

Independent Investigation

into the

Care and Treatment Provided to Mr X and Mr Y

by the

East London NHS Foundation Trust

Commissioned by NHS England

**Report Prepared by: HASCAS Health and Social Care
Advisory Service**

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1. Investigation Team Preface

1.1. The Independent Investigation into the care and treatment of two mental health service users - Mr X (the perpetrator of the homicide) and Mr Y (the victim of the homicide) - was commissioned by NHS England pursuant to *HSG (94)27*.¹ The Investigation was asked to examine a set of circumstances associated with the death of Mr Y who was found dead on 21 June 2013.

1.2. Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of the Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help to improve the reporting and investigation of similar serious events in the future.

1.3. Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's Senior Management Team who granted access to facilities and individuals throughout this process. The Trust's Senior Management Team has engaged fully with the root cause analysis ethos of this work.

2. Condolences to the Family and Friends of Mr Y

2.1. The Independent Investigation Team would like to extend their condolences to the family and friends of Mr Y. At the time of writing this report HASCAS had not yet been able to arrange a meeting with Mr Y's mother and children.

3. Incident Description and Consequences

Background for Mr X

3.1. Mr X is a 44 year old gentleman of Orthodox Christian Eritrean origin. He came to live in England in 1991 having fled Eritrea to avoid being enlisted into the army against his will. He has had no family contact since this time and has never reported a significant relationship with anyone. Mr X has been unemployed since 2005 because his mental health problems became too severe for him to work.

3.2. Mr X received two prison sentences in 2004 and 2009 for possessing a bladed object. The Prosecution Service (following the homicide of Mr Y) noted that Mr X also had three other convictions between 2001 and 2013 for theft and three cautions (one of these also for theft and one for possessing a bladed article). Mr X had not been known to be involved in any act of violence prior to the homicide of Mr Y.

1. Health Service Guidance (94) 27

3.3. From as early as 2001 Mr X came to the attention of mental health services. In 2006 he registered with the Health E1 Homeless Medical Centre - a primary health care facility for the homeless in Tower Hamlets. This led to him being referred to the Specialist Addictions Unit at Tower Hamlets in 2008. In December 2010 Mr X went to live at Daniel Gilbert House - a hostel for the homeless which is supported living accommodation. Over the years it became apparent that Mr X experienced psychotic symptoms and in February 2011 a referral was made to the Bethnal Green Community Mental Health Team – he was placed on a full Care Programme Approach (CPA).

3.4. Mr X continued to have input from all four services until the time of the homicide. He had a diagnosis of Paranoid Schizophrenia/Schizoaffective Disorder and Polysubstance Misuse. In May 2013 Mr X was taken off full CPA as he appeared to be stable at this time.

Background for Mr Y

3.5. Mr Y was a white British gentleman who was 44 years old when he died. At the time of his death he was living at the Daniel Gilbert Hostel where Mr X also lived. He was registered with the Health E1 Homeless Medical Centre where he received a service for his many physical problems. Mr Y had a longstanding polysubstance misuse problem and was a service user with the Specialist Addictions Unit at Tower Hamlets. He had six children in care and begged on the streets. Mr Y had 36 convictions for 70 offences – mostly in relation to drug dealing and theft. During his time living at the Daniel Gilbert Hostel he was involved in numerous fights and altercations which led to him being injured on several occasions.

Incident Description and Consequences

3.6. On 21 June 2013 it was noted by staff who worked at the hostel that Mr Y was in good spirits. He had won £900.00 on the roulette table at the “bookies”. Mr Y spent time at the hostel between 10.30 -11.00 and later on in the afternoon when he left with a fellow resident. Prior to the homicide Mr X and Mr Y had been in a dispute about a drug debt; Mr X wanted payment and Mr Y refused.

3.7. A report prepared for the Court stated that between 18.30 and 19.00 staff at the hostel heard loud shouting and screaming coming from Mr X’s room. Members of staff went to investigate. Mr X opened his door and apologised for the noise. He was in an emotional state. There was no one else in the room. A chest of drawers had burn marks on it and there was a device used for smoking drugs on the chest. Mr X left his room at around 18.45. The hostel staff took the opportunity to examine the defendant’s room more thoroughly. The smoking device had gone.²

3.8. Around 19.00 Mr X returned to his room. He was in an angry and upset mood. A few minutes later the shouting started again. The police were called but they advised hostel staff to contact the mental health team as no offense was being committed. Hostel staff called mental health services but received an out of office reply. Mr X calmed down after support from hostel staff was given and he apologised for his behaviour.

2. Psychiatric Report for Central Criminal Court (3 March 2014)

3.9. CCTV footage showed Mr Y returning to the hostel at 21.37 – he was alone. The same CCTV captured Mr X leaving the hostel at 21.55 – he was never to return.

3.10. The following day at around 17.00 a member of the hostel staff went to check on Mr X. There was no reply so she entered his room using a master key. Mr Y was found lying on his left side with a severe injury to his throat. Mr Y was examined by paramedics and life declared extinct at 17.34.

3.11. Mr X was not apprehended until 9 July 2013. He was arrested at the Elephant and Castle shopping centre. When asked what he knew about the murder of Mr Y Mr X replied “*I don't know ... [Mr Y] but I heard something bad had happened*”. He was arrested and made no reply to caution. Subsequently Mr X was convicted of the murder of Mr Y and sentenced on 6 March 2014 to life imprisonment. He is detained at HMP Belmarsh Prison.

4. Background and Context to the Investigation (Purpose of Report)

4.1. The Health and Social Care Advisory Service was commissioned by NHS England to conduct this Investigation under the auspices of Department of Health Guidance *EL(94)27, LASSL(94) 4*, issued in 1994 to all commissioners and providers of mental health services. In discussing ‘when things go wrong’ the guidance states:

“... in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved”.

4.2. This guidance, and its subsequent 2005 amendments, includes the following criteria for an independent investigation of this kind:

- i)** When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.
- ii)** When it is necessary to comply with the State’s obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.
- iii)** Where the SHA determines that an adverse event warrants independent investigation. For example if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.

4.3. The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to

be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

4.4. The role of the Independent Investigation Team is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Investigation Team to form a view of what should have happened based on hindsight, and the Investigation Team has tried throughout this report to base its findings on the information available to relevant individuals and organisations at the time of the incident.

4.5. The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and the interest of the wider public. This case has been investigated fully by an impartial and independent investigation team.

5. Terms of Reference

5.1. *“Individual Terms of Reference will be developed in collaboration with the successful Offeror for each individual investigation. However, the following generic terms of reference will apply to each investigation:*

- *Review the trust’s internal investigation and assess the adequacy of its findings, recommendations and action plan.*
- *Review the progress that the trust has made in implementing the action plan.*
- *Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user’s first contact with services to the time of their offence.*
- *Compile a comprehensive chronology of events leading up to the homicide.*
- *Review the appropriateness of the treatment of the service users in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.*
- *Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.*
- *Examine whether either service user should have been managed under Safeguarding Vulnerable Adults procedures. Also examine the issue of increased service user vulnerability to homicide and violence and ascertain whether either Mr X or Mr Y should have been managed specifically with these factors in mind.*
- *Examine the effectiveness of the service user’s care plan including the involvement of the service user and the family.*
- *Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.*
- *Review and assess compliance with local policies, national guidance and relevant statutory obligations.*
- *Consider if this incident was either predictable or preventable.*

Independent Investigation Mr X and Mr Y

- *Provide a written report to the Investigation Team that includes measurable and sustainable recommendations.*
- *Assist NHS England in undertaking a brief post investigation evaluation*³.

6. The Independent Investigation Team

Selection of the Investigation Team

6.1. The Investigation Team was comprised of individuals who worked independently of the East London NHS Foundation Trust. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in Investigation work of this nature. The individuals who worked on this case are listed below.

Independent Investigation Chair

Dr Androulla Johnstone

Chief Executive, Health and Social Care Advisory Service - Chair, nurse member and report author

Investigation Team Members

Dr Elizabeth Gethins

Health and Social Care Advisory Service - Associate, Consultant Psychiatrist - medical member

Mrs Tina Coldham

Health and Social Care Advisory Service - Associate, service user member

Mr Frank Mullane

Health and Social Care Advisory Service - Associate, lay member

Ms Sara Egan

Health and Social Care Advisory Service - Associate, housing and addictions member

Support to the Investigation Team

Mr Greg Britton

Health and Social Care Advisory Service Investigation Manager

Independent Advice to the Investigation Team

Ms Janet Sayers

Solicitor: Kennedys

3. NHS England London Region 23 March 2015

7. Investigation Method

7.1. In November 2014 NHS England London Region commissioned the Health and Social Care Advisory Service (HASCAS) to conduct this Independent Investigation under the Terms of Reference set out in section five of this report. The Investigation Methodology is set out below. It was the decision of NHS England that full anonymity be given to Mr X and Mr Y and all witnesses to the Investigation.

Communication with Mr X

7.2. NHS England London Region wrote to Mr X via his legal team, Irvine Thanvi Natas Solicitors, and on 20 August 2014 he provided a signed consent form giving permission for the Independent Investigation Team to access his clinical, social care, housing, police and Court records.

7.3. During the course of this Investigation Mr X was detained at HMP Belmarsh Prison. The Independent Investigation Team is mindful of the fact that he is unsupported by family and friends and suffers from a severe and enduring mental illness. In order to provide support to Mr X and to ensure that he was prepared in an appropriate manner communication with him took place via his legal team.

7.4. At the time of writing this report a meeting with Mr X was still in negotiation.

Communications with the Families of Mr X and Mr Y

7.5. The Independent Investigation Team could not contact any members of Mr X's family as there are no extant records of their whereabouts.

7.6. Mr Y's family were difficult to find but were eventually located by the Independent Investigation Team via the Victim Support Service. On 15 July 2015 The Independent Investigation Chair wrote to Mr Y's mother explaining the investigation process and invited her to meet with HASCAS and NHS England London Region.

7.7. At the time of writing this report a meeting with Mr Y's family was still in negotiation.

Communications with the East London NHS Foundation Trust

7.8. On 28 November 2014 a start up meeting was held between NHS England London Region, HASCAS, and representatives from East London NHS Foundation Trust, NHS Tower Hamlets Clinical Commissioning Group, and the London Borough of Tower Hamlets Drug and Alcohol Action Team. On this occasion the Terms of Reference were discussed and suggestions for amendments made.

7.9. A meeting was held between the Independent Investigation Chair and the East London NHS Foundation Trust Chief Executive on 9 January 2015. This meeting was held in order to discuss the investigation process and to set out a timetable for the work.

7.10. The Independent Investigation Team worked with the allocated Trust liaison person to ensure:

- all clinical records were identified and dispatched appropriately (sent in January, February and May 2015);
- each witness received their interview letter and guidance in accordance with national best practice;
- that each witness was supported in the preparation of statements;
- that a witness briefing workshop was held (16 April 2015);
- that each witness could be accompanied by an appropriate support person when interviewed if they so wished;
- that interviews were held on 6, 7 and 8 May 2015 at the Trust Headquarters and that the Investigation Team were afforded the opportunity to interview witnesses and meet with the Senior Managers of the Trust (interviews were also held via telephone on 27 May 2015);
- that a recommendations setting day was held (on 27 November 2015).

7.11. Factual accuracy and headline findings communications were held between the Independent Investigation Team and the East London NHS Foundation Trust in accordance with Investigation best practice. The draft report was sent to the Trust for factual accuracy checking on 9 September 2015. Clinical witnesses were also sent the report for factual accuracy checking. Throughout the Investigation process communications were maintained on a regular basis and took place in the form of telephone conversations and email correspondence.

Communications with the NHS Tower Hamlets Clinical Commissioning Group (CCG)

7.12. The Independent Investigation Chair initiated contact with the CCG Chief Operating Officer at the inception of the work. A meeting was held on 1 July 2015 to discuss commissioning and performance monitoring issues and a further telephone meeting was held on 21 July 2015.

Communications with the London Borough of Tower Hamlets Drug and Alcohol Action Team (DAAT)

7.13. The Independent Investigation Chair maintained contact with the DAAT following the investigation start up meeting of 28 November 2014. A telephone meeting was held with a Senior Officer from the DAAT on 14 July 2015 to discuss commissioning and performance monitoring issues.

Communications with the Hostel Service Providers

7.14. Both Mr X and Mr Y lived at Daniel Gilbert House which is managed by the Providence Row Housing Association. On 24 February 2015 contact was made with the Association's CEO. Arrangements were made for the hostel records to be sent to HASCAS. The first tranche was sent on 18 March and the second on 26 May 2015.

7.15. On 7 May 2015 an initial meeting was held at the Providence Row Housing Association Headquarters between members of the Independent Investigation Team and the Providence Row Assistant Director Client Services and Service Improvement Manager. Interviews with staff were held

on 7 July 2015 and a copy of the draft report was sent for factual checking on 14 October 2015.

Witnesses Called by the Independent Investigation Team

7.16. Each witness called by the Investigation was invited to attend a briefing workshop. Each witness also received an Investigation briefing pack. The Investigation was managed in line with national best investigation practice.

Table One

Witnesses Interviewed by the Independent Investigation Team

Date	Witnesses	Interviewers
6 May 2015	<ul style="list-style-type: none"> ▪ Trust CEO ▪ Trust Medical Director ▪ Trust Service Director Tower Hamlets/ Deputy Director Operations ▪ Trust Director of Corporate Affairs ▪ Associate Director of Assurance *** ▪ Trust SAU Consultant Psychiatrist *** ▪ Trust Care Coordinator Three 	Investigation Chair/Team Nurse Investigation Team Psychiatrist Investigation Team Lay Member In attendance: Stenographer
7 May 2015	<ul style="list-style-type: none"> ▪ Service Director Specialist Addictions and APMS Practices (Present) ▪ Service Director Tower Hamlets/ Deputy Director Operations *** ▪ Service Director Specialist Addictions (Past) *** ▪ Senior Operational Lead CMHT 	Investigation Team Nurse/Chair Investigation Team Psychiatrist In attendance: Stenographer
8 May 2015	<ul style="list-style-type: none"> ▪ GP 1 ▪ GP 2 ▪ Clinical Nurse Health E1 Homeless Medical Centre *** ▪ Clinical Director *** ▪ Speciality Doctor SAU *** ▪ Nurse Practitioner Blood Bourne Virus Team 	Investigation Team Nurse/Chair Investigation Team Psychiatrist Investigation Team Service User In attendance: Stenographer
27 May 2015	<ul style="list-style-type: none"> ▪ Telephone Interview with Internal Investigation Leads 	Investigation Team Nurse/Chair

		HASCAS Investigation Manager
7 July 2015	<ul style="list-style-type: none"> ▪ Director Client Services Providence Row Housing Association ▪ Service Improvement Manager Providence Row Housing Association *** ▪ Hostel Worker 1 ▪ Hostel Worker 2 	<p>Investigation Team Nurse/Chair</p> <p>Investigation Team Service User</p> <p>Investigation Team Addictions and Housing Member</p>

Investigation Procedures

7.17. The Independent Investigation Team adopted accepted good practice during the course of its work. These are set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:
 - (a) of the terms of reference and the procedure adopted by the Investigation; and
 - (b) of the areas and matters to be covered with them; and
 - (c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and
 - (d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and
 - (e) and that they may bring with them a work colleague, member of a trade union, lawyer or member of a defence organisation to accompany them with the exception of another Investigation witness; and
 - (f) that it is the witness who will be asked questions and who will be expected to answer; and
 - (g) that their evidence will be recorded and a copy sent to them afterwards to sign; and
 - (h) that they will be given the opportunity to review clinical records prior to and during the interview;
2. Witnesses of fact will be asked to affirm that their evidence is true.
3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.
4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.
5. All sittings of the Investigation will be held in private.
6. The findings of the Investigation and any recommendations will be made public.
7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.
8. Findings of fact will be made on the basis of evidence received by the Investigation.
9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

Independent Investigation Team Meetings and Communication

7.18. The Independent Investigation Team Members were recruited following a detailed examination of the case. This examination included analysing the clinical records and reflecting upon the Investigation Terms of Reference. Once the specific requirements of the Investigation were understood the Team was recruited to provide the level of experience that was needed. During the Investigation the Team worked both in a 'virtual manner' and together in face-to-face discussions.

7.19. Prior to the first meeting taking place each clinical team member received a paginated set of clinical records, a set of clinical policies and procedures, and the Investigation Terms of Reference (non-clinical team members received a timeline in lieu of the clinical records to preserve patient confidentiality). It was possible for each Team Member to identify potential clinical witnesses and the questions that needed to be asked at this stage. Each witness was aware in advance of their interview of the issues that they would be expected to address.

The Team Met on the Following Occasions:

First Team Meeting 29 April 2015

7.20. The Investigation Team examined and discussed the chronological timeline which had been produced following the receipt of the full clinical records. The Investigation Team confirmed which staff they wished to interview and agreed questions they would ask. The list of documents required was made; this consisted of various Trust Policies and Operational Policies together with information about the Trust.

7.21. There was opportunity during the interview schedule which allowed the Investigation Team to consider the evidence collected from the interviews and also to comment on additional policies and relevant information regarding the governance, organisation and management systems operated by the teams that had contact with Mr X and Mr Y.

Second Team Meeting 15 May 2015

7.22. Work was commenced on Root Cause Analysis processes and initial draft findings were framed.

Third Team Meeting 18 June 2015

7.23. Root Cause Analysis was developed further. Following this meeting the team worked to develop the draft report.

Other Meetings and Communications

7.24. The Independent Investigation Chair maintained communications on a regular basis with NHS England throughout the process. Communications were maintained inbetween meetings by email, letter and telephone. Further conversations were held following the completion of the Hostel Interviews held on 7 July 2015.

Root Cause Analysis

7.25. The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying causes that on detailed analysis are considered to have contributed to a critical incident occurring. This methodology is the process advocated by NHS England when investigating critical incidents within the National Health Service.

7.26. The ethos of RCA is to provide a robust model that focuses upon underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learnt to prevent similar incidents from happening in the same way again. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility. RCA is a four-stage process. The process is as follows:

- 1. Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews. A first draft timeline is constructed.
- 2. Causal Factor Charting.** This is the process whereby an Investigation begins to process the data that has been collected. A second draft timeline is produced and a sequence of events is established (please see Appendix One). From this causal factors or critical issues can be identified.
- 3. Root Cause Identification.** The former National Patient Safety Agency (NPSA) advocated the use of a variety of tools in order to understand the underlying reasons behind causal factors. This Investigation utilised the 'Decision Tree', the 'Five Whys' and the 'Fish Bone'.
- 4. Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

7.27. When conducting a RCA the Investigation Team seeks to avoid generalisations and uses findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

8. Information and Evidence Gathered (Documents)

8.1. The following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions. Over 5,000 pages of clinical documentation were examined.

- 1.** Trust clinical records for Mr X.
- 2.** GP records for Mr X.
- 3.** Hostel records for Mr X.
- 4.** Forensic and Court records for Mr X.
- 5.** Trust clinical records for Mr Y.

6. GP records for Mr Y.
7. Hostel records for Mr Y.
8. Trust Internal Investigation/Serious Case Review Reports.
9. Trust assurance and governance documentation.
10. Secondary literature review of media documentation reporting the death of Mr Y.
11. Independent Investigation witness transcriptions.
12. Independent Investigation witness statements.
13. Trust Clinical Risk Clinical Policies, past and present.
14. Trust Care programme Approach Policies, past and present.
15. Trust Benzodiazepine and Hypnotic Guidelines (July 2010).
16. Trust Dual Diagnosis Policy (November 2011).
17. Trust Addictions Service Prescribing Guidelines (march 2015)
18. Trust Incident Reporting Policies (September 2013).
19. Trust Safeguarding Vulnerable Adults at Risk Policy (November 2012).
20. Trust Supervision Policy (October 2011).
21. Trust Being Open Policy.
22. Trust Operational Policies (SAU, Primary Care and CMHT).
23. Daniel Gilbert House policies and procedures.
24. Healthcare Commission/Care Quality Commission Reports for ...NHS Foundation Trust services.
25. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm: a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive* (2006).
26. Guidelines for the NHS: National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed* (September 2005).

9. Profile of the East London NHS Foundation Trust

9.1. East London NHS Foundation Trust (formerly known as East London and The City University Mental Health NHS Trust) was formed in April 2000. It brought together mental health services from three community trusts in Tower Hamlets, Newham and the City and Hackney to become a large specialist mental health trust. In April 2007, the Trust was awarded University status in recognition of its extensive research and education work. The Trust was granted Foundation Trust status on 1 November 2007.

9.2. In February 2011, the Trust integrated with community health services in Newham and is now a Trust which provides both mental health and community health services. In June 2012, the Trust joined with Richmond Borough Mind to provide The Richmond Wellbeing Service.

9.3. In May 2013 the Trust took over the Health E1 Homeless Medical Centre in Brick Lane which had been run by nursing staff with GPs and other specialist nurses for those who couldn't register with a practice because they had no settled address.

9.4. The Trust provides local services to an East London population of 820,000 and provides forensic services to a population of 1.5 million in North East London. East London is one of the most culturally diverse parts of the country

but it is also one of the most deprived areas. It therefore poses significant challenges for the provision of mental and community health services. The Trust's services operate from 64 community and inpatient sites and comprise over 735 general and specialist inpatient beds. The Trust's annual income in 2012/13 was £259m.

9.5. The Trust also provides a wide range of community and inpatient services to children, young people, adults of working age, older adults and forensic services to the City of London, Hackney, Newham and Tower Hamlets. It provides psychological therapy services to the London Borough of Richmond and to Luton, as well as Children and Young People's Speech and Language Therapy in Barnet. In addition, the Trust provides forensic services to the London Boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest, and some specialist mental health services to North London, Hertfordshire and Essex.

9.6. The specialist Forensic Personality Disorder Service serves North London and the specialist Chronic Fatigue Syndrome/ME adult outpatient service serves North London and the South of England.

9.7. The Trust's specialist Mother and Baby Psychiatric Unit receives referrals from London and the South East of England.

9.8. The London Borough of Tower Hamlets population is *circa* 277,900. The borough has a larger than average proportion of adults aged between 20 and 39. Only 7.6 per cent of Tower Hamlet's population is aged 65 or over, compared to an 11.1 per cent average across the rest of London. Tower Hamlets has high socio-economic deprivation. 33 per cent of families live on a household income of £20k or less, and overcrowding of homes is common. 16 out of 17 wards are in the 20 per cent of the most deprived in the country. The borough unemployment rate is 12 per cent.

10. Chronology of Events

Root Cause Analyses First Stage

10.1. The chronology of events forms part of the Root Cause Analysis first stage. The purpose of the chronology is to set out the key events that led up to the death of Mr Y and to provide a history of the care and treatment that the two service users received. It also gives a greater understanding of some of the external factors that may have impacted upon the lives of Mr X (the perpetrator) and Mr Y (the victim) and their care and treatment from mental health and hostel services.

10.2 This chronology provides a factual summary of events taken from over 5,000 pages of clinical records and other supporting documentation – a great deal of detail has had to be omitted but key events are listed. The Independent Investigation Team took the decision to include a significant amount of personal detail, including criminal history, as it not possible to understand the issues relating to the care and treatment provided without this degree of context. The chronology is set out year-by-year and contains information pertaining to both service users; each section is prefixed with the service user's identifier.

Background for Mr X

10.3. Mr X is a 44 year old gentleman who was born and raised in Eritrea – he is an Orthodox Christian. He has described a normal and happy childhood and is one of six siblings. At the time of his arrest for the homicide Mr X stated that his father had died in 1999 at around 75 - 80 years of age and that his mother was still living in Eritrea aged 80. He has had no contact with his family since coming to live in England.

10.4. Mr X left school when he was around 14 years old with no formal qualifications and fled Eritrea in 1990 to escape the war of Independence. Since coming to the United Kingdom he worked mostly as a cleaner until 2005 when he became too mentally unwell to work.

10.5. Mr X has no friends or close relationships and prior to his arrest lived at the Daniel Gilbert House a hostel for the homeless in Tower Hamlets. He started to take Heroin when he was 28 years old due to peer pressure from the other residents in the hostel in which he lived at the time. Mr X was on a Methadone substitution programme and also misused Crack Cocaine and alcohol. Mr X had a forensic history and had been in prison on two occasions for carrying a bladed weapon – even though he had no convictions or cautions for violent behaviour. At the time of the homicide he was being treated by the Tower Hamlets Specialist Addictions Unit and the Bethnal Green Community Mental Health Team and had a diagnosis of Paranoid Schizophrenia/Schizoaffective Disorder.

Background for Mr Y

10.6. Mr Y was a white British gentleman who was 44 years old at the time of his death. He was originally from the Manchester area but had been living in London since 2007. He had six children who were placed in care and in 2010 his partner, who had remained in Manchester, committed suicide.

10.7. Mr Y had a significant substance misuse problem and begged on the streets – he also had an extensive forensic history mainly in relation to drug dealing and theft. As a result of his lifestyle his physical health was extremely poor and this was managed by the Health E1 Homeless Medical Centre for the Homeless. Mr Y was also a service user with the Tower Hamlets Specialist Addictions Unit and was in receipt of a Methadone substitution programme; he was known to top up with street drugs. At the time of his death Mr Y lived at Daniel Gilbert House and had accommodation next door to Mr X.

1993

Mr X Mr X made an attempt on his life by injecting himself with Heroin. There are no original records that detail this event or the subsequent actions that were taken or by whom.⁴

1999

Mr X Mr X made an attempt on his life by trying to electrocute himself in

4. X Electronic record p 225

the bath. There are no original records that detail this event or the subsequent actions that were taken or by whom.⁵

2001

Mr X Mr X was admitted to St Clements Hospital for a few weeks for his psychiatric condition. There are no original records that detail this event or the actions that were taken or by whom.⁶

2004

Mr X On **10 February** Mr was convicted of carrying a bladed article and was imprisoned for 28 days.⁷

2006

Mr X On **3 October** GP 1 wrote to Guys Hospital to say that Mr X had recently registered with the practice and that he would welcome a summary of his mental health history.

On **17 November** a Consultant Psychiatrist from Guys Hospital wrote back to say that Mr X had been known to his service since 2000 and he had been admitted to Guy's Hospital in November 2001. Mr X's mental disorder was thought to be linked to his Cocaine use at the time. He was prescribed Olanzapine 10mg at night. Since this time he had started to use Heroin and had become addicted. From 2004 he had been prescribed Methadone 40mg and Risperidone 4mg daily.

The Consultant Psychiatrist did not think Mr X had Paranoid Schizophrenia favouring instead a drug induced psychosis diagnosis. It was thought he would not need input from secondary care as the main issue was drug addiction.⁸

GP 1 wrote once again to Guys Hospital. In a letter dated **13 December** he enquired as to whether Mr X required secondary care input for his mental health problems (it was still not clear what the diagnosis was). The Practice was of the view that Mr X would be best served by a specialist addictions service which could address all of his problems (Mr X was ambivalent about this). At this time Mr X was being seen at the Guys Hospital outpatient clinic every two to three months. He had stopped taking his medication and was hearing voices.⁹

5. X Electronic record p 225

6. X Electronic record p 287

7. X Electronic record pp 223 - 224

8. File 6 GP records pp 70 – 72

9. File 6 GP records pp 1 – 2 & 41

2007

Mr X On **14 March** the Health E1 Homeless Medical Centre commenced Methadone prescribing for Mr X. It was noted that if he injected into his neck, or if his mental health issues continued, a referral would be made to the Specialist Addictions Unit (SAU). At this stage it was noted that Mr X had been hearing voices for at least 20 years and this pre-dated his illicit drug use.¹⁰

Mr X was reviewed at the Health E1 Homeless Medical Centre on **16 March**. He felt that 40mg of Methadone did not hold him and that he would like to try 50mg for one week. He was still injecting Heroin and hearing voices which bothered him. Mr X said he would like to re-start antipsychotic medication.¹¹

At a review on **22 October** it was noted that Mr X continued to hear voices. At this stage Mr X had been prescribed Aripiprazole for one week. The plan was to increase this to 15mg daily and the Methadone to 45mg daily and to review in two weeks. When Mr X was reviewed on **14 November** it was recorded that he was not taking his Aripiprazole as he did not think it was helping him. He continued to hear voices. He was using Heroin intravenously three times a week and Crack Cocaine twice weekly. The plan was to review in two weeks.¹²

2008

Mr Y On **20 January** a letter was written from a GP practice in Westminster to GP 2 at the Health E1 Homeless Medical Centre. The Health E1 Homeless Medical Centre had taken over Mr Y's Methadone prescribing. It was noted that he had improved since being with Westminster and had detoxed from Diazepam even though he was still on 30mg of Methadone daily. The letter noted that Mr Y had a history of deliberate overdoses – which had been serious attempts on his life requiring inpatient attention.¹³

Mr X Mr X continued to be reviewed by the Health E1 Homeless Medical Centre. He was still using Heroin intravenously but was having difficulty finding a vein and so was considering smoking in future. Mr X thought his voices were real and not the symptom of a mental illness. The team thought a referral to the SAU would be appropriate.

On **28 July** Mr X was seen at the Health E1 Homeless Medical Centre. He said his voices remained the same and made him take drugs. He did not want to see the Consultant Psychiatrist at the SAU and so the appointment was cancelled. Mr X did not think he was unwell. He blamed everything on his voices and did not see them as

10. File 6 GP records p 39

11. File 6 GP records p 39

12. File 6 GP records pp 33 - 34

13. Y Electronic records pp 39 - 41

being anything unusual. He was still being prescribed Methadone 40mg once daily.¹⁴

By **24 October** it was noted that Mr X was becoming increasingly psychotic and a referral was made to the SAU. Mr X was smoking Heroin six days out of seven and was prescribed 50mls Methadone daily. His attendance at the Health E1 Medical Centre for appointments was sporadic. He had however been seen by in house mental health services regarding his psychotic features but Mr X was not accepting of treatment and he still had no formal diagnosis. Mr X's self-care was poor and he was depressed. He described hearing a voice outside of his head but there was no evidence for command hallucinations. His appetite and sleep were also poor. He was becoming irritable and had been arrested for arguing with a police officer, he was refusing of antipsychotic medication.¹⁵

In **November** Mr X was assessed by the SAU. Mr X claimed to be using around £25.00 a week on drugs funded by benefits. Mr X appeared to be physically well. However on examination his mental state was found to be problematic. He had apparently been admitted to Guys Hospital in **2004** for depression and he reported having taken Olanzapine and Risperidone in the past but that he had stopped taking it because it did not work. At the time of the assessment he was hearing one female voice almost constantly.

It was noted that on two previous occasions Mr X had tried to kill himself; once by trying to electrocute himself in the bath and once by overdosing with Heroin. Mr X denied any current suicidal thoughts but he looked unkempt and there were signs of self neglect. He was adamant he did not want any antipsychotic medication at this time. Mr X had rent arrears, was on benefits, begged on the streets and lived alone. The impression was that he had Paranoid Schizophrenia. There was no known history of violence towards others, even though it was known he had been in prison. The plan was to take Mr X on at the SAU, for him to be assigned a Key Worker and gather more information about his past history.¹⁶

Mr X attended the SAU for the rest of the year with no problems.

2009

Mr X For the first quarter of the year Mr X continued to attend his appointments at the SAU. He reported that the Methadone was "*holding*" him. He was hearing voices but they were not distressing him as he was used to them – however they were continuous and were becoming more intrusive. Mr X still used Heroin but by **January 2009** requested his Methadone be reduced to 20mg and then to 10mg. Mr X was warned about the possibility of relapse. 20mg daily was supported by the medical team. As time progressed Mr X felt the

14. File 6 GP records p 25

15. File 5 pp 56 - 58

16. File 2 pp 48 – 50 and File 5 pp 36 – 37 & 62

20mg of Methadone was holding him and he had no opiate withdrawals. Mr X remained ambivalent about antipsychotic medication.¹⁷

On **7 March** Mr X was arrested for carrying a bladed article (services were not aware of this at the time). On **9 March** the SAU wrote to GP 2 at the Health E1 Homeless Medical Centre to say that Mr X's auditory hallucinations were worse and that Mr X described hearing third person auditory hallucinations and ideas of reference. The voices were derogatory in nature but did not tell him to harm people. Mr X also thought the television was connected to his thoughts.

Mr X was noted to be pleasant and relaxed; he denied any thoughts of harming either himself or others. Mr X now believed his symptoms were due to a mental illness and he agreed to antipsychotic medication. The impression was that Mr X suffered from Paranoid Schizophrenia and substance misuse. The risk of harm to himself was deemed to be moderate and to others low. The plan was to commence Amisulpride 200mg twice daily increasing the dose to 400mg twice daily according to response. The Key Worker was to monitor progress.¹⁸

In **April** Mr X appeared in Court in connection with possessing a bladed weapon. Services were not aware of this and in **May** he reported to the SAU an increase in his auditory hallucinations - the voices were constant and derogatory telling him to kill himself. He denied any suicidal ideation or intent. The diagnoses were Paranoid Schizophrenia and Poly Substance Misuse. It was noted that Mr X was currently compliant with his Methadone 40mg once daily and Amisulpride (200mg twice daily) which he said made him feel sleepy. Mr X said the medication made no difference to his psychotic symptoms. His risks at this stage were deemed to be low/moderate.¹⁹

In **August** a Probation Officer contacted the SAU to say that Mr X was due in Court on **4 September** for carrying a bladed article. He was subsequently imprisoned for three months. Services did not appear to know this at the time.

During **September** the SAU noted that Mr X was missing appointments. On **1 October** the SAU telephoned the Probation Officer who explained that Mr X was in prison. On **19 October** Mr X was released from prison. He had not been given his antipsychotic medication whilst in prison. Mr X was to be given 200mg of Amisulpride twice daily for one week rising thereafter to 300mg twice daily. A medical review was to be undertaken as soon as possible.²⁰

On **9 November 2009** the SAU wrote to GP 2 at the Health E1 Homeless Medical Centre to say that Mr X had been reviewed at the request of his Key Worker due to the worsening of his mental state.

17. File 5 pp 86 – 92 and 360 -365

18. File 2 pp 46 – 47

19. File 2 pp 42 – 45

20. File 5 p 106

Mr X said he had been released from prison following a three-month sentence for the possession of a weapon. He had not been prescribed antipsychotic medication whilst in prison. He continued to use Heroin but denied using Crack Cocaine. Mr X described his mood as being depressed but denied either suicidal or homicidal ideation. He said his voices were indistinct and he could not hear what they were saying; however he believed they made other people shout bad things at him. He said that if he knew who these people were he would kill them. Mr X was unkempt with long hair and a beard. Mr X's medication was increased to Amisulpride 400mg twice daily. He was to be reviewed on **12 November**.²¹

Mr Y On **5 February** the Health E1 Homeless Medical Centre noted that Mr Y had been under the care of Westminster until **24 January 2009**. His last scripted Methadone for 30mls had been on **23 January 2009**. In the interim he had been using street Methadone 30mls – and if this could not be accessed Heroin and Crack Cocaine – snowballing into thighs (injecting Heroin and Crack together which can cause great damage to circulatory system). Mr Y said he rarely used 'on top' (using illicit drugs as well as Methadone). Mr Y claimed to be using street Benzodiazepines and DF118 for leg ulcer pain together with street Diazepam (40 – 50mg daily). Mr Y was injecting up to £40.00 of Heroin daily and £10.00 daily of Crack Cocaine. Mr Y lived in a hostel (room 121 Aldgate Hostel) and begged on the streets. He had had several short stays in hospital due to his leg ulcers (he had three large full thickness ulcers). Mr Y had tried to overdose three times during the previous year. A drug and alcohol risk assessment form was completed:

- **Suicide:** Mr Y was noted to have made previous attempts on his life and was depressed.
- **Health:** Mr Y was a chaotic polysubstance abuser who injected and had a blood borne virus.
- **Violence and criminality:** it was noted that Mr Y had a history involving either a stay in a secure unit/ breach of ASBO (not stated which).
- **Social:** Mr Y was living in unstable housing conditions, had recently experienced a traumatic event (not noted what) and was prone to social isolation.²²

On **6 February** Mr Y was referred to the SAU. Mr Y continued to attend the Health E1 Homeless Medical Centre he was gaunt, unkempt and his leg ulcers were "*smelly*"; he was seen every week so they could be dressed.

In **March** Mr Y attended the SAU and a handover sheet was prepared. Mr Y was prescribed 70mg Methadone daily and supervised. He was also prescribed Dihydrocodeine 30mg for leg ulcer pain and Diazepam 40mg daily. Mr Y was also seen twice weekly at the Health E1 Homeless Medical Centre for his leg ulcer. Mr Y continued to inject into his groin. He had had leg ulcers for 10

21. File 2 pp 40 - 41

22. Y File 1 pp 21

years and liver problems for 14. It was noted he had made three previous attempts on his life and had also been in prison 10 times – although not apparently for violent offences. He was thought to remain at high risk of suicide.²³

A medical review took place on **22 May**. He was prescribed 70mg of Methadone and 40mg of Diazepam daily. Mr Y claimed to have cut down his daily intake to one bag daily from five – six bags of Heroin and Crack Cocaine. He was injecting anywhere on his body that he could find a vein. He still had three leg ulcers and had previously suffered from gangrene which had been treated. Mr Y was living at the Dock Street hostel where he was given two meals a day. He denied any involvement with violence but admitted to begging. He was deemed to have no current suicidal or homicidal intent. Mr Y had no hallucinations but was thought to be depressed. Risks were thought to be high to himself due to neglect and lifestyle. Mr Y was to continue with supervised Methadone for his own safety.²⁴

In **August** a care plan was developed by the SAU. The plan hoped to reduce Mr Y's on top habit and to reduce his opiate, Crack Cocaine and Benzodiazepine habit. The plan also hoped to address Mr Y's physical health problems and achieve stability for his mental state. He was to receive monitoring and support from the SAU and the GP. The contingency and crisis plans were to assess Mr Y if required (by the Key Worker and GP) and to refer to A & E if out of hours. Mr Y continued to be reviewed on a weekly basis by his SAU Key Worker.²⁵

In **December** Mr Y attended a Key Worker review at the SAU. He was still using Heroin and Crack Cocaine three times a week. He seemed to be relaxed and unusually agreed to a urine sample. He was asked to consider a move to the Tower Hamlets Community Drug Service in the new year. Scripts for two weeks Methadone 80mg and Diazepam 40mg were given. He was also given four bottles of Ensure (a high nutrient food substitute). The SAU wrote to all service users for whom they were prescribing Diazepam. The letter explained that a gradual reduction programme would be followed in the future.²⁶

2010

Mr X In **January** the SAU developed a care plan for Mr X. The aims were to reduce drug use and associated risks and to improve mental health. The plan was to maintain contact with Mr X and to provide psychoeducation. The Key Worker was to continue to monitor mental health and to support Mr X to be compliant with his antipsychotic medication. Mr X was also to be given support in relation to his Methadone treatment.

23. Electronic record p 379

24. Electronic record pp 164 - 169

25. Electronic records pp 119 - 130

26. Electronic record p 191 and p 375

Risks were recorded as being accidental overdose due to increased tolerance of Heroin, a history of attempted suicide, and mental health problems with auditory hallucinations and limited insight.

The contingency plan was for Mr X to maintain contact with the SAU Key Worker and for a medical review to be sought if required. The crisis plan was to assess and/or refer to A&E and/or to seek inpatient admission. Another review was planned for six months time. The Health E1 Homeless Medical Centre took over the prescription of Mr X's Amisulpride 400mg twice daily. Mr X ceased to be compliant almost straight away but SAU Key Worker picked this up and informed the Medical Centre.²⁷

On **14 May** the SAU referred Mr X to the Bow and Poplar CMHT for a needs assessment under CPA. Prior to this time Mr X had not wanted contact with Mental Health services but now appeared to be willing.

Mr X reported a long history of auditory hallucinations of a derogatory nature. His voices caused him anxiety, low mood and paranoia. Mr X also had a history of depression, poor appetite and self care and suicide/self harm attempts. Mr X had last been seen by the SAU Consultant Psychiatrist on **9 November 2009**, he had not attended for medical appointments since.²⁸

A risk assessment was completed by the SAU on **17 May**. Mr X had thoughts and plans of suicide and also a history of suicide with a history of impulsive behaviour. Whilst Mr X did not inject he did abuse more than one substance. It was noted he had a history of significant violence (not noted of what) and that he had been in prison. It was noted that Mr X carried a weapon and had current thoughts/plans of harming others. Mr X was also thought to be at risk of self neglect. Mr X came under the amber category for risk and so was not thought to require "*essential follow up or review*".²⁹

Throughout the rest of **May** and **June** the SAU followed up the CMHT referral. However it appears that Mr X had been referred to the wrong service for his catchment area. He was not taking his antipsychotic medication and it was decided that an inpatient admission might be required.³⁰

At the end of **June** a Supported Housing Income Officer wrote to Mr X to say that he would be evicted from his accommodation if he did not pay his rent arrears and that a Court hearing was set for **7 July 2010**. The SAU Key Worker endeavoured to liaise with the Court and Housing.³¹

For the rest of the year the SAU continued to pursue a CMHT referral. Mr X's compliance with medication continued to fluctuate and his mental state was poor. By **14 December** Mr X's rent arrears led to him being evicted from his accommodation and he was made

27. File 5 pp 71 – 74 and pp 330 - 337

28. File 1 p 60

29. File 5 pp 59 - 61

30. File 5 pp 236 – 237

31. File 5 pp 255 – 272

street homeless. He was however accepted rapidly by Gilbert Daniel House (a homeless hostel) on **20 December**.³²

Mr Y On **21 January** Mr Y was admitted to Globe Ward following an overdose. His former partner had committed suicide and this had left Mr Y feeling hopeless. He had Crohns disease and had also experienced three cardiac arrests the previous year. He was hepatitis B/C positive and had leg ulcers which necessitated the use of a crutch. Mr Y was discharged from the ward the following day as he was trying to recruit other patients to obtain Crack Cocaine for him. He was taken on by the Home Treatment Team.³³

On **29 January** it was noted by the SAU that Mr Y was now using £30.00 of drugs daily since he heard of the death of his partner two weeks earlier (his mother had telephoned him to give him this news). He had also been diagnosed with Cirrhosis of the liver. He was low in mood but had no thoughts of harming either himself or others even though he had taken an overdose earlier. He had been moved to a quieter flat within the hostel and was sleeping. He planned to travel to Manchester on 10 February to see his mother and one of his sons (aged 13) who was living with her. Mr Y had not seen his children for four years. In the event he did not make this trip.³⁴

On **26 February** Mr Y was seen by his SAU Key Worker. He said he had not injected for a month although he was still smoking a half bag of Heroin and Crack Cocaine twice a week. He gave a urine sample which showed positive for opiates and Crack Cocaine but negative for Cannabis and Amphetamines and Benzodiazepines. He was having his leg dressed by the Blood Borne Virus nurse at the hostel every week. He was given four weeks of Scripts for Methadone 80mg and Diazepam 40mg.³⁵

For the rest of the year Mr Y was followed up by the Health E1 Homeless Medical Centre and the SAU. His ulcers required regular dressing and his diet needed monitoring as Mr Y only had stumps for teeth and could not eat properly. His drug habits remained consistent but his Diazepam prescription was gradually reduced down to 24mg daily.

2011

Mr X On **4 February** the SAU Consultant Psychiatrist dictated a letter to the Bethnal Green CMHT Consultant Psychiatrist following an assessment made the previous day. Previous referral documentation had gone astray and the referral had not been progressed. During assessment Mr X said he took his medication but that it made him feel tired. He was described as being warmly dressed but malodorous. He maintained eye contact and a good rapport was

32. File 6 GP records p 18 and housing records pp 2-3

33. Electronic record pp 347 - 351

34. Electronic record pp 194 - 195

35. Electronic record p 198

established. Mr X reported almost continuous auditory hallucinations which made his life difficult as they told him to kill himself. He also thought these voices on occasions told him to kill other people. The impression was Schizophrenia and Poly Substance Misuse. The risk Mr X posed to himself was deemed to be moderate; however he had no current thoughts of suicide. Regarding risk to others it was noted that Mr X had two previous convictions (2004 and 2009) for carrying a knife but no history of ever having harmed anyone. It was also noted that Mr X had been at risk of self neglect which was lowered by him engaging with services. The SAU requested that the CMHT assess him for CPA and possible Clozapine prescribing. It was noted that when Mr X was on no medication his psychotic symptoms grew worse.³⁶

Mr X settled in well at Daniel Gilbert House. However it was recorded that Mr X had not been taking his medication for some weeks. He said he often forgot to take it. He agreed to go to the Health E1 Homeless Medical Centre as he did not feel well. Prior to this Mr X reported hearing voices almost constantly and this prevented him from interacting with other people. He found the noises in the hostel difficult to deal with.³⁷ Between **12** and **18 April** a risk assessment was undertaken at the hostel. Mr X's hostel Key Worker contacted the SAU Consultant Psychiatrist to say that there were concerns about Mr X's deteriorating mental health (he was hearing voices and could not get a break from them). The advice was for him to continue with his medication and for an ambulance to be called if he grew worse.³⁸

On **9 May** Mr X attended an appointment at the Bethnal Green CMHT. Mr X signed an information sharing agreement to facilitate the exchange of information between treating teams. The ensuing assessment stated that Mr X was a 40 year old gentleman who had a 20 year history of mental illness which had become worse over the past few years. He had an established diagnosis of Paranoid Schizophrenia complicated by a history of poly-substance misuse. Mr X was unemployed and had no social support other than that offered by hostel staff. He had little structure to his day and the referral had been made to the CMHT for Care Coordination and psychiatric treatment under the Care programme Approach (CPA). At this time Mr X's medication was listed as being:

- Amisulpride 400mg twice daily;
- Methadone 35mg once daily.

On assessment there was no evidence of thought disorder, however Mr X presented with delusional ideas believing that people with mobile telephones could get into his head. He also had ideas of reference through the television and he believed that his voices told other people to say or shout negative comments at him. The voices did not try to command him. It was acknowledged that Mr X had an

36. File 1 pp 67 – 69

37. Housing record 1 p 39

38. Housing records 1 pp 37 & 66 - 68

untreated mental illness. Mr X was motivated to work with services; he was supported by the SAU and the hostel and would also be allocated a Care Coordinator (CCO). The Care Plan was:

- the Care Coordinator (CCO) was to work collaboratively with the hostel and SAU;
- the Care Coordinator was to work with Mr X on employment and social inclusion issues;
- the Care Coordinator was to work to improve socialisation and social networks;
- Mr X was to be worked with under CPA to monitor his mood, mental state and risk and was to be reviewed by a member of the medical team.
- the CCO was to monitor self neglect issues and to support the SAU regarding substance misuse issues and Methadone replacement.³⁹

Mr X continued with the SAU and the CMHT. His medication compliance was at times sporadic. On **24 August** a CPA review took place with representatives from the hostel, the SAU and the CMHT were present. It was noted he was experiencing continuous auditory hallucinations (voices) with no breaks. Mr X was also experiencing sensations under his skin and he reported someone trying to control his thoughts. The voices sometimes laughed at him and “asked” him to die. He had expressed suicidal thoughts in the past and had once tried to electrocute himself. Mr X said he was taking his Amisulpride but admitted to sometimes missing it. It was estimated that he was missing his medication two thirds of the time.

Mr X reported having started to take street drugs (Heroin and Crack) four to five weeks previously, he had resumed again because he was “down”. He also said that he did not think his medication was working and that he did not see any point in taking it. He felt hopeless and helpless with no motivation to do things. His current medication was:

- Amisulpride 50mg twice daily;
- Methadone 35ml once daily;
- Citalopram 20mg once daily.

The **plan** was:

1. To commence Depixol 20mg depot injection fortnightly (to commence with immediate effect) and to reduce the Amisulpride (Mr X was not thought to be a candidate for Clozapine due to compliance issues).
2. To reduce Mr X’s Heroin and Crack Cocaine intake.
3. To possibly increase the Methadone.
4. Seek employment/community once Mr X’s mood improved.
5. To encourage Mr X to exercise.
6. To provide emergency contact numbers.
7. To conduct blood tests and an ECG (it was noted that an ECG

result had come back as “fine”).

8. To book another CPA review in four – six months time.⁴⁰

In the event Mr X was to refuse his depot medication The treating team did not want to provoke a compliance issue and felt it could not “chase him around” to administer the injection. It was decided to work with Mr X so that he took his oral medication and the CMHT would continue to work with the Health E1 Homeless Medical Centre. Mr X continued to have compliance issues.

On **5 September** Mr X’s Key Worker at the hostel wrote that when Mr X was using (illicit drugs) he was a different person – more aggressive and difficult to communicate with. The importance of him taking his medication was stressed. He was looking well and his personal care appeared to have improved.

Apart from a few issues with noisy residents at the hostel Mr X continued in much the same manner for the rest of the year with support from the hostel, SAU, and CMHT.

Mr Y In **January** it was noted during an assessment at the SAU that Mr Y’s physical health was a key risk in that he had experienced deep vein thrombosis and had hepatitis B and C.

On **23 February** Mr Y’s SAU Key Worker completed a care plan. The plan was to reduce Mr Y’s substance misuse and ‘on top’ habit. At this time Mr Y was attending the SAU regularly for meetings with his Key Worker. He had leg ulcers which were being treated and it was noted that he was using Benzodiazepines on top of his prescribed medication. The plan was for the Key Worker to monitor Mr Y’s mental health at each meeting, to offer psychosocial support and psychiatric and medical review as needed.

Risk was to be managed by providing education about his drug misuse. It was noted that Mr Y had made three serious suicide attempts in the past and Mr Y was advised to contact the SAU if needed or A & E out of hours. Mr Y’s physical health was poor it was recorded that he had a failing liver and leg ulcers which were being treated and monitored.⁴¹

In **June** another care plan was developed by the SAU. The plan was to monitor Mr Y’s mental state and to motivate him to avoid criminal activities such as begging. A risk plan stated that he was to continue with Diazepam detoxification and harm reduction strategies. Mr Y would use a needle exchange and practice safe sex. He would also refrain from injecting his drugs. If required appropriate psychiatric help was to be sought. Mr Y’s physical health would be supported regarding his leg ulcers and hepatitis.⁴²

In **August** a letter was written from the SAU to GP 1 at the Health E1

40. File 1 pp 38 – 40 and 65 -74

41. Electronic record pp 59 - 74

42. Electronic record pp 499 - 508

Homeless Medical Centre. Mr Y was maintained on 80mg of Methadone and had been reduced to 20mg of Diazepam which was being reduced by 2mg a week. His use of illicit drugs had been variable but Mr Y had stated that he had been abstinent from Heroin since the end of **July**. He had also stopped drinking alcohol. He said he took drugs out of boredom.⁴³

By **September** Mr Y was injecting again. He also tested positive for opiates, Cocaine, Cannabis and Benzodiazepines.⁴⁴ Between **12 and 19 December** a risk assessment was conducted and care plan developed by the SAU. Mr Y denied current intravenous drug use. Mr Y's physical health was identified as a key risk in that he had experienced deep vein thrombosis and had hepatitis B and C. It was noted that he had made three serious attempts on his life in the past and that he had six children with whom he had no contact. He was living in a hostel.

A care plan was developed. The plan aimed to maximise Mr Y's compliance with his leg ulcer and hepatitis treatment and to monitor his mental health regarding any suicidal ideation. Mr Y's continued drug taking was to be reviewed and it was noted that motivational work needed to continue.⁴⁵

2012

Mr X Mr X's Key Worker at the hostel wrote that before Christmas Mr X had lost all of his benefit money on gambling. He was so disgusted with himself he cut up his bank card. He was still on 35ml of Methadone. It was recognised that gambling was a significant problem for him.⁴⁶

The hostel reported to the CMHT that Mr X had been attacked by two men over Christmas and that he had pulled a knife to protect himself. The police were called to the scene and Mr X gave them the knife and explained why he had it in his possession. The Care Coordinator arranged to meet with Mr X on **26 January 2012**. Mr X explained to hostel staff that he had brought the knife with him from his previous flat. He had not intended to use it but had taken it out to frighten his attackers. He felt people were coming into his room – it was not clear if he was being paranoid or not. On **26 January** Mr X met with his Care Coordinator. He confirmed that he had been beaten up by four "area boys" for no reason. He had run back to the hostel and by the time the police had arrived the boys had run off. The police followed him to his room and had taken the knife. The police warned him not to carry or possess a knife again. The SAU continued to work with Mr X who appeared to be stable and calm and said he was taking his medication. Mr X was reminded not to carry weapons. It was noted that a CPA review with the CMHT Consultant Psychiatrist needed to

43. Electronic record pp 299 - 307

44. Electronic record pp 261 - 262

45. Electronic record pp 449 – 454 & 489 - 494

46. Housing records 1 pp 61 - 66

be arranged.⁴⁷

Mr X continued with the SAU and the CMHT. In **March** his Care Coordinator wrote to him inviting him to attend an appointment to monitor his wellbeing and discuss future plans. He was reported to be calm and stable.

In **April** his hostel Key Worker recorded that Mr X was angry and wanted to know why people kept knocking on his door asking how he was. He was told this was usual procedure. Mr X seemed to be paranoid as he thought he was being singled out for this treatment. Mr X looked as though he was losing weight; he had stopped dining in even though he was spending £70 every two weeks on service charges.⁴⁸

A CPA review was held on **10 May**. The CMHT Consultant Psychiatrist wrote to GP 1 At the Health E1 Homeless Medical Centre. Mr X had recently lost weight but had moved to a bedsit within the hostel and was reported to be happy with an improvement to his mental state. His personal care had improved a lot and he was taking care of his room. Mr X was still hearing voices but was presenting as better. His medication was:

- Amisulpride 500mg twice a day (the housing record's state this was increased to 600mg);
- Citalopram 20mg a day;
- Methadone 35ml a day.

Mr X was reported to be fully compliant with his medication. His depression was thought to be improved and his insight good. Mr X did not want a depot injection and was presenting as being better so it was decided to increase the Amisulpride instead to 1200mg at night. Mr X was to continue on Methadone and his Care Coordinator was to work with him to persuade him to try psychological therapy inputs. Mr X was also to receive advice about exercise. Mr X was to be medically reviewed in six months.⁴⁹

Throughout **June** and **July** Mr X attended the SAU and engaged with services. He put on a little weight and looked better. However his gambling was identified as being his main problem. The previous month he had lost £500.

On **15 August** Mr X attended a medical review at the SAU – his last meeting with a SAU doctor had been in 2009. Mr X appeared to be much improved however it was noted that he was still unemployed and taking Heroin and Crack Cocaine. It was understood that Mr X was being seen by the CMHT on a monthly basis and that he was reviewed by the CMHT Consultant Psychiatrist every six months. The plan was to continue with the Methadone and Key Worker input. The next review was planned for **12 September**. The Key Worker was to

47. File 1 pp 45 - 46

48. Housing records 1 pp 18- 19

49. File 2 pp 76 - 77

liaise with the CMHT Care Coordinator and blood and urine tests were to continue to monitor blood borne viruses and substance misuse levels. If Mr X continued to be stable he was to be transferred back to the care of the Health E1 Homeless Medical Centre.⁵⁰ When Mr X was reviewed by the SAU on **12 September** he continued to be stable and the plan was to discharge him back to the GP. In the event he was to continue with the SAU – the reason for this was not given.

On **1 November** a CPA review was held. Mr X said he felt better and that the voices were less noticeable and he was able to ignore them. He was tired but there were no biological symptoms of depression. He was compliant with his medication and he had no thoughts of either suicide or harming others. Mr X was taking Heroin and Crack Cocaine two - three days a week. Mr X's insight was good and he understood that he needed his medication. Mr X said no one was abusing him or mistreating him in any way. Mr X's medication was:

- Amisulpride 500mg twice a day;
- Citalopram 20mg a day;
- Methadone 24ml a day.

The plan was:

- add Amisulpride 200mg morning and 700mg at night;
- consider a higher dose of Methadone to prevent illegal substance misuse;
- to consider 're-work';
- to continue with the Key Worker and Care Coordinator;
- to be referred to psychology;
- to continue with the gym;
- to be reviewed medically in six months time, or sooner if required.⁵¹

A risk assessment was conducted by the SAU on **15 November**. It was noted that Mr X did not inject his drugs and this was thought to reduce his risk. He was on Methadone 30ml a day and he was deemed to be a low risk in this area. There were no reported risks associated with Mr X's physical health and no risks either from or to others were identified; no offending behaviours were noted. He lived in a bedsit at the hostel with no problems identified.

A star chart and action plan were developed. The most significant areas for development were identified as being social networks, managing finances and substance misuse issues. The plan was for the Key Worker to provide psychosocial interventions and for the plans to focus on a healthy lifestyle. Advice was to be given regarding relapse and recovery and the Key Worker was to monitor Mr X. Liaison was to be maintained between the Key Worker and the Care Coordinator. Mr X was also to be referred for Occupational Therapy support. Medication interactions were to be monitored by the Key

50. File 2 pp 63 – 67

51. File 2 pp 116 - 117

Worker (psychotropic medication and Methadone). Housing advice was to be ongoing. Psychological interventions were to be provided to support substance misuse abstinence.

Mr X's risks were to be managed by monitoring his substance misuse practice. Mr X's risks of vulnerability and neglect were thought to be low as he was now living in a hostel. A referral to Adult Social Care would be made if it was thought to be necessary and a harm reduction plan was to be developed. 'Safe and well' visits were to be made if deemed necessary. Liaison was to continue with the CMHT.⁵²

Mr Y Mr Y continued with the Health E1 Homeless Medical Centre and SAU with no problems identified until **5 March** when he was evicted from his hostel for fighting. It was recorded that the Outreach Team were trying to find him new accommodation.⁵³

Mr Y attended the SAU on **26 June**. He reported feeling sad, he was street homeless and his drug use was escalating which he funded by begging. He mentioned fleeting suicidal ideation. He was told how to access help if the thoughts changed to intent.⁵⁴ On **25 July** the SAU conducted a risk assessment. Nothing had changed. Mr Y was still street homeless.

On **19 August** Mr Y moved to Daniel Gilbert House. In **September** Mr Y was issued with two eviction warning notices in quick succession – he had been abusive to staff and obstructed a fire alarm. Also in **September** the Outreach Team requested a case conference as Mr Y had attempted to commit suicide at a railway station. He had been arrested because of the damage he had caused. Mr Y said he had no recollection of the incident; the Court case was pending. He reported feeling bossed around by staff at his hostel telling him what to do. The Outreach Team considered an inpatient admission might be needed in view of Mr Y's suicidal thoughts. The SAU discussed this and it was thought that an inpatient admission was not required but that a case conference should be held. This was arranged for **27 September**. In the event Mr Y said he did not want the case conference to take place and the plan was abandoned.⁵⁵

On **3 October** fellow residents complained about Mr Y dealing drugs from his room, he was noted to have Diazepam for sale. On **5 October** another eviction warning letter was sent to Mr Y for setting off the fire alarm.⁵⁶ Difficulties at the hostel continued with Mr Y rowing with fellow residents and his neighbours. He was asked to control his temper as this was placing his tenancy at risk. Mr Y was told not to bring street drugs into the hostel. It was also noted that Mr Y had too many internal and external visitors to his room. He was

52. File 4 pp 41 – 43 & 49, 60 – 79

53. Electronic record p 521

54. Electronic record p 526

55. Y Electronic record pp 532 - 535

56. Housing records 1 pp 21 and 60

reminded to do his laundry and clean his room as it smelled bad.⁵⁷

Mr Y's SAU Key Worker developed a care plan on **17 December**. The plan aimed to maximise Mr Y's compliance with his leg ulcer and hepatitis treatment and to monitor his mental health regarding any suicidal ideation. He was to be encouraged to live by the rules of Daniel Gilbert House so that he did not get evicted. Mr Y's continued drug taking was to be monitored and it was noted that motivational work needed to continue. Mr Y had been detoxed from Diazepam and no longer received a prescription for it. He was to continue to receive harm reduction inputs.⁵⁸

2013

Mr X Mr X continued to attend the SAU he appeared to be calm and stable. He was still using Heroin but denied any suicidal thoughts. Mr X was taking his medication because he did not want to relapse. He continued to gamble but did not appear to be addicted to it.

In **April** the CMHT referred Mr X to the Enhanced Primary Care Liaison Team. This referral was accepted.

On **2 May** a CPA review was held. Mr X was reported to be doing well in general. He was still hearing voices but was able to ignore them most of the time. It was reported that these voices were not command-style hallucinations. There was however some thought broadcasting and ideas of reference with persecutory ideas. Mr X was a little depressed but was taking his medication. The risk assessment noted that Mr X denied having thoughts of harming anyone despite his previous history of carrying a knife. The assessment did not identify Mr X as posing a risk to any other vulnerable adults. It was also noted that Mr X had an eight-year history of substance misuse and non-compliance with his medication and that he had a long history of untreated mental illness. No symptoms were identified as indicators of increased risk or harm to other people. Mr X continued to live at the hostel and continued to have poor social interaction with others, the only friends he had in the community were those associated with his substance misuse. His medication was:

- Amisulpride 200mg am and 800mg at night, the GP was advised to increase the medication to 1200mg and split it between two daily doses;
- Citalopram 20mg once daily;
- Methadone 50ml daily via SAU.

The recorded plan was to:

- observe behaviour and mood and to prevent further relapse;
- arrange CPA review and outpatient appointment as appropriate;

57. Housing records 2 p 10

58. Electronic record pp 461 – 468 & 471

- maintain regular contact with Care Coordinator;
- ensure the Care Coordinator continued to liaise with the hostel and SAU to ensure a multi-agency approach;
- he was to be referred to rework for employment;
- ensure Mr X continued to attend the Health E1 Homeless Medical Centre;
- remove Mr X from full CPA and review him again later in the year.

Mr X was taken off CPA on this date. He was to continue to be care coordinated by his SAU Dual Diagnosis Practitioner

Relapse Indicators were identified as being:

- non-compliance with medication;
- hearing voices;
- isolation.

Crisis Plan:

- the Care Coordinator was to arrange a home visit to assess the situation;
- out of hours the GP and/or A&E were to be contacted/accessed;
- the Home Treatment Team to be contacted if required to prevent a hospital admission;
- the duty AMHP was to be contacted if a Mental Health Act assessment was required;
- if the assessment merited it then an inpatient admission was to be considered.⁵⁹

In **June** Mr X was followed up by the SAU. He was however discharged from Tower Hamlets Mental Health Enhanced Primary Care Liaison Team as the GP did not think he was ready for this service.⁶⁰

On **4 June** the SAU conducted a risk assessment. It was noted that Mr X did not inject his drugs and this was thought to reduce his risk. The SAU planned to continue to monitor his drug use. No concerns were raised regarding Mr X's physical health, his mental health was being managed by the CMHT and the SAU was to continue to monitor this as well. Mr X denied he was a risk either to or from others. There had been no recent criminal offending behaviours or risk of escalation. He continued to live in a bedsit at his hostel and no recent "*traumatic*" events had been identified. A care plan was developed by the Key Worker. Needs were identified as:

- **Substance Misuse:** Mr X was to attend for SAU treatments regularly and strategies for change identified.
- **Physical Health:** liaison with the GP was to be maintained.
- **Mental Health:** advice was to be provided to Mr X by the Key Worker together with psychosocial interventions. The Key Worker was to liaise with the CMHT Care Coordinator and a referral was to be made for psychological intervention. The Key Worker and Care Coordinator were to liaise regarding employment, education

59. File 2 pp 1- 22 and 24

60. SARR report

and leisure support. Both SAU and CMHT were to monitor Mr X for change and needs.

- **Accommodation:** options were to be explored regarding alternative housing placements.
- **Overdose:** it was acknowledged that Mr X was at risk of overdose if he continued his illicit substance misuse on top of his Methadone. Mr X was to be made aware.
- **Physical Health and Self Neglect:** these were to be monitored in conjunction with the blood borne virus team.

The date of the next review was set for **4 December 2013**. A list of the key members of Mr X's treating teams was provided.⁶¹

On **13 June** Mr X met with his hostel Key Worker for a review. He was well kempt and appeared stable and cheerful. His only concern was disturbance from people outside of the hostel in the community shouting in the road. Mr X mentioned his CPA review in **April**. He said he was getting better and only needed to be followed up once a year. He was to continue to receive his medication and Methadone (administered under supervision).⁶²

On **19 June** Mr X attended the SAU – he appeared to be well. No concerns were raised at this time in relation to Mr X's mental health. He denied hearing voices although he was still using Heroin and Crack Cocaine. The care plan for the summer was yet to be developed.

On **21 June** Mr X became visibly agitated although not violent (even though damage was noted in his room). The police were contacted who advised no crime had been committed and that mental health services should be contacted. Mr X calmed down after support from hostel staff and he apologised for his behaviour. It was recorded in a case summary after the homicide that hostel staff had been concerned about Mr X *"he had been acting in fashion that gave staff cause for concern regarding his mental welfare"*. Prior to the homicide Mr Y and Mr X had been in a dispute about a drug debt. Mr X wanted payment and Mr Y refused. Mr X disappeared from the hostel and was not seen again until his arrest two weeks later.⁶³ Mr Y was found dead the following day.

Mr Y On **2 January** it was reported that Mr Y had been involved in a fight at his friend's home. During the fight Mr Y's leg got bumped and a boil burst trailing blood down his leg. During the fight Mr Y killed his friend's cat. An ambulance was called and the incident was logged.⁶⁴

Mr Y continued to be followed up at the Health E1 Homeless Medical Centre and the SAU. During an assessment with hostel staff on **9 March** Mr Y acknowledged that his lifestyle would probably kill him – he was depressed about the death of a friend who had died from a

61. File 4 pp 38 – 40 & 50 - 56

62. Housing records 1pp 7 - 8

63. File 2 p 25 and X Electronic records pp 156 - 158

64. Housing records 2 p 7

Diazepam overdose. Mr Y was deemed to have high risks in the following areas:

1. Self neglect – due to self harm and difficulty in managing physical health. The plan was to keep him engaged with all agencies and to encourage good hygiene and visits to the GP.
2. Suicide – he was to attend all appointments with workers and agencies.
3. Dangerous Behaviour - he had sexually inappropriate behaviour and was frequently angry and frustrated. He was to be encouraged to live amicably with others. Mr Y's use of Crack Cocaine, inactivity and lack of money were seen as risk triggers.⁶⁵

In **April** Mr Y had two reported sessions with his Key Worker at the hostel. He disclosed that he was using more drugs than ever on top of his Methadone and that this was causing him problems with his ability to manage his finances and cope with his life. He also said that he heard the voice of his dead wife telling him to commit suicide. On **12 June** Mr Y was given a 12 month prison sentence suspended for 18 months. He was also placed on probation for 12 months. This was a tremendous relief to Mr Y who had feared a prison sentence.⁶⁶

In **June** Mr Y continued much the same. It was noted that he had missed his first probation appointment.

On **22 June** Mr Y was found stabbed to death in Mr X's room at Daniel Gilbert House.

2014

Mr X Mr X's mental health broke down following his arrest and he was transferred to the John Howard medium secure forensic psychiatric unit.

On **7 February** Mr X made a serious attempt on his life when he attempted to hang himself. He was taken to A&E in a semi conscious state and later said that he wished he had died.

On **19 February** Mr X was discharged from the forensic psychiatric unit. He pled not guilty to the killing of Mr Y but was convicted of murder by the Court on **19 February 2014**. On **6 March 2014** he was sentenced to life imprisonment and sent to HMP Belmarsh Prison. Mr X's mental illness was not given as mitigation.

65. Y Housing records 2 pp 37 - 43

66. Electronic record p 554

11. Identification of the Thematic Issues

Thematic Issues

11.1. The Independent Investigation Team identified 14 thematic issues that arose directly from analysing the care and treatment that Mr X received from the East London NHS Foundation Trust. These thematic issues are set out below.

1. Diagnosis and Presentation. In the case of Mr X it took several years for health care workers to diagnose what mental illness he actually had and he was rather belatedly seen through the lens of Paranoid Schizophrenia (and more latterly Schizoaffective Disorder) instead of just his polysubstance misuse. This served to delay him receiving a care and treatment package that could address his needs for several years.

In the case of Mr Y - who had a diagnosis of polysubstance misuse and depression - no specific issues emerged; it was noted that both his mental and physical health problems were identified and treated in a timely manner.

2. Medication and Treatment. Mr X had a history of occasional non-compliance with his medication and a variation in his levels of insight for its continued use. During the last three months prior to the killing of Mr Y, and following his discharge from CPA, it would appear that he had not been taking his medication (based on reports to the Court). It is evident that there were no plans in place to monitor this situation. Also in the case of Mr X it was also noted that his Methadone prescription was below a therapeutic dose and perhaps the continued prescribing of this should have been reviewed with a view to stopping it. From a general treatment point of view there were plans for psychoeducation and CBT – which was good practice – but Mr X did not want to comply.

In the case of Mr Y a significant finding was made in relation to his Diazepam prescription. On occasions this was prescribed even when he tested negative for Benzodiazepines and there is clear evidence that he was dealing Diazepam on a regular basis at the hostel in which he lived. The Independent Investigation Team was also told that a friend of Mr Y, to whom he dealt drugs, had died of a Diazepam overdose. Whilst no connection can be made to the Diazepam prescribed to Mr Y and his drug dealing habits it is a precautionary finding in relation to the management of people with a chaotic and drug-dealing lifestyle.

3. Use of the Mental Health Act (1983 and 2007). Neither Mr X nor Mr Y appeared to have met the criteria for a Mental Health Act assessment during the time they were engaged with service. Whilst both service users experienced crises these were managed appropriately on an informal basis.

It is evident that Mr X acted out of character immediately prior to the homicide of Mr Y. However he was not assessed and it has not been possible to ascertain whether or not he would have met the criteria for a Mental Health Act (1983 & 2007) assessment on this occasion.

- 4. Care Programme Approach (CPA).** Mr X was on full CPA between May 2011 and May 2013. It was evident that he was eligible for CPA a considerable time earlier but the referral process failed to access the help he needed for a year. During this year he became mentally unwell, lost his accommodation and became street homeless - all of which could possibly have been avoided had he followed a more appropriate care pathway. In May 2013 the decision was taken to discharge Mr X from full CPA – in itself this decision was reasonable – however it was undertaken without full communication first taking place between the hostel and the SAU. This meant that the continuing care and risk management plans of the hostel and SAU were implemented without a full understanding of the reduced input from the CMHT. At the point of his discharge from CPA Mr X had no ongoing plan that all services were signed up to.

Mr Y was not eligible for CPA and no findings were made.

- 5. Risk Assessment.** The Independent Investigation found that the Specialist Addiction Unit, the hostel and the CMHT all conducted risk assessments but that these assessments were not routinely shared between the teams leading to important information being missed. There was also a ready acceptance in general of the homeless carrying knives and living chaotic lifestyles which in future should perhaps be captured in diagnostic and risk formulations for those identified as having a severe and enduring mental illness. In the case of Mr X this was not done and his polysubstance misuse, Schizophrenia, command hallucinations, vulnerability and gambling habits were not all brought together and assessed 'in the round'. This was a significant omission.

Both Mr X and Mr Y lived in hostel accommodation. The hostel population at Daniel Gilbert House was volatile. Each individual presented with a degree of risk – some of a relatively mild nature – others with significant risk profiles. The levels of risk within the hostel could rise and fall with no systematic process to monitor collective risk and there were weak mechanisms by which the service could escalate concerns and seek additional support.

- 6. Referral and Discharge Planning (examined under CPA in section 12.4 of the report).** In the case of Mr X referral and discharge processes could have been managed better on two occasions: the first between May 2010 and May 2011 when the attempt to refer Mr X for Care Coordination failed; and the second being his discharge from CPA in May 2013. On both occasions the process was compromised by a lack of assertive communication that ensured all health and social care partners were directed appropriately.
- 7. Safeguarding and Vulnerability.** The Independent Investigation found that there were different concepts of what constituted vulnerability in operation across each service. Neither Mr X nor Mr Y would have met the criteria for being a Vulnerable Adult in any legal sense of the definition. However on occasions both were rendered vulnerable by virtue of their lifestyle and mental and physical conditions. These issues were identified and clear strategies to manage them (particularly in respect of Mr X and Mr Y's continued self neglect) were put into place. However the issue of

placing some 90 adults with varying states of vulnerability and anti-social behaviour into Daniel Gilbert House presents an ongoing situation that requires examination. The collective risk of placing so many people together serves to increase the need for an active multiagency safeguarding strategy.

- 8. Housing.** Both Mr X and Mr Y had experienced periods of rough living on the streets. At the time of Mr Y's death they were both domiciled at Daniel Gilbert House – a hostel for the homeless. Both service users were eligible for Supported Living and as such accessed a significant amount of input from hostel staff. Overtime the amount of liaison between hostel staff and NHS teams varied. In the case of Mr X this effectively tailed off during the nine months prior to his discharge from CPA. This had the effect of distancing the hostel staff from the ongoing work conducted by the NHS and meant that there was a degree of ambiguity about how best to manage Mr X's mental health.
- 9. Interagency/Service Working (examined under Housing in section 12.7 of the report).** There was a high degree of historical synergy between the Health E1 Homeless Medical Centre, the SAU, the hostel and the CMHT. It was evident that CPA reviews provided an opportunity for teams to come together to plan care and treatment and monitor progress. There was a consistent approach taken for both Mr X and Mr Y over the years. This was greatly facilitated by all services (apart from the hostel) being managed by the same provider – the East London NHS Foundation Trust.

However during the nine months prior to Mr X's discharge from CPA and the death of Mr Y Care Coordination did not appear to work so well as previously and ongoing communication and liaison diminished, in particular with the hostel. This happened at a critical juncture in Mr X's care and treatment.

- 10. Service User Involvement in Care Planning and Treatment.** Both Mr X and Mr Y were treated at all times by all services with respect, kindness and courtesy. Attempts were made on a constant basis to ensure full engagement was maintained no matter how chaotic either service user was in presentation. Complex mental and physical health conditions were managed by workers across all teams in a consistent manner that provided care and treatment against a backdrop of very challenging social conditions.

However the Independent Investigation found no mention in the clinical record of any attempt ever having been made to understand Mr X in the light of his asylum seeker/refugee status. Levels of professional curiosity were low and no consideration of stigma, masking of symptoms, denial of symptoms etc. (common features in people from East Africa) is evident in the clinical record. Had this been achieved Mr X might have been understood better.

- 11. Carer and Family Concerns.** Mr X had no family or friends who could act in a carer role. The hostel staff, as part of the Supported Living provision, acted in lieu of carers and as such should have been kept in close contact

as they were Mr X's main protective factor much of the time. In the nine months prior to Mr X's discharge from CPA and the killing of Mr Y communication between hostel staff and the CMHT appeared to decline. This served to diminish the effectiveness of the ongoing care and treatment plan in place for Mr X.

The SAU maintained contact with Mr Y's mother. This contact was put in place to ensure the continued safety of Mr Y and his family, who lived in Rochdale, on the occasions when he visited them. This was good practice.

12. Documentation and Professional Communication. In general the Trust clinical documentation for both Mr X and Mr Y was maintained well. It was noted that the record keeping maintained by the hostel was also of a good general standard. Over the years there were issues with letters sent out from the SAU and CMHT to other health colleagues with delays of up to eight weeks. This was noted on several occasions and would have served to slow down prescription advice and referral processes.

Professional communication was maintained between health services. However as has already been identified above, Care Coordination did not provide a reliable communication channel in the months prior to Mr X's discharge from CPA. This was of particular note with regard to Daniel Gilbert House.

13. Adherence to Local and National Policy, Procedure and Clinical Guidelines. In general adherence to both Trust and hostel policy and procedure was good.

14. Trust Clinical Governance and Performance. The Trust was found to have robust clinical governance systems and procedures in place. Team workforce capacity was found to be within national best practice guidance allowing supervision to occur on a regular basis and for all staff to receive mandatory training and appraisal. The Trust operates a robust clinical audit process and no link was made between the homicide of Mr Y and governance failings on the part of the Trust.

12. Further Exploration and Identification of Contributory Factors and Service Issues

12.1. In the simplest of terms root cause analysis seeks to understand why an incident occurred. An example from acute care utilising the 'Five Whys' could look like this:

- serious incident reported = serious injury to limb;
- immediate cause = wrong limb operated upon (ask why?);
- wrong limb marked (ask why?);
- notes had an error in them (ask why?);
- clinical notes were temporary and incomplete (ask why?);
- original notes had been mislaid (ask why?);

Independent Investigation Mr X and Mr Y

- (because/possible reasons) insufficient resources to track records, no protocols or clear responsibilities for clinical records management = root cause.

12.2. Root cause analysis does not always lend itself so well to serious untoward incidents in mental health contexts. The Court found Mr X guilty of murder and he was sentenced to life imprisonment – no mitigation was found in relation to his mental illness. Mr X is detained in HMP Belmarsh Prison.

RCA Third Stage

12.3. This section of the report will examine all of the evidence collected by the Independent Investigation Team. This process will identify the following:

1. Areas of practice that fell short of both national and local policy expectation.
2. Causal, contributory and service issue factors.

12.4. The terms ‘causal factor’, ‘contributory factor’ and ‘service issue’ are used in this section of the report. They are explained below.

12.5. Causal Factors: in the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide independently perpetrated by them. The term ‘causal factor’ is used to describe any act or omission that had a direct causal bearing upon the failure to manage a mental health service user effectively and a consequent homicide.

12.6. Contributory Factors: the term is used to denote a process or a system that failed to operate successfully thereby leading an Independent Investigation Team to conclude that it made a direct contribution to the breakdown of a service user’s mental health and/or the failure to manage it effectively. These contributory factors are judged to be acts or omissions that created the circumstances in which a serious untoward incident was made more likely to occur. It should be noted that no matter how many contributory factors are identified it may still not be possible to make an assured link between the acts or omissions of a Mental Health Care Service and the act of homicide independently perpetrated by a third party.

12.7. Service Issue: the term is used in this report to identify an area of practice within either the provider or commissioner organisations that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing upon the death of Mr Y need to be drawn to the attention of the provider and commissioner organisations involved in order for lessons to be identified and the subsequent improvements to services made.

12.8. The findings in this chapter analyse the care and treatment given to Mr X and Mr Y. The reader is referred to the narrative chronology for supporting information.

12.1. Diagnosis and Presentation

Context

12.9. Diagnosis is the identification of the nature of anything, either by process of elimination or other analytical methods. In medicine, diagnosis is the process of identifying a medical condition or disease by its signs and symptoms, and from the results of various diagnostic procedures. Within psychiatry diagnosis is usually reached after considering information from a number of sources: a thorough history from the service user, collateral information from carers, family, GP, interested or involved others, Mental State Examination and observation.

12.10. The process of reaching a diagnosis can be assisted by a manual known as ICD 10. The International Statistical Classification of Diseases and Related Health Problems (most commonly known by the abbreviation ICD) provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease as determined by the World Health Organisation. In the United Kingdom psychiatry uses the ICD 10 (10th revision - published in 1992) Classification of Mental and Behavioural Disorders which outlines clinical descriptions and diagnostic guidelines to enable consistency across services and countries in the diagnosis of mental health conditions, ensuring that a commonly understood language exists amongst mental health professionals.

12.11. Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework that can allow conceptualisation and understanding of their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis can provide a platform on which to address care, treatment and risk management issues. The nature of the individual's personality can also often shape the presentation of the illness.

12.12. A substantial number of service users may well meet the diagnostic criteria for more than one diagnosis at any given time, for example, a person may have a Personality Disorder, a Depressive Disorder and substance misuse problems. For those service users with a number of concurrent diagnoses, or who have very complex presentations, a case formulation can be an invaluable aid to understanding the service user and providing guidance for treating teams in terms of prioritising treatment goals.

Paranoid Schizophrenia and Schizoaffective Disorder

12.13. Schizophrenia is a major mental illness characterised by delusions, hallucinations, abnormality of thought process and emotional blunting. It can also be characterised by a lack of insight. The ICD 10 classification for Paranoid Schizophrenia and Schizoaffective Disorder are set out verbatim below.

Paranoid Schizophrenia

“This is the commonest type of schizophrenia in most parts of the world. The clinical picture is dominated by relatively stable, often paranoid, delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances.

Disturbances of affect, volition, and speech, and catatonic symptoms, are not prominent.

Examples of the most common paranoid symptoms are:

- *delusions of persecution, reference, exalted birth, special mission, bodily change, or jealousy;*
- *hallucinatory voices that threaten the patient or give commands, or auditory hallucinations without verbal form, such as whistling, humming, or laughing;*
- *hallucinations of smell or taste, or of sexual or other bodily sensations; visual hallucinations may occur but are rarely predominant.*

Thought disorder may be obvious in acute states, but if so it does not prevent the typical delusions or hallucinations from being described clearly. Affect is usually less blunted than in other varieties of schizophrenia, but a minor degree of incongruity is common, as are mood disturbances such as irritability, sudden anger, fearfulness, and suspicion. "Negative" symptoms such as blunting of affect and impaired volition are often present but do not dominate the clinical picture".

Schizoaffective Disorder

"A disorder in which schizophrenic and depressive symptoms are both prominent in the same episode of illness. Depression of mood is usually accompanied by several characteristic depressive symptoms or behavioural abnormalities such as retardation, insomnia, loss of energy, appetite or weight, reduction of normal interests, impairment of concentration, guilt, feelings of hopelessness, and suicidal thoughts. At the same time, or within the same episode, other more typically schizophrenic symptoms are present; patients may insist, for example, that their thoughts are being broadcast or interfered with, or that alien forces are trying to control them. They may be convinced that they are being spied upon or plotted against and this is not justified by their own behaviour. Voices may be heard that are not merely disparaging or condemnatory but that talk of killing the patient or discuss this behaviour between themselves. Schizoaffective episodes of the depressive type are usually less florid and alarming than schizoaffective episodes of the manic type, but they tend to last longer and the prognosis is less favourable. Although the majority of patients recover completely, some eventually develop a schizophrenic defect".

Findings

Findings of the Internal Investigation Process (Serious Incident Review Report)

12.14. The Trust internal investigation report did not examine the diagnoses of either Mr X or Mr Y in relation to the suitability of the care and treatment plans offered to them.

Findings of the Independent Investigation

Mr X

12.15. In 2008 Mr X was diagnosed as having Paranoid Schizophrenia with co-morbid Poly Substance abuse. This combination is not uncommon in that a number of service users can 'self medicate' with illicit drugs as a way of managing their psychotic experiences. Unfortunately this can mask their early presentation as illicit drugs can in their own right cause psychotic symptoms.

12.16. Mr X was known to mental health services since 2000. In 2001 he had an admission to St Clement's Hospital for a number of weeks for treatment of his mental health problems, but little is known about this or his contact with mental health services over the next few years. He had an admission to Guy's hospital in 2004 when he presented with auditory hallucinations but again little is known about this episode. Mr X registered with the Health E1 Homeless Medical Centre in 2006 and the practice actively sought information about him. The correspondence they received indicated that Mr X was thought to have a drug induced psychosis linked to his cocaine use. He had also relatively recently started using Heroin and had become addicted. The mental health services at Guys Hospital did not think that he had Paranoid Schizophrenia at this time.

12.17. Mr X's care was initially provided by the staff at the Health E1 Homeless Medical Centre and he was managed as someone with poly substance abuse problems; efforts were made to stabilise his Methadone dose but with limited success. Mr X had previously been prescribed antipsychotic medication (Olanzapine, and later Risperidone) but stopped taking it and his auditory hallucinations became worse, he was also irritable and was not consistent in taking his Methadone.

12.18. The Health E1 Homeless Medical Centre referred Mr X for more intensive management of his addictions to the SAU in October 2008. At the time of their first assessment in November 2008 the impression was that Mr X had Paranoid Schizophrenia as well as his co-morbid substance misuse. Unfortunately Mr X was adamant that he would not take antipsychotic medication, so the SAU team took on his care, appointed him a Key Worker and worked with his addictions in the first instance.

12.19. The ICD 10 outlines the diagnostic criteria for Schizophrenia. It divides symptoms into a number of groups that are particularly important for diagnosis and often occur together. Nine groups of symptoms are identified including: thought disorder, thought echo, thought insertion, withdrawal and thought broadcasting, delusional experiences, hallucinatory experiences, persistent delusions that are culturally inappropriate or completely impossible, etc. The diagnostic guidelines stipulate *"the normal requirement for a diagnosis of schizophrenia is that a minimum of one very clear symptom (and usually two or more if less clear cut), belonging to any one of the above listed eight groups, should be clearly present for most of the time for a period of one month or more"*. Mr X clearly had been experiencing auditory hallucinations for in excess of 20 years and it was established in March 2007 that the voices had existed prior to his drug use.

12.20. From 2008 onwards Mr X was seen by mental health services as a man with a primary diagnosis of Paranoid Schizophrenia and co-morbid

polysubstance abuse – these diagnoses remained consistent through out the rest of his contact with mental health services (although a diagnosis of Schizoaffective Disorder was made at the point of his discharge from CPA in May 2013). It is to the SAU team's credit that they managed to develop a relationship with Mr X and persuade him to start taking antipsychotic medication in March 2009. It is clear that his SAU Key Worker worked hard with him to establish and maintain a relationship, monitor his mental state, monitor his Methadone, work with him to take anti-psychotic medication, encourage him to reduce his substance misuse, and to engage him in the assessment of any potential physical healthcare problems, for example, assessment by the Blood Bourne Virus Team.

12.21. Unfortunately Mr X was incarcerated for a period of three months mid 2009 during which time his Schizophrenia went untreated. He was seen by the SAU in November 2009 and restarted on his antipsychotic medication; attempts were made to stabilise his Methadone use. At this appointment he was bedraggled, low in mood and complaining of auditory hallucinations with little evidence of any insight. He became non-compliant with his antipsychotic medication as soon as prescribing responsibility was transferred to the GP in January; this was picked up by the Key Worker. In May 2010 he was referred to the CMHT for case management under CPA – non engagement and his mental health were clearly problematic and outside the care and treatment remit of the SAU. It took a year before he was seen by the appropriate CMHT (this will be dealt with in a later section). During this year he became very unwell, lost his accommodation and became street homeless. It was evident that Mr X needed a more robust approach to be taken in order for his Schizophrenia to be properly managed and understood.

12.22. At some stage prior to Mr X's discharge from CPA in May 2013 the Independent Investigation was told that the CMHT Consultant Psychiatrist changed the diagnosis to Schizoaffective Disorder. There is no rationale provided in the clinical record for why this change was made. Whatever the diagnosis the Independent Investigation Team found that Mr X was understood poorly in the context of his Schizophrenia/Schizoaffective Disorder. There appeared to have been a limited understanding regarding how individuals from East Africa can present (for example denial of symptoms and masking of symptoms often due to perceived stigma).⁶⁷ Mr X often denied that he heard voices. However when pressed it was evident that he had consistently experienced command hallucinations which asked him to kill himself and, on occasions, to kill others. The Independent Investigation found there to have been a marked difference in the level of disclosure Mr X made to NHS and hostel services. Whilst NHS services may have been of the view Mr X's voices were under control, he told staff at Daniel Gilbert House that they were so intrusive he had to isolate himself in his room because otherwise they were intolerable.

Mr Y

12.23. Mr Y had long been known as a chaotic drug user (since the age of 16) who also had a history of serious, deliberate overdoses which had required in-patient treatment. He was in poor physical health mainly as a result of his lifestyle choices including his substance misuse. He was also known to have

⁶⁷ <https://ethnomed.org/culture/eritrean/eritrean-cultural-profile> & <http://www.researchasylum.org.uk/problems-mental-health-eritrean-community-london>

bouts of depression and low mood. He was referred to the SAU in February 2009 and maintained his contact with them and with the GP service until the time of his death. In terms of mental health diagnoses Mr Y was seen as a man whose primary problems related to his addictions. He also had several physical health care problems which included leg ulcers and treatment for a Blood Bourne Virus.

Conclusions

12.24. The Independent Investigation Team agree that the diagnosis for Mr X of Paranoid Schizophrenia/Schizoaffective Disorder with co-morbid poly substance abuse was accurate and appropriate; although it is less easy to understand the latter diagnosis of Schizoaffective Disorder. It is unfortunate that it took so long to confirm the initial diagnosis of Schizophrenia. The Investigation concluded that had this had been diagnosed earlier, and Mr X been managed as a man with a mental illness *and* secondary substance misuse rather than being seen only through the lens of his addictions, this might have changed the pathway/trajectory on which he travelled. We are mindful that to a certain extent this is speculative, but we are also mindful that during the year it took to get Mr X seen and taken on by the CMHT under CPA, he lost his private tenancy flat and became increasingly unwell and ultimately street homeless. The Independent Investigation also concluded that based upon all of the evidence presented to it Mr X may not have always been understood properly in the context of his mental illness and ongoing symptoms.

12.25. Mr Y was managed as a man with an addiction problem and the ensuing chaos that that often comes with it. He presented with a history of overdose, substance abuse, bouts of depressed mood, was often involved in fights, and was homeless and irascible. He had likely learned to cope with life by using bravado and drugs. In the scheme of things the first task of the NHS treating teams was to keep him alive and to attempt to stabilise his drug use – this they did. They also managed his physical health diagnoses very well in conjunction with his complex addiction problems.

12.26. It is the conclusion of the Independent Investigation that the diagnoses given for Mr X and Mr Y were appropriate and that the issue of establishing their diagnoses *per se* did not influence the outcome of this case. However we also conclude that the diagnostic formulation for Mr X was weak and that more should have been done to understand him in the context of his ethnicity, symptoms, day-to-day social functioning and risk.

- ***Contributory Factor One: Mr X was understood poorly in the context of his ethnicity, presenting symptoms and social functioning. Whilst this was not found to have any causal relationship to the death of Mr Y it impacted upon Mr X's quality of life and potential for recovery.***

12.2. Medication and Treatment

Context

12.27. The treatment of any mental disorder should have a multi-pronged approach which may include psychological treatments (for example cognitive behaviour therapy, supportive counselling etc.), psychosocial treatments

(problem solving, mental health awareness, compliance, psycho-education, social skills training, family interventions etc.), inpatient care, community support, vocational rehabilitation and pharmacological interventions - medication. This section focuses upon the issues of medication and psychological treatments in relation to the care and treatment delivered.

12.28. Psychotropic medication (medication capable of affecting the mind, emotions and behaviour) within the context of psychiatric treatments fall into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety) and mood stabilisers. In substance misuse services, medications fall into a number of categories: those used in detoxification and withdrawal (for example Benzodiazepines), medication used for substitution and maintenance (for example Methadone) and medication supporting abstinence (for example Acamprosate or Disulfiram/Antabuse).

12.29. Psychiatrists in the United Kingdom tend to use the Maudsley Prescribing Guidelines and/or guidance from The National Institute for Health and Clinical Excellence, as well as their own experience in determining appropriate pharmacological treatment for mental disorders. Specific guidance is available from NICE for the treatment of Schizophrenia, Schizoaffective Disorder and Drug misuse, amongst other clinical conditions.

12.30. In prescribing medication there are a number of factors that the prescribing clinician must bear in mind. They include consent to treatment, compliance and monitoring, and side effects.

12.31. Consent is defined as *“the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent”*, (Code of Practice, Mental Health Act 1983, Department of Health 2008). Wherever practical it is good practice to seek the patient’s consent to treatment but this may not always be available either because a patient refuses or is incapable by virtue of their disorder of giving informed consent.

12.32. The patient’s ability to comply with recommended treatments can be influenced by their level of insight, their commitment to treatment and level of personal organisation, such as, do they remember to take their tablets at the prescribed time, are they motivated to engage in the process of change, to attend appointments, etc.

National Institute for Health and Clinical Excellence (Nice) Guidance - Schizophrenia

12.33. NICE first published Schizophrenia treatment guidelines in 2002. These guidelines were published in full in 2003, and updated in 2009. The 2002/3 Guidelines included the following:

- 1.** *“In primary care, all people with suspected or newly diagnosed schizophrenia should be referred urgently to secondary mental health services for assessment and development of a care plan. If there is a presumed diagnosis of schizophrenia then part of the urgent assessment should include an early assessment by a consultant psychiatrist. Where*

there are acute symptoms of schizophrenia, the GP should consider starting atypical antipsychotic drugs at the earliest opportunity – before the individual is seen by a psychiatrist, if necessary. Wherever possible, this should be following discussion with a psychiatrist and referral should be a matter of urgency”.

2. *“It is recommended that the oral atypical antipsychotic drugs amisulpride, olanzapine, quetiapine, risperidone and zotepine are considered in the choice of first-line treatments for individuals with newly diagnosed schizophrenia”.*
3. *“The assessment of needs for health and social care for people with schizophrenia should ... be comprehensive and address medical, social, psychological, occupational, economic, physical and cultural issues...Psychological treatments [to include]*
 - *Cognitive behavioural therapy (CBT) should be available as a treatment option for people with schizophrenia.*
 - *Family interventions should be available to the families of people with schizophrenia who are living with or who are in close contact with the service user.*
 - *Counselling and supportive psychotherapy are not recommended as discrete interventions in the routine care of people with schizophrenia where other psychological interventions of proven efficacy are indicated and available”.*⁶⁸

Health E1 Homeless Medical Centre (Primary Care Medical Centre)

12.34. *“Health E1 (the Transitional Primary Care Service) provides primary care services for homeless, vulnerably housed people having difficulties registering with a GP and accessing health services. It focuses on people who routinely spend the night outdoors, socially excluded patients including hostel dwellers and sex industry workers, and other marginalised groups referred by partner organisations”.*⁶⁹

The Tower Hamlets Specialist Addictions Unit (SAU)

12.35. *“The Tower Hamlets Specialist Addictions Unit provides assessment, care and treatment to patients whose drug and alcohol related needs require specialist interventions from a multi disciplinary team with expertise in stabilising, promoting drug and alcohol recovery and facilitating wider social inclusion for patients. As an integral part of the local drug and alcohol treatment system, their role is also to mainstream more stable patients into Primary Care and other treatment agencies”.*⁷⁰

The Blood Borne Virus Team

12.36. *“The Blood Borne Virus Team is a nurse team providing a harm reduction healthcare service as a satellite in 10 voluntary and statutory drug and alcohol services in Newham, Tower Hamlets and City & Hackney. The team deals with safer drug and injecting advice, testing for Hepatitis B, C and HIV, vaccinations (Hepatitis A, Hepatitis B, Influenza & Tetanus), diagnosis and treatment of sexually transmitted infections, emergency contraception and pregnancy testing, screening for TB, cervical cytology (smears),*

68. NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in primary and secondary care (2002/3) p 12-13

69. Mr Y Serious Incident Review Report p 9

70. Mr Y Serious Incident Review Report pp 9-10

*assessment for other general health problems and referral to appropriate agencies, monitoring of Hepatitis, HIV and liver disease, treatment for Hepatitis B and C and HIV through joint clinics, screening and monitoring for alcohol related health problems including liver disease”.*⁷¹

The Bethnal Green Community Mental Health Team (CMHT)

*12.37. “The community mental health teams are multi-disciplinary teams focusing on the care of people with severe and enduring mental health problems. The teams provide early assessment, comprehensive programmes of treatment and continuing care for clients. The objective is to reduce relapse of illness and admission to hospital, and to enable people to remain at home, thus improving their quality of life”.*⁷²

Findings

Findings of the Internal Investigation Process (Serious Incident Review Report)

12.38. The internal investigation found that both Mr X and Mr Y were well engaged with service. Both service users were deemed to have reduced their illicit substance misuse and for their health, social circumstances and functioning to have improved.

12.39. In the case of Mr X the following findings were made:

1. He had increased the dose of antipsychotic medication he was taking and his mental state had improved as a result.
2. He was maintaining a steady weight.
3. He was no longer injecting although he continued to smoke street drugs once or twice weekly.
4. He had maintained his residence in the supported accommodation for almost three years and was managing his finances better although he was limited in his engagement around activities of daily living.

12.40. In the case of Mr Y the following findings were made:

1. He was receiving anti-viral treatment for hepatitis and the viral loads had diminished.
2. His leg ulcers, although chronic, were less problematic for him.
3. He was topping up less frequently with street drugs and was no longer injecting.
4. He had maintained his residence in the supported accommodation and had a good relationship with his Key Worker.

12.41. The Independent Investigation Team agrees broadly with the findings of the internal investigation. However some of the findings run counter to the evidence both in the clinical record and in the internal investigation’s own chronology.

Findings of the Independent Investigation

Mr X

12.42. Once Mr X’s diagnosis was confirmed by the SAU in November 2008 efforts were made to start him on antipsychotic medication despite his initial

71. Mr Y Serious Incident Review Report p 10

72. Mr X Serious Incident Review Report p 11

adamant refusal. His Methadone was also increased in an effort to 'hold him' although he still used street drugs. The Methadone was reduced at his request during December 2008 – March 2009 to 30ml daily. While this was sub optimal treatment for his addictions Mr X believed that it was helping him and that it was sufficient to assist him manage his addiction. Allowing Mr X to have some autonomy over his prescription does seem to have worked to engage him, and during a review in March 2009 he was able to talk about some of his psychotic symptoms, such as, third person auditory hallucinations and ideas of reference. He also agreed to commence Amisulpride (antipsychotic medication) 200mg twice daily with a view to increasing the dose to 400mg twice a day depending on tolerance (in the event this didn't happen as he found the medication made him sleepy).

12.43. The Independent Investigation Team considered whether Mr X should have been referred to the CMHT at this point. We recognise the efforts the SAU Team made to engage with Mr X and work pro-actively with him; however a finding of the Investigation is that the Schizophrenia treatment may have been overshadowed by the addiction treatment at this point and that the treatment of Mr X's Schizophrenia was not specifically care planned. Had Mr X been managed under CPA, and in accordance with NICE guidance, early in 2009 his condition may not have deteriorated leading to him 'hitting rock bottom' in December 2010.

12.44. Mr X's engagement was disrupted by his incarceration in 2009 during which he was not given his antipsychotic medication. When he was seen in November 2009 he was depressed, dishevelled and psychotic; he was also still using Heroin. He was recommenced on Amisulpride at 400mg per day and this was monitored by his SAU Key Worker. When the prescribing of Amisulpride was handed over to the GP practice in January 2010, Mr X became non compliant almost immediately, this was picked up by his Key Worker which was good practice.

12.45. Mr X was referred to the CMHT for a needs assessment in May 2010; he now appeared to be willing to engage with mental health services. Although he had not attended for a medical appointment at the SAU since November 2009 he was seeing his Key Worker regularly. He was initially referred to the Bow and Poplar CMHT and then re-referred to the Bethnal Green CMHT. This referral seemed to be very difficult to progress despite the efforts of staff at the SAU and at the Health E1 Homeless Medical Centre who were concerned that Mr X was non-compliant with his medication, had started to isolate himself, suffered from self neglect and was now facing eviction. Mr X was evicted on 14 December 2010; he became street homeless although was rapidly accepted into Daniel Gilbert House on 20 December 2010.

12.46. During this period the SAU continued to follow Mr X up. When reviewed in February 2011 the SAU Consultant Psychiatrist wrote to the Bethnal Green CMHT again requesting they assess Mr X who had reported that while his street drug use was less he had almost constant auditory hallucinations (including command hallucinations to kill others) and was neglecting himself. The request was that Mr X be assessed for CPA and consideration given to Clozapine (anti-psychotic medication used in treatment resistance which needs close monitoring including frequent blood tests). Mr X had also been appointed a Key Worker at the hostel who worked well with him, and

advocated on many occasions for greater involvement to manage his mental health.

12.47. Mr X was eventually seen by the CMHT on 9 May 2011, one year after the initial referral had been made. A thorough assessment was undertaken, it was acknowledged that Mr X had an untreated mental illness and he was taken on by the team to be managed under CPA. He was appointed a Care Coordinator who took on the role of liaising with the other services Mr X was using (SAU, housing and primary care) and began to look at social inclusion issues. Mr X had a medical review one month later and his Amisulpride was increased to 500mg twice per day, he was also started on Citalopram 20mg (antidepressant) as he continued to present with low mood. His compliance improved although was never ideal. At a CPA meeting in August 2011 the team considered putting Mr X on a depot (injectable antipsychotic medication, often used for service users who find compliance with oral medication difficult) but Mr X refused. The team wanted to continue to work with him and not force a confrontation, so they listened to his concerns and Mr X continued on oral medication.

12.48. There is evidence to suggest that over the next few months Mr X's mental state was a little improved, he was calm and stable at review although was involved in a fracas at the hostel. He found the noise at the hostel difficult to manage, he was still using Heroin and the hostel staff noticed a change in him when he was using in that he was more irritable. It was also noted by hostel staff that he was more settled when taking his antipsychotic medication regularly. In the meantime he continued on Methadone maintenance therapy monitored by the SAU.

12.49. During this period his Care Coordinator (CCO) picked up that Mr X had significant debts (mostly due to housing arrears) and he worked well with him to address these and they were eventually dealt with. However the CMHT did not seem to be aware that Mr X was gambling and that this was problematic, something the housing staff were aware of.

12.50. During 2012 Mr X's mental health had stabilised somewhat; he was largely compliant with his medication, he moved into a bedsit at the hostel so the noise wasn't as difficult for him, his drug use seemed to be a little less chaotic, there was no evidence of violence or self harm, his personal care improved, he started going to the gym and the team referred him to psychology. He was still isolative and continued to use Heroin and Cocaine, but continued to engage with SAU staff, his housing Key Worker and his CMHT CCO. By the time of his CPA review in November 2012 Mr X told the team that he felt better, the voices were less intrusive and he was able to ignore them. There was no evidence of depression and he was compliant with his medication; at this stage he also appeared to understand why his medication was important. It was agreed to increase the Methadone slightly from 25ml to 30ml in an effort to reduce his illegal substance misuse further. There was a clear plan after this CPA review which addressed psychosocial interventions, healthy lifestyle, relapse and recovery plans, housing, Occupational Therapy and psychological treatments. This was good practice even though it appears the plan was neither developed nor implemented in full.

12.51. By January 2013 the housing records note that Mr X was cooking his own meals and taking his medication. He was still gambling but this appeared to be less problematic. A CPA review was held on 2 May 2013 which reported positive progress in general even though he was still hearing voices. He was able to ignore them most of the time and it was noted the voices were not command-style hallucinations. There was however some thought broadcasting and ideas of reference with persecutory themes. It was noted that Mr X was a little depressed but was taking his medication. The team decided to take Mr X off CPA – this decision is discussed in section 12.4 below.

12.52. In interactions with staff prior to the homicide Mr X appeared to be well. However after the death of Mr Y Mr X claimed to have been non compliant with his medication for some time. On reflection the Independent Investigation found there was no objective evidence of a sustained deterioration in his mental health which may have reduced his threshold for the discharge of violence. Indeed there is an entry in his GP records dated 17 June 2013 in which Mr X attended the Health E1 Homeless Medical Centre for his medication; he told the GP he had no problems and that he had been “100% compliant” over the last month. A medication prescription was issued for him four days before the homicide.

Mr Y

12.53. Mr Y did not have a major mental illness, and the focus for interventions was around his addictions, trying to stabilise his substance misuse, treat the physical consequences of his substance misuse and to keep him alive. Mr Y was a chaotic man who was described as provocative. He frequently incited rows and was involved in fights. He had rent arrears, he neglected himself, was frequently arrested for begging and for brawling.

12.54. Mr Y was registered with the Health E1 Homeless Medical Centre in January 2009 with a clearly documented long-standing history of illicit drug use. At that time he was prescribed Methadone 30ml but was also using street Heroin, Crack Cocaine, Benzodiazepines, DF118 and Diazepam, he also injected drugs. Mr Y had overdosed three times during the previous year and had painful leg ulcers. He was referred immediately to the SAU to oversee the management of his addictions; they assessed him quickly (18 February). His Methadone was increased to 70ml per day in an effort to stabilise his illicit substance misuse, he was also prescribed Dihydrocodeine for his leg ulcer pain, and Diazepam 40mg daily – even though he had tested negative for Benzodiazepine use on 9 February. In February 2010 he was again given a prescription for Diazepam even though he had tested negative.

12.55. The Independent Investigation Team questioned the rationale for this prescribing, and was assured at the panel interviews that this prescribing practice would not happen now (there is evidence in the electronic records of a letter informing all SAU service users that a gradual Diazepam reduction programme would be followed in the future). Mr Y’s Diazepam was gradually reduced and prescribing ended on 31 August 2011. However Mr Y continued to use street Diazepam and he tested positive for Benzodiazepines on a number of occasions afterwards. It should be noted that in October 2012 hostel tenants at Daniel Gilbert House complained that Mr Y was dealing drugs from his bedroom and he was understood to have Diazepam for sale. It is possible that Mr Y had been dealing the Diazepam prescribed for him by

the SAU prior to this being stopped. The extent of Mr Y's dealing could only have been understood once he was in a supported living facility that observed his day-to-day habits.

12.56. Mr Y's physical health needs were understood well, he had painful leg ulcers that interfered with his mobility, he had hepatitis B and C and liver cirrhosis, his dentition was poor (and subsequently so was his diet) and he was emaciated. Staff worked assertively with him in addressing these issues, he was prescribed Ensure for nourishment, and his hepatitis was treated by the Blood Borne Virus Team at the SAU who liaised closely with medical services. His leg ulcers were dressed regularly.

12.57. At that time there was a clear direction of care for Mr Y which was to reduce his substance misuse and 'top up' habit, work with him on harm reduction, treat his physical health problems and offer psychosocial support. Mr Y remained engaged with services and he complied relatively well with treatment. When he planned a visit to see his mother in June 2011, staff contacted her to make sure she was aware of his methadone programme which was good practice. In March 2012 Mr Y was evicted from his hostel for fighting. He had received several previous warnings relating to antisocial behaviour. He remained street homeless until August 2012 when he moved into Daniel Gilbert house. It is noteworthy that during the time he was street homeless; he remained engaged with the SAU and was still working with them at the time of his death in June 2013.

Conclusions

12.58. The Independent Investigation Team concluded that the compassion and commitment demonstrated by all of those staff who came in contact with Mr X and Mr Y constituted notable practice. It was clear that they did their best in very chaotic circumstances and that they cared about their patients. They accepted them for who they were and did not give up on them.

12.59. Once Mr X had been accepted by the CMHT in the spring of 2011 he received a robust package of care and treatment in keeping with his diagnoses. It was holistic and Mr X showed a degree of positive change. Mr X's antipsychotic medication prescribing was appropriate. Depot medication was considered on a number of occasions in an effort to aid/ensure compliance but Mr X was opposed to this and this was respected. The CMHT continued to work with him on his terms and succeeded in engaging him. Mr X was also prescribed an antidepressant which seemed to help him.

12.60. All of Mr X's medication was reviewed regularly (during outpatient clinics and CPA reviews). This included reference to side effects and possible drug interactions, for example, the antidepressant was changed during 2012 based on a concern about a possible drug interaction with the Methadone. When Mr X found the Amisulpride was making him sleepy, the dose was divided so that the majority of his medication was given at night time. Compliance was also monitored during this period. This was good practice.

12.61. The prescription for Methadone was somewhat unorthodox in that there was no clear plan to reduce its use, even though Mr X was on what would be regarded as a sub-therapeutic dose. However there was no evidence that Mr X abused his Methadone prescription.

12.62. At the point of discharge from CPA Mr X was subject to a comprehensive care plan, although once discharged from CPA there were indications who would actually deliver against the plan and monitor it. Of particular note was the monitoring of medication and psychological therapy input for which no arrangements appear to have been made. It was known that Mr X relapsed when not taking his medication and that compliance had historically been an issue. On 13 June 2013, just days before the homicide, Mr X reported to his Key Worker at the hostel that he was getting better and only needed following up once a year – it is possible that Mr X thought he no longer needed his medication at this point. We will never know the exact turn of events. However, based upon what was already known about Mr X, a more proactive medicines management process was indicated at the point of Mr X's discharge from CPA. At the point of discharge the CMHT had referred Mr X to the Enhanced Primary Team (a team that provides help and support for those with mental illness). However after his discharge from CPA, on 3 June, he was discharged from Tower Hamlets Mental Health Enhanced Primary Care Liaison Team as the GP did not think he was ready for this service. The implications for this regarding his ongoing monitoring, care and treatment do not appear to have been picked up. The fact that he was not ready for enhanced primary care probably meant he was not ready for discharge from CPA.

12.63. The Independent Investigation Team concluded that Mr Y's care and treatment were good. Staff at the Health E1 Homeless Medical Centre, SAU and housing worked hard to engage him and stabilise his life despite the challenges that his lifestyle choices presented. His addictions were recognised and managed well overall, as were his physical health and housing needs. However it would appear that based on the conversations he had with his Key Worker at the hostel he may have been economical with the truth when speaking to his NHS treating teams as he disclosed that his drug use was increasing and that he was not convinced he would live much longer.

12.64. It is the conclusion of the Independent Investigation Team that overall Mr X and Mr Y received good treatment from very caring and committed staff teams. Two weaknesses were identified - first: while Mr X's care plans were comprehensive they were often not followed through - second: communication processes were poor on occasions. Whilst it is evident that more could and should have been known and shared between the treating teams, the issue of medication and treatment *per se* was not an influencing factor in the outcome of this case. Communication issues, and other issues pertinent to communication, are addressed in the sections below.

- ***Contributory Factor Two: Mr X was subject to many comprehensive care plans. However these plans were not always implemented in full or followed through leaving areas of unmet need – this was of particular note during the nine months before the homicide of Mr Y (the reader is asked to refer to section 12.4 for a more detailed analysis of the care planning process).***

12.3. Use of the Mental Health Act (1983 and 2007)

Context

12.65. The Mental Health Act 1983 was an Act of the Parliament of the United Kingdom but applied only to people in England and Wales. It covered the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provided the legislation by which people suffering from a mental disorder could be detained in hospital and have their disorder assessed or treated against their wishes, unofficially known as 'sectioning'. The Act has been significantly amended by the Mental Health Act 2007.

12.66. At any one time there are up to 15,000 people detained by the Mental Health Act in England. 45,000 are detained by the Act each year. Many people who may meet the criteria for being sectioned under the Act are admitted informally because they raise no objection to being assessed and/or treated in a hospital environment. People are usually placed under compulsory detention when they no longer have insight into their condition and are refusing medical intervention and have been assessed to be either a danger to themselves or to others.⁷³

Findings

Findings of the Internal Investigation Process (Serious Incident Review Report)

12.67. The internal investigation report for Mr X mentions the Mental Health Act only once; this is in relation to the day of the homicide when Mr X was agitated at the hostel. The investigation concludes that even had a Mental Health Act assessment been conducted on this occasion it is unlikely Mr X would have met the criteria for detention. No mention was made of the Mental Health Act in connection with Mr Y.

Findings of the Independent Investigation

Mr X

12.68. On examination of the timeline it is evident that on two occasions assessment under the Act was considered as part of a crisis plan for Mr X. The first was in May 2011 following his first CPA review with the Bethnal Green CMHT. This consideration was made in the context of Mr X needing further assessment and a possible hospital admission under the Act if in crisis and presenting with high risk. The second was in May 2013 (once again following a CPA review) this review being the one from which he was discharged from CPA. On this occasion the crisis plan stated that the duty Approved Mental Health Professional (AMHP) was to be contacted if a Mental Health Act assessment was required. The crisis plan did not make explicit who was expected to contact the AMHP if such a situation arose or how this was to be identified/triggered out of hours.

12.69. On 21 June 2013 Mr X presented in an agitated and angry manner. The hostel staff were concerned enough to call the police who advised mental health services be contacted. Mr X was reported to be hearing voices and drug paraphernalia was seen in his room. Hostel staff were not certain how to

73. Mental Health Act Commission 12th Biennial Report 2005-2007

contact out of hours mental health services and in the event only a voicemail was left at the CMHT office. Mr X appeared to calm down and apologised to staff – no further concerns were raised until Mr Y was found dead the following day.

Mr Y

12.70. The Mental Health Act is not mentioned in Mr Y's clinical record. It was known that he suffered from depression and that he had overdosed on several occasions in the past, some of which were of a serious nature requiring hospital admission. In September 2012 Mr Y had lain down on railway tracks – he maintained that he did not remember why he had done this. At this time the Outreach Team thought that Mr Y might need a hospital admission and requested a case conference. The SAU did not think that Mr Y needed an inpatient admission but thought a case conference should still take place. Mr Y did not want a case conference and subsequently no further action was taken.

Conclusions

12.71. It is reasonable to assume that over the years neither Mr X nor Mr Y met the criteria for either Mental Health Act assessment or detention. However on occasions it is difficult to see how mental state was assessed when the service users were in crisis and a more thorough assessment process might have been indicated.

12.72. On the day of the homicide mental health services were not involved (for reasons that are explored in sections 4, 5 and 9 and 12). It is not possible to say with any degree of certainty what Mr X's mental state was on this occasion as no one from secondary care services was able to assess it. It is unfortunate that the CMHT crisis plan did not appear to have been either developed with, or communicated to, Daniel Gilbert House. Had this been the case then it would be reasonable to assume secondary care mental health services would have been involved at this time and an assessment of some kind undertaken – whether it ultimately involved the Mental Health Act or not.

12.73. The Independent Investigation Team concludes that Mr X was experiencing some kind of crisis on 21 June – this was evident in that hostel staff found his behaviour concerning enough to call the police. What cannot now be known is whether this crisis was driven by a relapse of Mr X's mental illness as no mental health service was accessed to assess his mental state and it is therefore not possible to conclude whether or not the Mental Health Act should have been considered at this time.

12.4. The Care Programme Approach

Context

12.74. The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness.⁷⁴ Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care Co-ordination in Mental*

74. The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990

Health Services: Modernising the Care Programme Approach to incorporate lessons learned about its use since its introduction and again in 2008 *Refocusing the Care Programme Approach*.⁷⁵

12.75. *“The Care Programme Approach is the cornerstone of the Government’s mental health policy. It applies to all mentally ill patients who are accepted by specialist mental health services”.*⁷⁶ (Building Bridges; DoH 1995).

12.76. The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework that can help achieve those positive outcomes for service users by enabling effective coordination between services and joint identification of risk and safety issues, as well as being a vehicle for positive involvement of service users in the planning and progress of their care. The Care Programme Approach is both a management tool and a system for engaging with people.

12.77. The purpose of CPA is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary function is to minimise the possibility of patients losing contact with services and maximise the effect of any therapeutic intervention.

12.78. The essential elements of any care programme include:

- systematic assessment of health and social care needs bearing in mind both immediate and long term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s), this should be recorded in writing;
- the allocation of a Care Coordinator whose job is:
 - to keep in close contact with the patient
 - to monitor that the agreed programme of care remains relevant; and
 - to take immediate action if it is not
- ensuring regular review of the patient’s progress and of their health and social care needs.

12.79. The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear. Up until October 2008 patients were placed on either ‘Standard’ or ‘Enhanced’ CPA according to their level of need.

Local Policy

12.80. The local policy in place at the time Mr X and Mr Y were receiving care and treatment from the Trust was developed in conjunction with Local Authority partners and integrated the Care Programme Approach (CPA) with Care Management (CM). The integrated policy aimed to:

75. Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008

76. Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH; 1995

- *“improve quality of care at key points throughout the service user’s or carer’s journey by making it clear how individual component parts fit together as a whole;*
- *facilitate closer and integrated working that ensures a co-ordinated approach to care delivery;*
- *provide opportunity to compare assessed need and planned care with the care actually given;*
- *enable better use of information by ensuring that variation is recorded, analysed and effectively improved and managed;*
- *support identification of priorities for skills development and service improvement priorities;*
- *reduce bureaucracy – avoiding duplication of record keeping between different professionals or parts of the organisation”.*

12.81. Section 2.4 states that *“Particular attention should be paid to people who have no permanent address and lead a transient lifestyle. It is recognised that homeless people who experience mental illness present with a variety of complex needs and have a greater need for a framework to help maintain the necessary links between user and services”.*

12.82. Section 4.1 states that *“The DH Refocusing CPA Guidance 2008 states that in the main, the individuals needing the support of CPA should be characterised by: multi-agency support, active engagement, intense intervention, support with dual diagnoses and those at higher risk. To provide clearer guidance to services, so that they can better target engagement, co-ordination and risk management to individuals that most need it”.*

12.83. Characteristics to consider when deciding if support of CPA is needed included:

- *“Severe mental disorder (including personality disorder) with high degree of clinical complexity;*
- *Current or potential risk(s), including:*
 - *suicide, self harm, harm to others (including history of offending);*
 - *relapse history requiring urgent response;*
 - *self neglect/non-compliance with treatment plan;*
 - *vulnerable adults;*
 - *exploitation e.g. financial/sexual;*
 - *financial difficulties related to mental illness;*
 - *disinhibition;*
 - *physical/emotional abuse;*
 - *cognitive impairment;*
 - *child protection issues;*
- *Current or significant history of severe distress/instability or disengagement;*
- *Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse;*
- *Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies;*
- *Currently/recently detained under Mental Health Act or referred to crisis/home treatment team;*
- *Significant reliance on carer(s) or has own significant caring responsibilities;*
- *Experiencing disadvantage or difficulty as a result of:*

- *physical health problems/disability;*
- *unsettled accommodation/housing issues;*
- *employment issues when mentally ill;*
- *significant impairment of function due to mental illness;*
- *ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious;*
- *...refugees and asylum seekers”.*

The Care Coordinator Role

12.84. The policy describes this role as taking “*a proactive and co-ordinated approach in identifying the most complex and vulnerable people with mental health problems, then co-ordinating and managing their care in partnership with the individuals and their carers*”. The role also:

- integrates and co-ordinates a person’s journey through all parts of the health and social care system;
- brokers partnerships with health and social care agencies and networks which can respond to, and help to meet the needs of the person who is experiencing mental health problems.

12.85. The policy (section 6.4.5) also states that crisis and contingency plans should make explicit the arrangements for contacting mental health services and that an appropriate “*emergency*” telephone number should be provided to carers, or those in lieu of them, as a basic minimum requirement.

12.86. When CPA was thought to no longer be needed the policy stated that “*A thorough risk assessment, with full service user and carer involvement, should be undertaken before a decision is made that the support of CPA is no longer needed*”.

Findings

Findings of the Internal Investigation Process (Serious Incident Review Report)

12.87. The investigation report for Mr X made findings in relation to “*overall*” care planning and risk assessment which were deemed to be largely satisfactory with provisos made about the effectiveness of communication processes between agencies. The quality of the CPA process, the Care Coordination role and the decision to discharge Mr X from it on 2 May 2013 were not addressed.

12.88. The investigation report did however make findings on the challenges faced by hostel staff in general when working with CPA recognising that partnership working with the NHS needed to be developed further. A contributory factor finding was that hostel staff in future should incorporate CPA care plans and risk assessments into the plans developed within the supported living scheme and that the service provision model between the London Borough of Tower Hamlets and the housing association may require revision to this effect.

Findings of the Independent Investigation Team

12.89. It is beyond doubt that Mr X met the criteria for CPA. It is evident from an examination of Mr X’s clinical record that he was deemed to have Paranoid Schizophrenia from as early as November 2008 – at this stage it was known

that he had been hearing voices for 20 years that predated his illicit drug taking habit. Mr X was also known to have a chaotic lifestyle, previous self harm attempts, a forensic history of imprisonment for carrying weapons, a history of command hallucinations when relapsing, a history of medication non-compliance, social isolation and unemployment. The Independent Investigation Team understands that Mr X did not want any other input from secondary care mental health services at this stage and the Health E1 Homeless Medical Centre and SAU worked with him well in maintaining his mental health as well as his substance misuse.

12.90. In late 2009 Mr X was imprisoned once again for carrying a bladed weapon. He had not been given antipsychotic medication whilst in prison and had subsequently experienced a relapse of his mental illness. On 9 November 2009, following his release from prison, the SAU wrote that Mr X continued to use Heroin but denied using Crack Cocaine, that he described his mood as being depressed but denied either suicidal or homicidal ideation. He also said his voices were indistinct and he couldn't hear what they were saying, however he believed they made other people shout bad things at him and that if he knew who these people were he would kill them. At this time Mr X was described as unkempt with long hair and a beard and there was evidence of self-neglect.⁷⁷

12.91. On 14 May 2010 the Tower Hamlets Specialist Addictions Unit referred Mr X to the Bow and Poplar CMHT for a needs assessment under CPA. Prior to this time Mr X had not previously wanted contact with Mental Health services but now appeared to be willing. At this time Mr X reported auditory hallucinations of a derogatory nature. His voices were causing him to be anxious, low in mood and paranoid. Mr X was also depressed, had poor appetite and self care problems. Mr X had last been seen by the SAU Consultant Psychiatrist on 9 November 2009 and had not attended for medical appointments since.⁷⁸

12.92. On 26 May 2010 a re-referral was made to the Bethnal Green CMHT (Bow and Poplar was outside of the catchment area). Numerous telephone calls were made throughout June 2010 to progress the referral with no success. Mr X continued to be treated by the SAU who continued to have concerns about his mental health. During this period it was evident that Mr X faced eviction from his flat for the non-payment of rent and that he was non-compliant with his antipsychotic medication.

12.93. By December 2010 it was evident that Mr X was not coping. His compliance with his antipsychotic medication was frequently described as "*patchy*" and he was evicted from his accommodation and became street homeless. He was however rapidly found a placement at Daniel Gilbert House.

12.94. On 4 February 2011 the SAU Consultant Psychiatrist dictated a re-referral letter to the CMHT (the letter was not in fact written until 17 March 2011). The referral was for CPA and for a consideration for Clozapine due to Mr X's drug resistant Schizophrenia. Concerns were rising in relation to his deteriorating mental health and constant auditory hallucinations. In the event

77. File 2 pp 40 - 41

78. File 1 p 60

Mr X was seen by the CMHT for a CPA assessment which took place between 9 and 19 May 2011.

12.95. In May 2011 a series of comprehensive assessments were conducted. A Clustering Assessment found most of his problems were in the “severe” category. On 7 June 2011 the CMHT Consultant Psychiatrist reviewed Mr X (it should be noted the letter pertaining to this review was not sent to the GP until 1 August). The plan was for:

- a CPA to be conducted every three – six months;
- a Care Coordinator to be allocated from the team;
- Amisulpride to be increased to 500mg twice a day and for Citalopram 20mg once a day to be started;
- Mr X to continue to be seen by the SAU;
- Mr X to continue to attend the surgery for blood tests and for results to be forwarded to the CMHT.⁷⁹

12.96. Between this time and November 2012 CPA appears to have been conducted in keeping with both local and national policy best practice. Whenever possible the SAU, the Health E1 Homeless Medical Centre and the hostel Key Worker were invited to attend CPA reviews and be part of the care and treatment planning and delivery process. This appears to have been coordinated well though CPA and its success was in no small part due to the efforts of all of the clinical and care staff involved who maintained a high degree of both formal and informal communication. Mr X appeared to improve during this period. This was good practice.

12.97. In September 2012 Mr X was progressing so well that the SAU planned to discharge him back to the GP. In the event this was not done. The CMHT also noted an improvement in Mr X and in May 2013 a decision was made to discharge him from CPA. The decision appears to have been made without SAU or hostel representatives being present (they are not listed as being present in the CPA documentation). During this period communication and ‘inter-service join up’ appears to have declined. At this CPA review it was noted that there was a history of:

1. *“Non-compliance with medication.*
2. *Long history of substance misuse.*
3. *History of untreated illness.*
4. *Little social activity or structure to his day.*
5. *Decline in personal hygiene when unwell”.*⁸⁰

12.98. Protective factors were identified as:

1. *“Use of Medication.*
2. *On-going support from Local CMHT.*
3. *Treatment from SAU.*
4. *Hostel Accommodation.*
5. *Motivation to work with services”.*⁸¹

79. File 1 pp 85 – 86

80. File 2 pp 1- 22 and 24

81. File 2 pp 1- 22 and 24

12.98. Ongoing plans acknowledged Mr X lived at Daniel Gilbert House and that the Care Coordinator would need to maintain links with hostel staff. It was also noted that the Care Coordinator would need to continue with ongoing social inclusion activities as Mr X still had needs identified in this area. The plan was for the Care Coordinator to continue to monitor his mental state (two-three monthly) and for regular engagement to take place with both Mr X and the Hostel staff.

12.99. The contingency plan was for:

1. *“Care Co-ordinator to arrange a home visit in attempt to ascertain circumstances, which may give rise to a crisis.*
2. *For Care Co-ordinator to encourage and facilitate purposeful and meaningful activities.*
3. *Care Co-ordinator to arrange an outpatient appointment in order to obtain a current mental health report.*
4. *Care Co-ordinator to liaison with the Drug agencies involved in ... [Mr X’s] care”.*⁸²

12.100. The Crisis Plan was for:

- the Care Coordinator to arrange a home visit to assess the situation;
- out of hours the GP and/or A&E to be contacted/accessed;
- the Home Treatment Team to be contacted if required to prevent a hospital admission;
- the duty AMHP to be contacted if a Mental Health Act assessment was required;
- if the assessment merited it then an inpatient admission to be considered.⁸³

12.101. The CPA review documentation was comprehensive and in keeping with the Trust’s policy. However the procedure followed and the plan of care decided upon are confusing. On the one hand it appears that the decision was taken to take Mr X off CPA and yet on the other hand it appears that Care Coordination was to continue. At this stage whilst Mr X’s situation appeared to have improved the CPA documentation listed a range of needs that still required ongoing secondary care input. Not mentioned in the CPA review documentation was the decision to refer Mr X for Enhanced Primary Care input and how this was to fit into overarching clinical management picture. Whilst the CPA documentation appears to be comprehensive there are several factors that give cause for concern.

1. The ongoing role of the Care Coordinator in the absence of CPA is confusing.
2. The plans were sound, especially in relation to contingency and crisis management, but there is no evidence to suggest the Care Coordinator followed this up with a visit to hostel (as agreed in the plan) to ensure implementation.
3. There had been no apparent communication with the hostel in the months since the last CPA review in November 2012 and it would appear from the

82. File 2 pp 1- 22 and 24

83. File 2 pp 1- 22 and 24

evidence given to the Independent Investigation that no communication had been forthcoming regarding Mr X's possible discharge from CPA.

4. Hostel staff and the SAU staff were not present at the 2 May 2013 CPA meeting and, in the case of the hostel, no CPA documentation was sent to them or ensuing communication undertaken, to explain the decision made and what additional input would subsequently be required from them. It is a fact that hostel staff only found out about the discharge when Mr X himself told them several weeks later.
5. No contemporaneous rationale was provided within the CPA documentation for the decision to discharge Mr X from CPA. The Independent Investigation were told that NHS Tower Hamlets Clinical Commissioning Group had requested a review of service users on CPA and for reviews to be undertaken and discharges where possible to be made.

Mr Y

12.102. The Independent Investigation Team made no findings in relation to Mr Y as he was not subject to, or eligible for, CPA.

Conclusions

12.103. The Independent Investigation Team made three separate conclusions in relation to CPA.

12.104. **First:** There were significant delays in accessing CPA for Mr X between 2010 and 2011 (for over one year). The delays were not due to eligibility criteria and appear to have been due solely to a system that was not working properly. This was remiss and was not in Mr X's best interests. As a result his mental health continued to deteriorate and his ability to manage his affairs so poor that he became street homeless. This was a serious failure in care delivery.

12.105. **Second:** The CPA process between May 2011 and November 2012, notwithstanding some minor issues, was of a good standard. There is ample evidence to demonstrate that NHS staff and hostel services were working in alignment as a result of good care coordination and that Mr X's mental health and social situation improved as a consequence. Mr X received care and treatment that was holistic in nature and delivered in manner that was acceptable to him. This was good practice.

12.106. **Third:** It was the conclusion of the Independent Investigation Team that Mr X met the criteria for CPA up to, and including, the time of the decision made on 2 May 2013 to discharge him. His mental health and social circumstances all pointed to the fact that he met the eligibility criteria in full. Despite his apparent improvement it could be argued that he would always require a high degree of secondary mental health care input due to his complex needs and treatment resistant Schizophrenia. Mr X was receiving input from several NHS services and from supported living accommodation – this indicated a need for ongoing care coordination and management overview.

12.107. That being said, the Independent Investigation Team did not find the decision to discharge Mr X from CPA to be a 'wrong' decision *per se*. It was evident that care planning by the CMHT was to continue and that Mr X could be routed back into the service should he need to be. There were plans for

follow up by the Care Coordinator and also by the CMHT Consultant Psychiatrist.

12.108. However whilst care planning and monitoring were to continue from the CMHT the issue of care coordination is less clear. It is difficult to understand what the continued role of the Care Coordinator was to be if Mr X was no longer on CPA. It is evident that from the point of Mr X's CPA discharge on 2 May 2013 communication between the NHS teams and the hostel ceased. It is also evident that the follow up work planned at the 2 May 2013 CPA review did not take place. This was remiss in that when a crisis did occur no one at the hostel knew what to do or who to contact. The CMHT should have ensured that the decision to discharge Mr X was clearly communicated and that all action plans in relation to the discharge were implemented. That being said no causal link was made between this omission and the killing of Mr Y (the rationale for this is explored below in chapter 13).

- ***Contributory Factor Three: the difficulties in accessing CPA for Mr X between May 2010 and May 2011 made a significant contribution to the continued deterioration of his mental health. Whilst CPA worked well between May 2011 and November 2012 a marked decline in communication occurred in the winter of 2012 until his discharge from CPA on 2 May 2013. At this stage Care Coordination did not deliver against care planning and this meant that important ongoing aspects of Mr X's care were neither implemented nor communicated.***

12.5. Risk Assessment

Context

12.109. Risk assessment and management are essential and ongoing elements of good mental health practice and a critical and integral part of the Care Programme Approach. Managing risk is about making good quality clinical decisions to sustain a course of action that when properly supported, can lead to positive benefits and gains for individual service users.

12.110. The management of risk is a dynamic process which changes and adjusts along the continuum of care and which builds on the strengths of the individual. Providing effective mental health care necessitates having an awareness of the degree of risk that a patient may present to themselves and/or others, and working positively with that.

12.111. The management of risk is a key responsibility of NHS Trusts and is an ongoing process involving and identifying the potential for harm to service users, staff and the public. The priority is to ensure that a service user's risk is assessed and managed to safeguard their health, wellbeing and safety. All health and social care staff involved in the clinical assessment of service users should be trained in risk assessment and risk management skills.

12.112. It is essential that risk assessment and management is supported by a positive organisational strategy and philosophy as well as efforts by the individual practitioner.

12.113. Best Practice in Managing Risk (DoH June 2007) states that *“positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach ... any risk related decision is likely to be acceptable if:*

- *it conforms with relevant guidelines;*
- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed.*⁸⁴

12.114. As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time.

12.115. Effective and high quality clinical risk assessment and management is the process of collecting relevant clinical information about the service user’s history and current clinical presentation to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves and /or others, or of being harmed. The assessment and management of risk should be a multidisciplinary process which must include where possible and appropriate the service user and their carer. Decisions and judgements should be shared amongst clinical colleagues and documented clearly, particularly when they are difficult to agree.

Local Trust Policy

12.116. The Clinical Risk Assessment and Management Policy in place at the time Mr X and Mr Y received their care and treatment stated that risk formulation should provide *“An explanation of how risks in specified areas arise in a particular individual given the presence of and relevance of conditions that are assumed to be risk factors for a hazardous outcome that is to be prevented. A risk formulation should account for the role of protective factors as well as risk factors”*.

12.117. The policy also set out the requirement for risk assessment and management plans to be documented on the Trust CPA documentation template. Section 7.10 of the policy states that:

“Risk assessment and subsequent management planning should be communicated to all relevant clinical and management staff. This will depend upon the clinical setting and the level to which any individual patient’s risk is managed on a day to day basis, be it by a whole team such as a ward or mainly by key individuals such as a care co-ordinator and outpatient doctor. Risk information should be readily accessible to any staff member who may be required to provide some form of clinical intervention to a patient regardless of their prior involvement with the patient. Consideration should be given by each clinical team about how risk information can be easily accessed when needed by staff outside of their team, who

84. Best Practice in Managing Risk; DoH; 2007

may be required to provide assessment or urgent care to patients presenting to their services”.

12.118. The policy required the risk assessment and management documents to be reviewed routinely at key intervals during the patient’s care, such as, ward round reviews, discharge planning meetings and CPA reviews. Risks were expected to be escalated and de-escalated in response to any changing factors which altered the overall profile of the risk.

Findings

Findings of the Trust’s Internal Investigation

12.119. Findings from the internal investigation process stated that overall risk assessments from an NHS perspective were *“largely satisfactory”* in relation to the care and treatment provided to both Mr X and Mr Y but that communication arrangements between agencies might not have been optimal.

12.120. Findings were also made in relation Daniel Gilbert House not having individual crisis plans in place and that work should be undertaken to ensure they were developed and incorporated into the accommodation scheme’s internal processes.

12.121. In relation to Mr X his history of carrying weapons was noted. The report went on to say that he heard voices on the 21 June 2013 and was found with drug paraphernalia in his room. It was recognised that the two factors together might have increased his risk of experiencing psychotic phenomena. However it was concluded that Mr X appeared to be lucid and calm once his outburst had abated and that neither health nor third sector staff could have predicted or prevented the homicide of Mr Y.

12.122. In relation to Mr Y it was noted that he had several factors present that would have increased his risk of being a homicide victim *“he was male with a history of polysubstance misuse and street homelessness, he was unemployed with mental health issues and was living away from his family in a large city. He would act in disinhibited/risky ways under the influence of Benzodiazepines”*. However the internal investigation acknowledged that he appeared to be doing well at the time of his death. It was concluded that his death could not have been either predicted or prevented by health or third sector staff.

Findings of the Independent Investigation Team

Mr X

12.123. From an examination of the clinical record it would appear that Mr X was subject to many formal recorded risk assessments. Between November 2008 and the spring of 2011 the SAU conducted and recorded the following risk information:

- 1. 19 November 2008:** it was noted that Mr X had a history of suicide attempts and impulsive behaviour. It was also noted that he had served a term in prison and suffered from a major mental illness with erratic engagement.

2. **27 May 2009:** Mr X's risk of either suicide or homicide was deemed to be low/moderate and his risk of self neglect was deemed to be moderate.
3. **10 July 2009:** following the development of a care plan Mr X's risks were considered to focus around his Heroin usage and possible accidental overdose. His history of attempted suicide and his mental health problems, lack of insight and auditory hallucinations were also noted but not graded.
4. **12 November 2009:** the identified risks were the same as those of previous assessments but they now included the information that he was carrying a weapon and was known to have thoughts of harming others.
5. **1 January 2010:** Mr X's risks were deemed to focus around his Heroin usage and possible accidental overdose. His history of attempted suicide and his mental health problems, lack of insight and auditory hallucinations were also noted but not graded.
6. **17 May 2010:** during this risk assessment it was noted that in addition to the risks already identified previously Mr X had active thoughts and plans of suicide, had current self-harming behaviour, was in debt, was impulsive and socially isolated, and at risk of self neglect. It was noted once again that Mr X had a major mental illness and was known to carry a weapon. On this occasion he did not have thoughts of harming others.
7. **4 February 2011:** Mr X was noted to report almost continuous auditory hallucinations which made his life difficult as they told him to kill himself. He also thought these voices on occasions told him to kill other people. Even so, despite his weapon carrying history, his risks were deemed to be low/moderate.

12.124. The risk assessment form used by the SAU stated that 'trigger risks' included:

- current plans of suicide, self-harm or overdose;
- *"GBH, murder, sexual crime, pregnancy, carries weapon, reports violence or threats of violence";*
- threats from others.

12.125. The Independent Investigation Team found that the risk assessments were robust in relation to the identification of risk but were not so robust in the formulation of risk in relation to diagnoses and the development of active management plans. We were told that chaotic lifestyles and the carrying of a weapon were 'normal' for east London and this service user group. However it is a finding of the Independent Investigation Team that, on occasions, between 2008 and 2011 Mr X presented with an unacceptable level of risk particularly in the light of his Paranoid Schizophrenia, command hallucinations, weapon carrying and non compliance with medication. This was a situation that could not realistically have been managed by the SAU and a more determined attempt to have Mr X referred to the CMHT should have been made.

12.126. Between the spring of 2010 and Mr X's discharge from CPA on 2 May 2013 the following risk assessments were conducted:

1. **12 – 18 April 2011:** a risk assessment was undertaken by the hostel. Risks were deemed to be low/medium. However Mr X found it difficult to mix with others because of his constant voices. It was recognised that risk was associated with deterioration to his mental state. The hostel Key

Worker contacted the SAU regarding the concerns held about the deterioration in Mr X's mental state.

2. **9 – 19 May 2011:** the CMHT assessed Mr X for the first time. It was noted that Mr X had a history of self neglect, two previous suicide attempts and two previous periods of imprisonment for carrying a bladed weapon (he denied he wanted to harm others during the assessment). Whilst the need for a further period of assessment was recognised Mr X's risk were all deemed to be low. The SAU and hostel were thought to be key protective factors.
3. **24 August 2011:** a CPA review noted that Mr X's voices often "*asked him to die*".
4. **5 September 2011:** the Key Worker at the hostel noted that when Mr X was using illicit drugs he was different person becoming aggressive and difficult to communicate with.
5. **7 January 2012:** Mr X's hostel Key Worker conducted a risk assessment. Gambling, poor personal hygiene (which had led to fights with other residents) and a need to remain compliant with medication were identified. His risks were deemed to be low/medium.
6. **17 January 2012:** Mr X had been involved in a knife incident at the hostel over Christmas and the police were called. The hostel Key Worker called the CMHT Care Coordinator on 17 January (see chronology above) and it was agreed that a review with the CMHT Consultant Psychiatrist needed to be arranged. This review did not appear to take place (although a CPA was held on 22 February - to which Mr X did not attend) and it does not appear the knife incident was discussed.
7. **12 April 2012:** a risk assessment was conducted at the SAU. Mr X's risks were all deemed to be low.
8. **15 August 2012:** Mr X was reviewed at the SAU. His risks were deemed to be low. He appeared to be stable and well kempt.
9. **1 November 2012:** a CPA review was held by the CMHT. No risks were noted.
10. **15 November 2012:** the SAU conducted a risk assessment. All of his risks were deemed to be low. A referral to Adult Social Care would be made if Mr X's vulnerability increased in the future and a harm reduction plan was to be developed.
11. **2 May 2013:** a CPA review was held. Even though Mr X was still hearing voices and experiencing persecutory thoughts he denied having any thought of harming anyone despite his previous history of carrying a knife. The assessment did not identify Mr X as posing a risk to any other vulnerable adults. No symptoms were identified as indicators of increased risk of harm to other people.
12. **4 June 2013:** a risk assessment was conducted by the SAU. No risk behaviours were identified.
13. **13 June 2013:** the hostel conducted a review. Mr X appeared to be well and no risks were identified.

12.127. As can be seen from the long list above Mr X received risk assessment on a regular basis. Risk assessments were not always shared between the teams, but even so it can be evidenced that Mr X appeared to improve over an 18 month period. However whilst risk was regularly identified there was a distinct lack of formulation which addressed the potential outcome of any relapse of Mr X's Schizophrenia, his continued substance misuse and his chaotic lifestyle. Progress and recovery were deemed to be linear and did not

appear to consider the ongoing latent risks in connection with Mr X's known impulsivity, knife carrying and continued auditory hallucinations.

Mr Y

12.128. From an examination of the clinical record it would appear that Mr Y was subject to many formal recorded risk assessments. Between February 2009 and the time of his death in June 2013 the following took place:

- 1. 5 February 2009:** the Health E1 Homeless Medical Centre conducted a review. Risks were identified as being suicide (past attempts on his life were noted) blood borne viruses, criminality, unstable housing conditions and social isolation.
- 2. 22 May 2009:** the SAU conducted a review. Risks were noted to be high due to his lifestyle and substance misuse (poor physical health was noted in particular).
- 3. 20 January 2010:** Mr Y was risk assessed by the SAU. He had taken an overdose following the suicide of his partner. He was considered to be at current risk of suicide and self harm. All other risks were assessed as being in relation to his substance misuse habits and homelessness. A few days later he was risk assessed again and he was no longer thought to be at risk of suicide.
- 4. 9 April 2010:** the SAU conducted a risk assessment. Mr Y was deemed to be at chronic risk of suicide and also at risk from physical health problems. The contingency and crisis plans were to assess Mr Y if required (Key Worker and GP) and to refer to A & E if out of hours.
- 5. 23 August 2010:** Mr Y was seen by the SAU. He was not thought to be at risk of suicide or harming others.
- 6. 3 December 2010:** no new risks were identified.
- 7. 12 January 2011:** the SAU conducted a risk assessment. His risks of deep vein thrombosis and hepatitis were identified.
- 8. 13 June 2011:** a SAU risk plan stated that Mr Y was to continue with Diazepam detoxification and harm reduction strategies. Mr Y would use a needle exchange and practice safe sex. He would also refrain from injecting his drugs. Mr Y's mental state was to be monitored and support given in order to prevent suicide and if required appropriate psychiatric help would be sought. Mr Y's physical health would also be supported.
- 9. 12 – 19 December 2011:** a risk assessment was conducted by the SAU. Mr Y's physical health was identified as a key risk in that he had experienced deep vein thrombosis and had Hepatitis B and C.
- 10. 6 February 2012:** a risk assessment was conducted by the SAU. Mr Y's physical health was identified as a key risk in that he had experienced deep vein thrombosis and had Hepatitis B and C.
- 11. 25 July 2012:** a risk assessment was conducted by the SAU. Physical health, substance misuse and homelessness were identified as key risks (Mr Y was living on the streets at this time).
- 12. 17 – 27 September 2012:** the Outreach Team had concerns about Mr Y following his incident on railway tracks as he was thought to be suicidal. It would appear no in-depth risk assessment was conducted at this stage.
- 13. In October 2012:** three incidents of Mr Y fighting with residents at Daniel Gilbert house were noted by hostel staff. He was also dealing drugs from his bedroom.
- 14. 12 December 2012:** the SAU conducted a risk assessment - all risks appeared to be well managed at this time.

15.9 March 2013: the hostel conducted a risk assessment. Mr Y's risks were deemed to be high in relation to self neglect and dangerous behaviour (such as sexually inappropriate behaviour and angry outbursts). Mr Y was aware that his lifestyle would probably kill him.

12.129. Mr Y received regular risk assessment. It is evident that a comprehensive set of plans were in place to work with the risks associated with his lifestyle and substance misuse. Mr Y was a capacitous adult and although he frequently suffered from depression and made impulsive attempts on his life, it is difficult to see what else his treating teams could have done to keep him safe. Clear monitoring plans were in place and arrangements identified to intervene in a crisis.

12.130. What was not so well understood was Mr Y's role as an instigator of violence and criminality. The 'cheeky chappy' persona that he presented with may not have been an accurate representation. It is obvious from reading through his health and housing records that he was sexually inappropriate, aggressive and provocative. This served to place both him and the people around him at increased risk especially in the context of Daniel Gilbert House which contained many vulnerable people with impulse control issues and mental illness.

Conclusions

12.131. Both service users had risk assessments conducted on a regular basis and both service users could be seen to have stabilised either by virtue of their improved mental health and/or social circumstances. This was a positive feature of their care and treatment and should not be underplayed. The health and housing teams should be commended for the unswerving attention both Mr X and Mr Y received over the years. This was good practice.

12.132. However the Independent Investigation concluded that there was a certain degree of resignation on the part of all services involved in relation to criminality, weapon carrying and the consequent risks. Mr X and Mr Y both held latent risks with regards to their potential for violence. For Mr X the risk revolved around his Schizophrenia and auditory hallucinations which were never totally in abeyance. For Mr Y it revolved around his impulsivity, lifestyle and criminality (principally drug dealing). It would have been good practice if these risks had been more openly acknowledged together with a clear rationale explaining the limitations of NHS and care services. A clear omission was the marked lack of ongoing liaison with probation services for both Mr X and Mr Y over the years.

12.133. While risks were assessed on a regular basis the prevailing view appeared to be that progress was a linear feature and not enough attention was given to relapse. Another feature that will be addressed in section 12.8 is the collective risk often to be found in hostel accommodation and the increased risks that present when individuals such as Mr X and Mr Y are domiciled together.

12.134. Whilst the death of Mr Y was not predictable, based upon what was known and what should have been known about Mr X and Mr Y, a violent incident of some kind definitely was - if not involving each other then with different people under different circumstances. The Independent Investigation

Team recognised that sadly this was probably something that even the tightest of risk management processes would not have been able to prevent. However it must be emphasised that had a clear contingency and crisis plan been in place for Mr X on the night of 21 June 2013 then a more robust stance could have been taken – this is an important general lesson for learning for all Tower Hamlets services for the future.

12.135. That being said on the night of Mr Y's death Mr X's agitation appeared to diminish quite rapidly and hostel staff felt the situation had resolved. It should also be noted that Mr X was not directing his anger towards any individual and Mr Y was not in the building when Mr X lost his temper. Of particular relevance is the fact that no assessment has ever been able to determine whether Mr X was mentally ill at the time of the homicide to the extent that his capacity was diminished. The Court found Mr X guilty of murder and no mitigation was made in relation to his mental health diagnoses. To this end the Independent Investigation concludes that while there are lessons for learning regarding risk assessment processes the death of Mr Y could not have been either predicted on the night of the 21 June 2013 or prevented.

- ***Service Issue One: risk assessment and management processes did not provide a comprehensive formulation that took into account the whole diagnostic picture for both Mr X and Mr Y. Risk assessment was seen as a linear trajectory and did not take fully into account latent risk in the context of relapse and chaotic lifestyle. On occasions the risk assessment process, whilst providing lists of issues, did not always end in comprehensive management plans.***

12.6. Safeguarding

Context

National Context

12.136. Safeguarding Adults is a responsibility placed on Local Authorities by Section 7 of the Local Authority and Social Services Act (1970). Through this legislation, statutory social care organisations have a duty of partnership to work with other statutory bodies, the NHS and the police, to put in place services which act to prevent abuse of vulnerable adults, provide assessment and investigation of abuse and ensure people are given an opportunity to access justice. The Department of Health issued its guidance *No Secrets* in 2000. This guidance notes:

“The aim should be to create a framework for action within which all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety”.

12.137. Following national consultation in October 2008, the Department of Health published a document which tied existing systems of Clinical Governance into Adult Safeguarding in order to clarify responsibilities and expectations of NHS staff in relation to this issue. By 2010, Local Authorities were expected to have an Adult Safeguarding Board/Committee and a

safeguarding framework/procedure in place. Social care staff would be expected to be trained in this area of work and familiar with adult safeguarding policies and procedures.

12.138. There was a clear expectation from the Department of Health that *No Secrets* would apply to all statutory agencies; however it took sometime before it was fully implemented in the NHS. In the preamble to the Safeguarding Adults: A National Framework of Standards it is noted that:

“All persons have the right to live their lives free from violence and abuse. This right is underpinned by the duty on public agencies under the Human Rights Act (1998) to intervene proportionately to protect the rights of citizens. These rights include Article 2: ‘the Right to life’; Article 3: ‘Freedom from torture’ (including humiliating and degrading treatment); and Article 8: ‘Right to family life’ (one that sustains the individual).

Any adult at risk of abuse or neglect should be able to access public organisations for appropriate interventions which enable them to live a life free from violence and abuse. It follows that all citizens should have access to relevant services for addressing issues of abuse and neglect, including the civil and criminal justice system and victim support services”.

Local Policy in Place at the Time Mr X and Mr Y were Receiving Care and Treatment from the Trust

12.139. The Trust has its own Safeguarding Vulnerable Adults at Risk Policy Guidance document. The policy is designed to be the overarching document that staff need to refer to for clarification of Trust commitments, and should be read in conjunction with Protecting adults at risk: *London multi-agency policy and procedures to safeguard adults from abuse*, otherwise known as the Pan London procedures.

12.140. Vulnerable Adults/Adults at risk were described thus:

“These interchangeable terms are defined in No Secrets (1) and Protecting adults at risk (2) as an adult aged 18 or over ‘who is or maybe in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.’ The recent emphasis has been to take account of how different environments can impact on a person’s vulnerability and that a person may not always be vulnerable in every situation. In practice, staff will need to consider whether a service user is likely to be vulnerable or at risk either in the community in which they live or within a hospital ward or other service. Determining this is the first trigger as to whether using the safeguarding procedures should be considered as appropriate”.

12.141. The policy set out clearly what constitutes abuse, neglect and domestic abuse together with the roles and responsibilities of East London NHS Foundation Trust staff.

Findings

Findings of the Internal Investigation Process (Serious Incident Review Report)

12.142. The internal investigation process recognised that safeguarding and vulnerability were key issues that needed to be addressed. To this end the East London NHS Foundation Trust and the London Borough of Tower Hamlets jointly commissioned reviews into the care and treatment Mr X and Mr Y received.

12.143. However the investigation report format did not allow for safeguarding issues to be addressed. This meant that certain safeguarding cues were absent and consequently were not explored. There are no specific analyses of either safeguarding or vulnerability. In the report prepared for Mr Y it is noted that his lifestyle rendered him more vulnerable to an act of homicide but this falls short of an actual examination.

12.144. The reports however did say *“the provider [hostel] may need to develop its policy and procedure [regarding CPA and residents with mental health and substance misuse problems] for those deemed to be vulnerable adults to ensure that there is a model of support and intervention that sits beneath the identification of those with increased support need”*.

12.145. The reports made the following recommendation *“LBTH should develop guidelines with their supported accommodation providers for supporting vulnerable adults within their services. The guidelines should be developed in consultation with the relevant ELFT teams, the CMHT, the SAU, Health E1 and the BBV team”*.

Findings of the Independent Investigation Team

12.146. During the course of the Independent Investigation frequent attempts were made to clarify whether or not Mr X and/or Mr Y were actually considered as Vulnerable Adults/Adults at Risk. A key finding of this Investigation is that different teams and services all worked to a different notion of what safeguarding and vulnerability thresholds might be.

12.147. Each NHS team and hostel worker, when reviewing Mr X and Mr Y, always considered vulnerability as part of the ongoing risk assessment process. This was good practice. It would appear that when considering abuse and neglect neither service user met the threshold for intervention. However this still begs the question as to whether either service user should have been identified formally as a Vulnerable Adult/Adult at Risk as part of a risk profiling exercise.

12.148. Witnesses from Daniel Gilbert House were of the view that all individuals eligible for Supported Living should be deemed as Vulnerable Adults/Adults at risk. However they recognised that the Local Authority threshold might not allow for this and formal interventions when difficult situations at the hostel arose were not always easy to access.

Conclusions

12.149. Whether Mr X or Mr Y met the threshold or not may not help local services to understand better how best to work in the future with service users of this kind. Both Mr X and Mr Y were capacitous and able to make decisions

about their lifestyles – even if these were often destructive. The levers available from a formal safeguarding stance would not have been able to support them most of the time.

12.150. The Independent Investigation Team was also told that there was a prevailing notion that Supported Living somehow kept people safe and that nothing else needed to be considered. It would appear that no formal multiagency consideration or review took place to consider vulnerability of individuals and that all services/agencies who delivered care did so without a clear understanding of thresholds. It would appear that whilst NHS and Hostel workers bore vulnerability in mind there was no process as to how to apply this in action unless a very definite trigger was apparent.

12.151. The Independent Investigation Team also concluded that the collective risk and safeguarding concerns for Daniel Gilbert House were understood poorly by health partners. Whilst the hostel was providing a service to Vulnerable Adults and those rendered vulnerable by virtue of their lifestyle little consideration was given to how individuals safeguarding risk could be elevated by being in a hostel environment rather than being managed and supported by it.

12.152. It would not be appropriate for the Independent Investigation Team to undertake a retrospective review regarding the vulnerability of Mr X and Mr Y especially as no analysis of this was undertaken by the internal investigation process closer to the time of the incident. However we conclude that whilst vulnerable neither Mr X nor Mr Y met a threshold in the months before the homicide that could have triggered a response to prevent Mr Y from being killed. However the incident does raise the issue that safeguarding processes need to be understood better by all services particularly in relation to supported living facilities and those receiving substance misuse and secondary care mental health services.

- ***Service Issue Two: whilst NHS and hostel workers had distinct notions of what constituted a Vulnerable Adult/Adult at Risk it was evident that different notions were held. How safeguarding processes need to be operated in the future for individuals such as Mr X and Mr Y need further clarification so that they can be applied in day-to-day practice.***

12.7. Housing and Interagency Working

Context

12.153. Supported living is a combination of housing and support services provided to help people to be independent, have choices, and take control of their own lives. Daniel Gilbert House is a supported living hostel for homeless, vulnerable adults. It is spread over four floors, and at the time Mr X and Mr Y lived there residents' accommodation comprised a small bedroom and shared bathrooms on each corridor.

12.154. The target group for Daniel Gilbert House comprises single homeless people with support needs, including people with alcohol, drug or mental health issues, ex-offenders, women with a history of sex working and people

with complex needs. In order to be eligible potential residents must have a local connection to the London Borough of Tower Hamlets.

12.155. The hostel provides 24 hour waking cover and a Key Worker system for up to 87 residents – some 12 or so are subject to CPA at any one time. Each Key Worker has around 16 residents on their caseload and each resident is provided with between four - five hours of personalised support each week with a dedicated Key Worker session is held every month. Action plans with agreed outcomes are developed for each resident and reviewed quarterly. Staff can provide support with alcohol, drugs, physical health, mental health, self-care, social care, meaningful occupation, financial management and life skills.

12.156. One staff member specialises in substance misuse and another specialises in mental health. Other support sessions in alcohol, drug and mental health are run by external workers. A resettlement officer is also based on-site to provide support around move-on arrangements and six months follow-up.

Findings

Findings of the Internal Investigation Process (Serious Incident Review Report)

12.157. The internal investigation made a series of findings in relation to Daniel Gilbert House.

- 1.** Mr X had maintained his tenancy for three years and was managing his finances better although engagement around his activities of daily living remained limited.
- 2.** There was limited communication between E1, the BBV team, the SAU and the CMHT with the hostel Key Workers in relation to appointments, compliance with prescribed treatment and incidents regarding weapon carrying (in the case of Mr X). All involved agencies were found to bear responsibility for this.
- 3.** Hostel staff were unaware of how to contact out of hours emergency mental health services.
- 4.** The hostel used an electronic recording system which was not always kept up-to-date from the hard copy daily logging process.
- 5.** Mr X's long-term hostel Key Worker left the scheme and there was a significant period of time prior to a new worker being allocated. The monthly minimum meeting with Mr X did not appear to have taken place in the months leading up to the incident. Both the SAU and the CMHT each believed a different worker was acting up.
- 6.** Hostel accommodation has not historically supported people on CPA and that there is no established process in place for a shared set of understandings of expectation between organisations (CMHT, SAU and hostel etc.).
- 7.** Housing and the London Borough of Tower Hamlets need to revise policy and process in relation to vulnerable adults to include staff skills and training – together with a more assertive and personalised model of support that is delivered within the principals of a recovery model.
- 8.** Communication between health, local authority and third sector providers needs to be improved to optimise care for people with serious mental

health and/or substance misuse problems and attending the SAU or subject to CPA.

9. No act or omission on the part of the hostel staff bore any causal relation to the death of Mr Y.

Findings of the Independent Investigation Team

12.158. The Independent Investigation found that Daniel Gilbert House had a full suite of appropriate policies and guidance, such as, safeguarding, room searching, weapons policies, risk assessment and notifiable incident reporting procedures.

12.159. It was apparent from reading though the clinical and housing records that both Mr X and Mr Y appeared to have experienced an improvement in their social circumstances and wellbeing and this was in no small part due to the input they received at Daniel Gilbert House. It was evident that regular meetings took place between the two service users and their Key Workers (notwithstanding the difficulties with Mr X's Key Worker input during the first part of 2013) and that both men built up trusting and therapeutic relationships with them. The standard of care planning, needs and risk assessment was good providing evidence for a detailed and progressive system of working. There was also ample evidence to demonstrate that the Key Workers involved were both experienced and skilled; this was noted in particular in relation to the first Key Worker that Mr X was allocated during the first two years of his placement.

Mr X

12.160. Witnesses told the Independent Investigation that Mr X was on an assured short-hold tenancy. On an assured short-hold tenancy hostel staff have to give the service user notice in most cases (unless there are concerns for their safety) to enter their room or bedsit areas. Privacy and access issues were set out within Mr X's license which limited staff access to his personal space. Such a tenancy would be rare today within a hostel context with licenses usually allowing staff the right of entry. Had the hostel been aware of his weapon carrying then a different contract might have been negotiated at the outset.

12.161. Witnesses told the Independent Investigation that all of the residents at the hostel were deemed to be vulnerable and that a list was maintained to identify those with the highest levels of need. This was good practice. Initially Mr X had been placed on this list due to his mental health and drug taking problems. Those on the list would be discussed by the hostel team and met with every day to ensure that all was well. Mr X disliked what he saw as constant checking and asked to be removed from such monitoring as it disturbed him. To this end Mr X was encouraged to seek staff out himself everyday so that checks could be made in a less intrusive manner. At the time Mr X lived at Daniel Gilbert House there were no routine arrangement in place for sharing any of the risk assessment documentation or risk concerns with the CMHT. We were told that this has recently changed and that all documentation is now shared with the CMHT Care Coordinator if a resident is subject to CPA.

12.162. When Mr X first came to Daniel Gilbert House he was not on CPA. However witnesses told us how this arrangement would have worked once he

had been placed on it. At the time Mr X lived at the hostel most communication with the SAU or the CMHT was either managed informally by the hostel Key Workers or via written communication made directly to the hostel manager. Invitations to CPAs were often provided at short notice and on pre-set days which meant Key Workers were often not available to attend. In the case of Mr X the CMHT would often write directly to him and hostel staff would not know what had been planned unless he decided to share the information. At no time did anyone from the CMHT make a visit to Mr X at the hostel to assess him in the context of his accommodation and living conditions and talk directly to hostel staff.

12.163. At interview we were told that hostel staff had not been consulted about the plan to discharge Mr X from CPA and that no one had been invited to the 2 May 2013 meeting. Had a Key Worker been consulted then the advice would have been to perhaps wait a little longer to ensure Mr X's improvement could be maintained. The hostel only found out that Mr X had been removed from CPA when he himself later volunteered the information to his new Key Worker. However that being said at the time no one at the hostel thought this was necessarily the 'wrong' decision to have taken and saw it as an ongoing sign of his improvement.

12.164. At present the Bethnal Green CMHT is making more effort to write to the hostel in advance of CPA reviews and Key Workers try to attend if given sufficient notice. CPA documentation is now shared, providing the hostel requests it, and hostel staff currently make contemporaneous notes detailing the content of CPA meetings that they attend in order to expedite the communication process within the Daniel Gilbert House team.

12.165. One of the issues to arise from Mr X's trial was that of his self-reported medication non-compliance in the months preceding the killing of Mr Y. We were told that residents coming to Daniel Gilbert House were expected to be able to manage their own medication as the hostel was not registered to supervise this aspect of care. From a medication management point of view hostel staff consistently reinforced the message to Mr X that full compliance with his antipsychotic medication was important. However hostel staff were limited in how far they could reasonably go in relation to medication compliance. Key Workers would ask Mr X if he had taken his medication and would have to be satisfied when he said he that he had. There were ongoing arrangements with the Health E1 Homeless Medical Centre to flag up when a resident was not collecting medication from the practice, however apart from this the hostel had no other powers to intervene apart from the day-to-day monitoring of apparent health and wellbeing.

12.166. In the days before the killing of Mr Y Mr X appeared to be well. There were no indications that his mental health was deteriorating. On the night of the incident Mr X become angry and the police were called, they however declined to make a visit as no crime had been committed and suggested that the mental health team be contacted instead. The Bethnal Green CMHT number was called – but this went through to voicemail. It was apparent hostel staff did not know how to contact emergency mental health out of hours services. In the event Mr X calmed down, apologised to staff and the situation appeared to resolve itself. None of the hostel staff had any idea that Mr Y had been killed until later the following day when his body was found.

Mr Y

12.167. Hostel staff described Mr Y as a likeable person who appeared to have settled down well at Daniel Gilbert House. During his time living at the hostel Mr Y was placed on the 'vulnerable' list due to his poor physical health. However Mr Y was not found until the day after he was killed. Although his room had been checked every shift he was not there. Mr X was no longer on the list and so was not checked up on until later the following day when Mr Y's body was found in his room.

In General

12.168. During the time Mr X and Mr Y lived at Daniel Gilbert House there were some 90 residents. Two workers would be on a 'waking shift' at night and between two – four workers would be present during the day (two of which would usually carry out management functions). All staff received regular training based upon their role and identified need. New staff also received an induction programme and the housing provider with whom Daniel Gilbert House sits was recently recognised with a silver Investors in People award (an independent human resource management quality benchmark). Recent examples of training include:

- drugs and alcohol;
- mental health;
- safeguarding;
- the Care Act;
- risk assessment;
- de-escalating challenging/violent behaviour;
- motivational interviewing;
- Cognitive Behaviour Therapy.

Conclusions

12.169. The Independent Investigation Team concludes that the care provided at Daniel Gilbert House to Mr X and Mr Y was of a good standard. Key Workers got to know both men well and it was evident that they had built up trusting relationships which provided a degree of stability and security in their lives.

12.170. Whilst concurring with the findings of the internal investigation reports the Independent Investigation Team also found that in the months prior to Mr X's discharge from CPA the process as operated by the CMHT was weak. It was evident that the CMHT did not recognise the hostel as a key stakeholder in relation to Mr X's care pathway and that while the CMHT recognised the fact that the hostel was a significant protective factor for Mr X not enough was done to ensure that the essential safety net it provided could work effectively. No accommodation-based assessment was conducted as set out in the 2 May 2013 plan and no contingency or crisis plan was made available to the hostel staff. The CMHT as part of a statutory agency had a clear responsibility to take the lead on this.

12.171. The Independent Investigation heard about the work that was in train to improve communication between NHS mental health services and the hostel. It would appear that CPA processes have been improved with ongoing liaison now taking place between the Bethnal Green CMHT and Daniel Gilbert House. It would also appear that a more streamlined set of guidance is now

available to ensure residents at the hostel can access emergency out of hours services with direct support from secondary care mental health providers. This is good practice.

12.172. Despite the difficulties in accessing secondary care mental health services on the night Mr Y was killed the Independent Investigation concludes that no act or omission provided a causal link to his death – this is mainly due to the fact Mr X was not considered by the Court to not have been incapacitated by a mental illness at the time he killed Mr Y. However it is a significant lesson for learning that hostels such as Daniel Gilbert House manage high levels of risk on a day-to-day basis with limited staff numbers and many vulnerable adults under one roof. It is essential that services such as this are visible to secondary care mental health services and robust communication, protocols and procedures are developed between them to ensure the continued safety of hostel staff, residents, and members of the public.

- ***Service Issue Three: Daniel Gilbert House was not always considered to be a key stakeholder in the care and treatment of Mr X. The role of the hostel in acting as a protective factor was understood poorly and not always recognised by the CMHT.***

12.8. Service User Involvement in Care Planning and Treatment

Context

12.173. The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that: “... *the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes*”.

12.174. In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that “... *people with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care*”. It also stated that it would “... *offer choices which promote independence*”. Good practice also requires care and treatment planning and delivery to be person-centred and sensitive to both cultural and social diversity issues.

Findings

Findings of the Internal Investigation Process (Serious Incident Review Report)

12.175. This aspect was not examined by the internal investigation team.

Findings of the Independent Investigation Team

12.176. The Independent Investigation Team found that both Mr X and Mr Y were treated at all times by all services with respect, kindness and courtesy. Attempts were made on a constant basis to ensure full engagement was maintained no matter how chaotic either service user was in presentation. Complex mental and physical health conditions were managed by workers

across all teams in a consistent manner that provided care and treatment against a backdrop of very challenging social conditions. It was evident that both service users had their preferences taken into account and that they were involved fully in care planning and treatment. This was notable practice.

12.177. However the Independent Investigation found no mention in the clinical record of any attempt ever having been made to understand Mr X in the light of his asylum seeker/refugee status. Levels of professional curiosity were low and no consideration of stigma, guilt, masking of symptoms, denial of symptoms etc. (common features in people from East Africa) is evident in the clinical record. Had this been achieved Mr X might have been understood better in the context of his mental illness.

Conclusions

12.178. Following the killing of My Y Mr X was remanded to HMP Belmarsh Prison. However he was transferred to the John Howard Centre (a medium secure forensic unit in east London) when his psychosis became apparent. This offered the first opportunity to assess Mr X under close observation for an extended period of time. Whilst in prison Mr X had not been taking his antipsychotic medication. He was reluctant to take medication as he did not think it had ever made any real difference to his constant auditory hallucinations. The John Howard Centre confirmed the diagnosis of Paranoid Schizophrenia/Schizo affective Disorder. It was also noted that he consistently denied any responsibility for the index offence during his time at the John Howard Centre hence no one was able to establish from him any causative explanation as to why he killed Mr Y. However his mask-like face and lack of emotion - that the police and Court saw as signs of malingering and signs of wellness - was deemed by the John Howard Centre as being a negative symptom of Mr X's Schizophrenia. It is entirely probable that over the years Mr X's calm and reserved demeanour, instead of demonstrating wellness and recovery, was a negative symptom that masked significant problems.

12.179. Mr X's presentation and consistent denial of symptoms and/or their relevance is common for people from East Africa. It was evident that hostel staff who spent time with Mr X were able to get 'underneath' some of his issues when he confided that he isolated himself because it was the only way he could manage his auditory hallucinations. It is an important lesson for learning that individuals like Mr X need an in-depth period of assessment and diagnostic formulation that is made by staff teams who are culturally competent.

- ***Contributory Factor Four: despite being with secondary care mental health services for many years it would appear that Mr X was not understood fully in the context of either his ethnicity or his mental illness.***

12.9. Family Concerns and Involvement

Context

Carer involvement

12.180. The recognition that all carers require support, including carers of people with severe and/or enduring mental health problems, has received

more attention in recent years. The Carer (Recognition and Services) Act 1995 gave carers a clear legal status. It also provided for carers who provide a substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. It ensured that services take into account information from a carer assessment when making decisions about the cared-for person's type and level of service provision required.

12.181. Further to this, The Carers and Disabled Children Act 2000 gave local councils mandatory duties to support carers by providing services directly to them. It also gave carers the right to an assessment independent of the person they cared for.

12.182. The Carers (Equal Opportunities) Act 2004 placed a duty on local authorities to inform carers, in certain circumstances, of their right to an assessment of their needs. It also facilitated cooperation between authorities in relation to the provision of services that are relevant to carers.

12.183. In particular in mental health, Standard Six of the NHS National Service Framework for Mental Health (1999) stated that all individuals who provide regular and substantial care for a person on CPA should:

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis;
- have their own written care plan which is given to them and implemented in discussion with them.

Findings and Conclusions

Findings of the Internal Investigation Process (Serious Incident Review Report)

12.184. The internal investigation identified that no family or friends were known for Mr X as he had not maintained contact with them since leaving Eritrea. In the case of Mr Y it was acknowledged that he had recently established contact with his family again and that this was regarded as a positive feature in maintaining his wellbeing.

Findings and Conclusions of the Independent Investigation Team

12.185. The Independent Investigation Team has little to add. Neither Mr X nor Mr Y had any family or friends who could be identified as carers. In the case of Mr Y the SAU acted in an exemplary manner in that on the three occasions Mr Y made plans to visit his mother a telephone call was made to her in advance to ensure child safeguarding issues were assessed, Mr Y's Methadone was managed safely and any risks pertaining to his behaviour and physical condition were understood. This was good practice.

12.186. However as a general point of learning it should be remembered that individuals such as Mr X and Mr Y who are socially isolated require more effort to be made by NHS teams to engage formal paid carers (such as hostel staff in supported living schemes) who represent a significant protective factor in recovery and the maintenance of wellbeing.

- ***Service Issue Four: formal paid carers were not always incorporated into care and treatment planning and the maintenance of recovery.***

12.10. Documentation and Professional Communication

Context

Documentation

12.187. The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have issued clear guidance regarding clinical record keeping. All of the other statutory regulatory bodies governing all other health and social care professionals have adopted similar guidance. The GMC states that:

*“Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off”.*⁸⁵

12.188. Pullen and Loudon writing for the Royal College of Psychiatry state that:

*“Records remain the most tangible evidence of a psychiatrist’s practice and in an increasingly litigious environment, the means by which it may be judged. The record is the clinician’s main defence if assessments or decisions are ever scrutinised”.*⁸⁶

Professional Communication

12.189. *“Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion”.*⁸⁷

Jenkins *et al* (2002)

12.190. Jenkins *et al* describe the key interagency boundary as being that between secondary and primary care. The Care Programme Approach when used effectively should ensure that both interagency communication and working takes place in a service user-centric manner.

12.191. Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and/or have a history of criminal offences cannot be met by one agency alone.⁸⁸ The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively.⁸⁹ The Department of Health *Building Bridges* (1996) set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required.

85. <http://www.medicalprotection.org/uk/factsheets/records>

86. Pullen and Loudon, *Advances in Psychiatric Treatment*, Improving standards in clinical record keeping, 12 (4): (2006) pp 280-286

87. Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) p121

88. Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing*, Institute of Health Services, (1999) p 144

89. Ritchie *et al* *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

Findings

Findings of the Internal Investigation Process (Serious Incident Review Report)

12.192. Communication was a key finding for the internal investigation. It was found that while communication was of a generally good standard between the four NHS teams this was not the case in relation to information sharing with the hostel. It was noted that all agencies shared a responsibility for this. It was also identified that there were issues with the hostel's recording system in that hard copy daily logs were not always transferred into the electronic record in a timely manner. Other issues included the hostel using informal communication processes which needed to be reviewed in the light of increasing requirements under CPA.

Findings of the Independent Investigation Team

Documentation

12.193. The Independent Investigation Team found the documentation maintained by the four NHS services and the hostel (notwithstanding the issues identified by the internal investigation team) to be of a good general standard over time. This was good practice.

12.194. On careful examination it was apparent that letters between NHS teams were sometimes delayed by up to a period of eight weeks and this appears to have been due to overloaded administrative systems. It was not possible to determine whether or not this had a direct detrimental effect on the care and treatment provided to either Mr X or Mr Y over the years.

Professional Communication and Interagency/Service Liaison

12.195. Professional communication between NHS services was of an overall good standard. This was in no small part due to the fact that the SAU, CMHT, BBV and Health E1 Homeless Medical Centre were provided by the same Trust, were located close to each other and had been able to build up robust working relationships over the years. Whilst on occasions risk assessment and care planning may not have been as joined up as they could be this should not detract from the fact that NHS services were able to provide a relatively seamless service to two chaotic service users. This was good practice.

12.196. As has already been discussed in sections 4, 5 and 7 above professional communication between the NHS and hostel services was not always optimal. However witnesses from the hostel were at pains to say that the Health E1 Homeless Medical Centre was always responsive and that good professional communication was always maintained between them.

12.197. Communication between the Bethnal Green CMHT and the hostel (in relation to Mr X) was of a poor standard between November 2012 and the time of Mr Y's death in June 2013. It would appear that this occurred for a number of reasons:

- informal communication arrangements on the part of both agencies;
- an overreliance on the service user to act as a bridge between the two agencies;
- a change of Care Coordinator (CMHT) and Key Worker (hostel) personnel at approximately the same time during 2012 – breaking continuity;

- a lack of routine documentation sharing (CPA documentation from the CMHT and risk assessment forms from the hostel);
- a failure to invite hostel workers to CPA meetings in a consistent manner;
- the failure to consult hostel staff regarding decisions made by the CMHT (such as Mr X's discharge from CPA);
- the failure to visit the hostel in accordance with the 2 May 2013 plan in order to identify and develop appropriate contingency and crisis plans;
- the failure to communicate the 2 May 2013 crisis plan to the hostel.

Conclusions

12.198. The Independent Investigation Team concludes that on the whole both documentation and professional communication was of an overall good general standard over the years between NHS services. Whilst we accept the notion (as identified by the internal investigation) that all agencies had a responsibility to ensure communication flowed well between them our conclusion is that whilst Mr X was subject to CPA and Care Coordination an additional responsibility was placed upon the CMHT to ensure that this was conducted in a robust manner. This is after all a key tenet of CPA and Care Coordination and is an expectation held nationally. Therefore we conclude the main responsibility for failures in communication between November 2012 and June 2013 rest with the CMHT.

12.199. The Independent Investigation Team was told by witnesses how things have improved in service delivery since the homicide of Mr Y. Communication has improved considerably with formal processes now being adhered to. Whilst there is some evidence to suggest the new approaches still require a period of embedding it would appear that lessons have been learned from Mr Y's death to ensure that similar professional communication issues will be less likely to occur again.

- ***Service Issue Five: a core role of a Care Coordinator is to act as a key liaison conduit between agencies and services. This is an underlying tenet of CPA. Between November 2012 and 2 May 2013 communication processes were poor between the CMHT and the hostel. This served to prevent important information from being shared and meant that crisis planning was not fit for purpose.***

12.11. Adherence to Local and National Policy and Procedure

Context

12.200. Evidence-based practice has been defined as *“the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients”*.⁹⁰ National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

12.201. Corporate Responsibility: policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their

90. Callaghan and Waldoock, *Oxford handbook of Mental Health Nursing*, (2006) p 328

expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of Clinical Governance which is explored in section 12.12 below.

12.202. Team Responsibility: clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

12.203. Individual Responsibility: all registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any issues regarding the effectiveness of the said policies or procedures or to raise any implementation issues as they arise with immediate effect.

Findings

Findings of the Internal Investigation Process (Serious Incident Review Report)

12.204. This aspect was not examined by the internal investigation team.

Findings of the Independent Investigation Team

12.205. Both the Trust and the hostel had an appropriate set of robust policies and procedures in place. The policies recognised the national best practice context and were maintained with senior oversight.

12.206. There are three specific times when Trust policy was not adhered to. They are:

- 1.** The 2010 delay to the referral made by the SAU to the CMHT. This took over one year and a great deal of chasing when the referral should have been processed within 28 days (according to the CMHT operational policy).
- 2.** Benzodiazepine prescribing for Mr Y was not in accordance with the then Trust policy guidance in relation to his negative blood test results.
- 3.** The CPA process was managed poorly and was not in alignment with policy guidance in the run up to Mr X's discharge from CPA in 2 May 2013.

12.207. The lack of policy adherence could only be detected on the three occasions listed above. However each of the three occasions represented a serious departure from policy guidance and placed both Mr X and Mr Y at risk.

12.208. Apart from the three departures highlighted it should be noted that in general policy adherence appeared to be good and does not feature as a persistent finding throughout this investigation.

Conclusions

12.209. The Independent Investigation Team concluded that clinical care and treatment adhered to both local and national best practice policy guidance. There was ample evidence to suggest that policy was routinely adhered and well understood. The Independent Investigation was confident that Trust training and audit systems were (and are) robust and worked effectively to support good clinical practice.

12.12. Clinical Governance and Performance (to include clinical supervision, professional leadership and organisational change)

Context

12.210. *“Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish”*.⁹¹

12.211. NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

12.212. During the time that Mr X was receiving his care and treatment the Trust would have been subject to two main kinds of independent review from the NHS Regulator. The first kind of review took the form of an annual performance ratings exercise and the second kind took the form of a Clinical Governance evaluation. The reader is asked to look at the Care Quality Commission website for more information as to how the national performance framework is managed.

12.213. It is not the purpose of this Investigation to examine closely all of the Clinical Governance issues relating to the Trust prior to the death of Mr X. The issues that have been set out below are those which have relevance to the care and treatment that Mr X received.

Findings

Workforce Issues

12.214. Workforce issues were not cited by either the Trust Corporate Team or clinical witnesses as being a particular issue. The Independent Investigation Team was told that staffing and caseload numbers fell well within national best practice standards.

Clinical Supervision

12.215. The Trust sets out clear standards for leadership, support and development in its Organisational Development Strategy, Workforce Strategy, and policies for:

91 Department of Health http://www.dh.gov.uk/en/PublicHealth/Patientsafety/Clinicalgovernance/DH_114

Independent Investigation Mr X and Mr Y

- supervision;
- appraisal;
- mentoring and coaching;
- statutory and mandatory training;
- access to training and study leave.

12.216. Provision of appraisal and supervision in line with policy are closely monitored via a positive returns system, and regularly reported on to the Service Delivery Board.

Governance and Performance Issues

12.217. Despite operating in a challenged health economy in East London, the Trust is a high-performing organisation, based on regulatory and other national standards, as set out below. The Trust's success is based on the quality of its workforce, and in the 2014 National Staff Survey the Trust obtained the joint highest score in the country for overall staff engagement. The Trust has also successfully delivered a £41m Cash Releasing Efficiency Savings (CRES) programme from 2010-2014. In the context of increasing demand and resulting pressures on inpatient bed capacity across London, the Trust has maintained occupancy rates of 82.4 per cent (adults) and 62.9 per cent (older adults) in 2014/15 due to the quality and efficiency of its community and inpatient services.

Category	Indicator	Performance
Monitor	Finance risk rating (on a scale of 1-4, with 4 being the best)	4
Monitor	Governance risk rating (on a scale from green to red, with green being the best)	Green
Care Quality Commission	Number of standards that are assessed to be non-compliant following CQC inspections	Nil
Care Quality Commission	Risk banding (on a scale of 1-4, with 4 being the best)	4
National targets	National targets relevant to mental health and community services	Fully compliant
National staff survey	National ranking for overall staff engagement score	1st
National community patient survey	Overall national ranking	3rd

Governance Arrangements and Responsibilities

12.218. The Trust's governance structure was last reviewed between January and April 2012. This review took place in the context of a new system of regulation by the Care Quality Commission. It focussed on setting out a framework for governance activity to reflect the CQC essential standards and promote consistency in approach across Directorates, and between Directorates and Corporate functions. This was at a time of increased focus on patient and staff experience and outcomes, and the beginnings of a focus on quality improvement driven by Darzi's *High Quality Care For All* report, and

reflected in the CQC essential standards. Since 2012 the focus on quality, and quality improvement, has intensified internally and externally.

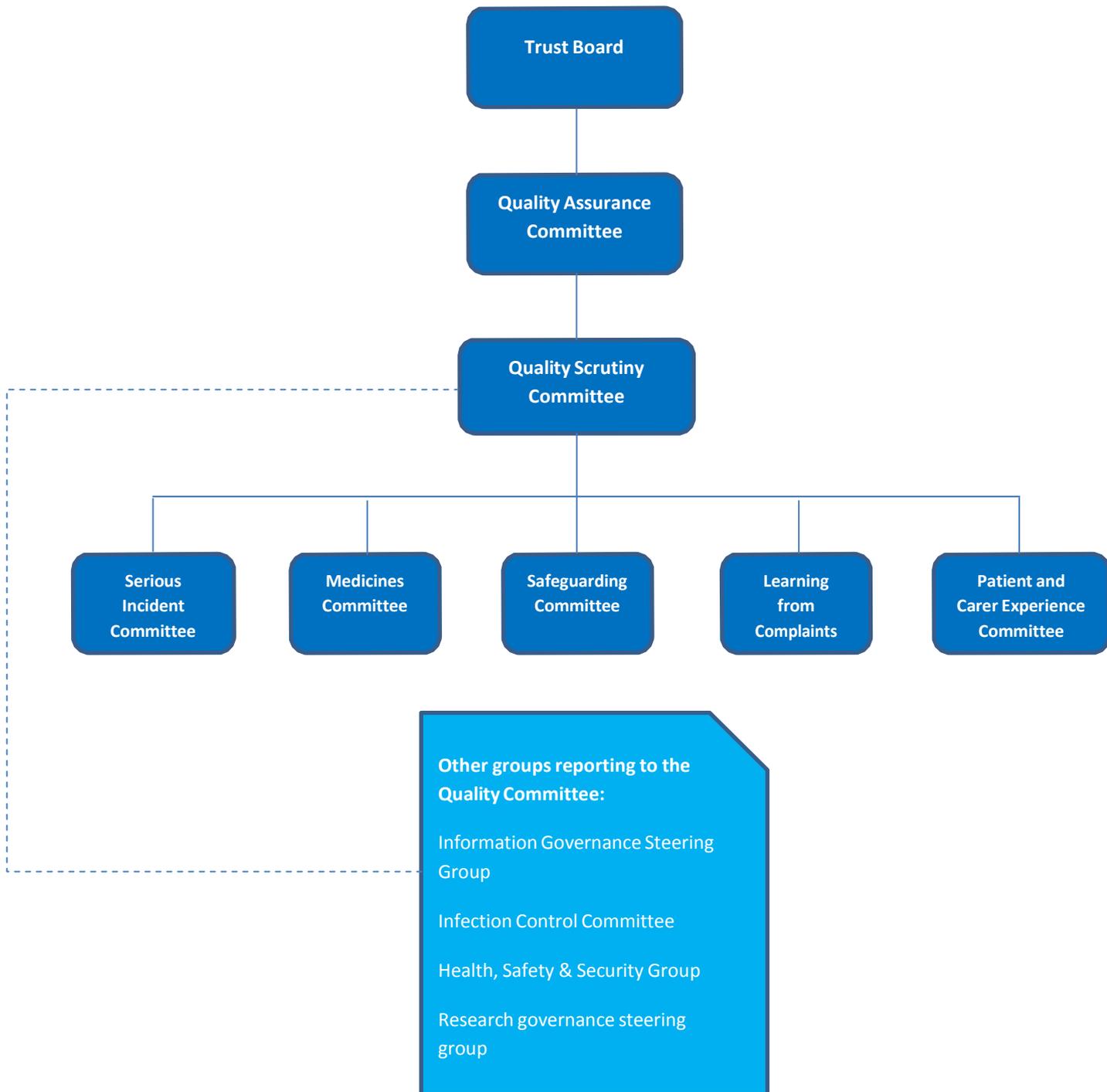
12.219. The Trust now has a clearly defined Quality Improvement programme, with explicit aims and a supporting structure in place. At the same time the CQC has renewed its approach to regulating and inspecting health and social care services. Governance structures were therefore further reviewed in light of these developments in June 2014.

12.220. The new structure is set out below, and reflects two separate but connected strands of work, quality improvement and governance/compliance. The challenge for any revised structure is to respond with clear definition and demarcation of responsibilities whilst acknowledging that neither strand of work takes place in isolation; a degree of integration of activity and data flow between improvement, governance (and performance) domains is essential to the achievement of the Trust's objectives, and the meeting of its statutory obligations.

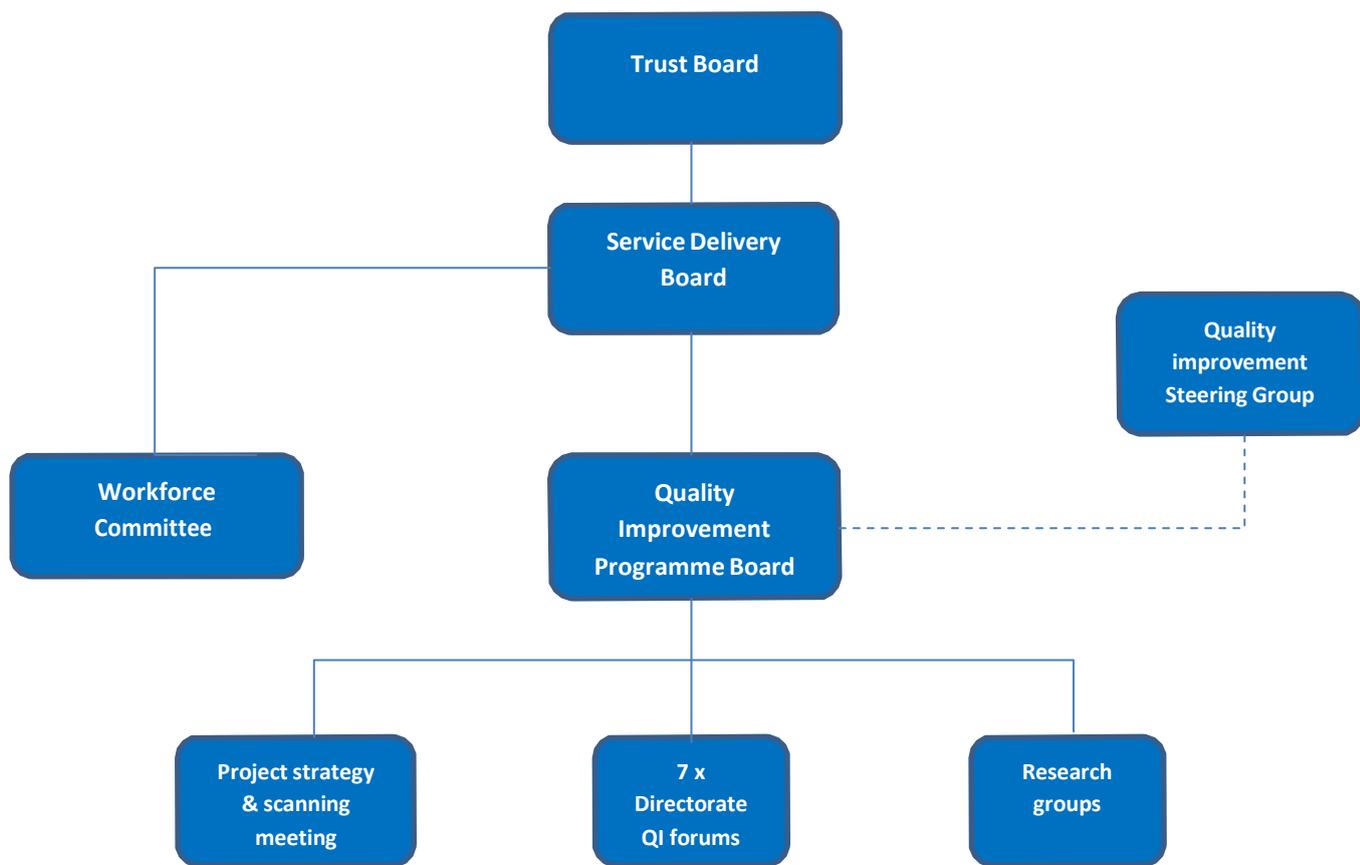
12.221. The Quality Assurance Committee is responsible for maintaining and monitoring the Board Assurance Framework, and oversight of compliance with clinical regulation (Care Quality Commission).

12.222. The Audit Committee is responsible for internal audit, and oversight of compliance with financial regulation and risk management (Monitor).

Governance and compliance structure



Quality Improvement Structure



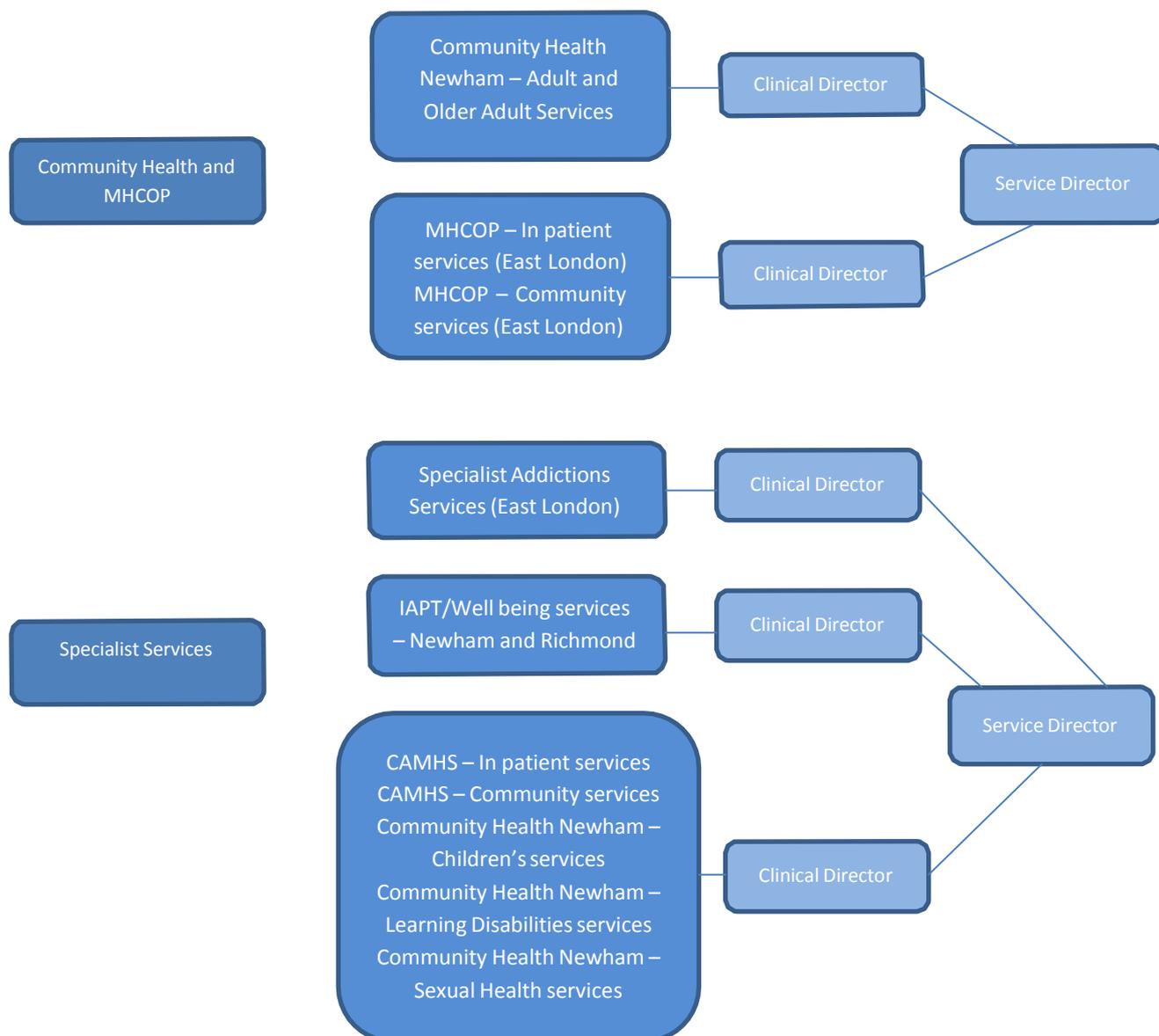
12.223. The Trust Quality Improvement programme is inextricably linked with its delivery of clinical services, its vision and values, and the achievement of its objectives. The Trust's Quality Improvement Strategy was approved by the Trust Board in December 2013. Since that time the Trust has invested in engaging staff and building capability in improvement, and is starting to see the results and develop a reputation for quality improvement.

Organisational Structure and Local Governance and Management Arrangements

12.224. The Trust is composed of eight Clinical Directorates, alongside a Corporate Services Directorate. Clinical Directorates are structured as below:



Independent Investigation Mr X and Mr Y



12.225. Each Directorate has Directorate Management Teams (DMT) which meet at least monthly, and a local governance structure beneath that, which comprises at least one Governance/Quality meeting, which may be broken down to sub-groups.

12.226. Each DMT maintains a risk register. Each Directorate Leadership has regular quality and performance meetings with the Executive, and will report annually on quality and risk to the Quality Assurance Committee.

Vision and Values and Strategic Objectives

12.227. The Trust’s vision, mission, and values are based on the core values of the NHS. They have been developed through engagement with staff as part of the Appreciative Inquiry project, consultation with the Council of Governors and learning from the Francis Inquiry.

ELFT's Vision:

"To be making a positive difference to people's lives"

ELFT's Mission:

"To provide the highest quality mental health and community care"

ELFT's Values:

"Our three core values are:

We Care:

Everyone is entitled to the highest quality care

We Respect:

Everyone should be treated with kindness and respect

We are Inclusive:

Everyone should have access to our services when they need them, and we actively seek suggestions from all on how we can improve"

"The following values support us in achieving our core values:

We Work Together:

Together with our service users, carers and partners we work as a team to promote the health, wellbeing and independence of the people we serve

We Strive for Continuous Improvement:

Our mission to deliver the highest quality services is a continuous process

We Discover and Share our Knowledge:

We encourage research and innovation to find new and better ways of treating people and keeping them healthy and well. We then share what we learn"

The Incident

12.228. The Trust told the Independent Investigation Team that it was saddened by the incident and was subsequently fully involved in the internal serious incident review. A statement was also provided for the Coroner's Inquest.

12.229. Learning has been disseminated in a number of ways. On completion of the Serious Incident review feedback meetings were held for the teams involved. This provided an opportunity for the service to review the care provided, discuss the care and service delivery problems and agree an action plan. As for all serious incident reviews the feedback meeting is an important part of the review process and affords the opportunity for the service to agree improvements to mitigate the risk of a reoccurrence of a similar incident. Review meetings are attended by the staff directly involved in the incident together with senior clinical and service management to ensure any lessons are disseminated across the directorate.

12.230. As for all incidents, further learning took place at the Trust's Serious Incident Committee where the review was discussed in detail. The Serious Incident Committee is attended by the Trust's clinical directors who provide valuable insight and are able to disseminate lessons learned to their own teams. Learning is subsequently further disseminated through directorate

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learning lessons events, Trust-wide learning events and through directorate management teams.

12.231. The Serious Incident review for this incident identified communication as a key issue. Since the incident considerable work has been done to ensure agencies communicate more effectively with each other. This includes a joint working agreement between CMHTs and hostels, clearly setting out responsibilities for each agency including information sharing, referrals process, care coordination and CPA. The Trust also circulated guidance for hostels on how to access support from CMHTs. Commissioner support was not necessary in developing these joint working arrangements as all agencies were willing to work together to improve communications.

12.232. Despite repeated attempts it was not possible to make contact with the victim's family. The only known details were a mobile telephone number for the victim's mother. The mother did not respond and the Trust did not have details for any other relatives.

Conclusions

12.233. The Independent Investigation Team concludes that the Trust's governance systems are robust and fit for purpose. It is evident that the organisation makes governance its core business and that it has been independently monitored over the years by both Monitor and CQC who have been able to confirm its high level of functioning. No connection was made in relation to any governance failures and the death of Mr Y.

13. Conclusions Regarding the Care and Treatment Mr X and Mr Y Received

Overview

13.1. Over the years both Mr X and Mr Y received compassionate care and treatment from both NHS and hostel services. The care and treatment was of a consistently good standard (generally in keeping with local and national best practice guidance) which ensured engagement was maintained so that it could be provided to two chaotic service users who were rendered vulnerable by virtue of both their lifestyle and diagnoses.

13.2. A particular feature was the excellent standard of care provided by the Health E1 Homeless Medical Centre, the Blood Borne Virus Team, the Special Addictions Unit and the hostel. The approach taken was notable practice and ensured that both service users, but Mr Y in particular, were maintained at their optimum levels of physical health. This was no easy task and the Independent Investigation commends the teams for their work.

13.3. Investigations of this kind take a longitudinal view of care and treatment over many years. It is inevitable that there will be findings that are made that show on occasions services did not always work as well as policy guidance suggests they should. However this is part of the normal day-to-day provision of

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mental health service and it is to the credit of all teams involved that these omissions are relatively few – even if they were serious in nature.

13.4. The Independent Investigation Team found that communication between the CMHT, the SAU and the hostel was not of a consistent standard in the months leading up to Mr X's discharge from CPA. This was unfortunate in that it left those providing ongoing care and treatment to Mr X somewhat 'in the dark'. However we note that Mr X was retained on the CMHT caseload and there were plans to monitor him into the future even if those plans had perhaps not been so clearly articulated to Mr X or to the other services who continued to be involved with him. The Independent Investigation Team concludes that this was primarily a failure of communication on the part of Care Coordination and the CMHT.

13.5. However that being said the Independent Investigation Team made no causal connection between any act or omission on the part of either NHS or hostel teams and the killing of Mr Y. On balance it would appear that the fatal altercation between Mr X and Mr Y was probably related to an unresolved drug debt. There is no evidence to suggest the homicide was psychotically driven and could therefore have been managed by a mental health team even had one been called to the hostel on the evening of 21 June 2013.

Predictability and Preventability

Predictability

13.6. Whilst it was predictable that a violent untoward incident of some kind was likely to occur in the lives of both Mr X and Mr Y at some stage, the killing of Mr Y on the evening of 21 June 2013 could not have been predicted.

Preventability

13.7. Even if an incident cannot be predicted it can often be prevented providing sound processes are in place such as care planning, risk assessment and crisis and contingency arrangements. Mental health services are required to ensure that specific safety nets are put into place in order to ensure the continued health and wellbeing of the service user and also the general public. Whilst the Independent Investigation Team concludes that more could have been done to ensure Mr X's ongoing management plans were more clearly understood (by the hostel in particular) nothing could reasonably have been expected to have prevented the killing of Mr Y on 21 June 2013. The rationale for this is examined below using three tests of reasonability.

Knowledge:

13.8. Whilst hostel staff had concerns about Mr X's mental wellbeing on 21 June 2013 – the concerns appear to have been short lived and the situation whereby Mr X was shouting and irritable appeared to resolve itself. No one had any knowledge that Mr X planned to harm Mr Y or that he continued to be agitated once he had calmed down and apologised for his behaviour.

Opportunity:

13.9. Hostel staff sought to intervene by calling the police and telephoning the CMHT office number. However neither intervention accessed the support the hostel was seeking and to all intents and purposes the situation appeared to

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have resolved when Mr X calmed down and apologised for his angry outburst. No one at the hostel was aware that Mr X and Mr Y met later on in the evening and no one knew that Mr X had attacked and killed Mr Y until the following day when his body was found – hence there were no further opportunities to intervene.

Legal Means:

13.10. The Independent Investigation Team concludes that Mr X was experiencing some kind of crisis during the evening of 21 June 2013 – this was evident in that hostel staff found it severe enough to call the police. What can now not be known with certainty is whether this crisis was driven by Mr X's mental illness relapsing due to the fact out of hours mental health services were not contacted at the time to assess his mental state. However it was a finding of the Court that Mr X's capacity at the time of the killing was not diminished and this would suggest that he would not have met the criteria for detention under the Act on 21 June 2013 and that there were no legal means available to intervene.

14. East London NHS Foundation Trust's Response to the Incident and Internal Review

The Internal Investigation

The Commissioning Process

14.1. The internal investigation process was jointly commissioned between the East London NHS Foundation Trust and the London Borough of Tower Hamlets (for whom it constituted a Serious Case Review). The care and treatment of both Mr X and My Y were examined and separate reports prepared.

The Internal Investigation Team comprised the following personnel (for both service users)

- 1.** A Consultant Psychiatrist from East London NHS Foundation Trust (Chair of the Review).
- 2.** The Clinical Director - Specialist Addiction Services East London NHS Foundation Trust
- 3.** The Commissioning Manager Supporting People - London Borough of Tower Hamlets

The Terms of Reference (for both service users)

14.2. The Terms of Reference comprised the Trust's standard approach and no additions were deemed to be necessary. They were:

- *“To review the initial incident management and support to those involved*
- *To establish the facts and any specific problems to be addressed*
- *To review the care the patient was receiving at the time of the incident*
- *The suitability of that care in view of the client's history and assessed health and social care needs in relation to policy and good practice guidance*

Independent Investigation Mr X and Mr Y

- *The extent to which the care corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies*
- *To look for improvements rather than apportion blame*
- *To establish how recurrence may be reduced or eliminated*
- *To formulate SMART recommendations*
- *To provide a report as a record of the investigation process and a means of sharing lessons from the incident”.*

14.3. The internal investigation scope consisted of the following for Mr X:

- *“The review covers the time period between the first contact of Patient with Trust services in September 2006 and the incident in June 2013*
- *It encompasses services provided by four Trust Services:*
 - *Tower Hamlets Specialist Addictions Unit*
 - *Health E1*
 - *ELFT Blood Borne Virus Team*
 - *Bethnal Green and Globe Town CMHT*
- *It reviews the services provided through the third sector organisation; Providence Row Housing Association at Daniel Gilbert House which offered supported accommodation to Patient from 20.12.10 and which was commissioned by London Borough of Tower Hamlets”.*

14.4. The internal investigation scope consisted of the following for Mr Y:

- *“The review covers the time period between the first contact of Patient with Trust services in February 2009 and his death in June 2013.*
- *It encompasses services provided by three Trust Services:*
 - *Tower Hamlets Specialist Addictions Unit*
 - *Health E1*
 - *ELFT Blood Borne Virus Team*
- *It reviews the services provided through the third sector organisation; Providence Row Housing Association at Daniel Gilbert House which offered supported accommodation to Patient from 29.08.12 and which was commissioned by London Borough of Tower Hamlets”.*

Method

14.5. The internal investigation method consisted of the following for Mr X:

- *“Case note review and electronic patient record review*
- *Tabular timelines collated from Trust and Supported Accommodation records*
- *Staff interviews with the Consultant Psychiatrist and Key Worker from the Specialist Addictions Unit, The Clinical Lead for Health E1, the Blood Borne Virus Nurse, the Consultant Psychiatrist, Operational Lead and Care Co-ordinator of the CMHT and the Assistant Director Client Services and the Service Improvement Manager of the supported accommodation provider*
- *Advice and consultation with the Metropolitan Police Service*
- *NPSA Contributory Factor Framework and Fishbone Diagram”.*

Independent Investigation Mr X and Mr Y

14.6. The internal investigation method consisted of the following for Mr Y:

- *“Case note review and electronic patient record review*
- *Tabular timelines collated from Trust and Supported Accommodation records*
- *Staff interviews with the Consultant Psychiatrist and Key Worker from the Specialist Addictions Unit, The Clinical Lead for Health E1, the Blood Borne Virus Nurse and the Assistant Director Client Services and the Service Improvement Manager of the supported accommodation provider*
- *NPSA Contributory Factor Framework and Fishbone Diagram”.*

Key Findings, Analysis and Conclusions

14.7. Good practice as identified by the internal investigation is summarised as being:

1. Both service users had been well engaged with service.
2. Both service users mental and physical health was understood to be improving.
3. Care planning and risk assessment were of an overall good standard.

14.8. Care and service delivery problems as identified by the internal investigation are summarised as being:

1. The review panel could not be assured of adequate communication between all of the agencies providing care. Deficits were identified between the interface of health and hostel services for which all agencies were regarded as being responsible.
2. The hostel recording arrangements did not allow for the transfer of hard copy notes to its electronic recording system.
3. Hostel staff appeared to be unaware of how to access emergency mental health care out of hours.
4. Key Worker continuity at the hostel with Mr X was not optimal in the months prior to the homicide. Neither the SAU nor the CMHT appeared to know who the Key Worker was.

14.9. Contributory factors as identified by the internal investigation are summarised as being:

1. Hostels have not historically worked with people on CPA and this may have led to embryonic communication systems being put in place. Communications were informal and usually took the form of telephone conversations or via the service user. This was compounded by hostel staff not being aware of the CPA process and their role within it.
2. Hostels do not appear to have individual crisis plans in place and there is often uncertainty as to what to do in an emergency. It was recognised that in future a crisis plan would need to be aligned to vulnerable adult processes.
3. The current service provision model agreed between the housing association and London Borough of Tower Hamlets may require revision in order to meet the needs of residents subject to CPA and in contact with the SAU. *“In addition, the provider may need to develop its policy and procedure*

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for those deemed to be vulnerable adults to ensure that there is a model of support and intervention that sits beneath the identification of those with an increased support need. This will need to cover skills, and experience of staff, but also a more assertive and personalised model of support that is delivered within the principals of a recovery model”.

14.10. Root causes as identified by the internal investigation are summarised as being:

1. The homicide of Mr Y was neither predictable nor preventable and that none of the services involved could have intervened to prevent it from occurring.

14.11. Lessons for learning were identified as being *“Communication across health, local authority and third sector providers needs to be improved to optimise care for people with serious mental health and/or substance misuse problems and attending SAU or subject to CPA”.*

Recommendations (for both Investigations)

1. *“The TH Directorate, with assistance from the LBTH Supporting People Team should extend its current protocol between CMHTs and mental health supported accommodation units to cover the homeless hostels in the Borough. The extended protocol should cover issues such as information exchange, CPA arrangements and expectations, and crisis contact arrangements.*
2. *LBTH should develop guidelines with their supported accommodation providers for supporting vulnerable adults within their services. The guidelines should be developed in consultation with the relevant ELFT teams, the CMHT, the SAU, Health E1 and the BBV team”.*

Independent Investigation Team Feedback on the Internal Investigation Report Findings

14.12. The independent Investigation concluded that the internal investigation was managed by individuals of senior standing with the necessary experience. However we noted that it was not possible to determine, from the resulting reports alone, whether all due process was followed and it is difficult from reading the evidence contained within the reports to understand how findings and conclusions were made. At the time of writing this report the Independent Investigation had not received the internal investigation archive despite the request having been made at an early stage. The Independent Investigation was also of the view that the internal investigation panel would have benefited from a nurse and/or safeguarding member.

14.13. The independent Investigation concurs broadly with the findings of the internal investigation. However we conclude that that internal investigation process and subsequent lessons for learning would have benefitted from a more detailed analysis of risk formulation, medication and treatment management, CPA and the referral and discharge process. The key findings focus upon the hostel and its working practices without placing the same

Independent Investigation Mr X and Mr Y

amount of emphasis on statutory mental health services which should have the lead accountability for many of the processes which were highlighted. A significant omission is the detailed examination of Safeguarding and vulnerable adults issues which were markedly absent.

Being Open

14.14. The National Patient Safety Agency issued the original Being Open guidance in September 2005; the guidance was then updated in 2009. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and expected to have their action plans implemented and a local Being Open policy in place by June 2006. The Being Open safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who had been harmed as a result of their healthcare treatment. The Being Open guidance ensures those patients and their families:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm done.

14.15. Although the Being Open guidance focuses specifically on the experience of patients and their carers it is entirely transferable when considering any harm that may also have occurred to members of the public resulting from a potential healthcare failure.

14.16. No contact could be made with the family and friends of Mr X as he was isolated and had not maintained contact with his family for many years. In relation to Mr Y the only next of kin contact known to either the Trust or supported accommodation staff was a mobile telephone number for his mother. The Chair of the review attempted to ring this number on several occasions but did not receive a response.

14.17. Whilst understanding the difficulties faced by the internal investigators when attempting to contact Mr Y's mother the Independent Investigation concludes that more should have been done to locate her and make contact with her. In the event the Independent Investigation made contact with her via the Victim Support Service. It is unfortunate that no one from the NHS has made direct contact with her in relation to the investigation process or ascertained whether she, or any of Mr Y's children, need any emotional support/medical intervention as a result of his death. In future NHS services

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should be mindful of any ensuing trauma and make every effort, either through the police or Victim Support, to trace relatives and ensure that information is provided and assistance offered.

Staff Support

14.18. Witnesses to the Independent Investigation were understandably anxious after Mr Y's death and during both the internal and independent investigation processes. However it was evident that the Trust supported its staff and when asked directly every witness said that the organisation was supportive and that there was no culture of blame.

Progress against the Trust Internal Investigation Action Plan

14.19. Information sharing following the internal investigation did not have an 'even coverage'. Whilst the Independent Investigation was told about the Trust's learning lessons programme many witnesses did not know the outcome of the internal investigation process and staff at Daniel Gilbert House were not privy to the report. The internal investigation report stated that *"This report including any recommendations and resulting action plan will be shared with the teams and staff involved, discussed at the local healthcare governance meeting and any learning which applies across the directorate or organisation will be disseminated via the respective communication channels. A feedback meeting has been held on 03.10.13 for those staff interviewed as part of the review and the relevant senior managers"*. It is evident that the available learning – even though the review was commissioned as a multiagency investigation was not shared with all partners. This will obviously limit the impact of any learning that needs to take place.

14.20. The investigation report sharing arrangements also included:

1. *"The Service and Clinical Directors*
2. *Service and team managers to whom the recommendations and action plan apply*
3. *The Assurance Department*
4. *The Serious Incident Review Sub-committee*
5. *North and East London Commissioning Support Group (Commissioners)*
6. *London Borough of Tower Hamlets Service Head of Commissioning and Strategy and Director of Education, Health and Wellbeing"*.

14.21. The recommendations identified were reportedly implemented by the end of April 2014. The Independent Investigation Team saw some evidence that the Bethnal Green CMHT have developed a communication and emergency working protocol. This is good practice. However it is not clear how well embedded this is at the present time. It was evident when interviewing staff at the hostel that process for working with vulnerable adults are still underdeveloped and require further work.

15. Notable Practice

Service User-Centered Care and Treatment

15.1. All of the services involved over time in the provision of care and treatment to both Mr X and Mr Y delivered this with respect, kindness and courtesy. Attempts were made on a constant basis to ensure full engagement was maintained no matter how chaotic either service user was in presentation. Complex mental and physical health conditions were managed by workers across all teams in a consistent manner that provided care and treatment against a backdrop of very challenging social conditions. This consistent approach has been identified as notable practice.

Joined up Working

15.2. On the whole Mr X and Mr Y received reliable and joined up care and treatment from Trust-based services. This was in no small part due to the GP practice, the SAU and the CMHT all being provided by the same organisation within the same locality. This ensured a high degree of joint working was possible by teams with longevity of service who were used to putting the patient at the centre of the care pathway. This is an unusual model and it provides an exemplar way of delivering services to chaotic and homeless service users.

16. Lessons for Learning

Understanding the Service User – Cultural Competence

16.1. As has been noted above, Mr X was always treated with dignity and respect. However he was not fully understood in the context of his culture and ethnicity. Had this been managed better it is probable that the treating teams could have got 'underneath' Mr X's presentation and a more robust plan developed to manage and treat his Schizophrenia/Schizoaffective Disorder. The need for cultural competence on the part of care and treatment teams, and a full understanding of the service user in the context of culture and ethnicity, was jointly identified by the Independent Investigation team and the Trust at the lessons for learning workshop. Whilst a deeper understanding would not have prevented the death of Mr Y, it is reasonable to assume that it would have potentially improved the care and treatment approach taken and subsequently Mr X's quality of life.

Professional Communication

16.2. Professional communication is an essential factor in the management of safe patient care and treatment delivery. This has been a consistent finding from the 1990s onwards of independent homicide investigations, such as this one, working across the country. Whilst no causal factors were found in relation to the care and treatment Mr X received and the death of Mr Y, it is a fact that professional communication failed over the nine months prior to the killing of Mr Y. The role of the Care Coordinator is fundamental to the maintenance of good professional communication – all Care Coordinators should be made aware of this role and trained and supported to achieve maximum impact.

Safeguarding

16.3. It was a finding of both the Trust internal investigation and joint Serious Case review and the Independent Investigation that guidelines for supported accommodation providers for managing vulnerable adults within their services needed to be developed further with all statutory services. The collective risk and safeguarding concerns for Daniel Gilbert House were understood poorly by health partners. Whilst the hostel was providing a service to Vulnerable Adults and those rendered vulnerable by virtue of their lifestyle little consideration was given as to how an individual's safeguarding risk could be elevated by being in a hostel environment rather than being managed and supported by it. The collective elevation of risk needs to be understood better and be more explicitly supported by guidelines and policy process.

17. Recommendations

Background

17.1. The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

17.2. The Independent Investigation Team worked with the East London NHS Foundation Trust, Daniel Gilbert House and NHS Tower Hamlets Clinical Commissioning Group (at a lessons for learning workshop) to formulate the recommendations arising from this investigation process. This has served the purpose of ensuring that current progress, development and good practice have been identified. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can improve further services and consolidate the learning from this inquiry process. **It should be noted that the Trust, the Local Authority, housing and the Tower Hamlets Clinical. Commissioning Group have all been working together to promote change and embed the learning from Mr Y's death. Therefore the recommendations below focus on embeddedness and the review and audit of the new ways of working.**

Progress Made To-Date

17.3. The Internal Investigation made the following recommendations:

1. *"The TH Directorate, with assistance from the LBTH Supporting People Team should extend its current protocol between CMHTs and mental health supported accommodation units to cover the homeless hostels in the Borough. The extended protocol should cover issues such as information exchange, CPA arrangements and expectations, and crisis contact arrangements.*

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2. *LBTH should develop guidelines with their supported accommodation providers for supporting vulnerable adults within their services. The guidelines should be developed in consultation with the relevant ELFT teams, the CMHT, the SAU, Health E1 and the BBV team”.*

17.4. Recommendation 1: Progress has been made with an active communication protocol having been developed. At the time of writing the report this protocol was in the process of being embedded.

17.5. Recommendation 2: It is less clear what exactly has changed in relation to this recommendation. When stakeholders and witnesses were met with it was evident that more needed to be done to ensure safeguarding guidelines were developed to specifically protect and manage individuals such as Mr X and Mr Y.

Recommendation One: Diagnosis

17.6. It was discussed at the lessons for learning workshop that a more “*stringent formulation*” process was required particularly for service users with a combined psychosis, substance misuse and forensic history. The issue was raised about the thresholds for forensic assessment to support diagnostic and risk formulation. The issue was also raised as to whether the Trust should lower the threshold for forensic assessment referral.

- **Action:** The Trust will review current liaison arrangements between locality directorates and Forensic Services, looking in particular at referral thresholds. The review will ensure that in future formulation processes will be sensitive enough to take into account complex presentations utilising the skills and services to be found within the organisation. This process will be completed within six months of the publication of this report.

Recommendation Two: Medication and Treatment

17.7. The role of housing should be clarified with regard to medication management. Some hostels in the area are required to support medication compliance and mental health monitoring – others are not. At the lessons for learning workshop we heard from the Tower Hamlets Clinical Commissioning Group that guidelines are now in place.

- **Action:** The Tower Hamlets Clinical Commissioning Group must review these guidelines in conjunction with health and housing partners to audit embeddedness and fitness for purpose. This process will be completed within six months of the publication of this report.

Recommendation Three: Referral System

17.8. The referral system has been improved since the transfer from paper to electronic records. Referrals are now highlighted and audited. The system is fully integrated at the present time

- **Action:** For the current arrangements to be audited within six months of the publication of this report.

Recommendation Four: Risk Assessment

17.9. Risk assessment processes need to be tightened for those service users with a stable/medium/long-term relationship with the Trust. Reviews should be conducted and an assurance provided that historic risk information is brought together and that ongoing/new risk information is considered as part of a dynamic risk assessment process as routine. Risk assessments should be multidisciplinary/agency and perhaps the CPA meeting should be used to assess risk in a more defined manner.

- **Action:** The Trust will develop an audit system sensitive enough to detect whether risk assessment is based upon historic information pertinent to the ongoing care and treatment of named service users. This to be developed within six months of the publication of this report.

Recommendation Five: CPA

17.10. A number of service users of the CMHTs have named Care Coordinators but are not subject to CPA. At present, no core CPA documentation such as Risk Assessment, Care Plan and Crisis and Contingency Plan need be maintained. It is noted that in the case of the incident in question, hostel staff had little information on the key professionals involved in Mr. X's care or how to respond in the event of a crisis.

17.11. Communications between the CMHT and hostel have significantly improved due to good practice initiatives. The Trust and the Local Authority etc. need to work through how the learning from the Mr X case, and the subsequent good practice arising from lessons for learning, can be rolled out across the whole Trust and other housing providers. We heard at the workshop that there was:

1. A new joint working protocol with simple guidelines to support housing providers accessing immediate support from secondary care mental health services (with a flow chart of all OoHs contacts).
2. Training to the Daniel Gilbert Hostel.
3. Work ongoing to consider a named CMHT link worker for each hostel/housing provider.

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4. Work ongoing to consider how care, crisis and contingency plans can be made available to housing for all mental health service users even those who do not meet Care Coordination/CPA criteria.

17.12. A key point was identified as being the role of the Care Coordinator in pulling all of the agencies and services together in the best interests of the service user, and once designated this role had key responsibilities over and above those other practitioners in other services to ensure the ongoing flow of communication. Care Coordinators need to be more mindful of their role. The communication between CMHTs and GPs is now part of the CQUIN process.

- **Action 1:** for the work already in train to be reviewed within six months of the publication of this report.
- **Action 2:** As a minimum care standard, service users who have a Care Coordinator but who are not subject to CPA will have a Crisis and Contingency Plan made available. This work should be embedded within six months of the publication of this report.

Recommendation Six: Interagency/Service Communication

17.13. The lessons for learning workshop discussed at length the issues around information sharing between agencies, particularly between health and hostels. The group decided that a core set of information should be agreed between the agencies and that this should form a recommendation. The recommendation should address issues pertaining to patient confidentiality, consent, safety thresholds etc. It was also agreed that an information sharing protocol should also be developed in order to promote safety and joined up working. A profile should be developed that outlines what information is expected from each professional (across all services and agencies) involved with a service user. This profile should identify who needs to know what and when. A core dataset should be developed (e.g. risk and crisis plans, relapse information, change of workers, medication etc.). The core data set should apply to ALL service users whether they are subject to CPA/CMHT services or not.

17.14. The workshop acknowledged that there were often chaotic service users who did not meet CMHT thresholds and that satellite clinics should be provided for advice to hostels and primary care. It was recognised that different types of service users would require specific information sharing criteria to be identified.

- **Action 1:** Following the incident involving Mr X and Mr Y and prior to both the internal and independent investigations, the Operational Lead of Bethnal Green CMHT met with senior representatives of Providence Row Housing Association to debrief and to exchange ideas about how tools could be introduced in order to improve communication between agencies. A Joint Working Protocol was developed between Bethnal Green CMHT and Daniel Gilbert House which includes guidance on mutual communication. This was subsequently extended to all hostel providers within Tower Hamlets following discussion with these

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providers. This process will be reviewed within six months of the publication of this report.

- **Action 2:** A tool has been developed for hostels to advise how to access support if staff are concerned about a resident, whether known or unknown to secondary mental health services and whether within or outside the CMHT hours of operation. This was designed as a flow chart in poster form for easy reference. Training has now been delivered by the CMHT to hostel staff on both these tools. The Joint Working Protocol has been subject to a review cycle following which it was amended. These tools to be rolled out to other directorates. It may be necessary to amend content to reflect local variations. This process will be reviewed within six months of the publication of this report.
- **Action 3:** Relationships between the CMHTs and hostel providers can be developed, and continuity of care improved, by identifying a small number of Care Coordinators as Link Workers for each hostel. Link Workers to act as point of contact for the hostels and to act as Care Coordinators for all service users in their link hostel who require Care Coordination under the care of a specific team. A similar arrangement has been successful following implementation in mental health supported accommodation provision. Changes of staffing to be clearly communicated between agencies. It was also agreed to consider, if practicable, the facilitation of CPA clinics at hostels and to develop an information sharing protocol between the CMHTs and hostels. This process will be reviewed within six months of the publication of this report.

Recommendation Seven: Safeguarding Thresholds in Hostels

17.15. Given the large number of residents at each hostel, many of whom present with significant and complex risk and varying states of vulnerability and anti-social behaviour, there is a need to develop an overarching strategy to monitor and as necessary respond to escalation of behaviour of concern related to relationships between hostel users.

- **Action:** For Health (commissioners and providers), Housing and the Local Authority to develop an Escalation Procedure in order to be able to respond to concerning behaviour from one hostel resident to another by use of planning and communication across teams and agencies. The procedure will also take into account the need for the 'global' situation within a hostel to be ascertained on a regular basis in order to assess the collective risk presented by having large numbers of people with chaotic lifestyles living together in one place. This process will be completed within six months of the publication of this report.

Recommendation Eight: Accommodation Pathways Working

17.16. Of the various hostels based in Tower Hamlets, the client group has changed over the years and now includes a greater number of service users under the care of secondary mental health services. Placements are accessed via the homeless services HOST Team but at the time of the incident there was no consistent system for placement review to explore potential move-on nor a forum to discuss interface issues and referrals pathways.

- **Action:** An Accommodation Pathways Working Group has now been established and meets every two months with membership including senior Trust managers and clinicians, LBTH Supporting People commissioners and a senior representative of the HOST Team. This process will be reviewed within six months of the publication of this report.

Recommendation Nine: Dual Diagnosis Service

17.17. Good practice has been highlighted regarding the relationship between the CMHT and Dual Diagnosis Service, the Specialist Addiction Unit, the hostel and Health E1 Medical Centre. However, issues have been raised regarding the operation of the Dual Diagnosis Service in terms of its relationship with partner addiction services and referral pathways.

- **Action:** The Trust, the London Borough of Tower Hamlets and housing will review the Dual Diagnoses Service strengthening the input for this large cohort of clients who currently do not meet the CMHT threshold. This work should be completed within six months of the publication of this report.

Recommendation Ten: Ethnicity, Diversity and Cultural Competence

17.18. Mr X was from an East African cultural background and as such there was an opportunity to explore issues surrounding stigma, denial of symptoms and masking of symptoms which can be common features in people of this background, however this was not explored.

- **Action:** To develop workshops involving themes of the stigma of mental illness and associated features of masking and denial of symptoms, in the context of comparison of various cultural norms as well as an appreciation of the service user as an individual who may or may not share various cultural/ social values. This work should be embedded within six months of the publication of this report.

Recommendation Eleven: Internal Investigation Findings Sharing

17.19. The Trust internal investigation and joint commissioner process did not communicate its findings to all of the stakeholders concerned. This prevented learning from taking place and the timely development of safer practice. This work should be embedded within six months of the publication of this report.

- **Action:** In future all multi-agency reports will be shared across all of the relevant agencies via a formal briefing process.

18. Glossary

Care Coordinator	This person is usually a health or social care professional who coordinates the different elements of a service user's care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occurs in a timely and user centred manner.
Care Quality Commission	The Care Quality Commission is a non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people's own homes.
Care Coordination	The process within the Trust where a patient is allocated to a Care Coordinator who is based within a Community Mental Health Team.
Clinical Negligence Scheme for Trusts	A scheme whereby NHS Trusts are assessed. It provides indemnity cover for NHS bodies in England who are members of the scheme against clinical negligence claims made by, or in relation to, NHS patients treated by or on behalf of those NHS bodies.
Mental Health Act (1983 and 2007)	The Mental Health Act 1983/2007 covers the assessment, treatment and rights of people with a mental health condition.

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National Patient Safety Agency

The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines.

Psychotic

Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.

Risk assessment

An assessment that systematically details a person's risk to both themselves and to others.

Service User

The term of choice of individuals who receive mental health services when describing themselves.