An independent investigation into the care and treatment of service user Ms Z

December 2011

A report for NHS London

NHS
London

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1. Introduction

1.1 Ms Z stabbed and killed her boyfriend, Mr Y, on 21 September 2007. Ms Z had been receiving mental health services since 1997. Mr Y had received mental health services between April 2005 and April 2006. Ms Z was sent to a secure psychiatric hospital after she admitted manslaughter on the grounds of diminished responsibility.

1.2 Ms Z had been under the care of the Camden Assertive Outreach Team (AOT) since November 2003. The AOT was part of the services of Camden and Islington NHS Foundation Trust (the trust). She suffered from psychosis and drug and alcohol abuse. She had a number of contacts with the police but there is no record of criminal convictions. She was admitted to hospital via the police using a Mental Health Act (MHA) 1983 section 136 (place of safety) on 25 November 2006. She was put on a section 2 and transferred to her local sector mental health ward. The section 2 was converted to a section 3 on 15 December 2006. Ms Z remained an inpatient with planned leave and was discharged from hospital on 15 May 2007. She was then cared for by the AOT until 21 September 2007 when the police arrested her for killing her boyfriend.

1.3 Verita is a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations. NHS London commissioned Verita to conduct an independent investigation into Ms Z's care before her arrest.

2. Terms of reference

2.1 This independent investigation is commissioned by NHS London in accordance with guidance published by the Department of Health in circular HSG (94) 27. *The discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33 – 6 issued in June 2005.

2.2 The aim of the independent investigation is to evaluate the mental health care and treatment provided to Ms Z to include:

- a review of the trust's internal investigation to assess the adequacy of its findings, recommendations and action plans;
- reviewing the progress made by the trust in implementing the action plan from the internal investigations;
- involving the families of both Ms Z and the victim as fully as is considered appropriate;
- a chronology of the events to assist in the identification of any care and service delivery problems leading to the incident;
- an examination of the mental health services provided to Ms Z and a review of the relevant documents;
- the extent to which Ms Z's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies;
- the extent to which Ms Z engaged with the substance misuse service;
- the appropriateness and quality of assessments and care planning;
- considering the effectiveness of interagency working;

- considering other such matters as the public interest may require;
- completing an independent investigation report for presentation to NHS London within 26 weeks of commencing the investigation and assist in the preparation of the report for publication.

3. Executive summary, overall conclusions and recommendations

Executive summary

3.1 Ms Z killed her long-standing boyfriend in his flat on 21 September 2007. She was living at the time in a local hostel in Brent and was being cared for by the Camden AOT.

3.2 Ms Z was born in London on 13 October 1976. She attended university in London where she studied English and drama. She started taking recreational drugs at university and did not complete her degree.

3.3 Ms Z's first contact with mental health services began in May 1997 at the age of 21 when she was admitted to hospital for two weeks. Her last admission began in November 2006 and she was discharged in May 2007. In all, she had an admission to hospital every year from 1997 until 2006 with the exception of 2003 and her admissions ranged from two weeks to 10 months in 2004. Many of Ms Z's admissions were compulsory under sections of the MHA. The number and regularity of these admissions show that Ms Z has a serious and enduring mental illness.

3.4 Ms Z's mother, grandmother and father were involved in supporting her in a variety of ways. In particular, her mother was involved in arranging her admission in November 2006. Her father was also regularly involved, sharing his concerns about her mental health with the ward and community staff. Ms Z's boyfriend, Mr Y, also spoke with staff at various times about his concern for her.

3.5 The principal diagnosis ascribed to Ms Z was that of schizoaffective disorder, complicated by a socially unstable lifestyle and the abuse of alcohol and illicit drugs. Ms Z threatened violence during a number of her admissions and was violent towards other service-users and staff. She once threatened her grandmother with a screwdriver.

3.6 Ms Z's last admission was characterised by a general failure to cooperate with her care team, often threatening them if she did not get what she wanted, such as certain drugs or leave. She often returned drunk when she was allowed leave from the ward.

3.7 When Ms Z was last admitted the housing association responsible for her flat was seeking repossession through the courts. She had not maintained it properly and she had allowed drug dealers to operate from it, causing considerable concern to other residents and the neighbourhood. The repossession occurred in February 2007, making her homeless, before her discharge in May 2007.

3.8 Ms Z was discharged from hospital on 15 May 2007 after some periods of trial leave. She was discharged to a hostel in the neighbouring borough of Brent. Ms Z's mental health seemed to have improved but her abuse of alcohol (and perhaps illicit drugs) was still evident. Her pattern of social instability continued after she was discharged and her father frequently expressed concerns about her.

3.9 Ms Z was living in a hostel in Brent but she was still in the care of the Camden AOT who had been involved with her since December 2003. Two days after her discharge she was arrested for being drunk and disorderedly and assessed under the MHA provisions while she was in custody. She was not deemed detainable. Ms Z was difficult to engage in the period up to 21 September and failed to cooperate with the AOT. She was erratic in receiving her depot injections and failed to attend appointments with her care coordinator and others.

3.10 Ms Z's finances were subject to appointeeship which meant that she had to ask staff for money which was budgeted for her. She often asked for extra and threatened staff when it was refused. Her father reported during this time that she was on a *"psychotic drugs binge"* and that she was behaving bizarrely.

3.11 As a result of this deterioration, on 7 September 2007 Ms Z's care coordinator referred her for a MHA assessment with a view to a compulsory admission to hospital. The referral was made to the adjacent borough of Brent, where Ms Z was living. Staff making the referral followed it up but the assessment was not carried out before the killing of Mr Y on 21 September.

3.12 The trust conducted its own investigation of the incident. Its report in 2008 contains 27 recommendations relating mainly to improvements in practice. These recommendations are appropriate to the failures identified but the trust investigation did not look into any systemic reasons leading to these failures in practice.

3.13 We set out below our overall conclusions to this investigation along with a small number of recommendations.

Overall conclusions

3.14 We make a number of observations about areas of improvements but most reinforce those of the trust panel. Ms Z was undoubtedly a difficult client to care for. She had complex needs, was difficult to engage and her presentation fluctuated over time. Despite these difficulties, staff both in hospital and in the community sought ways of helping her. The staff continued to find it difficult to engage her to assess her multiple needs, which would have allowed them to develop sufficiently robust care plans and make real progress in addressing her needs. This was not due to a lack of staff commitment or to their general competence.

3.15 Ms Z was an intelligent articulate woman and staff appeared more alert to her vulnerability than to her risks. Consequently, when she threatened violence or was violent, staff responded less vigorously than they might have with clients fitting a more usual risk profile. Trust staff often did not follow its risk assessment processes, resulting in a failure to understand what was leading Ms Z to threaten violence and occasionally to be violent.

3.16 Her discharge from hospital in May 2007 was a difficult decision for the staff because her psychotic illness appeared more stable but she was still as socially unstable and continuing to abuse alcohol and illicit drugs as when she had been admitted five and a half months earlier. It is difficult to see what staff could have done at that stage except continue her detention. If Ms Z were being discharged in 2011 the option of putting her onto a community treatment order (available since 2008) would have been available. This option might have provided a more suitable discharge regime, allowing Ms Z to be recalled to hospital by her responsible clinician without the need for a MHA assessment.[1]

3.17 Ms Z was still socially unstable once in the community and her mental health again deteriorated. The team referred her for a MHA assessment on 5 September but the homicide occurred on 21 September before this could be carried out. This gap was too long, though the AOT was in contact with Ms Z in the meantime.

3.18 Ms Z's last face-to-face meeting with the AOT was on 7 September - with her care coordinator and a support worker. They thought Ms Z was not detainable. The AOT also spoke with Ms Z by phone on 13 September and she agreed to meet with her consultant the next day but she did not attend.

3.19 We agree with the trust panel that the AOT could have avoided the delay in securing the assessment by arranging for it to have been undertaken by trust staff from another team. Even if they had, we cannot be sure that it would have resulted in Ms Z being admitted, particularly in light of the contacts with her after the referral on 5 September 2007.

3.20 The trust panel report contains many recommendations and we have added our own. Most of the trust recommendations relate to general improvements to team working (see section 9 for progress on implementation of the trust recommendations). We do not, however, believe that any action or inaction by individuals and teams who cared for Ms Z had a direct causal link to the homicide.

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[1] A community treatment order allows a clinician to recall to hospital a patient if she/he is of the opinion that the patient needs to receive treatment in hospital for his or her mental disorder and that there would be a risk of harm to the health or safety of the patient or to other persons.

Recommendations

R1 The trust and the PCT should review the commissioning of forensic services to ensure there is provision for co-working between staff in forensic and general adult services.

R2 The trust should fully implement its recommendation 16 for each AOT and ensure that this is a regular part of teamwork. The recommendation states:

> *"AOT to reflect on their operational policy to ensure that thresholds for action are not affected by high tolerance levels. Consideration should be given to external facilitation or supervision in order to challenge and reflect on the effects of continual work with a complex population of service users."*

R3 The trust should review/audit the number of staff in each AOT who have had recent and relevant updating in caring for clients with a dual diagnosis. If the audit reveals that too few staff have been recently and adequately trained, this should be remedied as promptly as possible.

R4 The trust should review the support available to AOTs to ensure that there is adequate provision of input from specialists in drug and alcohol services for the client group of the AOT. The provision should allow for joint working where needed and regular contact with each AOT.

R5 The trust chief executive should discuss with the SHA a review of the pan-London agreement to ensure greater clarity of the guidance and to promote agreements between London boroughs to allow staff to conduct assessments across London as appropriate.

R6 The SHA should undertake a review of the time it takes to carry out MHA assessments across all London boroughs from the time of referral. The review should identify any key delaying factors and consider how to reduce the time between referral for assessment under the MHA and the assessment taking place.

4. Approach and structure

4.1 The investigation team (referred to from now on in this report as 'we') comprised of Tariq Hussain, Dr Rosalind Ramsay and Ms Rosie Mundt-Leach. Biographies of the team are included at the end of this report.

4.2 We examined documentary evidence including policies and procedures from the trust, Ms Z's clinical records and the internal investigation report. A list of documents reviewed is included at appendix A.

4.3 We conducted interviews with the following people:

- trust senior managers
- ward managers and medical staff from Iris, RFH, Fortismere
- managers from Camden assertive outreach team (AOT)
- an assertive outreach team consultant
- head of social care, Camden and Islington Foundation Trust.

A list of those interviewed is included in appendix B.

4.4 We followed established good practice in conducting interviews. The interviewees were given the opportunity of being accompanied by a representative or a friend at their interview. They were provided with the opportunity to comment on the factual accuracy of the interview transcript.

4.5 The trust was given the opportunity to comment on the draft report and to provide an update on changes made to services in the light of its reflective review.

Contact with Ms Z, her parents and the family of Mr Y

4.6 As a result of difficulties in locating Ms Z we met with her at the latter part of the investigation. We explained the purpose of the investigation, our initial findings and received any information that she wished to give.

4.7 We attempted contact with Ms Z's parents but received no response to our offer to meet. We sought but were unable to locate Mr Y's family.

5. Chronology of care and treatment - 1997 - 2003

Background

5.1 Ms Z was born in London on 13 October 1976. She had a normal birth and developmental milestones. Her parents divorced when she was a teenager and she went to live with her grandparents. She performed well at school and applied for a degree in English but changed to drama at a London university. She started taking speed[2] and other recreational drugs and dropped out.

5.2 Ms Z was first in contact with mental health services in May 1997 when she was 21. She was admitted to the Central Middlesex Hospital for extreme irritability, hyperactivity, insomnia, abnormal and grandiose beliefs and behaviour suggestive of hallucinations and placed on section 2 of the MHA[3] 1983. She was diagnosed with a drug-induced psychosis. Ms Z discharged herself two weeks later when the mental health review tribunal lifted the section 2.

5.3 In August 1998 Ms Z was admitted to the Royal Free Hospital in a psychotic state under section 2 of the MHA. She was treated for psychosis and the section 2 was converted to a section 3[4]. She made an unsuccessful appeal against the section. She was discharged in April 1999. A full discharge summary was sent to her GP. Her discharge arrangements included:

- risperidone 2mg BD
- fluoxetine 60mgs
- day hospital follow up – to be seen by consultant psychiatrist 1
- visits by a community psychiatric nurse (CPN).

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[2] 'Speed' is the street name for a range of amphetamines such as amphetamine sulphate, dexedrine and dexamphetamine. Like cocaine, amphetamines are stimulants that people take to keep them awake and alert.
[3] Compulsory admission to hospital for up to 28 days for assessment.
[4] Compulsory admission to hospital for up to six months for treatment, which can be renewed for a further six months.

5.4 In May 1999 Ms Z was taken to A&E by the police under MHA section 136[5] and admitted again to hospital under MHA section 2 and later changed to MHA section 3. She was treated with anti-psychotic medication and discharged a month later.

5.5 In September 1999 Ms Z's consultant care was transferred from consultant psychiatrist 1 to consultant psychiatrist 2. Consultant psychiatrist 1 advised that she was unable to develop a therapeutic relationship with Ms Z. There is no record of why this occurred.

5.6 Consultant psychiatrist 1 had also referred Ms Z to the assertive outreach team but the team did not accept Ms Z because she was assessed as not meeting their criteria.

5.7 Ms Z applied for housing at Cara House, which was managed by the Irish Housing association. She was subsequently offered and took up tenancy of a flat run by the housing association but the date this began is uncertain.

[5] Power for a police officer to take a person suffering from a mental disorder and in need of care or control in a public place, to a place of safety-e.g. a police station or hospital, with a maximum detention of 72 hours.

5.8 In November 1999 Ms Z suffered a further psychotic breakdown. She was taken to the accident and emergency (A&E) department of the Royal Free Hospital by the police after trying to set fire to the basement of a flat and hoarding knives in her room. She was admitted under MHA section 3 at the Royal Free hospital. A diagnosis of a schizoaffective disorder was made. Ms Z's grandmother advised that she couldn't accommodate Ms Z in her house. In April 2000 treatment with depot medication was initiated but there was no change in Ms Z's mental state and in May 2000 treatment with clozapine was started. Ms Z was discharged on level 3 of the care programme approach (CPA)[6] in August 2000 to a new flat. The discharge plan included the following:

- medication – blood tests weekly
- a key worker identified
- weekly social work visits
- weekly housing support worker visits
- placement on supervision register
- follow-up in outpatients dept.

5.9 In February 2001 Ms Z was found wandering on railway tracks, saying she wanted to kill herself. She was admitted to Abbeydale Court in Walthamstow on an *"informal"*[7] basis. She was transferred to the trust's Drayton Park women's crisis project, a residential mental health crisis project for women living in Camden and Islington who would otherwise be admitted to hospital.

5.10 On 21 March 2001 a CPA meeting took place. Ms Z's father and the community psychiatric occupational therapist attended. Ms Z's father admitted to slapping her because she was taking drugs and having sex with strangers for money. In April 2001 Ms Z's grandparents became worried about her because she had become less communicative and withdrawn. She was therefore admitted informally to St Pancras Hospital until June 2002.

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[6] CPA is systematic approach to providing care which has four components: assessment; a care plan; allocation of a care coordinator and regular reviews.

[7] An informal admission to hospital is when a patient agrees to be admitted for treatment.

5.11 A letter dated 18 May 2001 from the assertive outreach team (AOT) was written to Camden CMHT saying that Ms Z met the criteria for assertive outreach but they could not accept her at that time and she should remain with the CMHT for follow-up.

5.12 In June 2002 the CMHT wrote to AOT asking if Ms Z could now be taken on (see 5.14 below).

5.13 Ms Z attended an outpatient appointment in July 2002 and presented as psychotic, thought-disordered and irritable. She was admitted to St Pancras Hospital, again under MHA section 3. She hit a member of staff after returning to the ward drunk. A CPA meeting took place and she was discharged in November 2002. The discharge plan included:

- outpatient follow-up
- regular follow-up with care coordinator
- regular follow-up with housing support team
- monthly follow-up with clozapine clinic
- medication.

Care by the assertive outreach team 2003-2005

5.14 In December 2003 Ms Z was again referred by the CMHT to and accepted by the AOT.

5.15 In March 2004 Ms Z was admitted to St Luke's Woodside Hospital via the AOT due to non-compliance with medication. The AOT visited her twice while she was in hospital. She was discharged in June 2004.

5.16 Ms Z's mother wrote to the trust chief executive complaining about the deterioration in her daughter's mental health and living conditions since the AOT took over her care.

5.17 In June 2004 Ms Z was re-admitted to St Luke's Woodside Hospital. She was escorted from her grandmother's house and taken to A&E by ambulance with a police escort. She was admitted informally but was then placed on MHA section 5(2)[8]. This was converted to a section 3 and she was treated formally until August when she was transferred to Sutherland Ward for rehabilitation. A CPA meeting took place on 3 February 2005 and she was discharged on 14 February 2005 with assertive outreach follow-up.

5.18 During 2004 Ms Z's flat had become so neglected that it was a health and safety risk.

5.19 During 2005 Camden AOT visited Ms Z. Her flat had been taken over by drug dealers whom police removed.

5.20 On 31 December 2005, staff from the drug rehabilitation centre (City Road Clinic) took Ms Z to A&E at University College London Hospital (UCLH) because she was behaving strangely. She was assessed in A&E and placed under MHA section 3 and transferred to Fortismere Ward at St Luke's Woodside Hospital. She had lived in a housing association flat but was being evicted because she had not taken proper care of it and had allowed other drug users to treat it as a crack den.

5.21 The hospital put her back on oral antipsychotic and mood stabilising medication as well as depot medication and she was referred for an electroencephalogram (EEG)[9] because of previous reported epileptic fits. Two appointments were made for Ms Z at the eating disorder clinic at the Royal Free Hospital but she did not attend.

Care by the assertive outreach team 2006

5.22 Camden AOT saw Ms Z during 2006. In August her flat was closed under an anti-social behaviour order (ASBO) and she faced possession proceedings from her landlord because drug dealers had occupied it again.

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[8] MHA section 5(2) allows the compulsory detention of a patient already receiving inpatient treatment for up to 72 hours by the doctor in charge of the case.

[9] An electroencephalogram (EEG) is a test to detect problems in the electrical activity of the brain.

5.23 In October 2006 Ms Z told the AOT that she had been a victim of domestic violence but she did not report it to the police. The AOT made a referral to the adult protection department.

Comment

We have found no evidence that this referral led to any action.

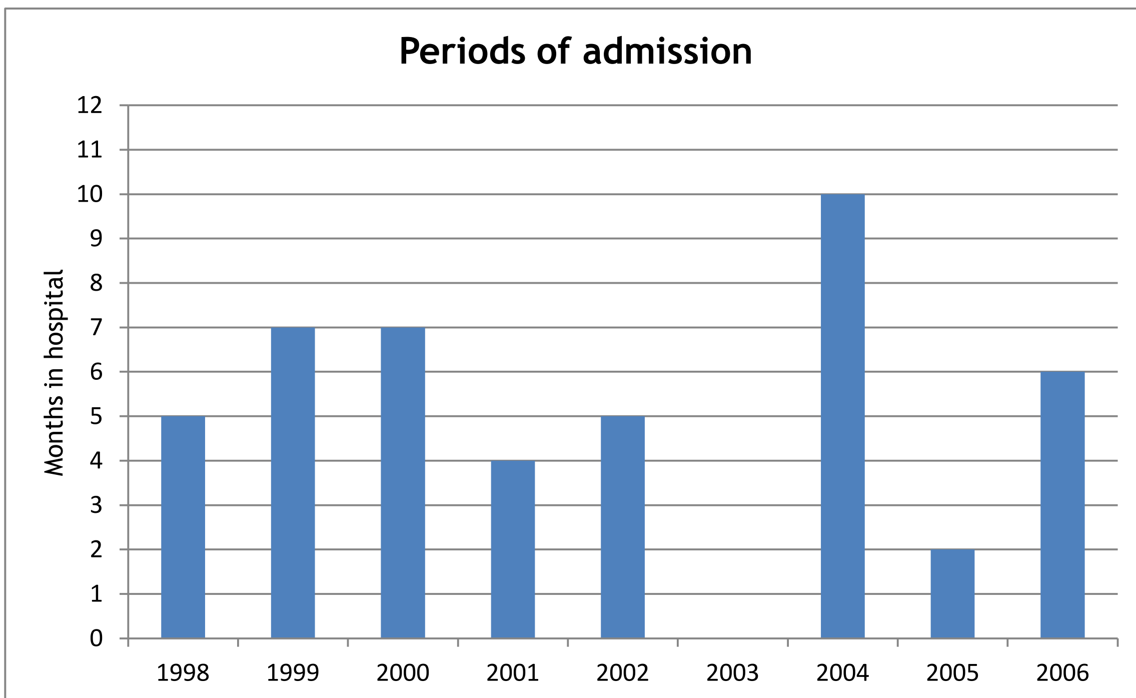
5.24 On 25 October 2006 a CPA meeting took place and Ms Z remained on enhanced CPA. Several actions were recorded to identify and manage risks. A review meeting was set for six months' time.

5.25 On 24 November 2006 Ms Z appeared in court because police wanted to extend the closure of her flat for three more months. The court granted their application. Police and staff from Cara House said Ms Z had appeared drunk in court and her behaviour was inappropriate, shouting and swearing during the proceedings. The AOT did not know at the time that she was attending court.

5.26 On the same day Ms Z's mother called the AOT to say that Ms Z had been to her grandmother's house, shouting and threatening, and had held a screwdriver against her throat. The team told Ms Z's mother to contact the emergency duty team or the police. The police transferred Ms Z to hospital under MHA section 136 the next day (see section 5 below).

5.27 To provide an overview we set out these admissions in table and graph form below. We also set out in the next section a more detailed account of Ms Z's last admission.

Hospital	Date	MHA section	Duration
Central Middlesex Hospital	1997	2	Two weeks
Royal Free Hospital	August 1998	2	Eight months
Royal Free Hospital	May 1999	2 and 3	One month
Royal Free Hospital	November 1999	3	Nine months
Drayton Park-women's crisis project Camden &Islington NHS Trust (C&I)	February 2001	Informal	One month
St Pancras Hospital (C&I)	March 2001	Informal	Three months
St Pancras Hospital (C&I)	July 2002	3	Five months
St Luke's Woodside Hospital (C&I)	March 2004	Informal	Three months
St Luke's Woodside Hospital (C&I)	June 2004	3	Eight months
St Luke's Woodside Hospital (C&I)	December 2005	3	Six months
Grove Centre and St Luke's Hospital (C&I)	November 2006	136 and 3	Six months



5.28 Ms Z had eleven admissions between 1997 (when she was 21) and 2006. Many of these admissions lasted a number of months and most were compulsory under a section of the MHA. Such frequent and long stays reveal the severity of Ms Z's mental health problems ranging over a number of years.

6. Last hospital admission: 25 November 2006 – May 2007

6.1 This section of the chronology deals with Ms Z's last hospital admission, which lasted about five and a half months. It is characterised by violence and threats of violence to staff and other service users. It also included frequent bouts of drunkenness during leave and general reluctance on the part of Ms Z to consider her needs fully with staff and engage in rehabilitation.

6.2 On 25 November 2006 Ms Z was admitted to Shore Ward at the Park Royal Centre for Mental Health (part of Central and North West London Mental Health NHS Trust) under MHA section 136. Staff found her racist, abusive and threatening to kill. A risk assessment was carried out and the care plan for Ms Z was:

- to be placed on section 5(2)
- to be prescribed lorazepam
- to contact duty nurse at St Luke's to obtain more information
- for clinical notes to be requested and received
- to be nursed in de-escalation room.

6.3 Later the same day the duty SHO assessed Ms Z and arrangements were put in place to transfer her to the Grove Centre where she was known.

6.4 On 27 November she was transferred to Solent Ward at the Grove Centre (part of Camden and Islington NHS Foundation Trust) under MHA section 2. She was uncooperative, irritable and elated.

6.5 The Solent Ward care plan was for:

- primary and associate nurse to build up relationship
- one-to-one time
- medication to be prescribed
- education re drug and alcohol intake
- encouragement to attend ward activities.

6.6 A risk assessment was completed but the document is undated.

6.7 The AOT continued to visit Ms Z while she was in hospital.

6.8 Staff from Cara House requested a meeting with the AOT and Ms Z because they wanted to seek full repossession of her flat, but staff said she was not well enough to attend and asked to be kept up to date on any further court proceedings.

6.9 Ms Z was behaving in a sexually disinhibited way and it was felt by the staff that an all-female environment would be more appropriate for her. On 2 December 2006 she was transferred to Isis Ward.

6.10 On 3 December a patient assaulted Ms Z. Her care plan was revised and she was nursed under close observation in a low-stimulus environment.

6.11 On 4 December Ms Z threatened to kill a nurse conducting close observation but the risk assessment was not updated to reflect this threat.

6.12 On 5 December Ms Z remained disturbed. She tried to put a scarf around another patient's neck. She hit a nurse undertaking close observations. An occupational therapy (OT) student overheard Ms Z threatening to kill a doctor. The risk assessment was not updated to include these incidents.

6.13 On 6 December, Ms Z's father visited the ward and told a member of staff that Ms Z's grandmother had died that morning but was unsure if he should tell Ms Z. Interviews from the trust's internal investigation show that Ms Z's mother blamed her for her grandmother's death because it happened a few days after the incident on 24 November 2006.

6.14 Ms Z remained disturbed. She made numerous phone calls to the police and needed rapid tranquilisation.

6.15 On 7 December Ms Z remained disruptive when she threatened an OT. The risk assessment was not updated to reflect this.

6.16 She remained on one-to-one observations.

6.17 Over the next few days Ms Z remained unwell and needed rapid tranquilisation. On 11 December she demanded zuclopenthixol[10] and threatened to kill everybody if she did not get it. This was reported *"to sound empty"* and the risk assessment was not updated in light of this threat.

6.18 Her clinical team discussed the possibility of restarting depot medication. Ms Z remained on one-to-one observations.

6.19 On 12 December Ms Z was discussed in the ward round. The care plan was to:

- start zuclopenthixol 350mg weekly
- clarify position with housing
- check sodium valproate levels
- invite care coordinator to next ward round
- maintain one-to-one observations
- speak to AOT regarding medication
- have first medical recommendation for MHA section 3.

6.20 On 13 December the close observations ended and the first medical recommendation for a MHA section 3 as agreed in the ward round was made.

Comment

A number of serious incidents in this period should have been included in an updated risk assessment. Staff could also have conducted a case conference or mini CPA review. The result of a case conference or mini CPA review might have been a request for advice from forensic services about her management or consideration for Ms Z's transfer to a psychiatric intensive care unit. We explore later in this report possible reasons why this did not happen.

[10] Zuclopenthixol is an antipsychotic drug prescribed to alleviate psychotic features such as paranoia and hallucinations sometimes associated with extreme mood.

6.21 On 14 December the care coordinator visited Ms Z in hospital and discussions took place about when to tell Ms Z her grandmother had died. It was agreed that Ms Z's father would break the news during the afternoon if he felt it was appropriate. Her MHA section 2 was converted to a section 3. North Camden Drugs Service visited Ms Z to undertake an assessment but she did not want to meet with them because she said she did not take drugs.

6.22 On 18 December 2006 the AOT complained to Cara House staff about not being informed of Ms Z's court date on 24 November 2006.

6.23 On 19 December North Camden Drugs Service visited Ms Z to undertake an assessment but she again refused to meet them, saying she did not take drugs.

Comment

Ms Z's denial of a having a drug problem and her lack of insight into her difficulties were part of her general uncooperativeness and made it difficult for the staff to find a means of partnership working with her.

6.24 Ms Z's care coordinator visited her again and brought her money and cigarettes. Cara house staff contacted the ward to advise that a court date had been set for beginning of January and Ms Z's solicitor was contacted.

6.25 On 20 December a ward round took place. MHA Section 17 leave was discussed and it was agreed that she could have half-an-hour unescorted leave. Ms Z said she wanted leave for Christmas and if she did not get it she would have the staff crucified and kill millions of people. This information was not included in the latest risk assessment.

6.26 Ms Z's housing needs were discussed by the clinical team and they agreed that arrangements would be made to transfer Ms Z to Fortismere Ward.

Comment

This move was in preparation for Ms Z's discharge, which was being planned at the time. Fortismere Ward had dedicated beds for clients of the assertive outreach team.

6.27 On 22 December the care coordinator visited Ms Z on the ward. Her clinical team confirmed that Ms Z would not have leave over Christmas.

6.28 On 29 December the care coordinator visited Ms Z on the ward and brought her cigarettes and cake. The care coordinator told ward staff she had spoken to Ms Z's father and he would tell her that her grandmother had died.

6.29 On 2 January 2007 the AOT visited Ms Z and accompanied her on leave.

6.30 On 4 January the care coordinator visited Ms Z on the ward and took her out for coffee. Ms Z remained delusional.

6.31 It was confirmed that the court case would take place on 8 January and that Cara House were applying for eviction. The care coordinator referred Ms Z for supported accommodation.

Comment

The practise of AOT staff visiting Ms Z and taking her out on leave is to be commended. It helped provide the continuity that would be needed when she was discharged.

6.32 The eviction trial date changed to 15 February 2007.

6.33 On 10 January a ward round took place. It was noted by the clinical team that Ms Z's mental health did not appear to be improving on the current medication, so the medication was increased. Her care plan was also revised.

6.34 On 14 January Ms Z appeared upset about her grandmother's death. She had been unable to attend the funeral and wanted leave to visit her grave.

6.35 On 17 January a ward round took place and the amount of Ms Z's depot drug injection was reduced.

6.36 On 23 January the AOT care coordinator visited Ms Z on the ward. A ward round concluded that Ms Z's mental state was improving. The plan was to:

- invite AOT to next ward round for section 117 (aftercare discussions)
- continue with medication
- aim for discharge in three weeks time
- increase leave up to three hours per day.

6.37 On 30 January a ward round took place and Ms Z's depot injection was reduced by her clinical team and her unescorted leave was increased to four hours per day.

6.38 On 1 February the care coordinator visited Ms Z again and they went for coffee.

6.39 On 1 February Ms Z was transferred to Fortismere Ward under MHA section 3. The AOT were not told about the transfer and Ms Z's father was angry about the short notice.

6.40 On 3 February the care coordinator visited Ms Z. Ms Z told the coordinator that she had been in contact with a Mr Y but that they were just friends at the moment.

6.41 On 6 February the ward team undertook a brief risk assessment. A summary of the risks included:

- non-compliance
- suicidal ideation
- violent behaviour
- sexually inappropriate behaviour
- drug and alcohol abuse.

6.42 A risk assessment was carried out but we found no record of a risk management plan.

Comment

This assessment of Ms Z's risks occurred at a time when the records show that plans were being made for her discharge. In the absence of a risk management plan to mitigate these risks planning discharge was a serious failure of practice by the care team.

6.43 On 6 February a ward round took place and it was noted by her clinical team that Ms Z was spending a lot of time in bed.

6.44 On 13 February Ms Z was discussed at the ward round and her clinical team reported that she had been interacting well on the ward. Ms Z had refused admission to Sutherland Ward for rehabilitation. Ms Z had been admitted in the past to Sutherland Rehabilitation Ward. She was transferred there in August 2004 after admission to St Luke's in June 2004 and remained there until 14 February 2005. A discharge CPA was planned for two weeks' time and her clinical team noted that she would need supported accommodation.

Comment

At this stage the care team had two options. First, transfer her (on section) to the rehab ward (subject to availability of places), which might have provided a more structured approach to her recovery. Second, discharge her with the support of the AOT. The team took the latter decision. In light of the minimal progress that seemed to have been made in getting her to take seriously her mental health, drug and alcohol problems, we think that discharging Ms Z back into the community at this stage may not have been the best option.

6.45 On 14 February Ms Z returned to the ward after leave and appeared drunk.

6.46 On 15 February the final tenancy court hearing took place and the flat was repossessed immediately. Ms Z accepted a rehabilitation bed, though she also applied to the local authority homeless persons unit for supported accommodation.

6.47 On 24 February Ms Z returned to the ward after leave, again smelling of alcohol.

6.48 A ward round took place on 27 February and her clinical team noted that Ms Z had been returning to the ward intoxicated. A visit to the homeless persons unit was arranged. Medication was reduced and overnight leave agreed.

6.49 On 2 March Ms Z went on overnight leave to Mr Y's flat and returned to the ward drunk.

6.50 The ward round on 6 March noted that Ms Z's mental state was still improving but she had now refused the offer of a rehabilitation place. Ms Z denied she had been drunk and angrily left the ward. Her leave was cancelled by her clinical team because of her drinking.

6.51 Ms Z told staff on the ward that Mr Y had only a year to live because he had liver cancer. Ms Z was upset about this and wanted to spend as much time as possible with him. Her clinical team noted that Ms Z was drinking heavily on the ward.

6.52 Ms Z's care plan was revised by her clinical team and she was encouraged to have leave, which would be cancelled if she returned drunk.

6.53 Ms Z did not attend the ward round on 13 March because she had left the ward earlier. The plan was to:

- consider written warning if found using drugs
- look into supported accommodation
- restrict leave to 30 minutes
- consider discharging if Ms Z returns drunk.

6.54 Later the same day Ms Z returned to the ward and asked for leave but she was refused because she had been drunk every day. Mr Y came to the ward to see her. His bags were searched and strong lager was found.

6.55 On 15 March Ms Z returned to the ward smelling of alcohol.

6.56 At the ward round on 20 March the following plan was agreed:

- Mr Y would be banned from the ward if he tried to bring in alcohol
- leave restricted
- housing needs to be prioritised.

6.57 On 20 March Mr Y attempted to bring alcohol onto the ward and was banned. Ms Z was referred to the London Borough of Camden for housing.

6.58 On 24 March Ms Z returned to the ward smelling of alcohol.

6.59 The ward round took place on 27 March and Ms Z was granted unescorted leave. This would revert to escorted if she returned drunk.

Comment

It appears at this stage that plans for discharge were progressing while at the same time Ms Z was regularly coming back to the ward drunk or smelling of alcohol. The threat of cancelling her unescorted leave as a result was not carried out. On the contrary, from this point on Ms Z was granted even longer leave.

6.60 On 4 April ward staff contacted the police because Ms Z was missing. AOT contacted her. She then went on two weeks' leave to Abbots Hostel, a placement offered by Camden's Homeless Persons Unit but in Brent's local authority area. This hostel was used for homeless families and bed & breakfast. It had a warden with some staff during the day.

6.61 Ms Z was due to go to the ward on 6 April for her depot injection but did not attend.

6.62 On 10 April Ms Z attended the ward round. She was calm at first but became abusive when challenged about not attending for her depot. Ms Z had depot medication and went on leave to the hostel for two weeks.

6.63 Ms Z's father contacted the ward to say that the hostel had told him that Ms Z had not signed in the previous night.

6.64 On 20 April the care coordinator met with Ms Z who said she had had an argument with Mr Y the previous evening. She was staying at his flat but signing in everyday at the hostel.

6.65 Ms Z attended the AOT office on 23 April smelling strongly of alcohol. Ms Z said she had had an argument with Mr Y and had returned to the hostel. Ms Z's father said he had spoken to Mr Y and they (Ms Z and Mr Y) had not had an argument. Ms Z's father felt that Ms Z was suspicious and angry.

6.66 On 24 April Ms Z met the care coordinator. Ms Z attended the ward round to take her depot medication. On the way there Ms Z vomited but appeared unconcerned, saying this happened regularly.

6.67 At the ward round Ms Z denied vomiting and being mentally ill.

6.68 Ms Z did not attend a planned outpatient appointment on 27 April. A further appointment was made for 4 May but Ms Z did not attend. Ms Z did attend the AOT office on 8 May and she was given her depot medication.

6.69 On 11 May Ms Z met with the care coordinator who noted that she seemed guarded. Ms Z asked for extra money and was hostile when this demand was not met.

6.70 A discharge CPA meeting took place on 15 May 2007 and Ms Z was taken off her MHA section and discharged. The discharge plan was as follows:

- AOT to have contact with Ms Z twice per week (Tuesday and Friday)
- Fortnightly depot injections with AOT
- appointeeship to be put in place for money management
- to encourage Ms Z to attend weekly AOT group
- supply of one week's medication.

Analysis

6.71 In this section we examine in detail some of the themes that arise from the chronology of Ms Z's last hospital admission. We identify the following themes:

- discharge
- risk assessments
- gender bias
- escalation
- case conferences.

Discharge

6.72 We have addressed the key question of whether Ms Z should have been discharged in May 2007. In addition to stabilising her medication regime, the team had brought in staff from the drug dependency service to assess her, which she refused. They had worked closely with her care coordinator and sought to get her to reduce her drinking.

6.73 At one point she was offered a place in Sutherland Rehabilitation Ward but after initially accepting the place, she later declined it. As a patient detained under MHA section 3, it would have been possible to move her to that ward without her agreement.

Comment

The possibility must have been slim that Ms Z would cooperate in a rehabilitation programme while she was still drinking, possibly also abusing drugs and involved with her boyfriend, Mr Y. This may have been one reason why the team did not take the option of transferring Ms Z without her agreement.

6.74 The trust report described the period leading up to her discharge:

> *"During the period of leave leading up to her formal discharge from Fortismere ward on 15 May 2007, Ms Z was continuing to display signs of non-engagement and challenging behaviour. She was not signing into her hostel, had argued with both Mr Y and her father, was reported to be paranoid, angry and suspicious by her father, did not attend two appointments with the AOT, and when she did meet with AOT was noted to be guarded and hostile."*

6.75 This is a helpful summary and highlights the difficulty the team faced while Ms Z was out on leave but clearly in some difficulty. Her five-and-half-month stay in hospital had stabilised her mental health symptoms but her social disruption and ability to manage her alcohol and drug use were still a matter of concern.

6.76 This discharge took place after Ms Z had had a period of trial leave and after she had accepted a place at Abbotts Hostel.

6.77 Ms Z was discharged to Abbotts Hostel in South Hampstead, Brent. The trust report says:

> *"The panel felt that the situation was not optimal because of Ms Z's history of vulnerability in the community. It also meant that Ms Z was not as accessible to AOT as she might have been if she had been within the Borough of Camden."*

Comment

Finding accommodation for Ms Z in the borough would have been ideal but she was placed not too far from the AOT team base. The distance was not a factor in engaging with her. We think the important issue that we discuss below was whether she should have been discharged and whether the discharge plan was sufficiently robust to address her vulnerability.

6.78 Consultant psychiatrist 3 (Ms Z's consultant), told us:

"When she left, it was with a sense that perhaps we had not succeeded in all our treatment interventions, as one hopes, but she had had a significant period of time in hospital and we had tried very hard and we had a medication plan which kept her relatively stable and she agreed to meet up with AOT once she was in the community."

6.79 Consultant psychiatrist 4 (an inpatient consultant not involved in Mr Z's care) told us:

"Then the question is are you going to keep someone in hospital for ever more because you sort of can just about guarantee their safety by doing that for ever more. You can't really, I don't think. Perhaps maybe 25, maybe 30 years ago when there were far, far more psychiatric beds you may have been able to do that. Even then was that really the right thing to do? Was that paternalistic or not? You may just have to get to a stage where you say, okay, we've got you as well as we can and you're going to have to go, but with the intensive community services which was what she was going back to."

6.80 The medical director for Camden and Islington NHS Foundation Trust told us:

"You should, in my view, take a firmer approach where you stop leave and you think about what the treatment plan needs to be, and that you're not in some ways rewarding and encouraging this drunken behaviour."

6.81 In light of Ms Z's failure to engage effectively with the ward and her continued drinking and her relationship with Mr Y, it is unlikely that the discharge plan would have provided the degree of supervision and help towards recovery that Ms Z evidently needed: she had already shown her unwillingness to cooperate with treatment and recovery plans.

6.82 The difficulty of providing a means of encouraging compliance to treatment by some community clients was addressed by the provision of community treatment orders (CTO) in the latest revision of the MHA[11]. Consultant psychiatrist 3 told us *"she would almost certainly have been on a CTO because I would not have been able to guarantee her compliance with a depot or full engagement"*. A CTO might therefore have provided the AOT with a way of securing Ms Z's cooperation with closer supervision and compliance. For example, she could have been asked not to stay at Mr Y's flat.

Comment

The use of a CTO was not available to the team and this hampered their ability to provide robust supervision. In a later section we consider what contact, support and supervision was available to support Ms Z when she was discharged.

Risk assessments and risk planning

6.83 The trust risk assessment policy in force at that time states:

> *"Service users should undergo a risk assessment under the following circumstances:*
>
> - *On first contact with services,*
> - *Periodically – for the ongoing routine management of severe mental disorder*
> - *Following an incident, and*
> - *Before granting approval for leave."*

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[11] CTO's were introduced in November 2008 as part of the revised MHA. A CTO can be put in place when a consultant is considering discharging or granting leave to a patient detained on section 3 of the MHA. Once a CTO is in place, the following actions can be taken:

- The patient can be *recalled* to hospital temporarily for assessment;
- Once recalled, the CTO can be *revoked*, which resurrects the detention;
- Alternatively, once recalled, the patient can be *released* back onto the CTO;
- The patient can be *discharged* from the CTO at any time.

6.84 Ms Z's inpatient admissions included frequent violence and threats of violence. We set out below a summary of incidents:

Date	Incident	Risk assessment
Solent Ward		
25 November 2006	Admission to Shore Ward (CNWL trust)	Full risk assessment
November 2006	Admission	Brief risk assessment completed
3 December 2006	Assaulted by a patient	No risk assessment
4 December 2006	Threatened to kill a patient	No risk assessment
5 December 2006	Ms Z tried to put a scarf around a patient's neck. She hit a nurse undertaking close observations and an occupational therapy (OT) student also overheard Ms Z threatening to kill a doctor.	No risk assessment
7 December 2006	Threatened a occupational therapist	No risk assessment
(Uncertain date) December 2006	Threatened to kill everyone if she did not get a certain drug	No risk assessment
20 December 2006	Threatened to crucify the staff if she did not get Christmas leave	No risk assessment
Fortismere Ward		
1 February 2007	Transferred to Fortismere Ward	No risk assessment on transfer
6 February 2007		Brief risk assessment completed
14 February to 24 April 2007	During this period the ward were planning Ms Z's discharge, granting leave. Ms Z was also regularly returning to the ward drunk.	No updated risk assessment during this period of over two months
15 May 2007	Discharged from the ward into the care of the AOT	No discharge risk assessment was carried out

6.85 We discussed this lack of risk assessments with the current matron, Matron 1:

> *"I think it's very different now compared to 2006, 2007. In those days we had paper records, RIO didn't exist so the starting point there was there was two types of risk assessments. There was, I remember, the brief risk assessment form which had to be done in five days and then you had this very long form. If they were in hospital longer than that you would have to get it done within 28 days and it was about a 10-page document. The problem in those days staff were meant to update it every time an incident occurred but because of the way it was laid out, unless they had it electronically, they were not very good at doing that routinely enough I felt."*

6.86 The trust internal report identifies that the risk assessments completed in November 2006 and February 2007 were brief and not updates of the full risk assessment undertaken in Shore Ward in November 2006. The trust report says this approach was not ideal because it:

> *"…duplicates paperwork already completed and second a continuous risk history is not maintained on one document."*

6.87 The purpose of a risk assessment is to determine whether a risk management plan needs to be developed or updated. Even the brief risk assessments carried out did not lead to a risk management plan.

Comment

It is important that a patient's risk history is maintained in one document so that it can inform risk management plans. Some of the incidents, such as those on 5 December 2006, were of serious concern and should have been documented, whatever the difficulties of updating paper-based risk assessments. The trust policy is clear that there should have been **"a more detailed risk assessment [which] is required following a suicide attempt or a violent incident".**

Even where risk assessments were completed, they did not lead to the revision or even construction of a risk management plan. This is poor practice and potentially unsafe.

Current situation

6.88 We were told by a number of our interviewees that significant improvements had taken place since the implementation of the trust's patient computer system, RIO. The system was implemented after this incident, so all risk assessments at the time were paper-based. The new system enables anyone directly caring for an individual to see all the risk history in one place. The medical director told us:

> *"It's just so much easier than it used to be, I will say, because what used to happen was people hopefully didn't write in a document, they would have done right at the beginning of this, but they would generate a new document every time they did it. So what happens now, what's easier, is that any of us can update someone's risk assessment whereas we couldn't before, so the care coordinator would be the holder of the document."*

Comment

The new system will lessen the likelihood that an incident like Ms Z's violence against her grandmother would not be part of the assessment record, making for a more comprehensive and cumulative picture of an individual's risks.

6.89 We were also told by some of our interviewees that risk care plans were now audited quarterly to ensure (among other matters) that a risk management plan was in place and, as the medical director said, the *"…document has a purpose and generates an action plan for the individual"*.

6.90 The medical director also told us that the AOTs had moved away from individuals managing clients on their own to more of *"managing risk together"*. They now meet daily to discuss the key current issues affecting a client's risk and cases are allocated a red, amber, and green (RAG) priority rating.

Comment

The implementation of RIO has undoubtedly made a significant difference to:

- ***encouraging regular updating of clinical records***
- ***maintaining a risk assessment that is comprehensive and cumulative***
- ***ensuring that all involved in direct care can get timely access to records.***

We learned that the system was being updated, with increased functionality to improve the core assessment document and to add a prescribing and MHA module.

The changes to team practice described above are undoubtedly helpful. But the need to complete risk assessments and to produce risk management plans has been well-established policy in the NHS for a number of years. The high level of non-compliance in 2007 is surprising.

Gender bias

6.91 We explored with staff whether Ms Z's gender contributed to the underestimate by staff in the community and in hospital of Ms Z's potential for violence or self-harm. For example, we asked whether the same actions would have been taken if it had been a man who had put a scarf around another patient's neck.

> Consultant psychiatrist 4: *"Yes, but because men are more dangerous, you may miss the smaller number of women who are dangerous as well because you slightly underestimate it."*
>
> Head of social care: *"I think that Ms Z probably, looking at the scale of risk across the team, as a woman would probably have not been put in a category of somebody who is… of a higher risk because there are a lot of very risky clients within the assertive outreach team who are men, who are big… and we know that our perceptions often of these clients are that they are the people who are most risk."*

6.92 Consultant psychiatrist 3 told us:

"…the threats to kill are an anomalous event for clients. Ms Z made that threat numerous times over the years and I think that people just became inured to it as part of a histrionic presentation and did not give it perhaps the same force as it might have from another client."

"…she did not strike me as the sort of person who was going to kill someone, whilst working with her. I felt that she was much more likely to be harmed by someone else, given the domestic violence issues and the history and the vulnerability she had shown. She was a tough person, I believe, that I never thought that she would actually stab someone in the way that she did."

Comment

It is clear from our interviews that the main focus of concern about Ms Z was her vulnerability as opposed to her propensity for violence. Men may be statistically more dangerous than women but there were enough indicators in Ms Z's frequent threats to staff, other clients and her family that should have triggered some warning to staff.

Undertaking risk assessments provides the time and opportunity for the team to consider issues of gender, ethnicity and to consider whether a client who's staff expect to be less risky is showing warning signals. Teams should also use their team meetings to challenge a possible bias in their thinking. Therefore risk assessment should not be allowed to become a tick-box routine – whether on paper or electronically.

Escalation

6.93 Consultant psychiatrist 3 told us:

"Ms Z was quite a challenging client for us to work with. She had probably the most socially disruptive dimension to her care that I can remember with any of my clients, and some of them have very severe and enduring mental illness."

Consultant psychiatrist 4: *"I think this lady would always be challenging. You know she would always be very difficult to support and when I was reading the story it was as if there was a self destruct button in there you know. I mean I think I read that more clearly than the kind of destruct other people button so that was the interesting thing."*

"She would be top end. She'd be top end in the kind of worry list because of all the things we've said already. She'd be one of the most challenging."

Comment

Ms Z clearly had complex needs, making her difficult to help and to engage with. Her presentation to staff fluctuated over time. The trust report finds that the AOT staff may have become used to high tolerance levels in working with difficult-to-manage clients. We believe this propensity can also impact on ward-based staff and may have done so in this case.

6.94 Ms Z was violent and made threats of violence. She was frequently non-compliant with contract conditions not to abuse alcohol and drugs. Even so, she was not assessed for transfer to a psychiatric intensive care service (PICU) and neither was a request made for a forensic assessment.

Comment

One of the difficulties the inpatient team faced was that Ms Z's mental health symptoms had subsided and her main difficulty was her social disruption and drug and alcohol abuse. Therefore a referral to a PICU was unlikely to have been accepted.

6.95 We asked Matron 1 and consultant psychiatrist 4 what access the team had to support from the forensic service:

> Consultant psychiatrist 4: *"Forensic is an interesting world because it's a post-event world."*
>
> *"You have to do something and you have to be convicted of doing something…"*
>
> *"This idea that forensic psychiatrists and forensic services know how to manage people who may be dangerous but don't have a conviction is one I'm not entirely sure of. Because what they know about is caring for people who are on detentions which means that they have to stay in a high secure or medium secure setting for many years."*
>
> *"So when I ask for forensic reports they tend to say keep them in hospital, don't give them any leave and keep them on high doses of medication and it's, in the real world that we are working in, we can't really do that."*

6.96 We also asked consultant psychiatrist 3 how he dealt with clients who made threats of violence:

> *"Since Ms Z's threat to kill and the aftermath of it, I have just become quite pedantic in some ways, so that anyone who makes a threat to kill now gets referred for a forensic assessment, urgently, basically."*
>
> *"…if it feels like if the client fits an identikit of someone who might commit a risk event – and most of our clients do – we now refer them for a forensic assessment. So that is one change in practice, it has become much more explicit."*

6.97 We were told in our interviews that one of the forensic consultants from a neighbouring trust visits the community services every Wednesday when individuals can consult them. We were also told in our interviews that few ward-based staff use this opportunity.

Comment

A number of trusts have developed links with forensic services to enable closer working and in particular co-working between the forensic service and trust practitioners. This co-working is not limited to consultant-to-consultant referrals but nursing and other practitioners as well. Closer working allows skills to be shared and greater understanding to develop.

Co-working between drug and alcohol and trust services is now common in some trusts and has resulted in clients with mental health and substance misuse problems receiving more holistic treatment. Forensic services may not be able to provide the expertise in how to manage clients with minimal restrictions but they can bring greater expertise in assessment and prediction of risk though their client group.

Recommendation

R1 The trust and the PCT should review the commissioning of forensic services to ensure there is provision for co-working between staff in forensic and general adult services.

7. Community care: May 2007 – 21 September 2007

7.1 This section covers a period of just over four months before the death of Mr Y. Ms Z often avoided contact with services unless she needed them for practical support, such as money. Ms Z had an allocated place in a hostel but she was living at various addresses. The AOT's contact with Ms Z was mainly at community venues such as cafes. This period is characterised by manipulation by Ms Z and unclear plans regarding how to help and respond to Ms Z by the AOT.

7.2 On 15 May 2007 Ms Z was discharged to a hostel in Brent outside the catchment area of the trust.

7.3 On 17 May Ms Z was arrested for being drunk and disorderly. A forensic medical examiner assessed her and recommended an assessment under the MHA. A referral was made to Westminster Emergency Duty Team (EDT) who confirmed that Ms Z had been discharged only two days earlier. The EDT and two MHA section 12 approved doctors tried to assess Ms Z but she refused to be seen. Neither doctor felt that they could make a recommendation for her detention because they did not have enough information, so she was kept in custody with a plan to reassess her the next morning. South Camden approved social work service and North Camden intake team disagreed about who should assess Ms Z because neither had received a referral. The care coordinator contacted Westminster duty team who said they were not dealing with the case either. This resulted in a delay in the MHA assessment. On 18 May 2007 Ms Z was placed on a MHA section 136 and North Camden intake team were asked to assess her.

7.4 On 21 May a social worker assessed Ms Z and she was able to leave the police station.

Comment

This confusion about who should assess her was based on territorial disagreements and was not based on what was best for Ms Z. It is important that professionals and their managers take a partnership approach with neighbouring boroughs so that emergency assessments are not hampered by territorial disputes that leave service users vulnerable.

7.5 On 22 May the care coordinator met Ms Z. Ms Z reluctantly admitted she had been arrested. She agreed to go to the AOT office for her depot medication but failed to attend.

7.6 On 1 June 2007 Ms Z failed to attend an appointment with the AOT. The AOT contacted Ms Z's father, who said that Mr Y had thrown her out. He said he did not know where she was.

7.7 On 5 June 2007 Ms Z kept an appointment with her care coordinator. She said she was back with Mr Y.

7.8 On 8 June 2007 Ms Z did not attend an appointment with the AOT. Ms Z's father contacted services a few days later to say that she showed evidence of psychosis and that she was staying with a female friend.

7.9 Ms Z's father contacted the AOT on 13 June to say that Ms Z was taking speed and had no medication. He felt she should be sectioned.

7.10 Ms Z phoned the AOT team manager to say she was no longer with Mr Y but living with another man in Camden. She also said she was taking her medication and did not need any more help.

7.11 On 15 June Ms Z failed to attend an appointment with the AOT. Later that day Mr Y contacted the AOT to say that Ms Z had a black eye and an injured nose. Ms Z had told him she had been raped. Mr Y was advised to tell police and take Ms Z to hospital but he said Ms Z would not allow it. Staff contacted Ms Z's father, who said that he had spoken to her in the last two hours and she sounded fine and did not complain of an injury. The AOT went to see Ms Z at Mr Y's flat the same day. Ms Z denied having been raped and was antagonistic.

7.12 On 19 June Ms Z did not attend a planned meeting with the AOT. The care coordinator went to Mr Y's flat but found no one in. Later the same day Ms Z contacted the care coordinator asking for money. When Ms Z arrived at the office she said she had been raped and badly beaten. The care coordinator noted that she had cigarette burns to her knuckles. Ms Z refused police involvement. The care coordinator noted underlying psychosis.

Comment

These were serious allegations and should have led to a referral to the adult protection department, an update of the risk assessment and consideration of review by relevant professionals involved with Ms Z.

7.13 On 22 June, three days later the care coordinator met with Ms Z, who appeared low and difficult to engage. She said she had fallen out with Mr Y and was living back at the hostel. A discussion also took place with the care coordinator about whether she should manage her own money rather than be subject to appointeeship, but they agreed it was not a good idea.

7.14 On 3 July the care coordinator met Ms Z. She wanted money to buy a snake. She continued to express dissatisfaction with being on appointeeship.

7.15 On 6 July Ms Z failed to attend an appointment with an occupational therapist.

7.16 On 10, 13 and 17 July Ms Z failed to attend appointments with the AOT.

7.17 On 19 July Ms Z called into the AOT office. She had shaved her head and looked unhealthy. Ms Z demanded £10.

7.18 On 24, 27 and 30 July Ms Z failed to attend appointments with the AOT.

7.19 On 6 August Ms Z's father contacted services to say that Ms Z was becoming more psychotic. The care coordinator met Ms Z and noted that she appeared well.

7.20 On 9 August Ms Z’s risk assessment was updated. The risk summary included the following:

- self-harm
- exploitation by others
- self-neglect
- non-compliance
- homelessness.

Comment

It is essential when updating a risk assessment to review the notes to ensure that previous risks have been recorded so that they can be taken into account when putting a risk plan into place. The trust identifies in its report that the following factors - matters of record before this date - had not been recorded in this updated risk assessment:

- ***the death of Ms Z’s grandmother, with whom she was close***
- ***Ms Z’s threats to kill staff when on the ward***
- ***assault of a ward staff nurse***
- ***Ms Z’s sexual disinhibition on Solent Ward.***

It appears that the focus of the risk summary was Ms Z’s vulnerability and her propensity to violence and threats was overlooked.

7.21 A plan was put in place which included:

- holding regular one-to-one meetings
- monitoring medication
- regular CPA meetings
- support Ms Z to report to police any instances of violence
- encourage engagement with housing worker
- help to find meaningful daytime occupation.

Comment

There is evidence that Ms Z was becoming increasingly unwell by now. On 19 June her care coordinator noted an underlying psychosis. On 6 August her father said she was becoming more psychotic. She failed to attend seven appointments in July. The team updated her risk assessment and put in place an updated plan to provide greater supervision.

7.22 The care coordinator went on long-term leave at this point and care coordinator 2 (a locum) was appointed to cover. Prior to going on leave the care coordinator told Ms Z and her father that this was happening.

7.23 On 10 August care coordinator 2 held the first meeting with Ms Z.

7.24 On 14 August the AOT met Ms Z in a café and reported that Ms Z looked unkempt and that she vomited. Ms Z asked for £50 for clothes. Two days later her father contacted care coordinator 2 to say that Ms Z was worse and on 17 August he requested that the AOT visit Ms Z at home. The AOT visited but Ms Z was not there.

7.25 On 21 August Ms Z failed to attend a planned meeting with AOT. The next day (Wednesday) Ms Z called to request £100 for collection on Friday.

7.26 On 23 August Ms Z's father contacted care coordinator 2 to say that Ms Z was on a psychotic drugs binge and had been walking along the canal at night. He said Ms Z had attacked him the night before and that he felt she needed sectioning. The same morning a discussion took place in the team and it was agreed not to grant Ms Z's request for £100 because of her poor record of engagement with the AOT. She called the AOT later that day and threatened to shoot staff if she was not given the money. She also accused a member of staff of taking money from her account. The risk assessment was not updated to include these threats.

Comment

Care coordinator 2 was a locum and therefore reliant on the handover from Ms Z's care coordinator and the team's knowledge of Ms Z. The team meeting discussed Ms Z on 23 August, so care coordinator 2 was able to draw on the team's knowledge of Ms Z. This is good practice.

7.27 On 24 August Ms Z's father contacted services to say that Ms Z had asked him to ring up to get the money and that she would shoot him if she did not get it. The AOT decided to refer Ms Z to the EDT/crisis team because she was breaking down. The risk assessment was not updated to include new information about threats.

Comment

The failure to record Ms Z's threats is serious. The AOT is set up to support difficult-to-manage clients so the need to ensure that risk assessments and risk management plans are kept up to date and complete is even greater.

We found no record that Ms Z was referred to the crisis team and her care records provide no indication that any action followed a referral.

7.28 Also on 24 August care coordinator 2 met with Ms Z in the community café where she had met AOT staff previously. She was unkempt and had bruising on her legs and scarring to her temple. She said she had been in a fight with two prostitutes and that one had hit her over the head with a bottle. The café manager told Ms Z that she did not want her to visit her café again.

7.29 On 28 August Ms Z's father told services that Ms Z had turned up at a family party on 25 August in a bomber jacket and pyjama bottoms. She appeared aggressive and delusional.

7.30 Ms Z's father also said Ms Z had been with relatives on 22 August and threatened to attack two people in the street. The clinical risk assessment was not updated to include this information.

7.31 Ms Z's father said Ms Z was not staying at the hostel and that it was likely that she was taking speed or crack cocaine and drinking a lot. The AOT told Ms Z's father they would see Ms Z later that day. In the event, she missed the appointment.

7.32 On 29 August Ms Z's father contacted the AOT and said he had not seen Ms Z for a few days. He wondered whether she should be reported to police as missing.

7.33 On 29 August the AOT contacted the hostel and were told that Ms Z had not been there for at least four days.

7.34 On 31 August Ms Z did not attend a planned meeting with her care coordinator.

7.35 On 3 September Ms Z contacted the AOT and said she was living at Abbotts Lane Hostel and had no money for food. Ms Z also said her father was told that she could collect £100 from the AOT. This was not sanctioned. She went to the office later that day asking for the money.

7.36 On 4 September Ms Z and her father met a member of the AOT. Ms Z's father left saying he would pick up some of her things from her boyfriend's flat. Ms Z repeated her allegation that he had assaulted her. Ms Z made no specific threats but she was hostile and using threatening language. Ms Z's father returned at the end of the meeting and made clear to the staff member that he thought Ms Z was unwell and should be sectioned. A plan was made to discuss this in the team meeting in the afternoon.

Referral for a MHA assessment

7.37 This part of the chronology covers about three weeks. In this period the AOT decided that Ms Z needed a MHA assessment with a view to compulsory admission to hospital. Problems in communications meant the assessment was not undertaken before Ms Z killed Mr Y on 21 September.

7.38 On 5 September Ms Z's new care coordinator referred her for a MHA assessment to South Camden ASW service but was told by the team that she was out of their catchment area.

7.39 Consequently, the AOT team manager phoned Brent East Sector mental health service the same day to refer Ms Z for a MHA assessment. She was called back by the Brent East Sector team in the afternoon and was told they (Camden and Islington) should do the assessment themselves because Brent were short of staff.

Comment

A pan-London protocol deals with who should carry out MHA assessments when a client lives in another borough. We comment below on its effectiveness.

7.40 On 6 September the team manager asked care coordinator 2 to call Brent again. Care coordinator 2 phoned Brent and asked for a copy of the referral form, which was faxed to her.

7.41 On 7 September care coordinator 2 faxed the completed forms back to Brent East Sector service for a MHA assessment. Brent East Sector phoned back later that day to say that the referral would be discussed at a meeting the following week.

Comment

Care coordinator 2 did not realise at this point that the referral had mistakenly been accepted as a referral for attention by the community mental health team and not as requested for a MHA assessment.

7.42 On 7 September Ms Z phoned the AOT demanding £100 for clothes and travel expenses. She threatened to shoot staff or *"someone before midnight."* She refused to meet the team to discuss her engagement. The team manager and care coordinator 2 agreed that Ms Z would receive £50 for travel expenses.

7.43 Care coordinator 2 and a support worker met Ms Z at some point in the day and their impression was that she was not detainable. This was the AOT's last face-to-face contact with Ms Z.

7.44 On 7 September Ms Z's father phoned the AOT to advise that he had tried to get Ms Z to see her consultant and that she was still psychotic.

7.45 On 11 September Ms Z did not attend a meeting to collect her medication as arranged with the AOT and did not inform them that she was not attending. On enquiry the hostel staff confirmed that Ms Z had slept at the hostel and had been seen by them that morning.

7.46 On 13 September Ms Z phoned to say that she had gone to her meeting with the AOT outside the café but no one from the team turned up. She would not give staff her mobile phone number but agreed to meet with the consultant from the AOT the next day.

Comment

This was the last direct contact between the AOT and Ms Z before the homicide on 21 September, eight days later.

7.47 On 14 September Ms Z did not attend her meeting with the consultant. Staff contacted the hostel to check her whereabouts. The hostel staff confirmed that they had seen her the night before and during the morning but there was no answer from the telephone in her room.

7.48 A further meeting was set up for 18 September but Ms Z did not attend. Staff contacted the hostel to check her whereabouts. The hostel staff confirmed that Ms Z had last signed in on 16 September.

7.49 On 19 September care coordinator 2 called Brent East sector to follow up the referral. It transpired that it had not been placed in the MHA assessment referral book. The referral with a covering letter was faxed by the AOT to the team again. This referral follow-up occurred 16 days after the original referral for a MHA assessment.

7.50 On 21 September 2007 Ms Z stabbed and killed her boyfriend Mr Y.

Analysis

7.51 We now examine a number of themes arising from the period of Ms Z's care from her discharge from Fortismere Ward in May 2007 to the time she killed Mr Y. We identify the following themes:

- AOT team work
- safeguarding
- de-sensitised to risk
- appointeeships
- dual diagnosis
- pan-London protocol
- family involvement.

AOT teamwork

7.52 The principal responsibility for Ms Z's care when she was discharged from hospital now rested with the AOT. The AOT's role is described on the trust website:

> *"Assertive Outreach Teams, known also as assertive community treatment teams, provide intensive support for the severely mentally ill people who are difficult to engage in more traditional services. Many will often have a forensic history and a dual diagnosis. Care and support is offered in their homes or some other community setting, at times suited to them. Workers can be involved in direct delivery of practical support, care co-ordination and advocacy as well as more traditional therapeutic input.* ***The aim of the service is to maintain contact and increase engagement and compliance."[our emphasis]***

7.53 Ms Z was still displaying serious signs of non-engagement before she was discharged. She continued to get drunk and exhibit paranoia, anger and suspicious behaviour. Her arrest two days after discharge illustrates this.

7.54 Ms Z's discharge plan on her release from hospital in May 2007 included twice-weekly visits; appointeeship for handling her money and encouraging her to attend a weekly group.

7.55 We asked the medical director in her opinion *"…how assertive 'assertive' was in this case?"*:

> *"I mean, she was very difficult and she didn't want to be seen, but there were opportunities that we felt were missed, so things around going to collect money…whether or not we could in some ways link her appointeeship with her seeing her care coordinator, for example. Or whether or not we should actually be going round to this hostel more often, because I think that was the other thing that we felt, the gaps between attempting to see her seemed to us perhaps not as frequent as, as you say, an assertive outreach team…"*

> *"They're supposed to be creative in their ways of engaging people, so we felt that more could be done."*

Comment

One of our interviewees described Ms Z as* "top of the worry list"*. It is not unusual for some AOTs to plan to visit their clients daily when discharged from hospital and to reduce the intensity of visits in a planned way depending on their assessment of progress and risk. It is surprising that the team did not take a more assertive approach to Ms Z's care plan. This may have been due to the team being desensitised to risk due to the client group they care for, which we deal with below. It may also have been due to team's attitude to Ms Z because of her gender. We were told in interview that major changes to team working were being planned and we also deal with this below.

Safeguarding

7.56 It is clear from the chronology that Ms Z was a vulnerable individual. Drug dealers had taken over her flat; she was abusing drugs and alcohol. She had also been the subject of violence. As set out in the last risk assessment the risks that she faced were:

- self-harm
- exploitation by others
- self-neglect
- non-compliance
- homelessness.

7.57 Camden safeguarding procedures applicable at the time provided processes to bring together the relevant professionals and agencies to put in place plans to *"safeguard"* the individual. These procedures applied to individuals at risk of the following abuses:

- physical
- sexual
- psychological
- financial and material
- neglect and acts of omission or inadequate care
- discriminatory.

7.58 The safeguarding procedures allow for a case conference to be called to bring together all relevant agencies and as a result to put in place an adult protection plan.

7.59 The AOT had referred Ms Z to adult protection just before her last hospital admission but we found no record that any action was taken as a result and no follow up by AOT is recorded.

7.60 Despite the lack of a formal safeguarding case conference, consultant psychiatrist 3 told us:

> *"We had, I remember, with Ms Z, one of the longest CPA meetings that I have ever been* [in] *it was almost three hours which is unheard of. The reason is because we had the housing people in at the time and we had input from the police and this was just before the flat in Pratt Street was blocked off* [October 2006]. *A great deal of effort had gone into the housing issue in terms of trying to protect Ms Z from becoming homeless. A great deal of effort had gone into trying to engage her…* [including] *drugs support services. I think that the fallout from that meeting was that the immediate impression that one might have in a situation like that – let's do a case conference – may not have been as strong, because we felt that we had tried to deal with the various disparate social elements and it had not come to anything. Ms Z was a very strong-minded, independently minded person. She really did not take to being asked or suggested or told what to do."*

7.61 This case conference took place during Ms Z's last hospital admission and was in the spirit of the safeguarding procedures if not completely in line with them.

Comment

There were enough concerns about Ms Z's vulnerability during her community care between May and September 2007 and whilst she was living in the Brent hostel to call another case conference or to make a safeguarding referral. Such a referral would have provided an opportunity to bring together the various agencies such as housing, the police, her family, as well as trust staff to agree a plan to manage her rapidly deteriorating social situation and mental health.

7.62 Consultant psychiatrist 3 told us:

"I think that if there was one failure about which I feel very regretful, it is that we did not have an overview of all the bits [of information] *that were coming in from different places and maybe were not recorded in one particular place…"*

Desensitised to risk

7.63 The following quotes provide a context to this section:

Deputy manager, Camden AOT: *"I think sometimes we carry such huge amounts of risk on our shoulders that you can become not immune to it but because there is so much."*

Ms Mundt-Leach: *"Perhaps you become slightly desensitised."*

Deputy manager, Camden AOT: *"A little bit, I think you can,"*

Head of social care: *"I think it is very hard in assertive outreach team when you talk about tolerance levels and desensitisation because it's not just within the assertive outreach team but where we are geographically in Camden it is the busiest borough in the whole of England in terms of the amount of assessments that it actually undertakes under the Mental Health Act. We see incredibly high levels of illness, psychosis and mania that you probably do not see as frequently in other places. I think workers are consistently exposed to very acute distress all the time."*

7.64 The AOT carry a caseload of challenging clients. Ms Z was challenging as a result of her social disruption and potential vulnerability but she was not seen as potentially violent or at risk of committing a homicide.

7.65 The trust report acknowledged this difficulty and said:

"The panel considered the potential consequences of continual exposure to service users who meet these criteria might have an effect on tolerance levels within the team."

7.66 The deputy manager for Camden AOT told us:

"I think there are five or six clients that we all find particularly challenging, and I think we make an effort to avoid burn-out by making sure that they're not just seen by the care co-ordinator and that everybody participates and visits. Invariably these are the people that generate the most discussion, and sometimes possibly to the detriment of others but because of their profiles and the level of risk that they present or the cares that they're generating, we find that we do talk about them an awful lot."

7.67 The trust included in the report a recommendation that addressed this issue of becoming desensitised to risk:

"AOT to reflect on their operational policy to ensure that thresholds for action are appropriate and are not affected by high tolerance levels. Consideration should be given to external facilitation or supervision in order to challenge and reflect on the effects of continual work with a complex population of service user."

7.68 We address in the next section the progress the trust has made with its recommendations. Interviewees told us that while they had a psychologist do some external facilitation, this was about team building. The psychologist did not provide continuing external challenge or advice in how to maintain a sensitivity to risk with this client group.

Comment

Working with clients with such high needs and risks and in a part of London where the proportion of such clients is high must lead to the possibility that staff can become desensitised to such risks. It is important therefore that the staff and the trust recognise this risk. Staff should ensure that constructive challenge is part of the way the team works together. This should be combined with strict adherence to risk assessment, risk planning and safeguarding procedures. Trust senior managers should also be alert to the danger of desensitisation and burnout. Help should be given to teams to ensure that they are supported with time out for regular reflective consideration of how they are handling high-risk cases. The time out should be supported by external facilitation.

Recommendation

R2 The trust should fully implement its recommendation 16 for each AOT and ensure that this is a regular part of teamwork. The recommendation states:

> *"AOT to reflect on their operational policy to ensure that thresholds for action are not affected by high tolerance levels. Consideration should be given to external facilitation or supervision in order to challenge and reflect on the effects of continual work with a complex population of service users."*

Appointeeship

7.69 Part of Ms Z's discharge plan was to have her benefits controlled by local authority appointeeship arrangements. This arrangement allowed for the AOT with the local authority to supervise her finances. Before Ms Z could access her money, the local authority officer would check with the AOT that the amount she was asking for was appropriate.

7.70 The trust report panel said "…*consideration should have been given* [by the AOT] *to linking Ms Z's money with her appointments*". The panel made a recommendation in this regard (recommendation 19). This approach would have meant Ms Z attending the team offices to get her money. We received a mixed response to this suggestion:

> Deputy manager, Camden AOT: *"There are occasions when we do it, or if a client isn't going to be able to get down or if they've been admitted to hospital, then we'll go and collect their money. I think there is something, particularly if a client isn't engaging, and I think there's possibly some mileage around having some kind of protocol or pro forma around how we do that and when we do it and making sure that it's clearly documented, the reasons for doing it."*
>
> "*We have had an issue about a client accusing a worker of stealing money and so I would want to make sure that before we actually did that we had something very robust in place to actually support the clients from complaints really."*
>
> Head of social care: *"But it's also an ethical question, isn't it? How far do you go in terms of that engagement process and holding on to somebody's money, saying 'Come and see me and I'll give you money.' There are, I think, certain ethics.*"

Comment

Services dealing with socially disruptive and vulnerable clients have limited ways to promote effective levels of engagement. We think the use of money as an incentive should be explored. There are clearly practical procedures needed to avoid abuse and complaints. The ethical issues are not insurmountable, and the trust recommendation 19 should be taken forward.

Dual diagnosis

7.71 Ms Z had a long-term problem with the abuse of alcohol and drugs. Staff from the dual diagnosis service made arrangements to assess Ms Z during her last hospital admission but she denied that she had a problem. This denial made it difficult to work directly with her. We therefore explored what help and advice was available to the AOT either to work with clients or to provide advice and support. Both the team manager and her deputy told us that about a quarter of AOT clients had drug and alcohol problems as well as mental illness. We asked the AOT team manager, what provision for helping such clients was available for the team.

> *"There has been a change in the last couple of years: we used to have someone based within the drug services who would assess people at that pre-contemplative stage, or help us work with that, but that person isn't there any more, so there is less resource now than there was. Access to drug and alcohol services is very much if people are wanting to decrease and to abstain, so most of the pre-contemplative work would be carried out by care coordinators."*

7.72 The deputy manager for Camden AOT told us:

> *"…there is a dual diagnosis lead for the trust, a lady called D, who has certainly done some consultation work with us and has come and attended clinical meetings and actually had some time with care co-ordinators and that's been very useful.*
>
> *What we haven't had so much is any kind of collaborative work whereby a dual diagnosis worker or a substance misuse specialist has come out and actually seen clients. Again, I don't know what flexibility there is in substance misuse."*

Comment

This is a selection of quotes from our interviews related to this subject but our overall impression was of a reduction in resource for clients with a dual diagnosis within AOTs.

Recommendations

R3 The trust should review/audit the number of staff in each AOT who have had recent and relevant updating in caring for clients with a dual diagnosis. If the audit reveals that too few staff have been recently and adequately trained, this should be remedied as promptly as possible.

R4 The trust should review the support available to AOTs to ensure that there is adequate provision of input from specialists in drug and alcohol services for the client group of the AOT. The provision should allow for joint working where needed and regular contact with each AOT.

Pan-London protocol for MHA assessments

7.73 Ms Z was obviously deteriorating in May, August and September 2007. Two attempts were made in these periods to have her assessed for a compulsory admission under the MHA.

7.74 The first came two days after her discharge from hospital in May 2007 and the second in August-September 2007. The first attempt led to disagreements between North and South Camden intake teams about who was responsible for the assessment.

7.75 The second request for an assessment was made on 5 September to the South Camden Service. They said that Ms Z was not in their area so the team manager made a request to Brent East Sector Mental Health Service who initially asked that the Camden team do it themselves because they were short-staffed. They later accepted the referral but it was placed in the wrong in-tray and was not acted upon before the homicide.

7.76 London has a pan-London protocol[12] that gives guidance on what to do when a client lives in another borough. The guide says:

1. *"Under the 1983 MHA Approved Social Workers (AMHPs) are empowered to undertake MHA assessments out of the boundaries of their employing authority.*

2. *The Act also states that the legal responsibility for undertaking assessments lies with the Authority within whose boundaries the person is at the time when the need for the assessment arises.*

3. *Usually, best practice would indicate that the authority best able to provide a thorough and high quality assessment is the authority in which the person ordinarily resides. This is because that authority will have knowledge of health service and other local resources, alternatives to hospital, easier access to family and friends and on many occasions the person will be known to that authority and recorded information will be available."*

7.77 The guide encourages assessments to be undertaken by staff from the borough in which someone is *"ordinarily resident*", a term it does not define. Ms Z had been discharged from hospital and was placed in a hostel in a neighbouring borough. This leaves open the question of whether Camden and Islington, where she had lived for a number of years, or Brent where she was now living, was her place of ordinary residence. We discussed this with the manager of the approved mental health professional service for Camden at the time of the incident. She had worked in AOT as a manager until 2004. She had also regularly undertaken MHA assessments. We quote extensively from her evidence on this point because she appeared to be expert in this area.

[12] Good Practice Note for Approved Social work Assessments out of the Borough of Ordinary Residence.

Permission to undertake assessments in other areas:

"…you can work in any borough if you have a warrant, but if you go to work for another borough they have to say that you're a suitable person to act as an approved mental health person so you would have to go through their warranting process."

Local agreements

"The pan-London protocol says that if your client does move from one area to another, particularly if that area is your neighbour…then you should go out, you should follow your client through and undertake that assessment under the Mental Health Act. But what would be really helpful as part of this investigation is that actually that does not happen across London."

"In Camden now it happens because we had this investigation and I shared this protocol with people and said 'Look, none of us are abiding by this protocol'. What I did was worked really, really hard at developing those relationships with AMHP leads in all the other boroughs, so Westminster, City of London, Haringey, Brent, Islington, I think that's it, and we did put in place agreements with the AMHP leads that we would do our own clients' assessments."

Q. *"So they have said that your AMHPs are automatically warranted as long as your borough has warranted them."*

"Yes, we're all warranted…However if you leave a borough and go to work for another borough you are not warranted until you have been through that boroughs warranting process."

Q. *If you negotiated that but at the same time you're saying 'It's not working' is it not working with other boroughs?*

"There was a Brent resident in A&E at the Royal Free Hospital. The Camden AMHP was taking the referral and was just going to go out and deal with it and I said 'Why are you doing that?' This is Brent's responsibility under this protocol to come out and see their client and undertake that Mental Health Act assessment because it is the role of the AMHP to decide whether or not there is a least restrictive alternative to hospital admission."

Changes to the pan-London protocol

Q. *"What would you want to see changed in the pan-London guidelines?"*

"This is very old, so it probably will need to be looked at again. More weight needs to be given to the protocol and I'm not sure by whom, but it needs to be reworked, it needs to be looked at again, and it needs to be fed back to AMHP leads from local authorities probably that this is very from very, very senior management within local authorities, CEOs, who have come together, they've looked at this and they've said 'We want you to do this, this is best practice, you must follow your client through'."

"It's very, very tempting, and I have to be a hundred per cent honest, the key driver for me was that I understood that Camden is so busy and we do so many out of area assessments on people from Westminster who walk along the Euston Road and find themselves picked up by police and taken to UCH, or somebody from Brent. We are so busy with them: 37 per cent of assessments in Camden are done on people who don't belong to Camden. It was within our interest to have these agreements in place because actually not only was it good practice but it did actually lessen the workload for AMHPs in Camden."

Ms Z's assessment

"I remember it really, really clearly that [care coordinator 2] actually came to me as the AMHP manager and said 'Look, this person needs an assessment under the Mental Health Act'. I think her manager was not

around at the time and I said 'Well, look, you must call Brent. Try and organise it with them if you're having any problems let me know.'

"What our service would do is try and negotiate on the service's behalf if they were having problems. [Care coordinator 2] went away and spoke to Brent and they accepted the referral and then there was a delay in terms of this actually happening.

I truly believe that it's not good practice, especially when you have boroughs on your border, to be doing that."

7.78 The only person in the AOT warranted to undertake a MHA assessment at the time was in a late stage of pregnancy and was therefore advised not to do it, which is why care coordinator 2 was advised to ask Brent to undertake it.

7.79 The trust report says:

"The panel considered that arrangements should have been made for Care Trust services to assess Ms Z as the delay caused by referring out of borough was unacceptable."

Comment

We accept the panel's view that someone from another trust team could have been asked to undertake the assessment. The delay was significant in this case, though there is no certainty that an assessment would have inevitably led to a compulsory admission to hospital.

Time between referral and assessment

7.80 We explored how long after accepting a referral the assessment would take place. We were told in our interviews that before an assessment could begin not only must the social worker and doctors be available but in most cases also an ambulance, the police and often a locksmith, so that detention can be put into effect at once if necessary. Requests for assessments are not normally undertaken

if staff believe that an individual would or could be persuaded to attend hospital voluntarily.

AOT team manager:

> *"If you need police assistance, there are certain slots. Obviously if you go to see someone, they need there and then to be assessed and taken away, you can obviously call the police then, but in terms of what the arrangement is, there are certain times that the police will be available for Mental Health Act assessments, and we the duty team would book a mental health – so if we called, say on Friday, it might be that there's a police slot available the following Thursday. It could be a week, it could be two weeks, if police are needed."*

Medical director:

> *"We do have a problem with the police – in Camden they have one day a week when they will do Mental Health Act assessments, on a Thursday, that is an improvement on the previous situation. We do have to book in assessments, so in Islington we have to book in as well through something called the events team. I don't see a Mental Health Act assessment as an event, it's the same team that will coordinate for Arsenal football matches, any of those things it's the same people, and you have to book in, and that is really variable, so sometimes you can get that done very, very quickly, and sometimes you can wait for weeks. Two weeks is quite quick really."*

Recommendations

R5 The trust chief executive should discuss with the SHA a review of the pan-London agreement to ensure greater clarity of the guidance and to promote agreements between London boroughs to allow staff to conduct assessments across London as appropriate.

R6 The SHA should undertake a review of the time it takes to carry out MHA assessments across all London boroughs from the time of referral. The review

should identify any key delaying factors and consider how to reduce the time between referral for assessment under the MHA and the assessment taking place.

Family and boyfriend's involvement

7.81 Ms Z was not living with her parents or her grandmother but they were involved in supporting her. For example, Ms Z's mother was involved in her last admission to hospital in November 2006. Ms Z appears to have had a close relationship with her grandmother. Her father also contacted the inpatient and community teams a number of times to express his concern about Ms Z's deteriorating condition. He also consulted staff about how and when to break the news of her grandmother's death. Mr Y was also a key figure in Ms Z's life and he contacted services at various times to express his concerns for her.

7.82 Consultant psychiatrist 3 told us:

> *"More objectively, however, I think as I suggested, if we had had a case conference and maybe if we had had the father in – it was a strange dynamic with [him]. Sometimes he was posited as the most wonderful thing in Ms Z's life and she would deflect everything by saying that 'you are not as good a doctor as my father', she idolised him…But there were times which were recorded in CPA meetings, for instance, when she suggested that she did not want either of her parents to know what was going on."*
>
> *"Again, with hindsight it is a pity that I was never able to meet or talk with [him]. I have seen many parents of people with whom I work, but he was elusive or was not quite in the picture when one wanted him to be. For instance, I invited him to virtually every other ward round when she was at St Luke's. She would object to it, but when she did agree that he might come, he could not come, because he was afflicted by ill health. The one occasion that he came up, in all the years during which I worked with Ms Z, … I had to take a day off and that was really unfortunate. He came up for one ward round and it still niggles me, it was well before this event, but it would have been helpful, because what tends to happen is that if I meet a parent or a carer, they hopefully have a sense that they can make direct contact."*

"There were ample opportunities for [Ms Z's father] to meet me and we just never met up. When he was expressing his concern he was obviously phoning up members of the team, maybe getting a different member of the team each time. I don't think that anyone was ignoring what he was saying and the information was being fed back…"

7.83 The trust panel report summarises contacts Ms Z's father made and says he contacted the AOT 12 times between June and September 2007, expressing anxiety about his daughter. He twice said he felt that Ms Z should be sectioned. He also told the AOT that he felt she was putting on an act in front of members of the team.

7.84 The title 'assertive outreach team' indicates that the team should not wait for an individual to come to them but rather they should take the initiative. Mr Y played an important role in Ms Z's life but the team did not engage with him as part of their intelligence gathering and assessment processes. Ms Z's father was closely involved in caring for his daughter. Despite Ms Z's father's involvement it is clear that the team did not involve the family in a therapeutic partnership. This is important in producing an accurate risk assessment. The trust CPA policy, appendix 6, section 4.2.1 applicable at that time stated:

"An accurate history of violent incidents is perhaps the most important information to obtain in making an assessment of risk. This information can be obtained from records and referral letters, as well as by asking service users themselves, carers and other family members."

Comment

Enlisting the family as part of the team involved with Ms Z would have enhanced the AOT's ability to provide closer supervision of her.

7.85 The trust panel recommended that:

"Community mental health services should actively involve family members or carers in order to facilitate engagement or review. This should be documented in the care plan."

Comment

We examine later the trust's progress in ensuring this happens, but the involvement of families as partners in care is a long-established part of good mental health care professional practice and should have happened in this case.

8. Compliance with CPA

8.1 Ms Z was placed on enhanced CPA[13] and this level of CPA is for people:

- *"with multiple needs who require co-ordination between different agencies, such as health, social services or housing (even if they are only willing to co-operate with one professional or agency);*
- *who need more frequent and intensive interventions than provided under standard CPA, perhaps with medication management;*
- *who are more likely to be at risk of harming themselves or others."*

8.2 This was an appropriate level for Ms Z.

8.3 We have reviewed the compliance of the AOT and the hospital inpatient team with the trust's CPA policy. There was broad compliance with the policy about holding CPA reviews. The major deficits were inadequate care plans and compliance with risk assessment, which we have dealt with in detail earlier.

[13] There were two levels of CPA available at that time, standard and enhanced.

9. Review of trust internal report and recommendations

9.1 The trust conducted an internal trust investigation after the homicide. The panel consisted of three senior clinical staff and managers with a non-executive chair. The panel met three times in October, November and December 2007.

9.2 Appropriate terms of reference also covered the care of Mr Y, Ms Z's boyfriend. These have not formed part of this independent investigation.

9.3 The panel interviewed the following staff:

- Ms Z's consultant psychiatrist
- the locum care coordinator who took over Ms Z's care
- a staff nurse from Fortismere Ward
- the team manager of Camden approved social worker (ASW) service.

9.4 Ms Z's mother and father were invited to give evidence but declined on legal advice.

9.5 The panel reviewed the relevant clinical notes and a range of relevant policies, guidelines and procedures.

9.6 The panel also made contact with Central and North West London NHS Foundation Trust who launched their own investigation into why the MHA assessment was delayed. We have reviewed that investigation report.

The trust panel report

9.7 The report of the investigation contains 15 pages. It is supplemented by a three-page action plan and a comprehensive 47-page timeline of the care of Ms Z and Mr Y. The report is written thematically covering the following sections (we have listed only those in relation to Ms Z):

- Personal/social details
- Previous history
- Forensic history
- Clinical risk assessment and management plan
- Events leading up to the incident
- Key issues and recommendations
    - documentation
    - clinical risk assessment and management plan
    - use of alcohol whilst on the ward
    - housing
    - engagement with family and carers
    - AOT operational issues
    - approved social worker (ASW) arrangements
    - arrangements for primary healthcare
    - conclusions

9.8 The report contains 27 recommendations. Most of the recommendations provide advice on improvements to procedures or changes required in professional practice. We have reviewed the trust's latest version of the trust recommendation action plan update which shows that they have now implemented all the recommendations.

9.9 The report properly highlights the deficits in practice that needed remedying, but it does not examine in depth the reason for the deficits. The report does not examine whether the failures were specific to this case (a one-off) or whether they suggested deeper system failures, such as senior management supervision, trust governance and performance monitoring (particularly around risk assessment and planning) or other factors.

Comment

A report that contains 27 recommendations should look for root causes so as to avoid similar failures in other parts of the service. Because the events in this case happened almost five years ago (at time of writing) we have not explored root causes as much has changed since then.

Recent and planned changes

9.10 Our interview with the trust medical director and director of Islington mental health services covered the trust's progress in implementing the panel recommendations. A number of significant changes in service organisation and clinical practice have occurred which directly relate to our findings in this case. We set out these changes below as they provide evidence of the trust's commitment to learn lessons from serious untoward incidents.

Risk assessments

9.11 A number of our interviewees told us that since the introduction of the RIO computer system significant changes to risk assessment recording now allow for simpler updating and the facility to use the electronic records to review compliance with the policies and procedures. The medical director told us:

> *"In terms of teams, the other thing that we have is much better activity data, we know how many people they're seeing, how often, and for how long, now, so we can examine their caseloads and say, hang on a sec, that seems a bit odd, you're an AOT team and you seem to be seeing people not very frequently."*

Team structures

9.12 The medical director and the borough director for Islington also told us that the trust was moving to a new team structure because research after 30 months had shown that the outcomes of AOT team working were similar to those of other teams. The medical director told us:

> "*I think we're in a time of change, so looking at the evidence base for assertive outreach teams, it's not clear that there are any additional benefits in terms of service user outcomes…What the evidence shows us is that service users - because of the team working you don't just work to one care coordinator you could actually be seen by a variety of people – they [service users] are more satisfied with the service model…*"

"So we propose to keep the idea of team working, we propose to look at a newer model which is called the FACT - functional assertive community treatment model – which they implement in the Netherlands, but it's actually about, as we said before, RAG rating and looking at stratifying the levels of needs and having an assertive component, but not assuming that every single person in your assertive outreach team is of the same level of need and needs same intensity."

9.13 The following is a description of the FACT team model which the trust has prepared:

"The FACT model (Function) is based on a Dutch approach to delivering assertive outreach interventions for mental health service users who are identified as being difficult to engage and the assertive community treatment (ACT) is described as being just one of the functions the FACT team performs. (Remmers van veldhuizen, 2007[14]).

The basic premises of the FACT service delivery model remains the same in as much as service users receive a care co-ordinated approach to plan regular interventions which are linked closely to improving social outcomes; however the FACT model acknowledges that over time the intensity of the interventions will differ for clusters of service users who may require a different range of clinical and social interventions once the primary objective of long term engagement has been achieved.

The FACT model recognises these differing needs and plans interventions which offer alternatives to the fixed individual visits, e.g. clustering visits and group interventions to manage the clinical work. One of the benefits of developing the FACT/ACT model is the degree of flexibility it offers and the recognition that not all service users require a sustained high intensity service. Remmers van veldhuizen (2007) suggests that in 80-90% of cases the need for a more intense input was a temporary phase lasting a few weeks or months."

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[14] (Remmers van veldhuizen J. (2007) Community Mental Health Journal DO1:10.1007/s10597-9089-4)

Hospital admission and treatment

9.14 The trust has also reorganised the function of admission wards to create separate assessment and treatment wards. The following has been prepared by the trust to explain the benefits of separate admission and treatment wards

> *"The general principles of the assessment ward are to provide rapid and targeted assessment for clients who are likely to recover quickly and whose immediate diagnosis is unclear or whose presentation is significantly different from previous presentations. This is achieved by strong MDT working, high levels of medical input, decisive decision making and close links to the crisis teams with an emphasis on early discharge. This is because inpatient admission is disruptive and can be stressful. The training for the MDT is geared towards the primary objective of assessing and then ensuring onward movement through the most appropriate care pathway in a timely manner.*
>
> *This approach also allows the treatment wards to focus more on the recovery model in terms of managing clients with more complex conditions, documented risk histories, treatment resistance and issues relating to housing and social needs in the longer term especially decisions about supported housing etc. The treatment wards manage CTO recalls and transfers out of PICU too. These teams are able to focus more on specific evidence based therapeutic interventions, for example, to deal with Dual Diagnosis through the use of motivational interviewing."*

Referrals

9.15 One of the issues in this investigation was the delay in arranging a MHA assessment caused by the referral being sent to the wrong team. The trust has issued new guidelines to staff to ensure that in cases where a referral is sent to the wrong team it is passed on to the right team and not passed back. The following is the trust's "*No Bouncing Principle*".

> *"Any team receiving a referral that is more appropriate for another community team, will take responsibility for passing the referral to the correct team rather than ask the referrer to negotiate with another team."*

Other improvements

9.16 We have also reviewed changes that the trust has made to the following policies and guidelines which address a number of the findings in this investigation. The policies and guidelines are:

- care programme approach;
- practice supervision;
- clinical risk assessment and management.

Appendix A

Documents reviewed

- Ms Z clinical notes
- Trust internal report
- Clinical risk assessment and risk management policies
- CPA operational policies
- Camden Assertive Outreach Team operational policy and manual
- Observation policy
- Records management policies
- Camden multi agency safeguarding adults policy
- Carers policy

Appendix B

List of those interviewed

- AOT team manager
- Borough director for Islington
- Consultant psychiatrist 3
- Consultant psychiatrist 4
- Deputy manager, Camden AOT
- Head of social care for the Camden Islington Foundation Trust
- Matron 1
- Medical director Camden and Islington NHS Foundation Trust

Appendix C

Biographies

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.

Dr Rosalind Ramsey

Dr Ramsey is a part-time consultant in general adult psychiatry with experience in inpatient and a range of community teams in inner London. She is also a part-time associate clinical director at a south London mental health trust.

She previously was the associate director for clinical governance and clinical lead for suicide prevention work. She has been a panel member for a number of internal serious untoward incident investigations as well as a number of external investigations and is currently a chair of a serious untoward incident and complaints panel. She has experience in quality improvement work having been a trust NICE implementation lead until 2010 and a member of a NICE committee.

Rosie Mundt-Leach

Rosie is the head of nursing for the addictions clinical academic group of the South London and Maudsley Hospital. In this capacity her responsibilities include assisting the group with child and adult safeguarding, mandatory training and professional development for nurses, complaints and serious incidents.

She has carried out a number of internal investigations into serious incidents for the addictions group and oversees all clinical incidents that are reported. She has worked as a mental health nurse since 1994 and has specialised in the community treatment of substance misuse since 2000. Her particular focus for several years has been on improving physical healthcare for drug users and on improving substance misuse nurses' access to training in physical health provision. She is currently completing her training as a nurse prescriber.