basis and each care coordinator carried a considerably larger case load than their counterparts in EITs. The average care coordinator case load for the CMHT was 35. Also CMHTs generally approach their work in a different way. Their role was much more related to long-term support and recovery. They placed greater reliance on the individual client keeping engaged with the team and would generally not visit or maintain contact more than weekly and often two weekly. Although, they could increase levels of contact for short periods, as explained in the comment following paragraph 7.52.

8.23 The CMHTs' approach was possible because it was part of a range of services providing different levels of support. If necessary it could call on EITs or AOTs to visit a client two or three times a day, and a crisis team that could provide immediate 'hospital at home' care or assessment with a view to admission to hospital. CMHTs were at the lowest end of the range in relation to intensity of support provided to service users.

8.24 We spoke to PR, then associate director for adult mental health services, about the ability of CMHTs to take on clients from the EITs.

> *"The CMHTs had anxieties – understandable anxieties – about capacity. I did not think that was so much an issue. What was an issue, that I understood, was how they could replicate the early interventions – well, they couldn't – with caseloads of 30, 35. EITs' caseloads are 14 and of course you develop specialist skills or the specialist focus, so I could understand the anxieties.*

Comment

As part of the planning for the transfer of clients to the CMHTs managers should have considered what additional resources were required and if necessary amended the philosophy and ways of working of the generalist CMHTs.

Finding

F15 The CMHT could not offer TO the level of care that he had been receiving from the EIT and which he required to avoid deterioration of his mental health.

8.25 It is easy, but can be unfair, to use hindsight to point out how things could have been done better. We therefore asked DJ, current director of mental health for the trust who was appointed on 1 April 2010 but was seconded to the trust on 1 April 2009 as interim director of community services, to explain to us how cases are now managed by the trust's CMHTs. He told us:

> *"I am confident in my 12 months here that CPA implementation is quite robust and awareness of CPA is quite robust."*

8.26 He then told us how the trust audits compliance with CPA policy and procedure which appears to be robust. He also told us:

"...Risk assessments are much more robust. There is a systematic approach to risk assessment. Probably over the last 12 months there has probably been a reduction in untoward events,"

Q. *Risk assessment in your terms has considerably improved?*

A. *I believe so...*

Q. *... If TO was around now and stopped taking his depot injections and didn't want to talk about stuff, as he did when you did the SUI report, how would it now, in your opinion, be different? How assured can you be as the manager; that is the important point?*

A. *…what is really important is caseload management and understanding the complexity of the caseloads: having team managers understanding the dynamic nature of their caseloads and understanding the referrals in, understanding the people that can be taken on for short-term treatments and up to three months and those individuals who will move on to a longer term, who will require recovery services.*

Q. *It sounds to me that what you are saying is there is a much more important role for the manager, the leader of the team, than perhaps there was in the past, or it was there, but perhaps wasn't as actively operating in this case.*

A. *I don't think it was operating. The team leader, the CMHT team manager,* [is an] *absolutely pivotal role and it is about understanding and getting that mindset in and saying 'you are managing a caseload of quite vulnerable individuals, some are highly complex and we need to understand the movement between the unpredictability, if somebody hasn't been seen'*

The clinical and managerial supervision is pivotal as an underpinning programme for successful management."

Comment

We have not quoted all that DJ said about the changes already made to the way clinical teams are managed and to compliance with CPA and risk assessment, but It is clear from his interview with us that there has been considerable beneficial change since 2007 across all the CMHTs. This is much to be welcomed. However the changes that have been brought in are not cutting edge but rather bringing the service up to the standards that has been commonplace in other trusts for a considerable time. This suggests that in 2007, in respect of the work of CMHTs, the trust was lagging well behind established good practice at the time.

Pressure on CMHT team management

8.27 One of the issues that came across vividly in our interviews was the senior managers' focus on preparing a bid to become a foundation trust. Application to become a foundation trust requires a considerable level of management time and risks trust's losing their focus on clinical safety if not undertaken with care.

8.28 In our interview with SS, the CMHT team manager, we explored this issue:

> ***Q.*** *How was it impacting upon your role as a manager?*
>
> ***A.*** *It was hectic. That's all I could say - absolutely hectic. You thought you had completed one task and six others had come down. And it was all about performance targets and policies and...*

8.29 In our interview with PR who was the associate director for Luton Working Age Mental Health Services at the relevant time, we asked about preparing for foundation status.

> ***A.*** *Of course, the message that* [we] *have always had is 'keep it clinically safe'. And clinical issues are our priority. However, when you are faced with email after email after email on a daily basis, of course it does put you under tremendous pressure and I feel yes, all the team managers were under*

tremendous pressure at that time. Every manager was, operational manager, to be regarding targets, feeding the beast really."

8.30 We also interviewed PB who was acting locality director for Luton at the relevant time about foundation status.

> ***Q.*** *"Can you just help us, because there are other sorts of suggestions around the focus of the executive board at that time. Was it overly obsessed with that as an activity?*
>
> ***A.*** *I think it was obsessed about foundation status. I do."*

Comment

The minutes of the July 2006 board meeting record that one of the trust's non executive directors asked whether the provision of* "…good quality and safe services…" *was being compromised by the trusts application for foundation status. She was assured by an executive board member that the extra work was* "…built into the plans…" *Our interviews indicate that from the perspective of those we interviewed those plans were inadequate. The corporate challenges of applying for foundation status and meeting the budgetary reduction demands from the PCT created considerable extra demands on senior managers.

Finding

F16 We find that one of the managerial priorities at the time was preparing the trust for foundation status, which combined with meeting savings targets, created considerable extra demands on senior managers. As a result this extra pressure may have had an impact on ensuring the transfer of service users from the early intervention service was safely and effectively implemented.

Internal investigation report on the Luton South East CMHT

8.31 Following the internal investigation, the trust commissioned a report into the workings of the CMHT, which was published in January 2008. The report gave an initial general impression of the team as follows.

> *"The team may benefit from a clearer understanding of the criteria used with which to define a multidisciplinary team as the interviews imply varying criteria for defining the team, for example, psychiatric outpatients are mostly considered to be part of the team however also seen as a discharge pathway (therefore separate to the team). Perhaps the most disparate part of the system is the psychology staff that are consistently <u>not</u> described as being part of this team however there are individual psychologists who work well with members of this team.*
>
> *Whilst it is impossible to foretell future events, or even to estimate in any measurable way the likelihood of untoward incidents occurring, the staff and the systems of Luton South East community mental health team do not appear to present any significant identifiable risk to the welfare of clients or staff.*
>
> *The processes for making clinical decisions within the team are not unlike those in many other teams, similarly the use of case notes and written communications are comparable with other teams; however both of these themes should be looked at as a possibility for improvement rather than being accepted purely because other teams work in similar ways.*
>
> *Better use of management information would also bring benefits to the team and therefore it clients, this does not necessarily require additional information rather improvements in the use of existing information.*
>
> *It is clear following discussions with the locality director and service director that these themes are applicable to most, if not all, of the teams within the system of care…"*

Comment

In our investigation we have focused on the care delivered to one individual and we must be careful not to generalise from the particular. Nevertheless our interviews and the interviews conducted by the trust internal investigation would lead us to suspect that the standard of practice of this team was well below what should have been expected of a CMHT in 2007. We therefore find some of the conclusions of this report difficult to understand. In particular that:

> **"…the staff and the systems of Luton South East community mental health team do not appear to present any significant identifiable risk to the welfare of clients or staff."**

We set out in the next section evidence of sub standard practice by the CMHT in respect of CPA, which at the time clearly led to a risk to the welfare of TO and may have applied also to others.

9. Compliance with CPA policy

9.1 An examination of the trust's CPA policy in force at that time shows that it was not followed by the CMHT in TO's case. We set out below the main requirements and failures to comply. Earlier in paragraph 8.18 we deal with the fact that failures to comply with CPA were also evident across the trust with other clients.

9.2 The CPA policy in force at the time was a 49-page document covering all eventualities for service users of all ages and their families and carers. We have focused on those parts of the policy that show how TO's care should have been managed by the CMHT.

Risk assessment and management

9.3 The policy provides that:

- a brief risk assessment must be completed when a client is taken onto a care coordinator's caseload. It should be completed within one day of initial assessment and reviewed at the time of formal CPA review meetings or at times of significant change in the service user's condition
- if the brief risk assessment identifies a risk of two or more on a scale of four, and the client is on enhanced CPA, a full risk assessment, consisting of a risk checklist, a risk chronology and a risk descriptor must be completed within 10 working days
- risk assessment must be completed on the basis of information collected through clinical interview, self-report questionnaires, the inspection of case notes and other documentation, and other relevant assessment methods. Information should be derived from interviews with the service user, informal carer or other informants, the case notes and other team members where appropriate. Where information is hard to obtain from extensive case notes, the most recent two summaries in the case notes must be considered
- the consultant psychiatrist must be involved in discussion and decision making about the level of risk, and the management of that risk.

9.4 Between 4 September 2006 and 11 June 2007, two brief risk assessments were recorded by JS. The first was on 7 September, three days after JS' first meeting with TO at his bedside in hospital, and a week before their second meeting (see paragraphs 7.1 to 7.3 for details). Risk was assessed at level 2 for 'risk of severe self-neglect' and 'risk of committing an offence', but there is no evidence on file that a full risk assessment was then, or indeed ever, carried out. The form does not show the sources from which JS obtained the information from which he assessed the risk. There is no risk management plan.

9.5 The second brief risk assessment was carried out on 30 January 2007. It is very limited, consisting only of an updated scoring of the types of risk listed on the form. The scores are the same as on 7 September, except that the score for 'risk of abusing others' has gone up from 1 (low risk) to 2 (medium, significant, risk). There is no mention on the form that TO is refusing medication, no mention of his hospitalisation in December 2006, no risk management plan and no subsequent full risk assessment.

Comment

Except to the extent that the brief risk assessment form was partially completed on both occasions, there is little evidence that either the letter or spirit of the policy on risk assessment and management was complied with by JS and the CMHT.

The first brief risk assessment was carried out in isolation, three days after a handover meeting at which there is no evidence that a risk assessment of TO took place. It may be that JS relied on information provided during his unrecorded earlier meeting with MK, but if this is the case it seems odd that he should have assessed the risk so differently (see paragraph 6.34 for the assessed risks recorded by MK on 26 July 2006).

The second brief risk assessment was carried out promptly, on the day JS saw TO on his return from Nigeria, during which meeting TO refused his injection, said that he would not take any psychiatric medication in future, and was evasive about setting a date for their next meeting.

Because JS had raised the risk of abusing others from level 1 to 2, it shows that he considered the risks anew, but it is less clear that he took into account TO's history of attempted suicide (see chronology Appendix A entries 25 May 2004 and 18 March 2005) (which he continued to rate at 0) or his risk to others when unwell (which he continued to rate at 1).

Both of these brief risk assessments should have led to full risk assessments, with risk management planning, within 10 working days. Neither did, within that period or ever.

There is no evidence that Dr M was ever involved in these risk assessments, as he should have been.

Brief risk assessments should be reviewed at CPA reviews and at times of significant change in the service user's condition. JS told us that outpatient appointments were used as CPA reviews. TO had an outpatient appointment with Dr M in November 2006, which JS attended, but there is no evidence of a review of the brief risk assessment.

Finding

F17 In December 2006 the CMHT care coordinator was aware that TO had stopped attending ACE Enterprises, and was hospitalised for at least nine days with problems caused by non-compliance with his insulin regime. However, neither of these events triggered a risk assessment review, as they should have done.

Disengagement

9.6 The CPA policy includes a section on what to do if contact with a service user is lost, or if the service user refuses care. The care coordinator must:

- inform the GP, any carer, the emergency duty team, community team members, A&E liaison CPN and external agencies
- update the full risk profile based on the latest known information

- inform the next of kin if the completed risk profile identifies significant risk.

Comment

None of these steps were taken in TO's case, because JS and the others in the CMHT considered that TO was not refusing care because he had occasional contact with JS.

9.7 This section of the policy also provides that if a service user on enhanced CPA is deemed to be at risk of losing contact with the service, a referral must be made to the assertive outreach service.

Comment

It is clear that, despite TO failing to keep most appointments and failing to respond to phone calls and messages, JS and the CMHT did not think that it was appropriate to refer him to the AOT.

9.8 In February 2008 the trust produced a non-concordance and disengagement policy, which outlined the steps to be taken if a client is non-concordant with a prescribed treatment regime and/or disengages from contact. The document is careful to establish that the policy applies if a client disengages either partially or fully with services, but the actual procedure to be followed in the case of someone in TO's position still relies on the care coordinator deciding if a break in contact amounts to a loss of contact justifying further action.

9.9 Unlike the CPA policy, this policy does not make any provision for referring existing clients to AOT if it is thought that there is a risk of them losing contact with services. Also, although the policy sets out what should happen if an inpatient rejects his or her treatment plan or leaves hospital against medical advice, it is silent on the action to be taken if a community patient refuses treatment, other than to say that community patients are entitled to do so except in circumstances governed by the Mental Health Act.

Comment

No doubt the new policy was intended to clarify and strengthen the existing CPA policy. In terms of processes of communication and record keeping it is certainly stronger, but in its description of action to be taken in certain circumstances it is weaker than the existing CPA policy for a community patient who limits his contact with services in the way TO did, and is silent on how to respond effectively to a community patient who refuses to accept his prescribed medication regime. Perhaps all the CMHTs understand that in such circumstances clients should be referred to AOT or one of the other specialist teams, but it is a pity that this has not been spelt out.

Recommendation

R2 We recommend that SEPT review its non-concordance and disengagement policy within six months. The change should ensure that the policy is clear what action should be taken in circumstances where a community service user is partially engaged as happened in the case of TO.

Care planning

9.10 The CPA policy states that the care plan for someone on enhanced CPA, as TO was, must be based on a comprehensive multidisciplinary needs assessment and must include details of the following:

- the service user's CPA and legal status
- summary of main problem or needs
- goals/objectives (specific, measurable, achievable, realistic, time limited)
- an estimated timescale or frequency by which goals will be achieved
- specific interventions and anticipated outcomes
- interventions that address specific **cultural** needs
- interventions that address **employment** needs

- actions necessary to achieve the agreed goals
- people involved in providing care
- details of everyone responsible for contributing to the planned care
- summary of agreed interventions
- set date for reviewing the care plan
- prescribed medications
- diagnosis
- the service user's signature
- the care coordinator's signature.

9.11 The trust care planning policy requires that a CPA review for clients on enhanced care must take place every three to six months. The only care planning document in the notes relating to TO's nine months in the care of the CMHT is one dated 15 September 2006, which was the day on which TO and JS met for the second time. The details are set out in paragraph 7.7.

9.12 Nothing in the notes suggests that there was any kind of multidisciplinary needs assessment. The following mandatory elements of the care plan as set out above were absent:

- an estimated timescale or frequency by which goals will be achieved
- specific interventions and anticipated outcomes
- interventions that address specific cultural needs
- interventions that address employment needs
- actions necessary to achieve the agreed goals
- details of everyone responsible for contributing to the planned care
- set date for reviewing the care plan
- prescribed medications
- the service user's signature

9.13 TO's involvement with ACE Enterprises and his local church, and their significance to his recovery, were not mentioned, although both had been detailed in the last EIT care plan of 8 August 2006. The records provided to us contain no evidence

of any subsequent formal care planning.

Comment

As with the risk assessments, the evidence provided to us suggests that care planning in TO's case by the CMHT was minimal, and did not comply with the trust's policy.

Findings

F18 The CMHT care coordinator's compliance with the trust's CPA policy including risk assessment, action to be taken on risk of loss of contact, and general care planning was seriously deficient.

F19 The failure to comply with the CPA policy should have been identified by the care coordinator's manager and other members of the Luton South East CMHT.

F20 The inadequacies in care planning and risk assessment and management were not simply technical breaches of detailed trust policy, but evidence of individual and team poor practice within Luton South East CMHT. SS team manager and Dr M team consultant confirm that JS kept them and the rest of the CMHT updated on TO's non-compliance with medication and his elusiveness therefore the poor practice involves the whole team.

10. Background to the closure of the early intervention service

Background

10.1 In January 2005 TO was referred to the trust's early intervention service. This service was a new service started in 2003. As can be seen from the chronology section of this report, between January 2005 and September 2006 TO had a number of hospital admissions for his mental health needs and some admissions for his physical health problems. During this time he was under the care of the Luton Early Intervention Team.

10.2 The trust at this time had two early intervention teams one based in Luton and commissioned by Luton teaching PCT and the other based in Bedford commissioned by Bedfordshire PCT and Bedford Heartlands PCT[4]. The Luton EIT had 47 clients.

10.3 The Department of Health issued guidance in 2000 for the national expansion of EITs to 50 by December 2004. It also set a target that by 2006 all young people who had experienced a first episode of psychosis in the past three years received the early intensive support they needed. The references below include Department of Health guidance on the development of early intervention services[5].

10.4 We reviewed a paper entitled *Proposal for the re-development of early intervention services in Bedfordshire and Luton* by JR, consultant clinical psychologist. We include extracts of this paper in appendix C. It sets out very helpfully the history of

[4] Primary care trusts have the responsibility of deciding what health services should be provided in their area and commissioning the services. In simplistic terms they decide what services should be in place and contract with the trusts to provide the services.

[5] 1 Department of Health. *A national service framework for mental health modern standards and service models*. Department of Health. London.1999.
2 Department of Health. *The mental health policy implementation guide*. Department of Health. London. 2001.
3 Department of Health. *Letter from Duncan Selbie, director of programmes and performance*, Department of Health. *Recovery plan for early intervention services*. 2006.
4 Department of Health. *LDPR guidance for early intervention services 2006/7*. Department of Health. London.

the rationale for the development of these services and in particular the evidence for their value and effectiveness.

10.5 JR, consultant clinical psychologist, states:

> *"Early treatment is crucial because the first few years of psychosis carry the highest risk of serious physical, social and legal consequences. One in ten people with psychosis commits suicide - two thirds of these deaths occurs within the first five years of illness.*
>
> *Intervening early in the course of the disease can prevent initial problems and improve long-term outcomes. If treatment is given early in the course of the illness and services are in place to ensure long-term concordance (co-operation with treatment), the prospect for recovery is improved."*

10.6 She also states:

> *"There is no evidence that a standard or enhanced CMHT model is capable of matching the outcomes achieved by the specialised EI service model recommended by the DH."*

Comment

The teams in Luton and Bedford had been formed in 2004 and consequently the BLPT trust was complying with the Department of Health policy implementation guidance on early intervention services during 2005/6.

Budget cuts

10.7 From our review of papers and interviews, Luton PCT during 2005/06 was facing serious financial pressures. In the PCT's turnaround plan dated 8 June 2006, it states towards the bottom of page 4 that:

"An initial savings plan of £9.3m (4.5%) has been agreed by the tPCT board and is being implemented … A further £7m of savings is required…"

10.8 And then at the top of page five:

"The tPCT's overall target level of savings is, at 7.8%, significant."

10.9 As a result of this scale of savings BLPT along with other parts of the local health service was required to make service reductions to contribute to the required PCT savings. The amount the trust was required to save was £2,087k for the year 2006/7 but this was reduced to £1,022k as the savings would not be made until part of the year through. This was in addition to its requirement from the Department of Health to make efficiency savings of 2.5 per cent.[6]

10.10 As a result of these required savings BLPT proposed a number of service reduction options to Luton PCT. Following a number of discussions held between the trust and Luton PCT a final list of options was agreed. These options were ranked according to the most preferred options (1 = most preferred option). The temporary closure of the early intervention team was ranked as 1, i.e. the most preferred option.

- reduce Luton community outreach by 1 WTE 2
- reduce psychology in Luton team 3
- reduce 6 beds at Limetree 2
- temporary closure of the Luton early intervention team 1
- Closure of Calverton Rd 4

Comment

The savings options listed above includes the* "temporary closure of the early intervention team"** ***and ranks it as the most preferred option. Our review of trust papers and emails provides no evidence of how long temporary was. A paper prepared for Bedfordshire and Luton Joint Scrutiny Committee (30 June 2005)

[6] From Bedfordshire & Luton Partnership Trust, Budgets 2006/07 – Financial Plan

"Disinvestment in the Early Intervention Service" ***states that the*** **"…proposed disinvestment is a temporary arrangement,"** ***but does not indicate how long temporary was to be. Also as part of the budget reduction consultation process the Patient and Public Forum responded to the possible changes by stating in their formal response:***

> **"No guarantee could be given of when re-commissioning might take place. Temporary has been used to mean the cutting of a service, which could possibly be reinstated at an unknown future date, possibly beyond 2006/7."**

We have therefore referred in this report to the closure of the EIT service as at the time of closure there appeared to be no definite plan for when it would be reinstated.

10.11 A BLPT paper, *Financial stability proposal*, dated May 2006 sets out the main effects of closing the early intervention service.[7] We quote below the papers view of the main clinical risks associated with the closure.

10.12 In the service delivery section it states:

> *"Existing clients on case load would be transferred to CMHTs. Not compliant with NSF PIG guidance[8]. Would not deliver on key targets for expectations of a service in Bedfordshire. Would put additional pressure on CMHT."*

10.13 In the clinical governance and risk section it states:

> *"Opposition by consultants due to increase pressure put on CMHT. Clinical outcomes for individual patients compromised by reverting to a non EIS intervention."*

[7] This related to the possible closure of both the Bedford and Luton EITs
[8] Department of Health, National Service Framework Policy Implementation Guidance

10.14 In the workload shifts section it states:

> *"Existing and future work of the EIT would need to shift to the CMHTs. There may be an increase in acute admissions as people with first episode psychosis would be worked with less intensively."*

Comment

This paper was written in May 2006 before the decision to close the service was finally made and properly sets out the possible impact that the service closure could have on patient care and the risks of deterioration.

Discussions about closure of the Luton EIT, July 2005

10.15 We have been supplied with copies of a letter (July 2005) between the chair of the trust medical staff committee and the PCT and the reply (also July 2005). These letters indicate that during 2005 and in the financial year 2005/6 Luton PCT was considering decommissioning (removing the funding) the Luton EIT.

10.16 We have also seen evidence that a possible merger of the Luton and Bedfordshire EITs were being considered prior to June 2006. Staff in the Luton EIT had been given statutory notice that they were at risk as a result of the possible merger.

Comment

The fact that the Luton EIT team was being considered for either merger or closure as far back as July 2005 makes it difficult to see why the process for closure of the team and the transfer of clients to other teams was undertaken in such a short timeframe between June and September 2006.

Concerns raised by the SHA and the Department of Health

10.17 As part of the papers supplied to us we have reviewed an email trail which identifies that during August 2006 the SHA (NHS East of England) raised concerns about the closure of the early intervention service. The following quote from an email on 24 August 2006 from the director of finance and performance management at BLPT to a large number of senior colleagues puts this into context:

> *"I've just seen a letter from LM* (director of provider development) *at the SHA (copied to M) in which she states that the closure of the EI service is unacceptable and she wants the PCT and BLPT to address this as soon as possible."*

10.18 Further in the email it says:

> *"We have already put plans in place to re-locate the existing staff and pass caseloads on to other CMHT staff, so that the service can cease in mid-September."*
>
> *"The question is then, what do you want us to stop doing to make up these shortfalls."*

10.19 There is also email evidence that the PCT and trust were aware that the secretary of state for health was about to make a statement about the closure of a neighbouring EIT. We are not aware of the nature of the statement but as early intervention services were Department of Health policy it is unlikely that the statement would be in favour of closure.

Comment

Our review of the papers show that the PCT and the trust were (as they were required to do) seeking to manage their services within the budget constraints that were placed on them. Nevertheless it is difficult to see why they chose to close a service which was part of the National Service Framework, was flagged up

as having possibly serious negative effects on clients, possibly increasing the risk of deterioration and which the Department of Health and the SHA opposed.

Reinstatement of the service

10.20 Having taken the decision to temporarily close the service a director of commissioning at Luton PCT states in an email dated 29 August 2006:

> *"In light of the recent discussions that have taken place between our respective chief executive officers and the intervention of the East of England Strategic Health Authority, Luton tPCT recognizes that it will need to put in place measures to reinstate the early intervention service for 2006/7."*
>
> *"As I understand the current service has already been wound down with individual cases transferring to other community teams…"*

Comment

The Luton EIT was at this stage in the process of being closed down, clients were being transferred and staff either being redeployed or considered for redundancy.

This letter indicates that the service should be reinstated in the same financial year that it was being closed. We therefore assume that the required savings were to be found from elsewhere. Undoubtedly the pressure applied by the SHA and possibly the Department of Health led to the change but It is difficult to understand why the PCT had not consulted more widely before making the decision to close the service.

As a consequence of the closure of the service, TO who had been receiving quite intensive support from his care coordinator in the Luton EIT was transferred to the Luton South East CMHT and the intensity of his support and the nature of that support changed dramatically.

Finding

F21 The PCT failed to properly consult on the closure of the early intervention service which led to it being closed then reinstated. The decision to close the service despite it being a key part of the National Service Framework was wrong.

11. BLPT's serious untoward reviews

11.1 In this section we review the trust's reviews and investigations into TO's case.

11.2 The trust carried out three reviews:

- 72-hour internal management report: undertaken by the associate director, Luton Working Age Mental Health Services, 14 June 2006

- a desktop review of clinical records: undertaken by a panel of four chaired by the BLPT medical director, 14 November 2007

- RCA report: undertaken by a panel of senior management and clinical directors, February 2009.

72-hour internal management report

11.3 This report was prepared by PR, associate director responsible for Luton South East CMHT. The author states that the purpose of the report as:

> *"This report is an initial 72-hour internal management report and is a fact finding exercise about clinical and risk issues observed during the care and treatment of TO."*

11.4 The report is 21 pages in length. It is based on a documentary review of the medical and nursing notes (six files). It contains two chronological summaries covering April 2004 to September 2006 and September 2006 to June 2007.

11.5 The report is comprehensive and provides a valuable early overview of TO's care. In the conclusion section the author sets out suggestions for next steps and three issues that require further exploration, they are:

- the potential impact of the closure of the EIT on the care and treatment of TO

- clinical reasons why TO was not referred again to the AOT for more intensive support

- the capacity of the CMHTs to monitor effectively service users such as TO who are difficult to engage and for whom non-compliance with medication is a recurrent issue.

Comment

We agree with the author that these are key questions and have dealt with them in our report.

Finding

F22 The 72-hour report was thorough.

A desktop review of clinical records

11.6 This review was undertaken during August 2007 by a panel of clinicians and managers. The panel did not undertake interviews *"In order not to compromise any subsequent enquiry or investigation…"* The report is 14-pages long.

11.7 The objectives of the report were:

- *"identify any deficiencies relating to the process of risk assessment and management*

- *determine whether there are any deficiencies in practice on the part of one or more practitioners*

- *determine whether there are any major issues that require immediate action."*

11.8 The review primarily focused on TO's care from September 2006 to June 2007 and consequently the care provided by the EIT was not reviewed.

11.9 The report deals with the following:

- compliance with the CMHT operational policy
- compliance with the CPA policy in particular the processes for mental health assessment, risk assessment, risk management planning and care review.

11.10 The report reflects a thorough review covering the areas listed above. We quote below two of the three paragraphs of the report's summary; findings and overall impression.

> *"It is the considered opinion of the panel that the documentation available within the clinical records for TO shows deviation from the process pathway, a lack of any demonstrable evidence confirming any comprehensive re-assessment of the service-user's needs and risks or multidisciplinary/multi-agency care reviews between Sept 2006 and June 2007, and little clear evidence of the sharing of information between teams and agencies.*
>
> *Although this report highlights a number of concerns about the care process that was followed and the lack or poor quality of completed documentation, especially with regard to mental health, needs and risk assessment, risk management planning, care-planning and care reviews,* ***there is no evidence within the clinical records to indicate that the treatment and care decisions of the care coordinator were wrong*** *(our emphasis). Furthermore, there is no indication that such poor adherence to trust policies and guidelines contributed directly to the unfortunate incident. It is also noteworthy that the care coordinator made several active efforts to maintain contact and non-compliance over the last six months and did indicate a need for multidisciplinary review."*

Comment

We have put in bold a section of the quote above as it is obviously part of a key finding. We understand that this report was a desktop review and that no interviews were undertaken. In the light of our review of the clinical records we are of the view that they clearly indicate a serious failure to address TO's limited engagement and his refusal to take his depot medication. Consequently we take the view that this judgement is not supported by the records and is premature. Consideration of whether the actions by the staff had a direct bearing on the incident should have been left to be resolved following the fuller trust RCA panel investigation which was to follow.

11.11 The report has two conclusions.

> *"a. **Deficiencies relating to the care process within the Luton South East CMHT***
> *The lack of specific detail within the risk assessment, lack of a risk management plan, lack of collaboration in forming the care plan, lack of sharing of information between different teams and the lack of multidisciplinary review of TO's treatment and care are considered deficiencies and raise questions about the standards and effectiveness of practice on the part of those practitioners involved with TO within the Luton South East CMHT.*
>
> *b. **Evidence to suggest poor practice within the Luton South East CMHT***
> *Whilst there is no clear evidence to suggest that wrong decisions were made about TO's treatment and care, and active efforts were made to maintain contact with TO during the period from January 2007, a comprehensive re-assessment of TO's needs and risks, with a multidisciplinary review and consideration of other treatment options, should have been documented. This constitutes evidence of consistently poor practice in the care and treatment of TO on the part of those practitioners involved with his care programme within the Luton South East CMHT."*

Comment

We generally agree with conclusions a and b, but we do not accept that there is no clear evidence that wrong decisions were made about TO's treatment and care.

11.12 Arising from their findings the panel made five recommendations relating to improving the managerial and clinical practice of the South East Luton CMHT. They also made two recommendations related to the wider trust community teams. The trust RCA panel investigation considered these recommendations and incorporated them into their conclusions and recommendations. We deal with that report below.

Final RCA report

11.13 This is a report of the trust's full internal investigation dated February 2009. Interviews were conducted in November 2008. It is described as a RCA report which means that the panel used a root cause analysis methodology to indentify the issues that they needed to investigate and to arrive at some of its conclusions and findings.

11.14 The investigation was conducted by a panel of five senior trust directors with management, clinical and social care portfolios. The panel also sought specialist advice and expert counsel from external parties.

11.15 The terms of reference for the investigation were as follows.

- *To compile comprehensive documentary and qualitative evidence (including a clear chronology of events) relevant to the incident of 11 June 2007 which led to the death of a police officer in Luton Town Centre.*

- *To investigate the mental health care and treatment offered and provided to TO throughout his entire care episode from the 22 April 2004 to 11 June 2007 with particular focus on the period between the 5 July 2006 and 11 June 2007.*

- *To pay particular attention to the appropriateness of his care in relation to:*

- *his assessed health and social care needs*
- *his assessed risk of posing harm to others*
- *the extent to which his care corresponded to statutory obligations (e.g. CPA and the mental health act), relevant guidance and local policies and procedures*
- *the proper exercise of professional judgment*
- *any interagency/primary care issues*
- *the nature, extent and relevance of any previous criminal involvement.*

- *To incorporate the analysis and findings of a desktop review conducted on 14 November 2007 as well as any other emergent themes with a particular focus on record keeping and risk assessment.*

- *From the analysis above to identify any service or care delivery problems and examine these using appropriate root cause analysis techniques in order to draw out important learning.*

- *To recommend any actions that need to be taken with respect to policies, procedures, professional practice or the physical care environment as required and to consider the implementation of any learning since the incident derived from the desktop review."*

Finding

F23 The trust's final RCA investigation including its panel membership and terms of reference were robust and appropriate.

11.16 In addition to reviewing all relevant documentation including the 72-hour report and the desk top review report, the panel interviewed:

- Luton South East CMHT manager
- former care coordinator, EIT
- former care coordinator, EIT

- care coordinator, Luton South East CMHT
- former specialist registrar, EIT
- former consultant psychologist, EIT
- consultant psychiatrist, Luton South East CMHT
- service director
- in addition comments were received from the former EIT manager.

11.17 All interviews were recorded and transcribed.

Comment

We have reviewed the transcripts of these interviews and they indicate that the interviews were conducted fairly, openly and robustly. The availability of the transcripts has made the task of this external independent investigation much easier.

11.18 The main sections of the report cover:

- chronologies for TO's care from his first contact with the trust up to his arrest
- events of 11 June 2007 and consequences
- findings and recommendations
- conclusion
- recommendations
- arrangements for shared learning.

11.19 It is not part of our task to summarise the report but to comment on whether the investigation was robust and whether the conclusions, findings and recommendations can be supported by the evidence.

11.20 The report including chronologies dealing with the evidence consists of 15 pages and covers:

- application of CPA

- risk assessment
- supervision
- CMHT policy application
- documentation
- decommissioning of the early intervention service.

Finding

F24 The panel undertook a thorough RCA investigation and analysis in line with its terms of reference.

The report's conclusions

11.21 In section six of the report the panel sets out its view of the root causes of the incident:

> *"1. Inadequate dissemination and uptake of policy throughout trust structures*
> *2. Lack of structure in risk assessment*
> *3. High morbidity of the Luton South East Community Mental Health Team caseload*
> *4. Apparent lack of process of MDT working*
> *5. Inadequate communication of risk history between teams*
> *6. Mandatory CPA training was of an inadequate standard*
> *7. Failure to adhere strictly to the disengagement process within the CPA policy by CMHT*
> *8. Multiple service user files*
> *9. Decommissioning of EI service"*

Comment

Whist we agree with the conclusions set out above we are of the view that they appear to identify the problem as one of system failure. We agree that system

failure was part and parcel of the cumulative factors in this case but at times systems fail because individuals have not carried out their duties adequately and we take the view that item seven on the list above conceals the key responsibility of the clinical team individually and collectively to ensure that TO's disengagement was dealt with particularly as TO was not taking his medication.

11.22 The report makes the following nine recommendations:

> ***"(Trust) Recommendation 1***
>
> *An audit be undertaken to assure the trust that key staff are aware of the CPA and disengagement policies.*
>
> ***(Trust) Recommendation 2***
>
> *Review team caseloads annually and ensure team managers review care coordinator workloads on a monthly basis.*
>
> ***(Trust) Recommendation 3***
>
> *Undertake a review of mandatory training for CPA, practice risk assessment and practice risk management for attendance, capacity and quality.*
>
> ***(Trust) Recommendation 4***
>
> *Ensure all those with management responsibilities are engaged in appropriate leadership activities which sit within a framework for leadership across the organisation and which are clearly recorded in appraisal and development paperwork.*

(Trust) Recommendation 5

Undertake a review and ensure clinical risk assessments and risk management systems are in line with best practice guidance published by the Department of Health in 2007 and other relevant national best practice.

(Trust) Recommendation 6

Review support and supervision arrangements for team managers and ensure existing policy reflects national best practice.

(Trust) Recommendation 7

A standardized pro forma should be introduced for conducting and recording CMHT meetings, which addresses the consideration of issues such as risk, complex cases and handover between teams and care coordinators.

(Trust) Recommendation 8

Develop and implement a plan for the creation of unitary service user clinical records in line with national best practice.

(Trust) Recommendation 9

All service changes likely to impact on the quality of patient care should be risk assessed as part of the broader business case for change, and detailed risk assessment carried out where the risk is significant. Risk assessments must be shared with commissioners where relevant."

Comment

We agree that these recommendations are appropriate to the systemic and individual failures identified by the panel.

Recommendation

R3 We recommend that PCTs and SEPT should consider carefully BLPT recommendation 9 and that PCTs and SEPT must not agree to implement service changes unless they have been provided with adequate evidence that the actions set out in the recommendation have been followed and the risks of change have been effectively assessed.

Comment

BLPT recommendation 9 deals with how proposed service changes should be risk assessed. As a consequence of UK's forthcoming budgetary challenges and the possible impact this might have on the NHS this recommendation is timely.

Trust action plan

11.23 In response to the recommendation of the RCA report, the trust produced an action plan for taking forward each of the nine recommendations. We have reviewed the updated action plan dated 4 November 2009. We have also interviewed the recently appointed director responsible for these services to check with him the current position with these actions and the service position generally.

Finding

F25 The trust has satisfactorily taken and completed all the necessary actions in response to the recommendations of the RCA investigation report.

Recommendation

R4 We recommend that the PCT should report to the SHA within six months on the progress that SEPT has made on implementing our recommendations and the continuing progress it has made with the recommendations contained within the final BLPT RCA report as set out below.

Appendix A

Detailed chronology from April 2004 to December 2005

22 April 2004

TO was referred to Dr R by his GP at that time, Dr E. Staff at the bail hostel were concerned about his behaviour and statements about a connection with the spirit world which seemed to occupy his thoughts. TO was known to use cannabis occasionally at that time.

25 May 2004

TO was seen by Dr S (senior house officer) and Dr M (consultant psychiatrist). Four months previously he was arrested for exposing his genitalia to women. He was now staying at a bail hostel in Luton. During this initial assessment TO reported having taken an overdose of 24 paracetomol in November 2003. TO reported that he was due to be moved to Milton Keynes and was constantly worried about this. He had not worked for 18 months. He expressed a desire to return to Nigeria. He expressed no suicidal ideation and no evidence of hallucinations or delusions was observed.

1 June 2004

TO did not attend this outpatient appointment.

9 June 2004

TO's probation officer stated that he had been moved from Luton to Milton Keynes after he was discovered watching parents taking and collecting their children from school. His explanation was that 'women walk in code and he was waiting to see a woman who could explain this code and that she would reveal herself to him'. He was seen by a community psychiatric nurse (CPN) in Milton Keynes who believed he was showing symptoms of schizophrenia. The CPN discussed the issue of medication with TO who was reluctant to take it as he feared his 'head would crash like a computer'.

(Throughout the records there are references during TO's care and treatment to other delusional thinking such as TO stating he has powers over others; that women are gods; that he can influence the fight between God and Satan; and references to an image

that is female and that controls him. Throughout the records there are reports that these symptoms are exacerbated when TO smoked cannabis, and that they decreased significantly when he was compliant with prescribed antipsychotic medication; non-compliance being another theme throughout his care and treatment with BLPT).

22 June 2004

He was seen in outpatients on 22 June 2004 at which point he announced he was working in Milton Keynes in a warehouse. No evidence of psychotic or depressive symptoms was observed. A further appointment was made for three months time.

20 August 2004

Dr M's team wrote to the Milton Keynes mental health services requesting that they offer TO an outpatient appointment now that he had moved to Milton Keynes. This letter was acknowledged on 2 September 2004. On 6 September 2004 Milton Keynes services wrote again handing the case back as TO had moved back to Luton.

17 January 2005

TO was referred by his probation officer to the EIT due to concerns over TO's 'fantastic accounts of his dreams and abilities', low mood, and statements that he would like to hang himself, and having extreme feelings of anger. He had recently been the victim of an unprovoked assault. He was also socially isolated at the hostel.

22 February 2005

TO was assessed by the EIT. Dr A (associate specialist) noted TO's strong feelings about his mother's death, and his confused thought disorder. He was prescribed olanzapine but later expressed a fear of taking medication, which he later refused to take.

7 March 2005

TO was seen by Dr A. Expressed feelings that somebody was taking thoughts from his mind as well as statements about special powers, opposing God, and himself and the television having the same thoughts.

9 March 2005

TO was seen by Dr A and EIT. He was refusing to take prescribed medication. He had been found in London in a 'terrible state' after trying to make his way back to Nigeria. He had been socially isolated at the hostel, not buying food, and expressing suicidal ideation. The team's care plan at this time was to allocate a care coordinator with Dr A seeing TO on a weekly basis.

18 March 2005

TO was referred to CRHT due to suicidal ideation. TO rejected their help.

25 April 2005

TO was seen in outpatient clinic. The records make a suggestion of vulnerability to financial exploitation. TO expressed anger and at one point 'stormed' out of the clinic. Later he referred to a female image which controls him. Concerns were raised by Dr A that he might be learning disabled and referrals were planned for cognitive assessments.

A CPA4 brief risk profile was completed. The risks identified were as follows:

- risk of suicide – score 1 (low risk)
- risk of being exploited – score 1 (low risk)

All the other risks recorded were scored 0 (very low risk). These were risks of violence or harm to others, deliberate self-harm, accidental self-harm, severe self-neglect, to children, abusing others, committing an offence.

(See appendix D for a summary of key information the CPA4 brief risk profile form).

1 May 2005

A CPA5 care plan was completed by the EIT. The core needs identified were very low mood, low self esteem, cannabis use, suicidal ideation. The core interventions identified were for the care coordinator to see TO weekly, and for Dr A to see him in outpatient clinics as required, as well as the team offering support with accommodation and rehabilitation.

21 June 2005

A CPA4 brief risk profile was completed in the community. The risks identified were as follows:

- risk of violence or harm to others – score 1 (low risk)
- risk of suicide – score 1 (low risk)
- risk of abusing others – score 1 (low risk)
- risk of being exploited – score 1 (low risk)
- risk of committing an offence – score 2 (medium/significant risk)

All the other risks recorded were scored 0 (very low risk). These were risks of deliberate self-harm, accidental self-harm, severe self-neglect, to children, committing an offence.

It was noted on the risk profile that TO had been threatening other residents (throwing cutlery, etc). Also that he had threatened to throw a pot of water at Dr A. Also that he had been expressing a wish to die stating he wants someone to kill him. It was also noted that at that time TO had been agitated, and hallucinating about his dead mother, his father, and other family members, as well as being fixated with clouds, cars and people.

21 June 2005

TO was detained under section 2 of the Mental Health Act and admitted to Calnwood Court due to non-compliance with medication, auditory and visual hallucinations, and aggression to others at the hostel.

At the time of admission his symptoms were thoughts of self-harm, expressing a firm wish to kill himself, preferably with a gun, and stating he had been depressed lately because his niece asked him to find a wife and get married. TO also described a 'symptom' inside him telling him to hurt others and kill himself. He was observed to be visibly upset at this. On admission he was observed to be very tearful when discussing his mother, whom he stated he missed a great deal. He was observed to be pre-occupied with memories of his mother. He also felt rejected by his siblings. He spoke

about his mother who he stated was a nurse in the police force in Nigeria and died of a stroke, stating he missed her and wanted to be with her. He was calm and co-operative on admission.

During his stay he talked about hearing voices and was taking antipsychotic medication, making a significant recovery. Hence there was no further formal detention when his section expired.

One nursing entry on 13 July 2005 describes how TO stated the sun is controlling his life and he needs to kill himself to find out which part of the universe he is from. There are also reports during the admission of pre-occupation with sexual thoughts during the admission.

June-July 2005

A CPA4 brief risk profile was completed on the ward environment. The risks were reviewed three times on 21 June 2005, 9 July 2005, and 24 July 2005. The scores were as follows:

- risk of violence or harm to others – scores of 3 (high risk), reducing to 1 (low risk), and then 0 (very low risk)
- risk of suicide – scores of 3, 0 and 0
- risk of deliberate self-harm – scores of 3, 0,and 0
- risk of accidental self-harm – scores of 0, 0, and 0
- risk of severe self-neglect – scores of 3, 1, and 0
- risk to children – scores of 0, 0, and 0
- risk of abusing others – scores of 0, 0, and 0
- risk of being exploited – scores of 0, 1 and 1
- RISK OF committing an offence – scores of 2 (medium/significant risk), 1, and 1.

29 July 2005

TO became an informal patient at Calnwood Court.

4 August 2005

TO was discharged from Calnwood Court and found temporary accommodation at Vernon Road. No occupational therapy assessment had been carried out on the unit as TO refused to participate in one. He was found unconscious the following day in his flat and was admitted to the Luton and Dunstable Hospital. He was diagnosed as having type 1 diabetes and was also started on depot medication. Concerns were expressed by the medical consultant, Dr R, about TO's understanding of his diabetes and his ability to control it.

16 August 2005

A CPA4 brief risk profile was completed. Two risks were recorded – risk of accidental self-harm, and risk of self-neglect – both scored 3 (high risk). The EIT CPA care plan records three key issues: support with accommodation, remaining cannabis free, and complying with prescribed medication and engaging with the service. The plan was to offer support input to TO weekly by the care coordinator, with clinical follow-up from Dr A. It was noted on one of the CPA care plans that TO can be suspicious and aggressive with people, and that cannabis use could contribute to this.

24 August 2005

TO referred to his accommodation being a 'horror house', stating that it contained vampires.

21 September 2005

TO was discharged from the Luton and Dunstable Hospital after his diabetes had been stabilised.

29 September 2005

A CPA4 brief risk profile was completed by EIT staff. The scores were as follows:

- risk of violence or harm to others – score of 1
- risk of suicide – score of 1
- risk of deliberate self-harm – score of 0
- risk of accidental self-harm – score of 1

- risk of severe self-neglect – score of 1
- risk to children – score of 0
- risk of abusing others – score of 1
- risk of being exploited – score of 1
- risk of committing an offence – score 1.

It was noted on the risk assessment form that TO was at that time considered to be low risk as his psychosis was under control, however he still has 'residual thoughts that women mean specific things to him when he passes them by in the street and somehow they interfere with him causing distress. He still believes they are somehow god-like which agitates him, and makes him suspicious of their actions and what they mean to him.' It was also noted that when his psychosis gets out of control he feels that if he dies then spiritually he would be different and would not suffer the way he does now.

6 October 2005

A referral was made for a health psychology assessment of psychological factors which may be implicated in his diabetic control due to three admissions to the Luton and Dunstable Hospital where his diabetes had been out of control.

November 2005

Evidence of engagement with next of kin (sister) can be seen in the medical records.

7 November 2005

TO was re-admitted to the Luton and Dunstable Hospital after he stopped taking his insulin. He was discharged the same day. At this time TO was also using cannabis and alcohol and was expressing delusional beliefs.

8 November 2005

The care coordinator supported TO to open a bank account.

14 November 2005

A CPA4 a risk indicator checklist was completed. This gives two types of risk indicator – current indicators (present within the last month) and historical indicators (not present in the last month but known to have been present in the past).

The current risk indicators were suicide attempt, self-neglect, drug/alcohol abuse, inability to communicate feelings, failure to attend appointments, abuse/victimisation by others, high levels of stress on carers, chronic medical illness, and physical health problems.

The historical risk indicators identified were delusions, ideas of harming others, hostility, ideas of self-harm/suicidal ideation, physical harm to others, suicide attempts, plans to commit suicide, neglect of self, drug/alcohol abuse, unable to engage with service, compulsory admissions, conviction for sexual offences, and housing problems.

23 November 2005

TO was referred to the Ashanti team for support with cooking, and supportive counselling. TO went for the initial assessment at Ashanti, when he was accompanied by his care coordinator, and expressed a desire to participate in cooking and counselling sessions. He never turned up for any sessions and therefore was never formally admitted or discharged from the service.

12 December 2005

TO was assessed by the clinical psychologist in the General Medicine Clinic. He was considered as not suitable for individual psychotherapy due to his active symptoms of schizophrenia at that time, and his illicit drug use.

22 December 2005

Cannabis use seemed to be a factor in a deterioration of TO's mental state at this time, including a deterioration in his management of his diabetes leading to hospital admission. He had also been allowing people to use his flat to take drugs and drink alcohol, apparently intimidated by threats to beat him up if he didn't. A professionals meeting was held as a result of a Protection of Vulnerable Adults Meeting (POVA) (due

to self-neglect relating to the diabetes control). It was also becoming clear that TO had debts mounting due to non-payment of bills.

He was also seen by JR (clinical psychologist) on 22 December 2005, during which he demonstrated evidence of extensive delusional thinking about being 'the chosen one' and towards women. Dr R stated that she had 'a number of concerns regarding his delusional beliefs about women and the risk that this may pose at the current time'.

Following assessment by the Luton Crisis Resolution and Home Treatment Team TO was admitted informally to Calnwood Court on 22 December 2005 due to non-compliance with medication, suicidal thoughts, and paranoid ideas directed at women. He was placed on section 3 on 29 December 2005. During the admission it was noted he expressed remorse for the indecent exposure incident two years previously.

A CPA4 brief risk profile was completed by EIT staff. The scores were as follows:

- risk of violence or harm to others – score of 2 (medium risk)
- risk of suicide – score of 2
- risk of deliberate self-harm – score of 2
- risk of accidental self-harm – score of 3
- risk of severe self-neglect – score of 3
- risk to children – score of 0
- risk of abusing others – score of 2
- risk of being exploited – score of 3
- risk of committing an offence – score 2.

Appendix B

Referral criteria for the assertive outreach team

Adults aged between 18 and approximately 65 with the following:

1. A severe and persistent mental disorder (e.g. schizophrenia, major affective disorders) associated with a high level of disability.

2. A history of high use of inpatient or intensive home based care (for example, more than two admissions or more than 6 months inpatient care in the past two years).

3. Difficulty in maintaining lasting and consenting contact with services.

4. Multiple, complex needs including a number of the following:

    - History of violence or persistent offending
    - Significant risk of persistent self-harm or neglect
    - Poor response to previous treatment
    - Dual diagnosis of substance misuse and serious mental illness
    - Detained under Mental Health Act (1983) on at least one occasion in the past 2 years
    - Unstable accommodation or homelessness

Appendix C

Extract of paper entitled *Proposal for the re-development of early intervention services in Bedfordshire and Luton*

The trust has considered carefully how to cultivate their proposal for the re-development of early intervention services across Bedfordshire and Luton and, as a result, have decided to engage NIMHE leads to take this work forward.

1. INTRODUCTION

1.1 The purpose of this document is to present the evidence supportive of a new service model for re-commissioning early intervention services across Bedfordshire and Luton.

1.2 To establish a Policy Implementation Guide (P.I.G.) compliant Early Intervention Service across Bedfordshire and Luton

1.3 To review a range of options for service delivery and comment on the relevant merit of each option.

1.4 To analyse these options in comparison to other successful early intervention services from across the East of England and nationally.

1.5 To develop services which are relevant to local need and which deliver culturally sensitive, relevant and accessible interventions

2. THE CONTEXT OF EARLY INTERVENTION IN PSYCHOSIS IN BEDFORDSHIRE AND LUTON

2.1 Bedfordshire and Luton have previously commissioned services for people with a first episode of psychosis. These services were delivered across

the county from two stand-alone teams; one based in Luton and the other based in Bedford – covering the rest of Bedfordshire.

2.2 These services were withdrawn as a result of PCT requirements for cost reduction.

3. THE CASE FOR EARLY INTERVENTION

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

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

3.3 Nationally it is evidenced that it can take up to two years after the first signs of illness for an individual and his/her family to begin to receive help and treatment. Lack of awareness, ambiguous early symptoms and stigma all contribute to the delay in appropriate help being offered and taken up. Programs which monitor 'At risk mental states' have been shown to reduce this delay, and consequently, the disability associated with this delay. Cases who are suspected of having a psychosis and are being monitored by EI teams are now a necessary addition to counting for LDP reviews. These patients are described as being "Prodromal" and the count is the number of "prodromal" cases being monitored at the end of each quarter irrespective of the date at which monitoring started.

3.4 Early treatment is crucial because the first few years of psychosis carry the highest risk of serious physical, social and legal consequences, One in

ten people with psychosis commits suicide – two thirds of these deaths occur within the first five years of illness.

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

3.6 In 2000, the government set the NHS the two targets of: (1) expanding the number of early intervention teams to 50 by December 2004 and (2) ensuring that, by December 2006, all young people who had experienced a first episode of psychosis in the past three years received the early and intensive support they need.

3.7 Despite the progress made in establishing new early intervention services, it was apparent that the NHS was not likely to meet the target of serving 22,500 young people via early intervention teams between 2003 – 2006.

3.8 The department of health therefore published a 'recovery plan' stating that 'the availability of early intervention services remains a key mental health priority and the Government is committed to the goal of providing support for all young people developing a first episode of psychosis'. As a result, a recovery plan was put in track. The plan consists of three key elements:

3.8.1 A national objective for early intervention services to take on 7,500 new cases of psychosis during 2006 -07, with aim of building up to 22,500 cases by March 2009.

3.8.2 Strategic Health Authorities and Primary Care Trusts to be provided with an allocated share of the 7,500 new cases, in-line with their existing commitments.

3.8.3 Over the next three months (from publication) SHA's to agree with PCT's local delivery plans to ensure they meet their share of new cases by March 2007. At the moment these figures from the PCT and SHA are unavailable and it is unclear as to how this will compare to estimates for Bedfordshire and Luton within this proposal.

3.9 The national early intervention programme leads (David Shiers and Jo Smith 2006) recently submitted a briefing paper outlining the evidence base supporting why early intervention in psychosis should be delivered by a specialised service model. They outlined their main reasons as below:

3.10 ***Care for early psychosis provided through CMHT's is unacceptable to consumers, especially among the BME community.***

3.10.1 The Rethink campaign 'Getting help early' used a consumer survey to highlight negative attitudes held by users and carers towards traditional CMHT's. Users argued that contact with people with long term schizophrenia in CMHT's and admission units felt demoralizing and stigmatising to young users and was a major cause of the high rate of disengagement from these services (McGovern and Cope, 1995; Criag et al, 2005).

3.10.2 Generic CMHT's can be responsible for 40% of the delay in receiving treatment at the first episode (Norman et al, 2005). RETHINK users and carers have campaigned against unacceptable treatment delays averaging 12 months in the UK (Marshall et al, 2005) leading to unnecessary distress and clear evidence for long term damage in terms of markedly poorer outcomes (Marshall et al, 2005).

3.10.3 Generic CMHT's lack the focus and flexibility to respond quickly to emerging psychosis. Approaching 40% of first episodes are sectioned under the Mental Health Act at the first episode in CMHT's (Morgan et al , 2005);this rate is even higher for young

Black men (>50%). This breeds treatment reluctance and high service disengagement (See Craig et al, 2005).

3.10.4 **Conclusion: It is highly likely that there will be significant opposition to reverting to a traditional CMHT model from this client group, particularly from members of BME communities.**

3.11 ***The early phase of psychosis is a 'critical period' affecting long term outcome. This requires a model which can guarantee sustained early treatment and engagement.***

3.11.1 A recent systematic appraisal of the evidence for EI was published in the Cochrane Database (Marshall & Lockwood 2006). The reviewers analysed the research on duration of untreated psychosis ('DUP') and its relationship to outcomes for clients. They found strong evidence that the longer the period of DUP the worse the outcomes for clients. The evidence suggests that 40% of the DUP period can be attributed to the slow engagement process of CMHT's (Norman et al, 2005).

3.11.2 Outcome after three years strongly predicts outcomes 25 years later (Harrison et al, 2001). It is essential that young people are assertively following up in low stigma channels to assure consistent treatment. EI teams guarantee high levels of engagement and treatment (Craig et al 2005) which CMHT's cannot (Yung et al, 2003).

3.11.3 The first five years following the first episode carry a threefold increased risk of suicide (Wiersma, 2000 Schizophrenia Bulletin).

3.11.4 **Conclusion: A service model is needed which can guarantee sustained engagement and treatment in the early phase of psychosis.**

3.12 ***EI teams lead to high levels of engagement and improved outcomes compared to CMHT's.***

3.12.1 Value base of EIS versus traditional CMHT: Inherent in the EI model is an approach based on therapeutic optimism and expectation of recovery for young people. The culture of the traditional CMHT is a major difficulty for this young client group – it is inconceivable that a small island of EI practitioners would not end up drawn into the culture of the wider CMHT.

3.12.2 Two large scale RCTs have focused on providing intensive assertive outreach based care to young people (16-30yrs) during the 'critical period'. These have following the 'PIG' model and compared them with CMHT based care.

3.12.3 In the UK, the Lambeth Early Onset (LEO) study evaluated the effectiveness of an EI service compliant with the 2001 Policy Implementation Guide recommendations. They discovered that the EI team delivering specialised care for patients with early psychosis was superior to standard care for maintaining contact with services and reducing readmissions to hospital (Craig et al 2004; Garety et al, 2006).

3.12.4 The OPUS study in Denmark (Nordentoft et al, 2002) found decisive advantage in terms of lower readmission; symptoms and quality of life for EI service delivering integrated, sustained treatment compared to standard CMHT based care.

3.12.5 A recent trial from the Early Psychosis Prevention and Intervention Centre (EPPIC) in Melbourne compared outcomes for people with an early psychosis who were assigned to specialist early psychosis care or standard CMHT care (Yung et al 2003). The CMHT care group had longer duration of untreated psychosis, were more likely to be admitted and use of the police in the admission process was higher.

3.12.6 The results from the 'TIPS' trial (Mells et al, 2005; Larsen et al, 2006) shows that reducing DUP can be done by a community campaign which has benefits in terms of i) improving outcome ii) reducing suicide risk. This requires an integrated response across the whole population base and certainly not deliverable by CMHT sectors.

3.12.7 **Conclusion: There is NO EVIDENCE that a standard or enhanced CMHT model is capable of matching the outcomes achieved by the specialised EI service model recommended by the DH.**

3.13 ***Specialised EI teams pay for themselves as they reduce hospital admission and use of the Mental Health Act compared to CMHT's.***

The DH commissioned Profs Knapp and McCrome (2005) to research the cost effectiveness of specialised EI compared to CMHT's. They have now published their final report – The Impact of Early Intervention Services on Mental Health Care Costs, (Paul McCrone, Sujith Dhanasiri, Martin Knapp 2006), describes a model developed to estimate the economic impact of early intervention services compared to usual care. Care pathways were identified and the probabilities of patients moving through particular pathways and the costs of these were estimated.

3.13.1 They found that the expected cost for EI patients over one year was £13,370 whilst for usual care the figure was £29,369. This represents a 53% saving, which is maintained after three years when the respective costs are £41,054 and £88,108. (Under an alternative version of the model, where all EI patients can be admitted, the expected cost associated with EI rises to £57,665.) Three-year costs after discounting £31,864 for EI and £77,724 for usual care. With one exception, the findings were insensitive to changes in most parameters including the cost of the actual EI service.

3.13.2 **Conclusion: CMHT models of care for early psychosis are considered more expensive over time. Savings can be expected within the first year and will continue through the three years of the DH recommended model. Much of the saving will be gained by reduced use of hospital admission. Without an EI service this opportunity to reduce hospitalisation will be lost.**

3.14 *Traditional CMHT's and CAMHS:*

3.14.1 "*my daughter went from a CAMHS service that didn't do psychosis to an adult service that didn't do young people*". (Dr David Shiers).

One of the key problems with the traditional approach is its failure to work effectively across this transition. This is why the PIG highlighted the ability of an EIS service to work with people from as young as 14. And this younger age group often have the poorest outcomes, an even greater incentive for getting the service model right for this young age group. This is now being established around the country.

3.14.2 **Conclusion: Only specialised EI teams have the flexibility to work across this transition.**

3.15 Therefore, the report summarised that the evidence base for specialised EI teams is overwhelming. That service reform in EI is demanded by consumers; that the early phase is now understood to be a critical period and provides a clear rationale for a guaranteed specialised, intensive focus and that specialised EI teams are superior to CMHT based care on every outcome, including cost.

3.16 CMHT's are likely to remain the primary vehicle for delivering mental health care in Bedfordshire and Luton, however, the evidence suggests that this has been discredited as the vehicle for delivering early intervention in psychosis. Early intervention leads have therefore stressed that it is clearly unethical to revert to a model of delivering early intervention by CMHT model, without a sound evidence-based rationale for doing so.

4. DESCRIPTION OF THE DEVELOPMENT

4.1 It is proposed to establish an Early Intervention (E.I) in Psychosis Team across Luton and Bedfordshire, which will provide services to those aged 14 to 35.

Appendix D

Summary of scoring on the CPA4 brief risk assessment form

0 = no / very low risk

1 = low risk

2 = medium / significant risk

3 = high risk

4 = high and imminent risk

The risks covered on the form are as follows:

- risk of violence or harm to others
- risk of suicide
- risk of deliberate self-harm
- risk of accidental self-harm e.g. falling
- risk of severe self-neglect
- risk of harm to children
- risk of abusing others
- risk of being exploited
- risk of committing an offence
- risk of injury to self / others through moving and handling.

Appendix E

List of abbreviations

BLPT	Bedfordshire & Luton Mental Health & Social Care Partnership NHS Trust
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
EIT	Early Intervention Team
POVA	Protection of Vulnerable Adults
PCT	Primary Care Trust
EIS	Early Intervention Service

Appendix F

List of interviewees

DJ	Director for Mental Health
Dr HM	Medical director
JS	Care coordinator, CMHT (September 2006 – June 2007)
KE	Director of commissioning
LL	Service director for rehab inpatient services and day services
MS	Operational governance, quality and governance manager
CW	Team manager for Luton EIT (September 2006)
MK	Care coordinator, Luton EIT (September 2006)
PR	Service director for the children and young person's directorate
PB	Associate director
SS	Team manager of Luton East CMHT
Dr M	TO's CMHT consultant psychiatrist (he was not interviewed as part of this investigation but we quoted from his trust investigation transcript and have been in correspondence with him).

We did not interview the ex trust chief executive or ex trust non executive board members. We sent them a copy of the final draft of the report for comment and received some helpful comments and suggested amendments.

Appendix G

Biographies of investigation team

Tariq Hussain

Senior consultant Tariq is a former nurse director who brings to Verita his considerable experience of leading change management in the fields of learning disability and mental health services. Tariq has undertaken a wide range of projects for Verita which have included mental health homicide investigations and an investigation into sexual abuse by an eating disorder clinic manager. In September 2010 he completed a three year term of appointment as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.

Prior to Tariq's appointment with Verita he served for eight years as a non-executive director of a mental health trust with board level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting.

Lucy Scott-Moncrieff

Lucy qualified as a solicitor in 1978, and has worked in the fields of mental health and human rights law ever since. She is a member of the Law Society's Mental Health & Disability Committee and its Access to Justice Committee, having previously chaired both committees. In 2005 Lucy was awarded the Mental Health Legal Aid Lawyer of the Year award, and two years later her firm was short listed for the Law Society's award for Excellence in Innovation. Lucy is a director of Edge Training Limited, a company that offers training on the law to the purchasers and providers of health and social care, and a member of the QC Appointments Panel. She is also a commissioner with the Royal Mail regulator Postcomm. Lucy is on the editorial boards of the *Community care law reports* and the *Mental health law journal* and has written and broadcast regularly on legal issues over the years.