Report of the independent investigation into the circumstances surrounding the care and treatment of Mr A

February 2012

A report for NHS London
Undertaken by Caring Solutions UK Ltd

NHS London

Contents

1. Acknowledgements

The members of the independent Investigation Panel were asked to examine a set of circumstances associated with the tragic death of Mr David Richard James in the context of the Mental Health Services provided by the Central and North West London NHS Foundation Trust. At the request of Mr James' family his name has been included in this report.

The methodology undertaken by the Investigation Panel necessarily revisits the circumstances and events in great detail causing all of those involved to re-examine often difficult and sometimes disturbing experiences. The Investigation Panel wishes to acknowledge this, as well as the discomfort caused by the process itself. Nevertheless the investigation underlines the importance of ensuring that such processes are properly conducted in order to learn from them, improve the services to individuals and so continue to operate those services with appropriate risk management. The overriding impetus for the Investigation Panel and the commissioning body is to ensure that there is a comprehensive effort to support the delivery of this objective.

Those who attended to give evidence were asked to describe their contribution to the care of Mr A or Mr James or both, and provide other relevant information to the Investigation Panel. All have done so in accordance with expectations, and frank openness for which they must be commended. We are grateful to all of those who have given evidence directly, who have supported those giving evidence, and who granted access to facilities and individuals throughout this process. This has allowed the Investigation Panel to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

Condolences to the Family and Friends

At the outset of this report the panel would like to take this opportunity to publicly offer their condolences to the family and friends of Mr James who died. We were able to meet the immediate families of both service users and wish to express our most sincere thanks to them for the manner in which both families received our questions and entered into discussion with us, despite their grief and distress. We also wish to acknowledge their resilience and fortitude in how they are coping with their respective tragedies. Their contributions provided many valuable insights, assisting the Panel in their attempt to formulate a proper understanding of events.

2. Executive Summary

2.1 The Incident and the Consequences

On the morning of the 5th July 2007 Mr James was found dead in his flat with a number of knife wounds. Mr A, who lived in the adjoining flat, was arrested and taken into custody. He was subsequently found guilty of manslaughter with diminished responsibility and was the subject of a hospital order detaining him in a secure unit.

2.2 Care Support and Treatment

There had been a history of altercations between the two men, who had both experienced problems with other neighbours in the past. Of note the clinical staff were not aware of previous conflict between the two men, nor were they aware that they lived in close proximity.

Both men had experienced psychotic episodes with a diagnosis of schizophrenia. In differing degrees they had substance misuse problems and both men would have benefited from a referral to the Dual Diagnosis service for specialist assessment and advice. The two men had a history of episodes of relapse. The staff grade doctor based at Pembroke House provided treatment oversight for both men.

Both men were well supported by their respective families. The assessments prior to the tragic incident appeared to demonstrate that both men were progressing satisfactorily with no indicators of significant concern noted. The Investigation Panel have identified a lack of rigour in the assessment and management of the risk which both men presented, and some omissions in the CPA process.

It is of particular note that both men were reluctant to confide in professionals about the problems they had with each other or allow their families to seek help on their behalf. Their anxiety about the consequences of doing so is a common reason for patients and carers to withhold information resulting in an under reporting of risk. The Investigation Panel identified a lack of awareness of this issue and the need to develop relationships with service users and their families to effectively reduce the impact of the problem.

Mr A and his family had benefited from care coordination, but in the period leading up to the incident, the victim had not received the same level of care coordination and focus, this was compounded by the confusion about roles and responsibility when he attended the Pembroke Day Hospital.

2.3 Organisational Issues

The organisational systems and management processes that the Central and North West London NHS Foundation Trust (CNWL) inherited in 2006 were unsatisfactory, with

inadequate liaison between the Police and Housing services. Significant positive change has occurred, with formal working relationships now well established.

This investigation has identified significant developments and progress in the Trust's relationships with their key partners and the management direction and leadership of the Hillingdon services. The Trust services have improved their awareness of Dual Diagnosis and the provision of specialist advice for substance misuse problems. The introduction of the JADE information system has considerably improved the sharing of information.

The Investigation Panel have concluded that generally both men and their families received satisfactory care and treatment. Despite the inadequacies in risk assessment the panel have concluded that the serious and violent reaction could not have been predicted

The Independent Investigation Panel organised a "learning the lessons" event, involving key clinical and managerial staff. The aims of this event was to consolidate learning and enable staff to assist in the formulation of recommendations which are relevant to the current needs and state of development of the Trust and its Partner Services.

We commend the following recommendations:

Recommendation 1

The Independent Investigation Panel recommend that those responsible for commissioning ensure that there is managerial and professional competence to commission mental health services.

Recommendation 2

The Independent Investigation Panel recommend that the Trust should further develop its managerial and clinical supervision policy and procedures to facilitate supervision being used to provide assurance to the Trust Board that patient care is of the required standard. The supervision process should enable monitoring and support at every level to ensure clinical practice reflects the requirements of the clinician's professional duties and of prescribed changes in practice such as the recommendations contained in this report.

Recommendation 3

The Independent Investigation Panel recommend that the Trust reinforces clinical care management as the corner stone of patient care in their psychiatric services. The essentials of this are contained within the Trust's CPA policy and should include the appropriate use and sharing of clinical information to inform decision making and the management of risk.

This should be reflected and strengthened in the training programmes staff are required to attend and the priorities identified in individual and group supervision.

Supervision should facilitate the routine review of actual cases to ensure the appropriate application of the principles of CPA and enable corrective action to be taken if required.

Recommendation 4

The Independent Investigation Panel recommend that the Trust Medical Director should remind all doctors in the Trust Psychiatric services that they have a duty to ensure participation in the multidisciplinary decisions made for patients for which they are responsible.

Doctors should ensure that a patients medication is appropriate and being suitably managed within the CPA process. This issue should be regularly included in individual and group supervision at all levels.

Recommendation 5

The Independent Investigation Panel recommend that a forum involving Primary Care be established. Given the increasingly important role of Primary Care in the commissioning and provision of psychiatric treatments, the Internal review Recommendation 11 should be expanded to include a forum involving Primary Care to facilitate joint working and support the provision of appropriate Pathways of Care.

Recommendation 6

The Independent Investigation Panel recommend the continued provision of Dual Diagnosis expertise for people with serious mental illness. Given the prevalence and impact of substance misuse on patients within core psychiatric services, the Trust must ensure the continued provision of Dual Diagnostic expertise for this client group. It should seek to expand services and develop the skills of practitioners in this area and monitor them through the clinical supervision process.

Recommendation 7

The Independent Investigation Panel recommend that the Trust take account of the findings of this report in reviewing the process of identifying training needs, in particular how lessons from serious untoward incidents, and the ideas from the learning the lessons event, can be fed into the process of planning professional development, training, supervision and support.

Recommendation 8

The Independent Investigation Panel recommend that the Trust identify the skills necessary in forming positive relationships, effective communications and discerning information and concerns from family members. The Trust should ensure that these are included in professional development programmes and are the focus of clinical supervision and monitored through supervised practice.

Recommendation 9

The Independent Investigation Panel recommend that the Trust Board should formally review progress or otherwise of these recommendations after six and twelve months following publication of this report.

3. Introduction and Background

3.1 The Incident

Mr James, a service user receiving care from the North Hillingdon Community Mental Health Team, was found dead in his flat at approximately 9.00 am on the 5th July 2007 by the father of a neighbour, Mr A, who was also receiving care, support and treatment.

The Police arrested Mr A at his adjoining flat at 9.30 am, in the presence of his father and his Care Co-ordinator. He was charged with murder, detained in custody and was subsequently the subject of a hospital order.

3.2 Preface to the Report

This report outlines the findings and recommendations of the Independent Investigation into the death of Mr James and the care, support and treatment of both service users and their families.

The report is intended to enable the reader to understand the organisational context of care and treatment in the period leading up to the incident and to grasp the main issues of concern arising from the history of both men and the connections between them, which led to their relationship difficulties and the subsequent tragic incident.

Inevitably, an investigation commencing four years after the incident has resulted in a number of challenges. There has been significant positive change in policy, standards, systems and processes, a number of key witnesses have moved on, there is imperfect recall and we appreciate that the reopening of painful memories has caused anxiety and distress to both families and some staff members.

We have had to deal with the challenge of separating the care and treatment journey of two individuals who had personalised care plans delivered by different practitioners, within the same service and structures, but with some clinicians involved with both men.

There was a challenge for those interviewed as well as ourselves in considering the position in 2007 and how it is now in 2011. We have sought to turn this into a positive with

a consideration of how the services have developed and the impressions and evidence we have gathered that might support future service developments.

We have also been mindful that there was another homicide investigation taking place at the same time in the Hillingdon services relating to 2007, and we have aimed to pull together overlapping issues, common themes and learning.

The investigation was commissioned by NHS London. The incident had taken place several years previously but it was thought appropriate to commission a full independent investigation whilst acknowledging the difficulties involved in doing so. Taking account of the four year period that has elapsed since the incident, we consider it was sensible to have a prominent focus on how services had changed and to review the effectiveness of current service quality and safety.

3.3 This Independent Investigation was carried out by:

Malcolm Rae OBE FRCN – Panel Chair, Mental Health Nurse

Dr Clive Robinson - Psychiatrist

Nick Georgiou - Previously Director of Social Services and manager of a London mental health service.

3.4 Commissioner

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.

4. Terms of Reference

The Terms of reference were set by the Strategic Health Authority (NHS London). Slight amendments were made after initial consideration of the documents and information to ensure specific issues were targeted.

The aim of the independent investigation is to evaluate the mental health care and treatment provided to Mr A and the victim 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 investigation;
- Involving the family of both service users.
- 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 both service users and a review of the relevant documents;
- The extent to which both service users care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies;
- The suitability of that care and treatment in view of the service user's history and assessed health and social care needs;
- The exercise of professional judgment and clinical decision making;
- The appropriateness and quality of risk assessments and care planning;
- Consider the effectiveness of interagency working with particular reference to the sharing of information between the Substance Misuse Service and the Mental Health Services;
- The level of support to staff, service users and the families of the victims and service users following the incident;
- Consider other such matters as the public interest may require;
- Complete 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.

5. Approach and Methodology

5.1 Our Principles were:

- To distinguish between fact and opinion / comment
- To listen carefully to what was said
- To be open, fair and as objective as possible in our questioning, reasoning and conclusions
- To avoid being biased by hindsight
- To judge the care and treatment according to evidence based practice or recognised positive professional standards and national guidance
- To use reasonableness as our yardstick when deciding on what or was not a satisfactory or an acceptable standard of practice

5.2 Methodology

We each read the report of the internal review and relevant policies, procedures and professional guidance, and met to collectively share our initial analysis and thinking and to

identify other information requirements and agree our division of labour. We read the clinical records of both service users and began to prepare a timeline and chronology, identify issues of notable concern and relevance, and people who we wished to interview, and formulate questions and issues to pursue. We also requested reports on progress with the internal review recommendations, action plans and list of changes which had occurred.

The scope of the timeline was inclusive of the first indicators of mental health problems experienced by both men.

This preparatory work was helpful in enabling a comprehensive understanding of the organisational structure, systems, processes, attitudes and practice, both pre and post incident.

We were then able to triangulate our initial concerns and observations after analysing the range of documentation.

We were also able to amend and confirm the Terms of Reference. We met with a cross representation of clinical and managerial staff to explain our intended approach and gave the opportunity for questions. We then embarked on a programme of semi-structured interviews, beginning with the families of both service users.

We shared the Terms of Reference with them and invited their comments and any other concerns they wished us to include in our investigation.

We amended the timeline and chronology in the light of information which emerged from the interviews.

We organised a workshop on the 15th September, 2011 to verify our initial findings and engage the service in understanding the contributory factors and developing ideas to address some of the areas for improvement and to assist in the formulation of realistic recommendations.

5.3 Interviews

The interviews were designed to clarify some of the potential concerns emerging from the various sources of information and for us to gather information and ideas from the interviewees own experiences, observations and insights.

We invited those we interviewed to share with us examples of progress and positive practice. Each interview was recorded and the transcript sent to the interviewee, who was encouraged to make any amendments or additional comments they felt was necessary.
We were grateful for the opportunity to meet with Mr A and for his cooperation in talking with us.

6. Profiles of Mr A and Mr James

We thought it would be of value to provide a short personal profile of both men in order to enable the reader to have a fuller appreciation of their background, personality, interests and lifestyle and relationships, beyond the narrow clinical description.

6.1 Mr A

Was born in 1962 and was aged 45 years at the time of the incident.

He worked mainly in warehouse jobs and for the period 1983 – 1988 for an agency. His employment record was always satisfactory and he was never sacked. He had not worked since 1989 as a result of his mental health problems.

He was described as polite and shy, but a good mixer and was honest. He enjoyed his leisure time, particularly reading, films and listening to music and he enjoyed using a computer; he had eclectic tastes and especially enjoyed historical novel books. He also enjoyed watching TV and was a supporter of Chelsea Football Club. He apparently had three significant partners.

6.2 Mr James

He was 32 years of age at the time of his death.

He left school at the age of 16 years with four GCSE's. He initially worked as an apprentice carpenter but also had an interest in motor mechanics, later beginning an apprenticeship in this trade. He held a range of jobs but nothing permanent.

For a period he became socially isolated as a result of his illness but continued to enjoy cycling, swimming and watching TV and visiting his grandma in Wales. He was family orientated and fondly regarded by his brother's children.

Latterly, his mechanical aptitudes were put to good effect in helping his brother in his plumbing business. He attended a local gym and had been pleased to lose some weight. He had also begun to socialise more with friends.

7. Timeline and Chronology

We have provided a summarised timeline in a narrative form, which highlights the panel's observations, comments and indicates some of the questions arising out of key features and milestones in the course of the clinical history of both men. These are identified in bold type with comments in italics.

We have the benefit of seeing the unfolding story and we are aware that this may appear as hindsight. However, our comments and questions are aimed at enabling understanding and learning.

7.1 Mr A

October 1981 – First diagnosis of an acute psychotic episode with ideas of reference, persecutory and grandiose delusions. A few days later he was admitted to hospital with a diagnosis of Schizophrenia.

Several weeks later he was discharged and was prescribed a low dose of Chlorpromazine (an oral antipsychotic medicine), which he refused to take. His condition deteriorated and he was prescribed a depot antipsychotic injection Depixol.

In January 1982 - on no medication but by the end of the month his condition deteriorated and he was again prescribed medication. It was noted that he had been free from epilepsy for over three years and had been off anti-epileptic medication for a year.

Between 1982 and 1987, there were apparently no notable events or concerns. By January 1987, as he had been free from psychotic symptoms for five years he was advised to stop anti-psychotic medication. He expressed anxiety and concern that it would lead to relapse and so it was reduced slowly.

Three months later in March 1987 there were signs of relapse and his depot antipsychotic was increased to its previous level.

Panel comment *This was an early indication that medication was an important factor in maintaining a stable mental state. Mr A's anxiety about reducing the medicine may have also contributed to his relapse.*

1988 - Arrested for stealing bottles of wine and whisky. He asserted he had no money. His parents engaged a solicitor. The Crown Prosecution Service took account of his illness and judged it not to be in the public interest to prosecute.

Panel comment *No further criminal episodes have been reported.*

In October 1988 - his depot medication was again reduced but had to be increased again one month later because he was relapsing.

From 1989 until August 1991 no notable changes or events occurred.

In August 1991 he relapsed, attacked his father and smashed up the family home. He was removed to hospital by Police and admitted under Section 3 of the Mental Health Act (1983). He was subsequently discharged to his own flat.

Panel comment *A first indication of a propensity to violence. Following the admission under Section 3 his care becomes subject to Section 117 aftercare arrangements.*

1991 – 1994 No further reported concerns.

January 1994 - Relapsed; experienced a psychotic episode and was involved in a fight with his brother. Removed to hospital by Police for his third admission.

Panel comment *A second episode of aggression.*

1994 – 1998 - He was the subject of regular out-patient review, with attempts made to reduce his medication, however, his condition deteriorated each time the medication was reduced. Some evidence of positive symptoms and an increase in persecutory delusions precipitated by stress.

Panel comment *Further evidence that medication was an important factor in maintaining his mental health, and that stress aggravated his psychotic symptoms.*

February 1998 - Mental state deteriorated, and he was reported to be agitated, complaining vehemently about a neighbour whom he regarded as noisy and antisocial. Mr A complained to the council about his neighbour but with no apparent effect.

Panel comment *This was the first time Mr A complained about the behaviour of a neighbour. During his meeting with members of the Independent Investigation Panel Mr A, gave the lack of action on the part of the Housing Department on this occasion, as being the prime reason for not reporting his later concerns about Mr James. Of note, the neighbour about whom he had complained was subsequently re-housed in the same block of flats as Mr A had been moved to. Their relationship was reported as significantly improved and no further problems were noted. However, those responsible for the move had clearly not considered the possibility of further strife between Mr A and his neighbours.*

March 1998 - He was admitted to hospital for the fourth time following an urgent referral. He was described as feeling, “angry, ready to blow”, was agitated and complaining about his neighbour upstairs being excessively noisy. He believed his neighbour had a vendetta against him, and for this reason had recently been spending time at the home of his parents.

Panel comment *More evidence of Mr A being particularly sensitive to noise from neighbours, the detrimental effect of such stress on his mental state, possible paranoid thinking and his potential to respond violently. The possibility that at least some of his concerns about neighbours was based on delusional ideas needed to be considered. These issues should have featured in later risk assessments and care plans, and anticipated as potential problems in the forecasting of future vulnerabilities.*

1998 – 2002 - No indications of significant issues of concern, regarded as stable following assessment at regular out-patient reviews. Moved into his new flat in February 1999.
At some point between out-patient reviews in August 2001 and February 2002 his medication was again reduced.

April 2002 - Admitted for the fifth time informally and reported as being suspicious and paranoid, apparently triggered by cocaine abuse (although it is notable that his medication had again been reduced before the relapse). He believed people were entering his flat and examining his property. Other suspicious ideas involved invisible people tampering with his stools. Whilst in hospital, he struck another patient for no apparent reason. Haloperidol increased with improvement noted.

Panel comment *An indication of the use of illegal drugs having an adverse effect on his paranoid thinking, in the context of reduced medication. Also, a further link in a developing pattern of disordered thinking and paranoid delusions involving his home. Further evidence of a propensity for aggression.*

2003 - His Consultant Psychiatrist retired and his care and treatment was to be overseen by Dr O, Consultant Psychiatrist and maintained by Dr P, Staff grade Doctor

2003 – 2004 - Assessed as stable and compliant with treatment. During this period attempts were made to reduce his medication, but it had to be increased soon afterwards as he became emotional and ruminated about his brother who had died two years previously.

October 2004 - Seen urgently in out-patient clinic by Dr P at request of Mr A's father, who was concerned that Mr A was experiencing suspicious and anxious thoughts, believing people were able to enter his flat and steal CDs. He had requested that the locks be changed.

Panel Comment *A positive example of family support and the service responding swiftly to indicators of relapse. A further paranoid focus about his flat, which was now becoming an established pattern.*

Following this episode Dr P sought advice from Dr O, as she was concerned that despite having some insight he was relapsing. His depot medication was increased to 100mgs fortnightly and an oral antipsychotic Quetiapine 50mgs was added. He was referred to the Community Mental health Team (CMHT). Within a few days significant improvement was noted in his psychotic thinking with increases in Quetiapine, to 100mgs and then 150mgs. Parents advised about the plans and reassured.

Panel comment *Appropriate action taken by Dr P in seeking advice and continued support given to parents.*

Seen one week later by Dr P with further improvement noted, calmer and insightful. Feeling drowsy and tired during the day. Advice given, agreed to continue medication.

Panel comment *Negative effects of medication may have resulted in non-compliance. Monitoring and support regarding medication management required.*

He was seen over the next few weeks by Dr P with father present. Haloperidol reduced to overcome drowsiness and enable further rehabilitation. Advised to join social clubs and attend MIND drop in centre.

Panel comment *Further changes to medication in response to side effects and positive focus on recovery. At this stage the plan was to move from Haloperidol (an old drug) to Quetiapine (a newer drug with potentially less side effects), but the effectiveness of Quetiapine was not proven for Mr A and reductions in Haloperidol had in the past resulted in relapse.*

January 2005 - Reported as stable, no psychotic symptoms. He had been taking a higher dose of Orpheradrine on his own accord to combat side effects. The depot Haloperidol was reduced and the oral medication Quetiapine was continued with a view to it being his only antipsychotic medication.

May 2005 - Designated Care Co-ordinator assigned who was to remain in this role until the incident

June 2005 - Stayed at parents' house whilst flat was redecorated. Haloperidol reduced to three weekly.

July 2005 - Took overdose of Quetiapine 6 x 150mgs and was treated in ITU and the medical ward. Subsequently admitted to Riverside (an in-patient mental health unit), informally. The overdose was characterised as an impulsive reaction after his father had commented that he might not be alive for the 2012 Olympics. Mr A reported that he had a sense of abandonment and did not want to live alone. Initially he was described as not psychotic but during his in-patient stay psychotic symptoms were noted.

Panel Comment *These events demonstrate Mr A's ability to mask psychotic symptoms and reluctance to admit to symptoms. There is a possibility that his relapse was linked to the reduction in medication the previous month. The episode reveals Mr A's vulnerability and predisposition to act impulsively and dangerously (he required ventilating in ITU). Following this there should have been a reassessment of risk and reformulation of risk management plans but there is no evidence that this occurred.*

21st July 2005 - Discharged from hospital, seen in out-patients, father present, and commented that the trigger for the overdose was concern about his father's age. Medication increased.

9th August 2005 - Seen in out-patient clinic in advance of scheduled appointment at the request of Crisis / Home Treatment Team (CHTT). He was noted as relapsing with sleep disturbance, feeling 'high' and presenting with exaggerated responses. He expressed belief that neighbours were spreading stories to get him into trouble. He had also been experiencing hallucinations, hearing male and female voices. He had insight to ask for help. Denied taking drugs or alcohol but acknowledged all his friends did. Assessed as hypomanic behaviour.

Panel comment *Confirmation of the pattern identified in earlier comments and a worrying focus on delusional beliefs about neighbours when unwell. Effective involvement of CHTT.*

16th August 2005 - Review by Dr P with parents and apparent first mention of Care Co-ordinator, and two members of CHTT present. Medication increased by CHTT Consultant.

22nd August 2005 - Review with Dr P, Care Co-ordinator, CHTT and parents. He reports as feeling back to normal and expressed guilty feelings regarding impulsive overdose. Was having meals with parents. CHTT were considering discharge. Denied using illegal drugs or alcohol. Enhanced care plan developed and to be reviewed in six months time. To be seen by Care Co-ordinator every two weeks

Panel Comment *There seems to have been little exploration of the circumstances and reasons for his serious overdose and a ready acceptance of Mr A's denial of using drugs or alcohol. It was to become apparent that he was a regular user of Cannabis. The clinical team did not have the skills or resources to adequately address dual diagnosis issues at the time.*

12th September 2005 - It was subsequently reported that he had used a baseball bat in a confrontation with Mr James and there had been damage to Mr James' front door reported. The Police had been called but no action was forthcoming or records available.

19th September 2005 - Mr A was visited at home by Care Co-ordinator who reported him as being on edge, but no mention made about the conflict with Mr James.

Panel comment *No apparent knowledge of this incident found in records*

10th October 2005 - Seen at home.

February 2006 - Reported as stable and compliant with medication. Attending Redford Studios and awaiting employment assessment. Weight had increased so referred to weight loss clinic. Placed on three monthly out-patient appointments with six monthly CPA reviews.

1st April 2006 - First involvement with CNWL when Hillingdon Services were transferred.

June 2006 - Plan was to maintain stability on depot injections every two weeks and wean him off Quetiapine. Relapse signatures were discussed with him by the Care Co-ordinator.

Panel comment *Appears to be remaining relatively well. Good practice of developing relapse indicators with Mr A. Although probably reasonable to wean him off the oral Quetiapine, there was no rationale given in the entry in the notes or letter to the GP, and it was effectively another reduction in antipsychotic dose.*

July 2006 - Quetiapine ceased. Only prescribed Haloperidol every two weeks.

Panel comment *The plan to change from Haloperidol now seems to have been abandoned.*

27th July 2006 -- Care Co-ordinator expresses concern regarding his relationship with a female service user he had met in hospital

August 2006 - Reported as stopping Mirtazine (an antidepressant) on his own accord, and feeling fine. Complying with two weekly depot injections. Dr P discussed treatment with Dr O, who agreed with care and treatment plan.
Panel comment *It was appropriate for the Staff grade doctor to seek endorsement of the treatment plan.*

29th September 2006 - Call to Care Co-ordinator by father expressing concerns regarding state of flat. Mr A visited by Care Co-ordinator who makes an extensive entry in notes, indicating amongst other things that Mr A had been "beaten black and blue" and he had been left feeling "paranoid and agitated".

November 2006 - Enhanced CPA meeting attended by father. Mr A reported experiencing distress earlier in the month as a result of developing a relationship with a female service user, who had started living at his flat. She had subsequently been joined by her boyfriend, who was also drug addicted. Mr A reported the woman's boyfriend made accusations about Mr A which led to a physical altercation between the two men. Subsequently the couple wrecked his flat. This resulted in sleeping difficulties and the GP had reportedly advised him to take his medication at night. Mr A was assessed as not showing overt signs of psychosis but was a little excitable and not keen to avail himself of employment or day care. Care Co-ordinator was requested to discuss with Care Co-ordinator of female service user to prevent further friction.

Panel comment *This appears to be the right course of action, however were this to happen now the safeguarding policy should be enacted.*

March 2007 - Out-patient appointment with father in attendance. Mr A described as having displayed a sustained improvement with a routine and structure of visiting family and friends, household chores and shopping.

4th June 2007 - CPA review, father in attendance. Risk assessed for substance misuse, suicide and self harm. Reported as stable, coping well and content with lifestyle. He reported a difficulty in motivating himself for additional activities, felt lethargic in the afternoons but tended to have a nap.

No concerns expressed about conflict with neighbours, and no evidence of drug or alcohol misuse noted. The care management plan was to reaffirm the need for structure and purpose. He attended Pembroke Day Services one day a week.

Medication reduced to address lethargy and encouraged to be more active. He was discharged from employment link as he had not attended.

Panel comment *This was the last risk assessment prior to the incident. There did not appear to be any consideration of risk of violence or self harm. It is unclear if appropriate questions were proactively asked regarding previous concerns about his use of drugs, problems with neighbours, paranoid delusion, or violent impulses. The Panel heard evidence from witnesses that there was often a Cannabis aroma around Mr A's flat and he confirmed to us that he smoked Cannabis to help him relax. It would have been appropriate for staff to have discussed his use of Cannabis with him in more depth, seeking to inform him of the potential harmful effects and persuade him to engage in activities to reduce his usage*

A further episode of medication reduction.

13th June 2007 - Attended Current Affairs Group at Pembroke House.

19th June 2007 - Received depot injection at GP's surgery from practice nurse.

20th June 2007 - Further attendance at Pembroke House with no apparent change or problems discerned.

Panel comment *At this stage a comprehensive relapse indicator and contingency plan had been developed by the Care Co-ordinator, but without consultation with the staff grade doctor. In the risk management checklist the risk of violence was not completed, suggesting there was no recognition of previous episodes of aggression.*

3rd July 2007 - At 10.30am went shopping with his parents and visited friends during the day.

4th July 2007 - Woke at midday. Had breakfast and took a bath. At 3.30pm went to GP surgery and was given his depot injection by the practice nurse. He was reported as fine during this interaction. Returned at 5.00pm and had something to eat. He then went to visit a friend for two hours. It appears that he did not mention to any of his contacts during the day that he was having problems with a neighbour. After returning to his flat he played music and watched TV.

From the various reports, Mr A alleged that Mr James began to shout abuse in relation to Mr A and his parents. He has asserted that he could not tolerate this behaviour any longer, so he kicked Mr James' door open and entered. He alleged that he found Mr James ready for conflict. After exchanging words, Mr A sought to strike Mr James. They apparently exchanged blows and in anger Mr A returned to his kitchen and picked up a knife. He returned to Mr James's flat, a struggle ensued and he stabbed the victim several times. He then returned to his flat and placed the knife in the sink.

At approximately 10pm Mr A arrived at his parent's home in an agitated state and told them that he had fought with Mr James.

The father was concerned and drove to the flat and arrived there at approximately 10.40pm. As there was a light on in Mr James' flat when he arrived and he had perceived it

to be off when he had turned his car round, he formed the impression that Mr James was OK. He returned home, allowing his son to stay the night.

At 9am the next morning Mr A returned to the flat with his parents. His father saw the door was open and he went inside and found the victim dead. He then called the ambulance and Police.

5th July 2007 - 9.15am The Care Co-ordinator received a call from Mr A's father requesting that he attend immediately as Mr A had been involved in an altercation with his neighbour who was dead.

5th July 2007 - 9.30am. The Care Co-ordinator arrived to find the Police present. He followed the Police into Mr A's flat. When asked what had happened, he replied, "I will tell you everything, I have nothing to lie about". He was arrested and reports indicate he was trembling and disconcerted.

He then described what had happened and that he had "lost it". He asserted that he had just received his depot injection and Mr James had begun to play his music loudly and that it had been disturbing him; he had only gone to request that he turn the music down and he was not expecting the door to fly open. He was cautioned and had his rights read to him before leaving with the Police.

He was tested positive for Cannabis when first taken to Wormwood Scrubs.

After the homicide the Care Co-ordinator reports that in discussion with Mr A's father, the father commented on previous physical altercations between the two men and on the abuse and frosty relationship that existed. Unfortunately Mr A had insisted that his parents should not share this information with professionals at the time it was occurring.

7.2 Mr James

26th August 2000 - First episode of mental health problems. He was admitted to Mount Vernon Hospital after he cut his arteries and nerves and severely injured his fingers. He was reported as depressed and inebriated at the time.

29th August 2000 - His mother was involved in his discharge planning and he was to be followed up as an out-patient in the plastic surgery clinic. His GP wrote to the Housing Department requesting that he be re-housed, explaining that he was depressed, had injured himself and that he had a tendency to go to the top of high rise buildings after consuming alcohol. Reports indicate he was in denial about his significant alcohol consumption, which his GP considered made him susceptible to being angry and abusive.

He was advised to attend Hillingdon Action Group for addiction management (HAGAM) and the GP was advised that he could refer him to the Community Mental Health Team if help was needed in the future.

Panel comment *This first involvement with health services reveals potential for serious harm to self and misuse of alcohol on occasions.*

29th August 2000 - April 2002 - Nothing of notable concern reported.
April - August 2002 - Reported that Mental Health Services were contacted by the Housing Department on three occasions, who were concerned that complaints had been received from his neighbour about the noise nuisance and that it was alleged that he had displayed racist and abusive behaviour.

14th November 2002 - He was admitted on Section 2 of the Mental Health Act. It was reported he had been brandishing knives, scissors and a machete after hearing sounds in the attic and becoming agitated. Entry to his flat had been gained by the application of Section 135 of the Mental Health Act. He was assessed as being irritable, suspicious, perplexed and concerned his flat was dangerous.

Reports indicate he was consuming high levels of alcohol, over 40 units, but no symptoms of dependence were reported at the time. He was diagnosed as experiencing paranoid schizophrenia and treated with oral antipsychotic medication.

Panel comment *This admission confirmed the serious nature of his mental illness and continued concern about his alcohol consumption, which was first identified in 2000 when he self-harmed. Given this association, it would have been appropriate to refer him to a Substance Misuse Service for specialist assessment. It also reveals the potential for very high risk behaviour and the use of weapons.*

January 2003 - Health and Social Care assessment undertaken. Needs identified included, occupation during the day, support for his alcohol consumption and for his housing concerns to be resolved. Reports indicate that if these were not addressed relapse was likely. He was placed on CPA.

7th April 2003 - Letter confirming allocation of a Care Co-ordinator received.

13th April 2004 - Seen by Dr P for the first time as an out-patient at Pembroke Day Centre. This included a CPA meeting; his mother and Care Co-ordinator were present. He was assessed as mentally stable with no psychotic features. Reported as engaging well and keeping busy with a routine. The only concern was his weight gain. The plan was to reduce Risperidone to 3mgs once a day. CPA was reduced to standard level in July 2004 and a letter was written by the then Care Co-ordinator to the Staff grade doctor, letting her know that the doctor was the Care Co-ordinator from that point.

Panel comment *The social worker who had been the Care Co-ordinator and regularly in contact with Mr James' mother withdrew contact from this point. Following this change the main contacts were the staff grade doctor and the key worker from the day services. In*

the day services' terminology the patient's key worker was described as a Care Co-ordinator although they were not the CPA Care Co-ordinator and their responsibility for coordination related to day services only. This led to confusion amongst professionals as well as Mr James' relatives about who held the Care Co-ordinator responsibility.

6th September 2004 - Further out-patient appointment, accompanied by his mother. It was reported that he was engaging well in psycho-social programme and practising a disciplined routine to overcome weight gain. He requested a further reduction in Risperidone as he had been stable for two years. Dose reduced to 2mgs at night.

Panel Comment *Care strategies and risk plan should have taken account of the reasons behind his request to reduce medication, the potential for relapse following the reduction and potential for him stopping treatment.*

17th September 2004 - Call from mother concerned that he had been out drinking with his father and had stopped his medication as he did not think he needed it.

23rd September 2004 - A further call from mother regarding Mr James' drinking. Mr James was seen by the key worker at the Pembroke Centre. He denied there was a problem

22nd December 2004 - It was reported that he had become irregular with taking his antipsychotic medicine and had become withdrawn and quiet. However his key worker persuaded him to take his medication and he resumed his Risperidone 2mgs at night. He reported himself as feeling well and denied any problems. On examination, some negative symptoms present but he generally appeared well.

Panel Comment *These incidents are an indication of not always complying with treatment and potential for relapse. Strategies for discussing his concerns, discussing the importance and likely problems for relapse if he did not take his medication regularly, and persuading him to adhere, should have been prominent in his care and treatment plan and interventions. Mr James' use of alcohol is again a feature of this disruption in his treatment.*

8th February 2005 - Mother came to Pembroke and brought to the attention of the key worker that she had received a complaint from Mr James' neighbour about playing loud music. She expresses concern that he is drinking and not taking his medication. Later, Mr James was found drunk in the highway and was issued with a penalty notice.

9th February 2005 - Seen by the staff grade doctor and two health care professionals at his home at the request of his mother, who had expressed concerns about his heavy drinking, not complying with medication and playing loud music. It was reported that the previous night he had been involved in a fight, arrested and spent the night in a Police cell and that he initially had been too drunk to be assessed. He apparently displayed some aggression towards his mother. Admitted to drinking heavily but denied he had a problem. He was offered admission to the in-patient unit but declined. He agreed to take his oral medicine Risperidone 2mgs twice a day and to attend Pembroke Centre for review.

Panel Comment *His mother was sufficiently concerned about his behaviour to seek help and support. This episode was a further indication of Mr James not always complying with his medication. The fact that he was involved in a fight is an indication of his potential for engaging in conflict. It is a further incident of Mr James consuming excess alcohol. His consistent problems associated with his propensity to consume large amounts of alcohol, firmly point to a need to have had his alcohol problem fully assessed by a specialist from the Substance Misuse Service. Mother reported he had stopped taking his medication six weeks before because he was concerned about the side effects, weight gain, and that medication might kill him.*

The next day he was seen by the staff grade doctor and another heath professional on a home visit. He presented as sober and well kempt. He was assessed as not possessing full insight. Treatment discussed with Dr O. Medication by injection was offered but he refused. However, he agreed to a higher dose of Risperidone 4mgs at night and 2mgs a.m. He agreed to attend Pembroke Day Services 5 days per week.

Panel Comment *The suggestion by professionals that Mr James should consider taking a depot form of medication, implies they were concerned about non concordance with medication. In the light of this, it would have been helpful to formulate a plan to manage the possible issues arising from him declining a depot injection.*

February – September 2005 - Reports indicate significant improvement noted, with insight into his mental illness and alcohol consumption. Apparently he abstained from alcohol and was complying with medication and engaging well in day services.

Panel Comment *It was subsequently reported by Mr James' mother that there had been a confrontation between the two men on 9th May 2005 when her son was bringing in his bikes. The altercation resulted in Mr James losing some blood. We found no record of this in the case notes. However Mr James' mother insisted that she informed a member of staff who told her that the Police were dealing with it. It appears that there was no Police follow up.*

12th September 2005 - Reports of Police attending his home following an incident the previous day when it was alleged Mr A had threatened him with a baseball bat. The Police had apparently been called, they had attended, but no action was taken or formal crime report recorded. This incident apparently left him scared and intimidated.

Panel Comment *There is no mention of this incident in the clinical records*

29th September 2005 - Seen by Dr P in out-patients with mother. Mental state remains stable but some poverty of thought and a lack of spontaneity observed. Compliant with medication and Day Services attendance. The staff grade doctor agreed to reduce medication.

Panel Comment *There appears to have been no mention of recent incident with a baseball bat and no record of this in the case notes*

26th January 2006 - His mother reported to the service he was drinking heavily including binge drinking and not complying with medication. He had been involved in a fight two nights earlier. Out-patient appointment was brought forward.

26th January 2006 – January 2007 - All reports from out-patients' clinics point to a sustained improvement, with good insight. He had less involvement with Pembroke activities over previous year. There is evidence of communication from the service and the key worker kept in touch. He asserted he was abstaining from alcohol and complying with his medication. A notable feature was the regular support of his mother, who is reported as being satisfied with his progress. He had started assisting his brother in his plumbing business, socialising with friends and having the occasional alcoholic drink.

However, reports indicate he still required the occasional prompting to comply with his medicines. He was discharged from Day Services and had joined a gym, had lost weight and reports confirm he was looking physically better.

15th August 2007 - FACE Risk Profile highlights verbal aggression to neighbour in 2000, the assessment also comments on further difficulties with a neighbour in 2005.

Panel Comment *There is no record of the difficulties referred to in the case notes*

10th January 2007 - Mr James phoned for Police help. Mr A had confronted him with a baseball bat. Whilst he was uninjured in this encounter he had remained scared and intimidated.

Panel Comment *The above comment is extracted from the prosecutions opening for sentence remarks. We could find no mention of this incident in the clinical records. We understand from the case summary presented in the criminal court, dated 6th July 2008, that Mr James phoned the Police because Mr A had confronted him with a baseball bat. The comments in this summary state that though he had been uninjured this encounter left him scared and intimidated. The panel could find no other reference to this incident*

19th March 2007 - Attended minor injuries unit at Mount Vernon Hospital. Complained of having breathing problems for several weeks, especially at night. Diagnosis ? anxiety attack. He was given reassurance and stated that he would contact his GP the following morning.

14th April 2007 - Attended A&E department presenting with difficulty in breathing for a few weeks. He reported being concerned that he could have a chest infection. This was the diagnosis.

Panel Comment. *Accident and Emergency Department and Minor Injuries Unit records do not reveal any mention by Mr James of conflict with his neighbour.*

26th April 2007 - Seen in Out-patients Department supported by his mother. She confirmed that Mr James had remained well, stable, with good insight and was complying with medication. He continued to occupy himself by working occasionally for his brother and

going swimming and cycling. Was continued on Risperidone 2mgs at night and was given a further appointment to attend in October for a standard CPA review. The staff grade doctor considered he was in the best state of mental health with no apparent concerns from Mr James or his mother noted

The Forensic Scientist report following Mr James' post mortem examination indicated that alcohol had been detected in Mr James' blood. The concentration level was over twice the statutory limit for driving of 80mg per 100ml of blood.

8. Consideration of Reports relating to the Incident

8.1 Root Cause Analysis (RCA) Report

As part of the normal response to a serious incident such as this, Mental Health Trusts are required to investigate the circumstances of the incident immediately to ascertain if any urgent action needs to be taken. Subsequently, a more considered investigation into the care and treatment of the individual or individuals, is undertaken. This investigation and the resulting report should use a clear and established methodology, to try to ensure thoroughness, reliability, and validity. Root cause analysis (RCA) is a commonly used methodology. It is a group of problem solving methods aimed at identifying the root causes of problems or events. The practice of RCA is based on the belief that problems are best solved by attempting to address, correct or eliminate root causes, as opposed to merely addressing the immediately obvious symptoms. It is however, recognised that it may not be possible to prevent recurrence by simple corrective actions.

We examined both RCA management reports undertaken four weeks after the incident and which were completed within one month.

We acknowledge the thoroughness and quality of the information gathered and formulation of a detailed chronology and the reasonableness of their conclusions.

We noted that the RCA report regarding the victim did not make any recommendations even though it had identified his use of alcohol as a factor affecting his behaviour and therefore putting him at risk.

8.2 Internal review

The Trust established an experienced panel to conduct an inquiry into the circumstances of the victims death. The findings were reported in June 2008.

The panel consisted of a Non Executive Director as the Chair, a Consultant Psychiatrist, a Service Manager and an external Nurse Advisor. They were assisted by administrative support.

We commend the inclusion of an independent specialist advisor, which brought a sense of transparency, objectivity and experience from other services.

We interviewed the Chair and the independent advisor and found this of value as it enabled us to have a greater appreciation of their thinking and conclusions. We were impressed with the detailed approach, analysis and comprehensive nature of the internal review report, which we found to be very helpful. It was clear to us that a large amount of time and commitment had been given to the review.

The Investigation Panel were keen to avoid replicating the work of the internal review panel. Therefore the focus has largely been on appraising the quality of the internal review and measuring progress with their recommendations.

It would have been good practice to document contact with the family and carers of both service users, and where possible to have involved them in the investigation process. The internal review report indicates that Mr James' family contacted the Trust during the Inquiry asking to provide evidence as they had been unable to do so previously. The Panel agreed and oral evidence was provided. The Panel did not request any further evidence from Mr A's family as they had provided detailed information at the RCA stage of the process.

The prime conclusions of the internal review panel were:

- Staff had been committed to providing positive outcomes for both service users and had generally tried hard to engage with both individuals and their families.

- It was noted that both families had a high regard for Dr P, staff grade psychiatrist, who had overseen the treatment of both men.

- The medical treatment and nursing care provided to Mr A with regard to his mental illness was of an appropriate quality.

- Mr James received appropriate care and treatment in relation to his psychosis. However, staff at all levels within the multidisciplinary team had shown a lack of awareness of his dual diagnosis, and had failed to implement the dual diagnosis policy in relation to referring for assessment to identify and address a potential alcohol misuse problem.

- That the CPA process and recording for Mr A was in line with policy and guidance, but by contrast, the CPA process for the victim fell well short of stated policies and there was contradictory information regarding the level of the CPA resulting in confusion as to who was the designated Care Co-ordinator and the medical member of the team; inconsistencies in incorporating historical risk factors; failure to complete relevant sections of the forms, as well as an unsigned alteration to risk assessment forms

- The clinical management procedures followed in relation to CPA and risk assessment for both men were unsatisfactory. Junior medical staff, the Care Co-

ordinators and the Team Leader did not appreciate the relationship between the two processes.

- No formal clinical review had taken place in the case of the victim following his sudden death, as per CNWL Trust's Serious Untoward Incident Policy

- Clinical governance structures were in place, however, they lacked clarity in relation to individual responsibility and accountability

- There had been gaps in liaison, structured sharing of information and joint working with housing and Police departments

Drawing down from these conclusions the internal review panel made eleven recommendations designed to remedy issues of identified concern which we consider below:

Internal review Recommendation 1

The Trust should review the knowledge gap and potentially the skills gap of CMHT staff within the Hillingdon Service with regard to Dual Diagnosis as a matter of priority and subsequently audit the outcomes.

Action taken by CNWL

A lead for Dual Diagnosis (DD) was appointed in 2010. Team leaders attend monthly DD steering groups which focus on practice development, new initiatives and ways of working with clients who have substance misuse problems.

Pembroke Centre now has an identified link worker who attends weekly multi-disciplinary team meetings to provide intervention and supervision to all practitioners. There is now a rolling 5 day training programme. Staff have received training in the use of the Bromley Screening Tool, which assesses the intake of substances. There are now forums for practitioners to discuss practice concerns and skills and service development initiatives.

Panel Comments

The Trust need to be satisfied that the "skill gap" identified in the internal report does not extend beyond the Hillingdon Service and take measures to remedy if this is the case.
We were very impressed with the Dual Diagnosis Lead's activities to date. His approach has been well received and we were assured that the funding will be in place for this post to continue, which will ensure he is able to sustain the positive developments now in place, and in line with the Trust's stated priority for supporting people with a dual diagnosis.

Internal review Recommendation 2

The Trust should review the level and quality of training associated with CPA and risk assessment, ensuring that all relevant staff are individually trained, rather than through the cascade method.

Action Taken by CNWL

We were provided with records of individuals who have attended both CPA and risk assessment training. We also received copies of business meeting minutes, which confirmed the focus on training and positive outcomes from audits.

Panel Comments

The Trust has clearly taken steps to increase the effectiveness of the CPA process, risk assessment and management and they accept there are still gaps in awareness and the process, which is evident from other subsequent incidents. This issue was the subject of discussion at the learning event, from which a number of constructive suggestions emerged.

We have recommended a continued focus on the development of CPA, risk assessment skills, and their implementation by Trust staff by utilising an enhanced supervision process.

Internal review Recommendation 3

Given the limitation in terms of understanding the clinical practice of those interviewed, the Trust should consider training/re-training all clinical CMHT staff at Hillingdon in CPA and risk assessment and subsequently audit outcomes.

Action taken by CNWL

We were provided with copies of spot check audits, supervision records, quality metrics team reports.

Panel Comments

See above comment in Recommendation 2.

Internal review Recommendation 4

The Trust should clarify the role of team leaders in the CMHTs in respect of CPA and risk assessment processes and management function.

Action Taken by CNWL

The Trust has produced a job description for the Deputy Community Mental Health Manager/ CMHT Team Leader, Band 7, which has an expectation of performance management and quality development. The current structure of the two Team Leaders in each of the three CMHTs deputise for the Team Manager. It is part of the supervision process that they conduct a regular examination of the electronic case record of a sample of their supervisee's case work in their presence, to ensure that risk assessment and case management is up to date and of a required standard. Notwithstanding this, the Risk

Assessment and Management Policy is currently being reviewed and a more detailed section on responsibilities, including those of CMHT Team Leaders is to be included.

Panel Comments

Particularly as CMHTs are evolving with the introduction of service lines, the Trust will need to assure itself that the Team Leaders are fulfilling this responsibility.

Internal review Recommendation 5

The Trust should introduce the 'sign off' of risk assessment forms by a senior clinician with good working knowledge of patients being assessed, as per current practice within the Park Royal Service.

Action Taken by CNWL

Rather than have the risk assessment signed off by a senior member of staff, the template for the Risk Management Plan identifies those members of the Multi-Disciplinary Team who have a high level of involvement in the care of the patient. This makes the process more inclusive.

Panel Comment

As part of the enhanced supervision process, recommended by the Independent Investigation Panel, all those responsible for clinical supervision would routinely examine aspects of their supervisee's work relating to CPA and risk management, to ensure it is of the required standard and to enable corrective action to be taken when necessary.

Internal review Recommendation 6

The Trust should ensure that all consultants are aware of the cases on their clinical lists and that they have regular monthly print offs of their patients.

Action Taken by CNWL
There is evidence of this now on the JADE electronic records system.

Panel Comments
This appears to have addressed the concern.

Internal review Recommendation 7

The Trust should conduct audits to ensure that the recording of all clinical and social care information on to a single file is adhered to.

Action taken by CNWL
We were advised that all notes are now on JADE accessed by CNWL and local authority staff.

Panel Comments
See comments regarding Recommendation 5. Reviewing the practice of recording information appropriately would be a routine part of fulfilling the requirements of proper supervision.

Internal review Recommendation 8

The Trust should ensure that record keeping systems are introduced within Day Care Services in Hillingdon, with particular reference to client attendance as well as staff meetings with carers and relatives.

Action Taken by CNWL

There is a JADE screen showing community integration team where all notes / contacts are recorded.

Panel Comments

This seems appropriate action, but with current and future changes in the way community services are commissioned and provided, the Trust needs to assure itself that the necessary information about people receiving care from Trust services is recorded and communicated between partner organisations.

Internal review Recommendation 9

The Trust should review its mechanisms for ensuring that following patient death incidents, a full clinical review is carried out by the relevant Consultant Psychiatrist or most senior clinician as per Para 12.1 of the Trust Serious Untoward Incident Policy.

Action Taken by CNWL
Clinical reviews have been completed.

Panel Comments
This appears to have been addressed

Internal review Recommendation 10

In the light of the previous recommendation, the Trust should review and clarify the clinical governance structures to ensure that the chain of responsibility and accountability are both understood and implemented by all staff with regard to serious incidents.

Action taken by CNWL
Examples of local clinical governance meetings where SUI's were discussed, also, agenda and minutes of meetings held to specifically discuss learning lessons and dates for future meetings are examined.

Panel Comments

This appears to be working satisfactorily and additional ideas were generated at the learning lessons event.

Internal review Recommendation 11

The Trust should identify a mechanism by which inter-agency meetings can take place on a regular basis, in particular with the Police and housing departments in Hillingdon, so that relevant information can be shared on a timely basis.

Action Taken by CNWL

Various notes of meetings and strategy briefings with representatives from Housing and Terms of Reference for Police liaison meetings were made available.

Panel Comments

We have described improvements in detail in other parts of our report. Various notes of meetings and strategy briefings with representatives from Housing and Terms of Reference for Police liaison meetings were made available. These mechanisms should include Primary Care to facilitate joint working and support the provision of appropriate pathways of care. (See Independent Panel Recommendation 5)

8.3 Analysis of the Internal review Report

The Investigation Panel concur with many of the findings and recommendations of the internal review and have arrived at some similar conclusions with a small number of exceptions. Generally we are satisfied that the Trust has responded well in implementing the recommendations. We have made some observations, reflections and comment in more detail below

We positively acknowledge that their Terms of Reference were specifically amended following the panels initial discussions. There were several amendments to minimise ambiguity.

We understand the panel were set no parameters and were given the freedom to do whatever they considered was necessary. We were assured that the report, as are all similar internal review reports, was presented to the Trust Board by the Non-Executive member who had chaired the panel.

We were told that the panel had seen some people on more than one occasion to clarify issues. Of note however, one individual asserted that a request to return to discuss concerns had not been replied to and another member of staff had wanted to meet with the panel but her request had been deflected by a manager, without the panel being aware of this.

Of further note, and we acknowledge the subjectivity of their thinking, two members of staff felt aggrieved that they had not been given a fair hearing and considered they had not been

given the opportunity to consult their notes at interview, or been given the time or opportunity to clarify what they believed was a misunderstanding. In one case, however, the member of staff concerned told us that he had not read the report. This somewhat lessens the strength of his response, and puts into relief the Trust's missed opportunity to provide adequate feedback and address the problems.

We questioned at length and in detail another member of staff whose performance had been criticised by the review panel. We concluded that it appeared to us that a misperception may have occurred and that she had been unable to convey the full circumstances to the original panel. We noted the member of staff's professionalism and sincerity and we were satisfied that she had been placed in a difficult position by the confused systems at that time.

We acknowledged the good practice employed by the panel of reflecting and evaluating on the process and suggest this should be built into the policy for all similar internal reviews.

We considered there were just a few omissions or where a different emphasis may have been followed. These observations are made not as a criticism but suggested positive practice to be followed in the future:

- Structured communications with the Police and housing departments were not present when the service was managed by Hillingdon PCT. These were initiated when CNWL took responsibility but such processes and relationships take time to become effective. There would have been some merit in meeting with senior professionals of these services to discuss and inform them of the significant concerns and to start earlier the process of looking to improve the policies and communications and agreeing protocols.

- We also consider it would have been of value to have met with the GP's of both service users. GPs can provide relevant information about their patient's history and presentation, and can provide additional insights and perspectives on aspects of community services, prescribing, communication and liaison between the Trust and themselves.

- The biggest concern relating to the internal report is that the findings were not widely shared and key individuals criticised in the internal review report were not given appropriate feedback, or involved in reflection and discussions to consider how best to address the gaps in knowledge, systems and performance. We consider that this was a significant failing and a missed opportunity to learn lessons, provide specific counselling, support and supervision, and explore training and development needs to deal with problems identified. We consider that staff who had experienced stress associated with the traumatic events and who were close to both service users and their families deserved better. We were not able to discuss this with the service manager concerned as she had left the service by the time of our investigation.

- We have been reassured that processes are now in place to discuss with the staff the findings of future internal reviews and the implications for the service.

9. Context, including History, Organisational Arrangements and Interagency working at the time of the Incident

This section of the report will consider the organisational arrangements in place immediately prior to, and at the time of this incident. We are also aware that NHS London has commissioned another homicide inquiry that relates to a similar incident that occurred within the same time frame. A number of the organisational and interagency observations in this report are also pertinent in that inquiry.

These issues are the context for the clinical practice in this incident and as such are important to consider here. It is also the case that while we have heard evidence that significant service and organisational improvements have taken place since CNWL took on responsibility for Mental Health Services in Hillingdon, there remain significant challenges faced within the area. We also make some observations that we believe to be relevant to service management and delivery now and into the future.

9.1 Interagency partnership working in 2007

It is clear from the information that we have been given that there were few effective systems within the Hillingdon service when CNWL took over their management. As well as the internal management and procedural issues that needed to be addressed outlined in the paragraphs above, there were also issues in how the service engaged with its partners. It would seem that at this time, there were tensions with the London Borough of Hillingdon. Although Social Care staff were co-located within the CMHTs, there was not a formal Partnership Agreement in place or regular formal strategic or operational partnership meetings in place.

However, it must be said positively that in the case of both service users the service and Hillingdon Housing acted positively in securing accommodation for each of them when they each needed to be re-housed on discharge from hospital in the past. It is also the case that no concerns were reported to Hillingdon Housing in regard to either man while they were living at their neighbouring addresses prior to this incident.

Liaison between the mental health service, the Police, housing, and with Hillingdon Hospital A&E was not well established at the time of this incident. These issues are raised here as we are aware that CNWL is keen to build on the improvements it has made since 2007 in its formal working arrangements and liaison with partners. This will assume greater importance as all public services face challenges both now and in the future with significant spending reductions and reorganisations underway.

Liaison between the Hillingdon Drug and Alcohol Service and general psychiatric services in 2007 did not provide the necessary level of service for either of the patients who are at the centre of this investigation. It seems likely that other patients who presented with difficulties relating to dual diagnosis also received an inadequate service at this time. In

part, this was due to the lack of priority given to this aspect of care by the general psychiatric team, which in turn arose out of lack of awareness, inadequate training and absence of an easily accessible specialist service.

9.2 Hillingdon Mental Health Services in 2007

The Hillingdon Primary Care Trust (PCT) took on management responsibility for the mental health service from the Hillingdon Hospital Trust in 2002. The PCT was the responsible agency for the service until 2006 when CNWL took over responsibility for the service. At the time CNWL took on the service there were significant inadequacies in the service and the (then) Commission for Social Care Inspection (CSCI) and the Health Commission (HCC) were heavily involved in monitoring the service and an Improvement Plan was developed to address the concerns identified. There were several areas of inadequacy, ranging from budgetary control, the quality of both in-patient and community services, significant clinical vacancies and an absence of strategic direction and leadership.

Prior to CNWL taking responsibility for the Hillingdon Mental Health services the then PCT could not be described as an intelligent supplier. It did not contain sufficient managerial or professional understanding of the complexities of mental health provision. This deficit was compounded by the range of responsibilities it carried and, as consistently reported to the panel, mental health provision was at the margin of its concerns which affected support, professional competence, and resourcing. This meant that the service provided to the Hillingdon community was of a lesser quality than that provided by a competent supplier. We therefore make the following recommendation to relevant Commissioning agencies in the future:

Recommendation 1

The Independent Investigation Panel recommend that those responsible for commissioning ensure that there is managerial and professional competence to commission mental health services.

CNWL was, and is a focused mental health trust that took on the very serious challenges presented at that time. Experienced service managers were transferred from other localities within the Trust to manage the Hillingdon service. Staffing and organisational development needs were identified; resources were devoted to reviewing existing policies and practices within the Hillingdon service with a view to positively learning from good practice elsewhere in CNWL and in integrating the policies and clinical programmes. We have heard consistently from staff working in the service prior to CNWL taking on the service that this was welcomed as a very positive development which brought professional expertise, procedural clarity and managerial rigour to what had been a disjointed service - although one senior doctor reported that they had not noticed anything different.

It is in this context that this incident occurred. There were issues about the interpretation and usage of the CPA and Risk Management that have been discussed in Section 6. Policies and procedures were weak and CNWL was only in the early days of trying to

address these issues in Hillingdon and tackle service deficiencies and bring in support and workforce development for previously overstretched and under supported staff.

Both service users were occasional attendees at the Pembroke Day Service which was housed in the same building as the CMHT and the out-patient clinic. Both men were seen regularly in out-patients by the same staff grade doctor over an extended period in both cases.

Mr A had a designated Care Co-ordinator from within the CMHT but no designated key worker at the Pembroke Centre where he was only an occasional attendee; Mr James was a more regular attendee at the Pembroke attendee and he had a designated key worker. There was confusion about this person's role with Mr James, about whether she was his Care Co-ordinator or Key Worker at the centre.

This confusion was largely generated by the Day Services and CMHT using the same descriptive language, i.e. Care Co-ordinator to describe different roles in their respective settings, and the use of very similar paperwork to fulfil different purposes. This was further compounded when Mr James was placed on a standard CPA when he had previously been on an enhanced CPA (this division between categories of CPA is no longer applicable but was at this time) and the day services worker understood that the staff grade doctor had assumed the role of Care Co-ordinator.

The implications of this confusion in Mr James' care and treatment did not directly affect his care. However, there was an understanding by Mr James' mother that the day services worker was the Care Co-ordinator and she reports that she told the day services worker that there had been an altercation between the two men when Mr James had been hit with a baseball bat in September 2005. There is no record of this conversation in the files and when pressed on it, the day services worker has no recollection that this conversation took place. We have heard directly conflicting views about this reported exchange which has meant we have been unable to ascertain what information may or may not have been exchanged. This appears to be the only point at which staff working in the services might have been alerted to potential violence between these two men.

Mr James' mother also told this Investigation Panel that there had also been a violent exchange between the two men in May 2005 when Mr A had punched Mr James making his nose bleed, but there is no record of this having been reported to those working with either of the men in the records or in our interviews with people working in the services.

Mr A's parents told this Investigation Panel that his son and the victim did not get on and that there were problems of noise over a long period, often caused by music played loudly and at all times in the day and night. However, Mr A would not agree to his father telling the Council of this noise problem. Mr A's father expressed surprise that neither of his son's main professional contacts knew that another service user lived next door and that they did not have a good relationship.

None of those working with either service user were aware that these two men were next door neighbours sharing a party wall. Mr A's Care Co-ordinator visited him regularly and

had not picked up this connection nor had the staff grade doctor in her dealings with either man. At that time there was no way of pulling information together either through the management structure within which the discrete teams operated, or through an Information System that promoted shared inputting and reading of electronic records that any member of the clinical teams could access. However, even with a well-regarded system now in place, JADE, we were told that it is still possible, though much less likely, that it would remain unknown that people using the same services were living in close proximity.

It was notable that both service users were extremely reluctant to confide in professionals, or allow their families to tell professionals about their true anxieties, because of their fears about how they might be treated. This included the significant problems they were experiencing in their accommodation, resulting from the difficulties in their relationship as neighbours. Such fears often have some basis in reality (it is possible that such disclosures will be understood by the professional as evidence of mental illness and lead to recommendations to increase medication or even be admitted to hospital). It is therefore essential that professionals remain alert to the possibility of such withholding of information and actively address this difficulty in developing their relationship with the patient. Developing an open working relationship with family members (within the parameters of what is appropriate) can be extremely helpful in this respect.

10. Clinical Issues and Decision Making

Following the introductory section both service users will be considered separately under each of the sub-headings so as to indicate our consideration of each individual in their own right.

The purpose of any investigation involving homicide is to review the service user's care and treatment, leading up to and including the victim's death, in order to establish the lessons to be learnt to minimise the occurrence of a similar incident. In this instance both the perpetrator and victim were receiving psychiatric care from the same team within the Trust

The role of this independent investigation is to gain a picture of what was known, or should have been known at the time, regarding both patients, by the relevant clinical professionals. In doing this, it is hoped that it will be possible to raise outstanding issues for general discussion based on the findings identified by the Investigating Panel.

Members of the Investigation Panel are alert to the possibility of misusing the benefits of hindsight and have sought to avoid this in formulating this report. We hope those reading this document will also be vigilant in this regard.

We have remained conscious that lessons may be learned from examining the care of the individuals associated with this incident but also more generally from the detailed consideration of any complex clinical case. The Investigation Panel has endeavoured to retain the benefits of such a detailed examination but this does not assume that the incident itself could have been foreseen or prevented. There was a positive and open discussion at the September Workshop between the relevant professionals and agencies which reinforces this wider view

In addition the Investigation Panel is required to make recommendations for relevant service improvements. The process is intended to be a positive one that examines systems and processes in place in the Trust at the time of the incident and supports the Trust in its objective to enhance the care provided to service users. We can nevertheless, all learn from incidents to ensure that the services provided to people with a mental illness are as safe, and as comprehensive as possible, that the lessons learnt are understood and appropriate actions are taken to inform those commissioning and delivering the services.

It would be possible to suggest individual recommendations to try to address each of the identified service and delivery problems and for each of the lessons learned. In essence however, one might formulate the main problems seen in both services users care as being associated with the need to integrate appropriate information gathering with recording, and processing that information appropriately based on a sound clinical knowledge base. The skills required to obtain the necessary information and formulate the patient's problems in an accurate and helpful way, the skills necessary to be able to collaboratively develop plans to address the problems, and the skills required to contribute to carrying out the plans, all require training but also constant honing and development. Trying to ensure that all that needs to be done is done may be best achieved by focusing on constantly reviewing the process in action (in clinical reviews or ward round handovers etc.), and during clinical supervision (both individual and team supervision).

We have attempted to formulate an initial recommendation in this section, relating to supervision, that would enable the recommendations that follow to be embedded in the supervision process. We believe that this will increase the likelihood that the required changes in clinical practice actually take place and that the supervision process itself will be capable of providing assurance that the recommendations have been implemented.

10.1 Mr A

10.1.1 Mr A first presented with psychotic symptoms in October 1981, and the diagnosis of schizophrenia was made during his first admission to hospital the following month. In 1985 during an out-patient review it was noted that he had been free from psychotic symptoms for some time and a decision was made to reduce and stop his medication. Mr A was concerned that he might relapse and the reductions were staged over the next 18 months, but by 1988 the dose of medication had to be increased because there were indeed signs of relapse. Despite the increase of medication 8 months later in November 1988 Mr A was showing evidence of delusional symptoms when he was arrested for stealing alcohol.

10.1.2 From his first contact with services in 1981 until the homicide in 2007, Mr A had regular contact with members of the psychiatric team through out-patients and during his six admissions to hospital. During this period the diagnosis of schizophrenia does not seem to have been in doubt. There were several attempts to reduce Mr A's medication following the attempt in 1987, but on each occasion the dose had to be increased again because Mr A's psychotic symptoms returned or became more intrusive.

10.1.3 The reason for Mr A's last admission to hospital in July 2005 was given as distress related to something his father had said about possibly "not being around" (alive) for the 2012 Olympic Games. The notes at the time stated that Mr A was not psychotic but examination of subsequent notes indicate that he was experiencing auditory hallucinations. This did not appear to have been understood by the CMHT following his discharge because at the time the in-patient notes would not have been routinely available. Following the introduction of JADE electronic records progress notes would be easily accessible. In August 2005 three weeks after discharge from the ward Mr A again presented in a psychotic state and his oral medication was increased.

10.1.4 In addition to the diagnosis of schizophrenia, Mr A had at times used alcohol to excess and regularly used Cannabis. Subjectively Mr A felt smoking Cannabis helped him feel calm. Evidence, however demonstrates a well recognised propensity for Cannabis to increase paranoid feelings (although, it is the case that this varies between individuals).

10.1.5 During Mr A's contact with services a number of CPA meetings had taken place, the first in 2002 following an admission to hospital, and the last, on the 4th June 2007, one month before the incident. The internal report described a number of areas where the use of CPA was less than required, in particular the lack of historical risk data and the failure to translate the identification of some risks into appropriate care plans. The Independent Investigation Panel heard evidence that the CPA process, training and use of the JADE system has considerably tightened up the use of CPA.

10.1.6 The parents of both service users were regular attendees at their son's respective CPA Meetings. Both sets of parents expressed their anxieties about the consistency with which their son was taking oral medication. The parents of both men understood staff had been told about difficulties between the two men. Mr James' Mother believes she told staff about the baseball bat incident.

10.1.7 From Mr A's first presentation in 1981 until the homicide there were 5 episodes of violence recorded in the notes (1981, 1991, 1994, 2002 and 2006) four of these were definitely linked to his psychotic state at the time, and the fifth in the context of the difficulties with his flat, when he described being accused of having an affair by the boyfriend of the female service user. In the two years leading up to the victim's death there were specific episodes of violence towards him but staff told the Independent Investigation Panel that these events were not known to them and the Panel found no record in the notes.

10.1.8 Clinical Notes between 1981 and 2007 record nine occasions (including 2005 and 2006) when Mr A's medication was reduced and on each occasion, within a few months (on occasion within a few weeks) he relapsed. Sometimes there were other relevant factors such as stresses related to anxieties about his parents, or significant problems with the man and woman who took over his flat, but reduction in medication was a consistent feature.

10.1.9 Mr A had contact with the Crisis and Home Treatment Team (CHTT) following his admission to Hospital in July 2005. The internal investigation suggested that it was unclear

when CHTT discharged Mr A, but the progress notes indicate that he was discharged at a meeting with Mr A, his father and members of the CMHT on 22nd of August 2005. Initially he had been reluctant to be seen by CHTT but the Team persevered and were able to engage with him and the notes report that both he and his parents were grateful for the support he received.

10.2 Mr A – Assessment of Needs, Problems, Strengths, Risks

10.2.1 Mr A had been known to local services for 26 years and had received a number of comprehensive assessments. The diagnosis of schizophrenia was well established and based on good clinical assessment. The underlying treatment of his illness was based on standard treatment regimes, but did not include specific management of non-prescribed drug issues.

10.2.2 As discussed elsewhere, appropriate attempts were made to address Mr A's housing and other social needs, but some of the areas where these needs overlapped the consequences of his symptoms were not fully appreciated and were not addressed in his plan of care. Mr A had a history of problems with neighbours, and while this is not uncommon amongst tenants living in close proximity to one another, some of his difficulties in the past were clearly related to paranoid delusions arising out of symptoms of his illness. There was not sufficient attention given to Mr A's relationship with his neighbours in terms of searching for possible psychotic experiences and beliefs.

10.2.3 There was not sufficient attention given to Mr A's use of alcohol, and in particular his use of Cannabis. One must acknowledge the difficulties in trying to help someone alter their use of drugs when they are disinterested or unwilling to consider changing their lifestyle, but Mr A may have benefited from a sustained and clear approach to his drug use, from the team involved with his care. At least this would have been a consistent message that his use of drugs carried risks for his mental health and that there was help available to do something about it. Not providing this consistent approach runs the risk of implying acceptance of the use of drugs in this way, or for conveying a helplessness about the possibility for change.

10.2.4 Mr A's Care Co-ordinator made appropriate efforts to get to know him and develop a trusting working relationship but acknowledged that some of the background information contained in past notes was not easily available. With the changes in structure and development of new ways of working, it is likely that patients will encounter changes in Care Co-ordinator and other professionals. Mr A's vulnerability and his general gentleness were recognised and taken account of in the care plan, but his history of violence when psychotically disturbed and therefore his propensity for violence in those circumstances was not.

10.2.5 It is essential that information from previous assessments and treatment plans is available and known by those making clinical decisions now and in the future.

Recommendation 2

The Independent Investigation Panel recommend that the Trust should further develop its managerial and clinical supervision policy and procedures to facilitate supervision being used to provide assurance to the Trust Board that patient care is of the required standard. The supervision process should enable monitoring and support at every level to ensure clinical practice reflects the requirements of the clinician's professional duties and of prescribed changes in practice such as the recommendations contained in this report.

10.3 Mr A – Care Programme Approach

10.3.1 There still appears to be some uncertainty about the role of the CPA meetings as the main meeting to confirm the current position and plan for the future management and its position within the relatively new functionally split teams. The responsibility for decisions about treatment shifts as the patient moves between teams, such as In-patient, Community, and Home Treatment. This was the case with Mr A. Some information did not travel with Mr A when he was moving between teams, and decisions were made about changes in medication by people only transitorily involved, without any involvement of those with longer term knowledge of his problems, or responsibility for his longer term management. Potentially this is still a problem. There was some evidence that medical outpatient clinics may operate at times as a parallel service to the rest of the team. In Mr A's case the care plan and risk assessment and risk management plan were drawn up without involving the doctor. The Independent Investigation Panel were unsure of the practical mechanism for reviewing the risk history within the CPA process.

10.3.2 The Care Co-ordinator needs to be genuinely recognised as the key member of the clinical team co-ordinating care, ensuring close liaison between other key members of the team, in particular, the doctor and the family.

Recommendation 3 (See Internal Report Recommendations 2, 3 and 4)

The Independent Investigation Panel recommend that the Trust reinforces clinical care management as the cornerstone of patient care in their psychiatric services. The essentials of this are contained within the Trust's CPA policy, and should include the appropriate use and sharing of clinical information to inform decision making and the management of risk. This should be reflected and strengthened in the training programmes staff are required to attend, and the priorities identified in individual and group supervision. Supervision should facilitate the routine review of actual cases to ensure the appropriate application of the principles of CPA and enable corrective action to be taken if required.

10.4 Mr A – Risk Management

10.4.1 The Risk record did not reflect the actual risk history. The history of violence and the links between Mr A's episodes of violence and psychotic features in his mental state had not been recognised and was not included in the risk history or taken account of in the risk management plan.

10.4.2 The combination of not recognising that Mr A had a history of acting on delusions about neighbours, and shortage of knowledge about his past violence may have contributed to the lack of exploration of his relationships with his neighbours, and lack of probing for possible psychotic features in his mental state.

See Recommendation 3 (See Internal Report Recommendations 3 and 4)

10.5 Mr A – Information Sharing and Record Keeping

10.5.1 Some of the concerns regarding the sharing and recording of information related to Risk are outlined above.

10.5.2 Mr A's parents were regularly seen by Mr A's Care Co-ordinator but important information about Mr A's fears, anxieties, mental state, and behaviour was not shared with the professionals because Mr A insisted his parents should not divulge the information. Circumstances such as these are not unusual and ways of attempting to address the problems arising as a consequence need to be incorporated into all Trust staff contact with relatives and carers. This type of situation often causes anxiety for staff in relation to Patient Confidentiality and they require clear guidance on these issues.

10.5.3 The notes, CPA process and other information systems available at the time were not used adequately to record or convey some of the pertinent information adequately. Mr A's risk assessments and care plan were drawn up without consultation with other relevant clinicians such as the staff grade doctor and were based on only partial information. The presence of psychotic symptoms while he was in hospital was not communicated to the CMHT, and Mr A's presentation and activity at the Pembroke Centre were not recorded.

10.5.4 The Independent Investigation Panel heard evidence from a number of people at various levels in the Trust all of whom suggested that the introduction of the JADE information system would greatly improve the recording and access to relevant clinical information. For example the contemporaneous clinical record of Mr A's admission to hospital would now be available to the CMHT whenever required. While this is a significant improvement and the implementation of the JADE system has been commended in a number of sections of this report professionals still need to access and use available information in a thoughtful and therapeutic way.

10.5.5 The Panel considered that there was evidence that at times the different teams (e.g. In-patient, Day Service, Home Treatment, CMHTs) worked without adequate consultation and information sharing, and that there were examples of members of the same team working in parallel rather than as a coordinated team.

See Recommendation 3 (See Internal Report Recommendation 7 and 8)

10.6 Mr A – Medicines Management

10.6.1 There were occasions when people who had only brief contact with him and would not be involved in his long-term management adjusted Mr A's medication. It is desirable in such situations for there to be consultation with the professionals most involved who are likely to have useful information and a greater understanding of the issues. Clearly this is not always possible but ensuring the relevant people are informed of changes after the event should be feasible. It may not be enough that the change is recorded unless there is a system to bring it to the attention of the appropriate clinicians.

10.6.2 The most obvious area of concern with regard to Mr A's medication was the apparent absence of a long-term strategy to deal with attempts to reduce the dose of antipsychotic medicines. There were many attempts to reduce the dose or alter the combination of drugs in order to minimise the side effects, but on each occasion a relapse of symptoms followed. During the last CPA Mr A was again asked to reduce his medication and given his problems from side effects this may have been appropriate, but there does not seem to have been a recognition that this may have (and given the previous history, was likely to have) resulted in a relapse of psychotic symptoms. In this context the plan for a medical review in six months was inadequate. The information regarding the relapses following reduction in medication was contained in the notes but was not easy to extract without specifically searching for it and was not part of the case summary. "Non-compliance with medication treatment" was a relapse indicator listed in the CPA document from June 2007, but reducing medication as part of a plan does not seem to have been recognised as a risk.

Recommendation 4

The Independent Investigation Panel recommend that the Trust Medical Director should remind all doctors in the Trust's Psychiatric Services that they have a duty to ensure participation in the multidisciplinary decisions made for patients for which they are responsible. Doctors should ensure a patient's medication is appropriate and being suitably managed within the CPA process. This issue should be regularly included in individual and group supervision at all levels.

10.7 Mr A – Other Services (In-patient, Day Services, Crisis and Home Treatment [CHTT])

10.7.1 Some of the issues related to Mr A's contact with day care services are discussed in previous sections above. The Independent Investigation Panel heard from Mr A that he regularly attended the Pembroke Centre although his participation in formal groups appears to have been less regular. He did not have a designated worker within the day care system and there were no records of his attendance. There was therefore no clear mechanism for sharing any observations about his participation and mental health with members of the team responsible for his care.

10.7.2 In July 2005 the In-patient team doctor made a comprehensive entry in the notes detailing their assessment of Mr A, following his admission to the psychiatric ward

after his period in the general hospital. This included a collateral history from Mr A's father. Indeed it was a subsequent discussion with Mr A's father that alerted the doctor to the fact that Mr A was exhibiting psychotic symptoms. Unfortunately the past history of violence did not find its way to the risk assessment and Mr A's psychotic symptoms while in hospital were not picked up by the CHTT or CMHT.

10.7.3 The CHTT persevered with Mr A despite his initial reluctance to engage and although the team was aware that Mr A had acted on command hallucinations in the past they did not seem to be aware that he had been experiencing psychotic symptoms while in hospital. When they did become aware of him experiencing auditory hallucinations they responded quickly and involved the Community staff grade doctor in a joint assessment. Mr A did not wish the CHTT to visit him at his home, giving the reason that he would feel "pressurised". Given Mr A's initial reluctance to accept input from CHTT it is understandable that the team would not wish to insist on a home visit. Nevertheless it would have been helpful if there had been some documented exploration of what Mr A felt pressurised by, as it may have given more of an indication of his true anxieties.

See Recommendation 3 (See Internal Report Recommendations 7 and 8)

10.8 Mr A – Primary Care

10.8.1 Mr A saw his GP from time to time for physical concerns and during those consultations the doctor would enquire about psychiatric symptoms. Mr A was seen regularly by a practice nurse who gave him the depot antipsychotic injection. Summaries and clinic letters, containing relevant information, were sent by the psychiatric services and seen by the practice. Members of the primary care team were not actively involved in the CPA process and it was left to the practice staff to make contact with psychiatric services if they had concerns. It would have been good practice for Mr A's Care Co-ordinator, or another member of the team, to be in contact with the practice nurse who was administering depot medication. This would have facilitated proactively gathering information about Mr A's presentation at the time the injection was due and provided an opportunity to inform the nurse about any concerns and what to be looking for.

Recommendation 5 (See Internal Report Recommendation 11)

The Independent Investigation Panel recommend that a forum involving Primary Care be established. Given the increasingly important role of Primary Care in the commissioning and provision of psychiatric treatments, the Internal Investigation Recommendation 11 should be expanded to include a forum involving Primary Care to facilitate joint working and support the provision of appropriate pathways of care.
The evolution of clinical commissioning groups gives the process of engagement with GP's increased relevance.

10.9 Mr A – Dual Diagnosis

10.9.1 In the early years of Mr A's contact with psychiatric services there were frequent references to his use and concerns about his misuse of alcohol. In more recent times there had been much less concern about his use of alcohol but there was some concern about his use of Cannabis. Mr A regularly denied using the drug and when he did admit to using it said it was very little but has subsequently said he smoked regularly because it helped him feel calm. Use of Cannabis was listed in 'Relapse Indications' in his last CPA document from June 2007 and in retrospect staff have indicated that they think it would have been helpful to try to utilise the Dual Diagnosis service. It must be said that the service now available to teams is considerably superior to what was available in 2007.

Recommendation 6 (See Internal Report Recommendation 1 and comment)
The Independent Investigation Panel recommend the continued provision of Dual Diagnosis expertise for people with serious mental illness. Given the prevalence and impact of substance misuse on patients within core psychiatric services, the Trust must ensure the continued provision of Dual Diagnostic expertise for this client group. It should seek to expand services and develop the skills of practitioners in this area and monitor them through the clinical supervision process.

10.10 Mr James

10.10.1 Mr James' first contacts with psychiatric services was in the latter part of 2000, when he presented having severed arteries and nerves in his 3 right middle fingers while intoxicated with alcohol. There were differing views as to whether this was deliberate or accidental but there were reports that he was restless and paranoid even when not drinking.

10.10.2 The diagnosis of Paranoid Schizophrenia was made during an admission to hospital, under Section 2 of the Mental Health Act in November 2002. There had previously been significant problems with Mr James creating a noise nuisance, to the point that he had been threatened with eviction. The admission was in the context of Mr James exhibiting florid paranoid psychotic symptoms. He had been found "brandishing a knife, scissors, and a machete at his residence in a tower block". At the time he was experiencing auditory hallucinations and believed there was someone on the roof and that his flat was dangerous. He had been consuming in the region of 40 units of alcohol per week. Following discharge from hospital his care was coordinated via Enhanced CPA.

10.10.3 As Mr James had remained well in the community to that point, during a CPA meeting in June 2004 it was proposed that the level of CPA should be reduced from Enhanced to Standard. This change to the level of supervision was implemented in July 2004. The significance of the change to Standard CPA (under CPA arrangements at that time) had perhaps not been fully explained to Mr James' family and they had an expectation that there would be a similar level of contact with workers in the Day Services to that which had existed with the Care Co-ordinator under the previous provision.

10.10.4 Mr James spent 6 months in hospital but was concordant with medication and after discharge remained symptom free until late September 2004. Following planned reductions in medication in April and September, his mother raised concerns that he was drinking heavily, he had stopped medication, and his mental state was deteriorating. Although he was advised to take medication, his mother was still expressing concerns about him drinking heavily and not taking medication in January 2005. In February Police were involved in a disturbance between himself and an unnamed neighbour. He was offered an informal admission to hospital, declined but did restart oral medication and his mental state improved.

10.10.5 Throughout the rest of 2005 Mr James was reported to be taking medication, not drinking alcohol and remaining well mentally. There was a brief relapse in consuming alcohol in January 2006 accompanied by a report of him getting into a fight whilst intoxicated, but by March he was abstinent and doing well. Staff reported that he was discharged from Day Care because he was not attending, but was well and actively engaged in working with his brother.

10.11 Mr James – Assessment of Needs, Problems, Strengths, Risks

10.11.1 Mr James had been known to local services for 7 years and had received a number of comprehensive assessments, including during his admission to hospital under Section 2 of the Mental Health Act in November 2002. He also had a comprehensive Health and Social Needs Assessment in March 2003. The diagnosis of schizophrenia was well established and based on good clinical assessment. The treatment of his psychotic illness was based on standard drug treatment regimes. The assessments included information about him regularly drinking 40 units per week, but this was not translated into an identified need to address it as a problem (perhaps because he was noted not to be physically dependent).

10.11.2 There is extensive correspondence in Mr James' case notes detailing many episodes of serious noise nuisance and some episodes of aggression and violence associated with his use of alcohol and paranoid mental state. They do not appear to feature in the assessments as issues meriting a care plan.

10.11.3 As discussed above, some of Mr James' housing and other social needs were addressed, but some of the areas where these needs overlapped with the consequences of his use of alcohol and symptoms of illness were not fully appreciated and were not addressed in his plan of care. Mr James had a history of serious problems with neighbours, in particular his history of playing his music very loudly, causing noise nuisance. Some of his difficulties in the past were clearly related to his use of alcohol and possibly to symptoms of his illness. Given his past history there was not sufficient attention given to Mr James' relationship with his neighbours in terms of enquiring about possible violent episodes.

10.11.4 As indicated above, there was not sufficient attention given to Mr James' use of alcohol. As with Mr A, one must acknowledge the difficulties in trying to help someone alter their use of drugs or alcohol when they are not acknowledging it as a problem, but Mr James may have benefited from a sustained and clear approach to his use of alcohol, from the team involved with his care. In Mr James' case drinking to excess was clearly linked to serious problems of non-concordance with medication, acts of self-harm, other dangerous behaviour, and aggression. Mr James merited a more sustained and structured approach to his alcohol problems.

In relation to these issues there are notable similarities with Mr A's situation and for this reason we have not made separate recommendations although these similarities do reinforce the recommendations that have been made.

Please see Recommendations 2 and 3 along with the Independent Investigation Panel's comment regarding Internal review Recommendation 1.

10.12 Mr James – Care Programme Approach

10.12.1 Mr James was subject to Enhanced CPA arrangements from November 2002, following his admission to hospital, until July 2004. (The comments about CPA equally remain relevant in that there is uncertainty about the role of the CPA meetings as the main meeting to confirm the current position and plan for the future management of the person and its position within the relatively new functionally split teams.) Responsibility for Mr James' care did move between individuals, and to some extent teams. There was some discussion about the decision to downgrade his CPA status to Standard. The Care Co-ordinator spoke with the new Care Co-ordinator (the staff grade doctor), Mr James and his mother, but the decision had already been made in the Care Co-ordinator's supervision meeting.

10.12.2 Although there were letters, a CPA document and a transfer summary following the regrading to Standard CPA, some information was not incorporated into the care plan. It was difficult to find evidence that the care plan was used as a working document by all members of the team. Although the Independent Investigation Panel have heard evidence that the JADE Information System now makes this more likely there was some evidence that medical out-patient clinics may still operate in somewhat parallel way to the rest of the service. In Mr James' case this was emphasised by the evidence that the care plan, risk assessment, and risk management plan were drawn up separately from the doctor and the practical mechanism for reviewing the risk history within the CPA process was unclear.

10.12.3 The significance of the change to Standard CPA (under CPA arrangements at that time) had perhaps not been fully explained to Mr James' family and they had an expectation that there would be a similar level of contact with workers in the Day Services to that which had existed with the Care Co-ordinator under the previous care management provision. This may have contributed to misunderstandings between the Day Services worker and Mr James' family.

10.12.4 The decision to change the level of CPA appeared to be reasonable, given Mr James' progress at the time but it was taken in the context of a supervision meeting with the Care Co-ordinator and did not arise out of a discussion within a care planning meeting. The lack of a CPA meeting at which the change in arrangements could be debated may have contributed to the misunderstandings about the expected level of supervision, communication, and the confusion about who was to be the Care Co-ordinator.

Please see Recommendations 2 and 3 along with the Independent Investigation Panel's comment regarding Internal review Recommendation 1.

10.13 Mr James – Risk Management

10.13.1 The Risk record did reflect some of the significant events relevant to risk, but did not identify the association between the use of alcohol and the history of violence, and the relevance of this to Mr James' episodes of violence. Other risky behaviour and psychotic features in his mental state were recognised and included in the risk history both when he was subject to Enhanced CPA and in the 'Standard CPA' forms completed by the worker in the Day programme.

10.13.2 It is very unclear how the CPA documents were used to support the work with Mr James in practice. The Independent Investigation Panel heard evidence that the Standard CPA forms were completed by the worker in the Day Services because they were not routinely completed by doctors (even though the doctor was often the default Care Co-ordinator). It did not appear to be common practice for the Day Service workers to attend out-patient appointments and not clear that the care plan developed (somewhat in isolation) by the Day Service worker was used as a working document by the doctor in out-patients. As a consequence even when risk factors are identified in the CPA document they may not be addressed in the care plan developed by the doctor.

Please see Recommendations 2 and 3 along with the Independent Investigation Panel's comment regarding Internal review Recommendation 3 and 4.

10.14 Mr James – Information Sharing and Record Keeping

10.14.1 Some of the concerns regarding the sharing and recording of information related to Risk are outlined above.

10.14.2 Mr James' mother was in regular contact with his Care Co-ordinator while he was subject to Enhanced CPA arrangements but had much less contact after he was on Standard CPA. She was under the impression that her son's new Care Co-ordinator was the key worker in the Day Unit (the confusion was compounded by the fact that the Day Services Key Worker filled in the CPA paperwork) but in fact the staff grade doctor was the Care Co-ordinator. At times Mr James was reluctant to allow his mother to talk to staff about his problems with his neighbour Mr A and as a consequence important information about Mr James' difficulties was not shared with the professionals. Circumstances such as these are not unusual and ways of attempting to address the problems arising as a

consequence need to be incorporated into all Trust staff contact with relatives and carers. This type of situation often causes anxiety for staff in relation to Patient Confidentiality and they require clear guidance on these issues.

10.14.3 The Independent Investigation Panel heard evidence from Mr James' mother that following the baseball bat incident she was so concerned she insisted that her son accompany her to the Day Services Centre to tell staff about what had occurred. When we discussed this with the health care professional concerned, she was unable to recall the conversation. The health care support worker described as being present at the time had left the service and the Panel's attempts to locate him proved unsuccessful. We could find no evidence in the case note records of such a conversation having taken place. We noted the depth of concern expressed by the family at what they considered to be a significant omission by staff, which may have led to action by the clinical team to address the conflict between the two men.

10.14.4 We also listened carefully to the member of staff concerned, whom we noted to be sensitive to the feelings of the family and appeared to us to be genuine in not being able to recall the meeting. Other members of the clinical team also expressed their lack of knowledge at the time of this incident. It is a matter of serious regret that we were not able to locate for interview the former member of staff, who may have been able to provide us with further definitive information.

10.14.5 The baseball bat incident in September 2005 was not the only occasion when there had been a confrontation with Mr A. Mr James' mother showed us a document which, she told us, was blood stained as a result of Mr A's violence to Mr James when he was bringing his two bicycles into the communal area of the flats. Mr James' mother asserted that when this had been reported to the member of staff in the Day Services centre, they had been dismissive and had insisted it was a matter for the Police. We could find no evidence of the Police following it up.

10.14.6 The notes, CPA process and other information systems available at the time were not used adequately to record or convey some of the pertinent information. Notes were not kept of day to day attendance or of periodic assessments in the Day Services. The instances mentioned above highlight the inadequacy of that system. Mr James' risk assessments and care plan were drawn up without full consultation with other relevant clinicians such as the Staff grade Doctor and were based on only partial information. The Independent Investigation Panel have heard evidence from a number of sources that the introduction of the JADE information system has greatly improved recording and access to relevant clinical information. For example the entries made by different parts of the service are available to the doctor in the out-patient clinic. While this is a significant improvement and the implementation of the JADE system has been commended in a number of sections of this report professionals still need to access and use available information in a thoughtful and therapeutic way.

10.14.7 There may be particular issues for the working practices of the specialised teams to ensure adequate consultation and information sharing takes place in an increasingly busy environment. Patients are increasingly required to access services from a

variety of sources including other providers. The ability to identify and communicate relevant information across these boundaries will be essential.

Please see Recommendation 3 along with the Independent Investigation Panel's comment regarding Internal review Recommendation 7 and 8.

10.15 Mr James – Medicines Management

10.15.1 Non adherence with medication treatments is common. Individuals often weigh the perceived benefits of medication against the disadvantages. However this process can be complicated by impaired insight, the stigma of diagnosis and often troubling side effects of anti-psychotic medicines. Interventions to improve adherence include, encouraging acceptance of the illness, drawing analogies with treatment for medical disorders and involving the patient in decision making.

The skills required by clinical staff include being non-judgemental, encouraging the person to disclose problems, anticipating non-compliance and recognising that improvement in adherence will require a prolonged effort

10.15.2 Mr James' mother was a regular attendee at her son's CPA Meetings and subsequently often accompanied him to his out-patient appointments. On a number of occasions she expressed anxieties about the consistency with which he was taking oral medication. Sometimes this was associated with periods of him drinking to excess. On one occasion depot medication was suggested but declined by Mr James. In general, however there was no overall strategy to deal with Mr James' medication in the care plan, in part because care plans were usually written without direct input from the doctor.

Please see Recommendation 4 along with the Independent Investigation Panel's comment regarding Internal review Recommendation 1.

10.16 Mr James – Other Services (In-patient, Day Services, Crisis and Home Treatment [CHTT])

10.16.1 The Health and Social Needs Assessment and FACE Risk Profile tool completed in December 2002, during Mr James' stay in hospital, does not adequately reflect his problems associated with alcohol or his risk behaviour to himself and others. Despite the circumstances of his admission to hospital, the forms state there is no substance misuse problem and no risk factors associated with violence or the use of weapons. This appears to result from the assessment being based on Mr James' own responses to questions and on a cross sectional view at the time the assessment was conducted without reference to historical data, and without the benefit of collateral information from a carer. Fortunately, subsequent assessments from January and March 2003 do record the concerns about violence, the use of weapons, risks to himself, and their links to his psychosis and use of alcohol. These assessments were conducted while he was attending the first CMHT.

10.16.2 From the latter part of 2004 Mr James had been transferred to the care of a different consultant, and was already on Standard CPA. The forms filled in by the worker in the Day Services continued to contain information about Mr James' risk history but the out-patients appointments and the CPA reviews operated in parallel and it seems unlikely that this information was considered in any planning involving the doctor (who was by this stage the actual designated Care Co-ordinator). For example an entry in the notes by the doctor following an out-patient appointment dated 13th April 2004 reads "CPA Standard 6/12". On the 6th September 2004 there is an entry headed CPA and there is corresponding paperwork but the doctor was not involved. The next entry relating to CPA was 27th June 2005 the doctor was not mentioned and an entry made by the doctor following an out-patient appointment on 30th June made no mention of the CPA 3 days earlier.

Please see Recommendation 3 along with the Independent Investigation Panel's comment regarding Internal review Recommendations 7 and 8.

10.17 Mr James – Primary Care

10.17.1 Mr James' attendance at his Primary Care Practice was for relatively minor physical health care consultation and not for mental health reasons.

Please see Recommendation 5 along with the Independent Investigation Panel's comment regarding Internal review Recommendation 11.

10.18 Mr James – Dual Diagnosis

10.18.1 Although there are differing views as to the degree and frequency with which Mr James drank to excess, there are a significant number of entries in the notes linking his alcohol use with disturbed behaviour, non-compliance with treatment and at times violence. Problems with alcohol were identified as an issue in care plans but there was no strategic plan to address his use of alcohol. One of the reasons for this appears to be the view held by the clinical team at the time that because his drinking was "binge drinking" it did not require addressing. Despite substance misuse being common amongst patients with psychotic illness there was limited understanding of how to deal with the problems associated with dual diagnosis. It must be said that the Dual Diagnosis service available to teams currently is considerably superior to what was available in 2007.

Please see Recommendation 6 along with the Independent Investigation Panel's comment regarding Internal review Recommendation 1.

11. Professional Development – Education and Training

Arising from incidents of this nature it is inevitable there will be different degrees of individual, team and organisational learning required. We were informed by a significant

number of people that prior to CNWL taking on the Hillingdon Service, training and leadership development “Was in a mess”, with the main focus being on mandatory training.

We therefore, questioned most of the staff in some depth about the accessibility, range, quality and effectiveness of training. We also interviewed members of staff with responsibilities for organisational development, the training department and commissioning post registration clinical courses, for all staff across the Trust apart from medical staff.

11.1 Learning from reviews and incidents

We were told that the recommendations and actions arising from internal and independent investigations are fed through the organisation and learning group and these are considered along with information from other sources. This includes the Care Quality Management Group, formerly the Clinical Governance Group. There is then a process of prioritising for inclusion in training programmes and courses. However it wasn’t clear to us that all staff who need to receive information and increase their awareness access this information.

The panel noted that there are a number of initiatives underway for identifying themes and patterns from Serious Untoward Incidents and then ensuring they are appropriately addressed in training and development events.

11.2 Organisational Issues

We understand that a lot of the training provided is in-house, which includes training packages commissioned from external providers including, the Royal College of Nursing and the Association of Psychological Therapies (APT). A number of individuals commented on the flexibility of those who provide training, and their willingness to provide the learning events for groups in Hillingdon, rather than the time consuming journeys to other venues.

A management development programme for Hillingdon managers has been organised since 2009 running one day a month. We were made aware that an initiative considering the organisational culture as a whole and between teams and sites was being piloted. We understand that there is a monthly induction programme, and that mandatory training occurs in the third week of each month.

It appeared to us that there is a shortfall in the provision of partnership training for practitioners with key partners, in particular, the Police and housing. We consider this would enhance the understanding of issues such as safeguarding, housing processes and the impact and understanding of MAPPA and other important criminal justice issues.

We were told that a menu of training availability can be accessed on the Trust website. The panel were told that some training is not always directly related to practice. We understand that within the new service line arrangements it is intended that a training development lead would be identified, who will be the link with the central training team.

It was not made clear to the panel how individual appraisals inform training programmes. What is required is less of an ad hoc approach but a more precise, coordinated and cohesive approach to planning and an understanding of the key issues and pressures for training and a sharper approach to prioritising.

A challenge in designing training programmes is to make it sufficiently beneficial to the audiences' different levels of knowledge, experience and needs.

11.3 Evaluation

We were advised that whilst there are arrangements in place for evaluation of most courses, the corporate systematic evaluation of the quality and effectiveness of the training is less well established. The present arrangement for evaluation appears to us to be piecemeal and unreliable. However we were told that a member of the learning and development team will sit in a training session and review the training materials once a year. Following this, information will be fed back to the trainer. We were also informed that E learning courses were being developed and most of these build in an element of evaluation.

We were told that clinical supervision was a further means of managers and clinical leaders ensuring the individual has acquired the knowledge and skills expected. This was confirmed as happening by some of the individuals interviewed.

11.4 Clinical Skills Development

There is an identified CPA trainer, who apparently delivers training one day per month. In the past, the trainer has undertaken group training for specific teams. The panel were told that local authority staff are able to attend CPA and risk assessment courses free of charge.

Panel Comment
The panel's impression is that there is currently a significant investment in place but more emphasis is required in providing a greater range of effective learning opportunities and a system for prioritising and gaining maximum benefit from the resources available.

The panel also urge that active consideration is given for wider means of learning through opportunities for reflective practice, peer review, case conferences, project work, shadowing, secondments, action learning sets and visits.

11.5 Learning the Lessons Workshop

At the learning lessons event there was an extensive discussion and a specific focus was given to education, training, support and supervision. A significant number of positive ideas and suggestions were generated.

Recommendation 7

The Independent Investigation Panel recommend that the Trust take account of the findings of this report in reviewing the process of identifying training needs, in particular how lessons from Serious untoward Incidents, and the ideas from the "learning the lessons" workshop event can be fed into the process of planning professional development, training, supervision and support.

12. Family Members

At the outset, we met with the parents of Mr A. and the mother and brother of Mr James. We discussed with them the Terms of Reference, our intended approach and invited them to share with us their experiences and concerns.

We were keen to receive their views regarding the level of involvement, support, liaison and the information they had received from the mental health service and their partner organisations including the Housing Department. We also asked about their awareness of whom to contact if they had concerns in respect of their respective son's relapse. We also asked if a carer's assessment had been undertaken.

We particularly asked questions to gain an understanding of the impact of their respective son's mental illness and the care and treatment they had received, including their use of alcohol and other substances.

We explored with them the nature and extent of the relationship between the two men and asked about any previous incidents of conflict between them. We also invited their views on the internal review.

We noted the love and devotion of the parents of both men and this was evident from the way they had consistently supported their sons throughout their illness and accompanied them to out-patient appointments.

We have subsequently kept both families informed of progress and have met with them to share our findings and recommendations and offer support.

As indicated earlier we wish to record our appreciation of the manner in which both families received our questions and their willingness to enter into discussion with us. We have used their comments and insights throughout this report and the evidence they provided has been essential to our understanding of events and the formulation of our recommendations.

12.1 Findings – Family members

Both families were generally satisfied with the service their son's had received and the support they had experienced as close relatives. The exception being the criticism made by the mother of Mr James about the performance of the perceived Care Co-ordinator.

The carer's assessment undertaken by Mr A's Care Co-ordinator was impressively comprehensive. Mr James' mother should have received a further offer of a carer's assessment.

The panel have identified some concerns and issues that require to be addressed.

The lack of awareness of the presence of another person living in close proximity who was receiving support, and the conflict that had previously occurred, had largely remained unknown to the care team. This suggests gaps in awareness and skills in eliciting important information.

We acknowledge earlier in our report that no members of the respective clinical teams were aware of the co-location of both men. A number of good practice points emerged from the learning event including, more home visits, deeper engagement with service users to understand their lives and knowing what is important to them, and engaging more closely with family members, to ascertain their views of concerns the individual may be struggling with.

The issue of listening to the concerns of relatives was considered in detail at the Learning Lessons event. Ways to enhance this were identified as:

- More focussed listening to concerns
- Recognition of the family members expertise
- Overcoming concerns in respect of breach of confidentiality
- Carer groups, support and information for carers

The learning event also revealed an awareness of the importance in delivering effective treatment and care by giving a greater focus to family involvement and responsiveness to their needs.

Positive practice would be for staff to actively develop trusting, open and accessible relationships with family members, enabling them to feel confident to alert healthcare staff to any concerns which might impact on the wellbeing of their relative. In the case of Mr A, this was only partially achieved.

Recommendation 8

The Independent Investigation Panel recommend that the Trust identify the skills necessary in forming positive relationships, effective communications and discerning information and concerns from family members. The Trust should ensure that these are included in professional development programmes, and are the focus of clinical supervision and monitoring through supervised practice.

13. Action Taken, Changes and Progress since the Incident

CNWL have introduced significant service improvements since this incident four years ago. This section will consider specific areas of improvement and areas that continue to need to

be promoted in order to ensure that improvements are embedded and that the CNWL Hillingdon service is best able to deal with the immense challenges facing public services in the foreseeable future.

13.1 Interagency working and partnerships

These comments are not intended to be comprehensive in regard to all the partnership and liaison arrangements that CNWL are engaged in with their partner agencies working in Hillingdon or with other service areas in the NHS. They relate to issues that were apparent in this investigation.

13.2 Adult Social Care

The CMHT's have staff drawn from CNWL and the London Borough of Hillingdon (LBH). These staff are co-located together and as with many other CMHTs around the country, working arrangements are heavily dependent on working relationships with formal arrangements and the oversight of them less well developed. From our discussions we are aware that there is a desire on the part of both CNWL and LBH to complete a Section 75 Agreement that will set out clearer expectations, understandings, responsibilities, resource commitments and working protocols for the future. It is intended that this Agreement is finalised and agreed by the end of this financial year and that continuing monitoring and review arrangements are put in place.

As part of its service redesign into Service Lines and budget management the number of CMHTs in Hillingdon will reduce from three to two, one with specific responsibility for Primary Community and the other for Community Recovery. This significant change reinforces the urgency of this Section 75 Agreement, which is clearly an important document, as is the process by which it is generated and endorsed.

13.3 Housing

In this case both men had been re-housed in the past, and there is no evidence that Hillingdon Housing were aware of the tension between the two men. Both men are reported to have been noisy but neither was reported as causing a nuisance or as anti-social in their behaviour. Since the time of this incident the former Arms Length Management Organisation (ALMO) housing agency has been brought back into Hillingdon Housing and Hillingdon now operates a "tenancy neutral" Anti-Social Behaviour Team. From our discussions with both Housing and CNWL staff there is a positive recognition that when there are cases involving nuisance caused by people with mental health problems known to the Anti-Social Behaviour Team there is dialogue and positive engagement to try and resolve specific cases. It is also recognised that there can be tensions in individual cases because of the differing responsibilities but overall the impression was given that there is joint work at the individual level.

The view was expressed by people involved in both Housing and Hillingdon Mental Health services that there could be improved understanding about each other's services leading to a better grasp of the options available to each agency.

The pattern of discussions between the two agencies appears to be focused on operational work or individual cases rather than on working through and refining strategic agreements and working protocols. This has the potential to change for the better with the current input of a designated person working for LBH and with CNWL to develop the Section 75 Agreement referred to above.

There is an increasing pressure on Hillingdon's housing resources just as there is on Mental Health Services. This underlines the need to secure a robust Partnership Agreement and protocols, the implementation of which is overseen by the Hillingdon Partnership Board which we understood to be the subject of a review designed to strengthen its work.

Panel Comment

We are very happy to support this initiative and to reinforce the importance of securing formal agreements and protocols.

13.4 Liaison with Hillingdon Police

There is no accessible record that shows definitively that there was Police involvement, or the nature of it, as reported to us by Mr James' mother relating to an altercation between both men in September 2005**,** any Police record of this was no longer available. Police intelligence, organisational arrangements and the IT system now enables information to be made available to Police officers that they can use to check any history relating to a particular call address; and such information would continue to be accessible for retrospective investigations such as this.

There are issues about sharing information, both technical and in terms of confidentiality that can be mitigated through the development of continuing liaison and interagency protocols that Hillingdon Police would wish to develop further with CNWL.

It is not directly relevant to this investigation but it is clear from our discussions that the continuing dialogue between the agencies is very important in regard to Police engagement with both the in-patient wards and the Hillingdon Hospitals NHS Trust's A&E department. In regard to both these there are significant pressures to be managed that we have not commented on as they were not factors in this case.

At the time of this incident in 2007 there was no significant liaison between the Hillingdon mental health service and the Police. This has been remedied with the very valued liaison role established between a Police inspector and CNWL. In the main the focus has been with Riverside and the in-patient wards but there is also awareness and contact between the CMHTs and the Dual Diagnosis specialist. There is a question mark about the ability of

Hillingdon Police to maintain this role with the forthcoming retirement of the current liaison officer.

Panel Comment
We have heard of the much more positive working arrangements between the Hillingdon Service and Hillingdon Police. We have also heard from both agencies of some continuing concerns, often relating to the degree of understanding by front line staff in both agencies about the constraints and responsibilities of the other agency. This underlines the importance of continuing engagement and formal liaison arrangements, and it is to be hoped that the Police are able to maintain this resource, the value of which is clearly recognised, notwithstanding the enormous financial pressures they face with such significant budget reductions being made.

13.5 A&E department

Mr James' mother and brother reported that Mr James attended the A&E department in 2007. The attendance record shows that Mr James attended on two occasions with breathing difficulties. The A&E record system is not compatible with the CNWL Information System now let alone in 2007. We have not pursued this issue in this investigation but this was a more significant factor in the other case that happened in Hillingdon in 2007 and is addressed more fully in that report.

13.6 Communications and Information

At the time of this incident in 2007 there is a unanimous view that there was limited communication within the service and that information about individuals was inaccessible to professionals working within the same service.

The improvements made since that time are commendable and the information system that has been developed, JADE, is both very well regarded and used by professionals working across the service. It is notable that the system is used or accessible across the services, and by relevant partners who do not use JADE as their own system. This means, for example that A&E can use the system to check if someone attending A&E is known to Mental Health Services and has the potential to positively influence service provision for the individual.

A major improvement relates to the increased awareness and engagement that JADE promotes where an individual might be engaged with more than one service. The impact of this on people known to the Hillingdon Drug and Alcohol Service (HDAS) is significant, and it is commendable how well used this facility appears to be by HDAS.

Panel Comment
Hillingdon Mental Health Services are to be commended for the development of JADE and the extent to which professionals across the service make good use of it.

13.7 Dual Diagnosis

The Trust has formulated and published a comprehensive strategy document covering the five years from 2010 to 2015. The document places emphasis on “Mainstreaming” Dual Diagnosis Services to ensure that those patients with severe mental illness, who also misuse drugs and or alcohol receive interventions for their substance use within Mental Health Services themselves. The Independent Investigation Panel heard evidence from a number of sources at various levels in the Trust supporting the Panel’s impression that the appointment of a Clinical Lead for Dual Diagnosis in Hillingdon in 2010 has been of significant benefit to this client group.

14. Positive Practice

The Investigation Panel have identified some notable practices and developments, these include:

- The quality of the immediate RCA Review and the detailed and comprehensive internal review
- The regular involvement of both families by the staff grade doctor during the course of their sons’ treatment
- The development and use by clinicians of the JADE electronic recording system
- The effective involvement of the CHTT, when Mr A was relapsing in 2005
- The openness with which service personnel engaged with the Investigation Panel
- The enthusiasm and commitment to learn from this incident at the Learning the Lessons event on 11th September 2011

15. Fulfilling the Terms of Reference

To clarify that the focus of the investigation has been determined by the Terms of Reference, these are included as a framework with the relevant areas in the body of the report identified for reference.

Terms of Reference

Review of the Trust’s Internal Investigation to assess the adequacy of its findings, recommendations and action plans

The Panel consider the internal review was of good standard and identified the key issues of concern and made appropriate recommendations. Our comments and critique of the internal process are contained within Section 8 of the main report.

Review the progress made by the Trust in implementing the action plan
We saw evidence to support the successful implementation of many of the Trust's internal review Investigation Recommendations. This is reflected in our comments in Section 8 of the main report, as are our concerns that some problems may not have been addressed fully. Where necessary the latter are included in our own recommendations.

Involving the family of both service users
The Investigation Panel met with both families at the start of the investigation and have subsequently kept them informed and plan to share with them the outcome of the investigation. The evidence and insights from both families were essential in understanding the history and events, this has influenced the recommendations

A chronology of the events to assist the identification of any care and service delivery problems leading to the incident
A summarised narrative chronology is included in Section 7, this is annotated with comments from the Panel designed to illustrate to the reader aspects of the care and treatment plan, which, in our view, could or should have been assessed and delivered differently. It is hoped that this will aid understanding of how we arrived at our conclusions.

An examination of the mental health services provided to both men and a review of the documentation
The many and significant changes in the organisation of care delivered to both men following the CNWL taking on management responsibilities for the Hillingdon Mental Health Services in 2006, and the general improvement in services has been noted in Section 9. The more clinical aspects of their care is considered in detail in Section 10.

Consider the effectiveness of interagency working with particular reference to the sharing of information between the Substance Misuse service and the Mental Health Service
A significant gap in the service at the time was the level of service for people who experienced problems with drugs and alcohol, and we have specifically commented on the issue in Section 10 and with regard to the Trust's response to the problem in Section 13.

The suitability of the care and treatment in view of the service users history and assessed health and social care needs

The extent to which both service users care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies

The suitability of that care and treatment in view of the service user's history and assessed health and social care needs

These are dealt with in detail in the body of the Report. Where we have identified good practice this has been commented on and any significant concerns have been noted and have generated Recommendations if appropriate.

The exercise of professional judgement and clinical decision making

The appropriateness and quality of risk assessments and care planning

To consider the effectiveness of interagency working

We have carefully considered where we think there have been gaps and inadequacies in how each of the two men were cared for. These are explored in some detail in the main report. Most of our Recommendations are designed to facilitate good practice in these areas.

16. Closing Remarks

It is never a simple or straightforward matter to identify events in the care and treatment of an individual as causal factors in producing a particular outcome. When incidents occur there are usually many contributory factors interacting with many variables. It is extremely difficult, if not impossible to precisely predict or anticipate incidents of this nature. Once one removes the filter (only possible with the benefits of hindsight) the complexity of many factors combining to result in one particular outcome, out of many possible outcomes, becomes apparent.

This tragic incident has reinforced the extraordinary difficulties which services have in providing care and treatment for people with a psychosis who experience disordered thinking which may lead to impulsive actions. The problems are exacerbated when the individual conceals symptoms or when he is exposed to stress and conflict, or is misusing drugs. This was a feature in the lives of both men. In this instance, the problems were compounded by both men's reluctance to inform the clinical, or housing staff of the problems they were experiencing with each other. In addition, reductions in Mr A's medication frequently led to a deterioration in his clinical condition.

When considering if this event could have been predicted or prevented we have reviewed Mr A's history and how he presented. Even allowing for the failure to recognise Mr A's potential to be aggressive it is unlikely that the risk would have been assessed as high or as a danger to others. Whilst Mr A had been involved in a small number of aggressive episodes over the previous 26 years they had been in the context of involving his family and at a time when he was relapsing. No weapons were used in these incidents. People who knew him commented on what they regarded as his gentleness and vulnerability rather than the likelihood of him being aggressive. It appears that the previous violence between the two men was unknown to the clinical staff. We have concluded that despite the lack of rigour in his risk assessment and some omissions in his care management the seriously violent reaction to the friction between the two men could not have been reasonably predicted.

In the four plus years between this incident and the production of this report there have been many significant changes in the way in which psychiatric services are delivered to the people of Hillingdon, and indeed in psychiatric services throughout the country. Many of

these changes have been designed to try to improve the care and treatment of people in need of such care and some have direct relevance to the issues identified in this report. The degree and frequency of change, however often makes it difficult to maintain the stability and continuity of services. In producing this report the authors have sought to identify matters of significance in the care and treatment of both service users, and to make recommendations based on those findings. The intention is to address any shortcomings and improve services in general, but without committing the Trust to levels of change that would be counterproductive.

17. Recommendations

The purpose of the recommendations is to ensure that the areas of concern identified, are translated into actions which will inform and influence future practice, the development and management of the service and to enhance the quality and safety of care and treatment which service users and their families receive.

The Independent Investigation Panel also organised a “learning the lessons” event, involving key clinical and managerial staff. The aim of this event was to consolidate learning and enable staff to assist in the formulation of recommendations which are relevant to the current needs and state of development of the Trust and its Partner Services

Recommendation 1

The Independent Investigation Panel recommend that those responsible for commissioning ensure that there is managerial and professional competence to commission mental health services.

Recommendation 2

The Independent Investigation Panel recommend that the Trust should further develop its managerial and clinical supervision policy and procedures to facilitate supervision being used to provide assurance to the Trust Board that patient care is of the required standard. The supervision process should enable monitoring and support at every level to ensure clinical practice reflects the requirements of the clinician’s professional duties and of prescribed changes in practice such as the recommendations contained in this report.

Recommendation 3

The Independent Investigation Panel recommend that the Trust reinforces clinical care management as the cornerstone of patient care in their psychiatric services.
The essentials of this are contained within the Trust’s CPA policy and should include the appropriate use and sharing of clinical information to inform decision making and the management of risk.

This should be reflected and strengthened in the training programmes staff are required to attend and the priorities identified in individual and group supervision.
Supervision should facilitate the routine review of actual cases to ensure the appropriate application of the principles of CPA enable corrective action to be taken if required

Recommendation 4

The Independent Investigation Panel recommend that the Trust Medical Director should remind all doctors in the Trust Psychiatric services that they have a duty to ensure participation in the multidisciplinary decisions made for patients for which they are responsible.

Doctors should ensure that a patients medication is appropriate and being suitably managed within the CPA process. This issue should be regularly included in individual and group supervision at all levels.

Recommendation 5

The Independent Investigation Panel recommend that a forum involving Primary Care be established. Given the increasingly important role of Primary Care in the commissioning and provision of psychiatric treatments, the Internal review Recommendation 11 should be expanded to include a forum involving Primary Care to facilitate joint working and support the provision of appropriate Pathways of Care.

The evolution of clinical commissioning groups gives the process of engagement with GP's increased relevance

Recommendation 6

The Independent Investigation Panel recommend the continued provision of Dual Diagnosis expertise for people with serious mental illness. Given the prevalence and impact of substance misuse on patients within core psychiatric services, the Trust must ensure the continued provision of Dual Diagnostic expertise for this client group. It should seek to expand services and develop the skills of practitioners in this area and monitor them through the clinical supervision process.

Recommendation 7

The Independent Investigation Panel recommend that the Trust take account of the findings of this report in reviewing the process of identifying training needs, in particular how lessons from serious untoward incidents, and the ideas from the learning the lessons event, can be fed into the process of planning professional development, training, supervision and support.

Recommendation 8

The Independent Investigation Panel recommend that the Trust identify the skills necessary in forming positive relationships, effective communications and discerning information and concerns from family members. The Trust should ensure that these are included in professional development programmes and are the focus of clinical supervision and monitored through supervised practice.

Recommendation 9

The Independent Investigation Panel recommend that the Trust Board should formally review progress or otherwise of these recommendations after six and twelve months following publication of this report

Appendix One. Abbreviations and descriptions

Abbreviation	Meaning and description
A&E	Accident and Emergency
ALMO	Arm's Length Management Organisation
APT	Association of Psychological Therapies
CHTT	Crisis and Home Treatment Team
CMHT	Community Mental Health Team
CNWL	Central and North West London NHS Foundation Trust
CPA	Care Programme Approach
CSCI	Commission for Social Care Inspection
DD	Dual Diagnosis
FACE	Risk Assessment in Mental health System
GP	General Practitioner
HAGAM	Hillingdon Action Group for Addiction Management
HASCAS	Health and Social Care Advisory Service
HCC	Health Care Commission
JADE	The Trusts Electronic Information System
LBH	London Borough of Hillingdon
MAPPA	Multi Agency
MHA	Mental Health Act (1983)
Mr A	Perpetrator
Mr James	Victim
RCN	Royal College of Nursing
TOR	Terms of Reference