Strictly Confidential Independent Investigation into the Care and Treatment Provided to Mr. RT by the South London and Maudsley NHS Foundation Trust

Commissioned by NHS London Strategic Health Authority

January 2010

NHS London

Contents

1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. RT was commissioned by NHS London Strategic Health Authority pursuant to *HSG (94)27*[1]. This Investigation was asked to examine a set of circumstances associated with the deaths of Mr H1 and Mr H2 and the actual bodily harm of at least four other members of the public on the 14 April 2006, the 20 April 2006 and the 27 April 2006[2]. Mr. RT was subsequently arrested and convicted as the perpetrator of these offences.

Mr. RT received care and treatment for his mental health condition from the South London and Maudsley NHS Foundation Trust (the Trust). It is the care and treatment that Mr. RT received from this organization that is the subject of this Investigation.

Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of this 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.

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 to those who have supported them. We would also like to thank the Trust senior management who have granted access to facilities and individuals throughout this process. The Trust Senior Management Team has acted at all times in an exceptionally professional manner during the course of this Investigation and has engaged fully with the root cause analysis ethos.

The Investigation Team would also like to thank New Scotland Yard for their advice and support with regard to contacting the victims' families and also the survivors of the attacks.

This has allowed the Investigation to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

2. Condolences to the Victim's Families

The Investigation Team would like to extend their condolences to the families and friends of Mr. H1 and Mr. H2. Despite the best efforts of both the Investigation Team and the Police Service it has not been possible to make contact with them during the course of this Investigation.

3. Acknowledgement to the Survivors

Despite the best efforts of both the Investigation Team and the Police Service it was not possible to make contact with all of the survivors of the attacks that occurred during April 2006 during the course of this Investigation.

The Independent Investigation Team would like to thank Mr. JRD who sustained serious injuries as a result of one of the arson attacks for his full cooperation and input during the course of this Investigation.

4. Executive Summary

4.1. Incident Description and Consequences

Mr. RT carried out three arson attacks on newsagents and off licences in April 2006. These attacks led to the deaths of two members of the public, the serious wounding of several other members of the public and extensive damage to privately owned property.

Mr. RT was charged with two counts of murder and three counts of arson with intent to endanger life. The psychiatric report prepared by Dr. C in February 2007 stated the opinion that Mr. RT was suffering from paranoid schizophrenia at the time of the offences.

In July 2007, it was ordered that Mr. RT be detained under Section 37/41 of the Mental Health Act 1983 at Broadmoor Hospital indefinitely after he pleaded guilty to three counts of arson with intent to endanger life on the grounds of diminished responsibility. He also pleaded guilty to a further count of arson at a Tulse Hill newsagent. His Honour Judge Peter Beaumont ordered Mr. RT to be detained for an indefinite period.

4.2. Background to the Independent Investigation

The Health and Social Care Advisory Service was commissioned by NHS London (the London Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance EL (94)27, LASSL(94) 27.

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 minimize 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.

4.3. Terms of Reference

The Independent Investigation Team should undertake all the tasks listed below in order to produce a detailed report on the care and treatment Mr. RT received and make recommendations to help ensure that any mistakes made will not be repeated in the future.

Stage 1

Following a review of clinical notes and other documentary evidence the Team will:

- review the Trust's Internal Investigation and assess the adequacy of its findings, recommendations and action plan;
- review the progress that the Trust has made in implementing the action plan;
- agree with the Primary Care Trust any areas (beyond those listed below) that require further consideration.

Stage 2

a. To examine the mental health care received by Mr. RT in the context of his life history, taking into account any issues raised by cultural diversity which appear to be relevant in order to obtain a better understanding of:

- the extent to which Mr. RT's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC (90) 23 and local operational policies;

- the extent to which Mr. RT's prescribed care plans were effectively drawn up, delivered and complied with by Mr. RT;

- the appropriateness and quality of any assessment, care assessment plan and supervision having regard to his past history to include:

    - medication;
    - staff responses to service user and carer concerns;
    - involvement of Mr. RT and his family in the drawing up and appropriateness of his care plan;
    - the range of treatments and interventions considered;

- social care interventions;
- the reliability of case notes and other documentation.

- his assessed risk of potential harm to himself and others by compiling a comprehensive chronology of the events leading up to the homicide. This should specifically include:

  - the risk of Mr. RT harming himself or others;
  - the training of clinical staff in risk assessment;
  - the systems and procedures in place during the period of Mr. RT's contact with services.

b. Consider the effectiveness of interagency working, including communication between the mental health services and other agencies, with particular reference to the sharing of information for the purpose of risk assessment.

c. Involve the perpetrator and his family as fully as is considered appropriate.

d. Involve the victims' families as fully as is considered appropriate.

e. Review and assess compliance with local policies, national guidance and statutory obligations including (where relevant) the appropriateness of use of the Mental Health Act 1983 regarding admission, discharge and the granting of leave, and compliance with Human Rights legislation.

f. Consider any other matters arising during the course of the Independent Investigation which are relevant to the occurrence of the incident or might prevent a re-occurrence.

g. Use root cause analysis as appropriate for the purpose of enabling lessons to be learned.

h. Ensure that any action plan and recommendations take full account of the progress that health and social care services have made since the completion of the Internal Investigation report.

i. Consider such other matters as the public interest may require.

j. Prepare an Independent Investigation Report for the Primary Care Trust.

k. Work with the Primary Care Trust in the period between the delivery of the Investigation Report and its formal publication.

4.4. The Investigation Team

Investigation Team Leader

Dr. Androulla Johnstone	Chief Executive, Health and Social Care Advisory Service

Investigation Team Members

Dr. David Somekh	Medical member
Mr. Jim Mc Donald	Nurse member
Mr. Charles Holloway	Health and Social Care Advisory Service Associate. Lay Member
Mrs. Tina Coldham	National Development Consultant, Health and Social Care Advisory Service. Service User Member

Support to the Investigation Team

Mr. Christopher Welton	Investigation Manager, Health and Social Care Advisory Service

Independent Advice to Panel

Mr. Ashley Irons	Solicitor, Capsticks
Mr. Paul Grey	Independent Management Consultant, service user and advisor on cultural diversity issues

4.5. Findings and Conclusions

Key Causal Factors

The Independent Investigation Team has found two key causal factors relating to the care and treatment of Mr. RT and the subsequent events of April 2006. The key causal factors identified by this Investigation had a direct bearing on the breakdown of Mr. RT's mental health. Judge Peter Beaumont ruled that Mr. RT committed his offences on the grounds of diminished responsibility as a direct result of his paranoid schizophrenia.

- ***Key Causal Factor Number One. The failure to manage the ongoing assessment, care, risk and treatment needs of Mr. RT meant that his mental illness was at best partially treated. Judge Peter Beaumont ruled that Mr. RT's mental state had a direct bearing on the events of April 2006.***

- ***Key Causal Factor Number Two. Mr. RT's care and treatment plan never appeared to have been properly considered in the context of his diagnosis and its implications. The appropriateness and effectiveness of Mr. RT's medication and treatment regime were never effectively reviewed. The subsequent partial treatment of his condition had a direct bearing on his mental state.***

Contributory Factors

The Independent Investigation Team found eight factors that contributed to the less than effective care and treatment package that Mr. RT received.

- ***Contributory Factor Number One. The failure of the Trust to ensure a risk assessment was conducted that took full account of Mr. RT's personal, psychiatric and forensic history ensured that he fell through the safety net of care and contributed to the undetected breakdown in Mr. RT's mental health.***
- ***Contributory Factor Number Two. The failure of the Trust to provide Mr. RT with a comprehensive package under an enhanced level of the Care Programme Approach led to Mr. RT falling through the safety net of care.***

- ***Contributory Factor Number Three. Mr. RT was not actively involved in any aspect of his care planning by his clinical team. This lack of involvement may have exacerbated Mr. RT's inclination to disengage from services.***

- ***Contributory Factor Number Four. The services that were offered to Mr. RT and his family were not culturally sensitive and did not provide him with appropriate assessment, care and treatment options.***

- ***Contributory Factor Number Five. The Trust did not instigate appropriate interagency communication, particularly with the police, this meant that significant information regarding the risk Mr. RT posed to the general public was never understood.***

- ***Contributory Factor Number Six. Individual clinicians did not produce and maintain Mr. RT's clinical records to an appropriate professional standard. Local team management systems and corporate-led audit both failed to detect these shortcomings.***

- ***Key Contributory Factor Number Seven. Clinical supervision was not available to the health and social care professionals providing the care and treatment to Mr. RT. This ensured that poor adherence to Trust policy and procedure went undetected.***

- ***Contributory Factor Number Eight. Clinical practice within the Trust did not conform to internal policies and procedures.***

Service Issues

The Independent Investigation Team found two service issues.

- ***Service Issue Number One. No carer assessment was conducted.***
- ***Service Issue Number Two. No Safeguarding Children assessment was conducted.***

Conclusions

The care and treatment that Mr. RT received between 1999 and 2006 did not provide a comprehensive package that treated his condition effectively and adequately monitored him with regard to relapse.

The Trust had excellent policies and procedures during this period of time, but they were not adhered to. Despite the presence of robust clinical governance systems the inadequacies of Mr. RT's care and treatment were not identified or rectified. This

ensured that as the years went by Mr. RT was able to completely disengage from mental health services. Despite the presence of significant risk indicators and evidence that suggested Mr. RT's psychosis was only partially treated, secondary care services allowed him to slip through the safety net of care.

It is the case here that, despite excellent policies and procedures and sophisticated clinical governance systems, the basic building blocks of clinical practice which form the most essential components of patient care were not respected. Nothing can take the place of a detailed patient history set within the context of a sound and ongoing relationship with the service user. The notion of rapport building and engagement are fundamental to the provision of safe and effective care.

It is the conclusion of the Independent Investigation Team that had Mr. RT's full history been appropriately explored, based on the knowledge available to the Trust early in 2001, his case would have been managed entirely differently. Whilst it is impossible to say that the events of April 2006 could have been avoided, it is possible to say that Mr. RT's care and treatment plan could have been managed more effectively and that his mental illness could have been assessed and monitored more robustly.

4.6. Recommendations

Recommendation Number One. A number of the findings relate to core practice that would be expected and required of community staff, for example, developing a therapeutic relationship, managing and undertaking thorough risk assessments and completing forensic risk histories. The Trust should develop core competencies for community staff which will include the requirements for staff to work to established policy and procedure and to specify what actions need to be undertaken. The core competencies should be completed with care coordinators as part of the appraisal process. Team managers should also work towards core competencies which ensure that they know what is expected of them as part of their management role.

Recommendation Number Two. The potential of the Trust IRS system should be maximised to ensure that it delivers a focussed breakdown by team and by care coordinator to be available on the:

- completion of Care Programme Approach reviews;
- completion of risk assessments;

- completion of child in need risk screens;
- frequency that carers' assessments are offered.

Recommendation Number Three. A risk assessment policy review took place during 2008. The policy review included a review of the brief risk screen. The revised Policy on the Framework for Clinical Risk Assessment and the Management of Harm was ratified in September 2008. The Trust should conduct a full audit following the publication of the Independent Investigation Report to ensure that the revised policy is operating effectively and that any further revisions are made as necessary.

Recommendation Number Four. The Trust's Care Programme Approach Policy was reviewed during 2008 in light of new Department of Health Guidance. A revised Trust Care Programme Approach Policy was published in September 2008. The policy contains details of the Trust response to the needs of carers. The revised policy was publicised to staff through line management channels, and Directorate Clinical Governance Committees. The Trust should conduct a full audit following the publication of the Independent Investigation Report to ensure that the revised policy is operating effectively and that any further revisions are made as necessary.

Recommendation Number Five. The potential of the Trust IRS system should be maximised to ensure that it delivers a focussed breakdown by team and by care coordinator of evidence that service users have signed their care plans, and have received full copies of their CPA documentation. In the event that a patient shows significant and consistent non-compliance and lack of insight, it is essential that staff are supported by agreed protocols that allow them to continue to engage with the patient and attempt to address their treatment needs, rather than collude with the patient via disengagement.

Recommendation Number Six.

A) The Trust should revise and further develop its existing policies and procedures to ensure that an appropriate consideration is made regarding each individual service user's ethnicity when developing care and treatment plans. The capacity, role and functioning of SPEKTRA (the Trust Cultural Consultancy Service) should be incorporated into this review.

B) Due to the complex BME demography of Lambeth the Trust should develop a comprehensive audit to be conducted on an annual basis, based on the Department of Health's *Delivering Race Equality in Mental Health Care* (2005), which was

formally reported to NHS Lambeth and disseminated widely throughout the Directorate.

Recommendation Number Seven. The Lambeth Carers Strategy is a new approach which was introduced into the Trust in 2008. This strategy was developed in full consultation with local Voluntary Groups, the Local Authority and NHS partners. The strategy is easy to understand and based on thorough research and understanding of the Borough of Lambeth. This strategy has made a robust attempt to engage with ethnic minority groups within the Borough to ensure its relevance and success. The Trust should conduct an audit against the effectiveness of this strategy on the publication of this report and make any necessary revisions. The audit should as a basic minimum:

- determine how many carer assessments have been offered;
- determine how many carer assessments have been accepted;
- determine the ratio of carer assessments taken up by BME carers;
- determine the quality and effectiveness of the resulting care plans.

Recommendation Number Eight. Existing policies and procedures regarding police liaison should be reviewed in the light of the lessons learned from the Mr. RT case and revised accordingly.

Recommendation Number Nine. The existing clinical supervision policy should be reviewed and an audit conducted to ascertain its effectiveness. Any necessary revisions should then be made.

Recommendation Number Ten. All active Lambeth cases should be reviewed regarding the current Trust Safeguarding Children Policy to ensure that children are identified appropriately and that plans are in place to promote both their wellbeing and safety.

Recommendation Number Eleven. The Trust acknowledges the far reaching nature of the independent investigation and the opportunity that this provides for organization-wide learning. The Trust should arrange learning feedback sessions to enable the findings of this investigation to be raised with a wide audience and to help ensure that lessons are learnt.

Recommendation Number Twelve. The Trust should develop strategies to ensure that condolences, support and advice are offered to the families / loved ones of the victims of homicide without this endangering the police investigation and judicial processes.

Recommendation Number Thirteen. Structured investigations and Board Level Inquiry reports should be thoroughly examined to ensure that the recommendations are SMART. Examination should take place prior to the report's submission to the Serious Untoward Incident (SUI) Panel, at the SUI Panel and at any Board Level Inquiry. The Board Level Inquiry should routinely have an examination of the recommendations as a routine part of the inquiry terms of reference.

Recommendation Number Fourteen. The findings of the Independent Investigation should be raised and discussed at:

- forthcoming Child Safeguarding conferences;
- in Trust newsletters and Patient Safety Bulletins;
- Police Liaison Committees.

Recommendation Number Fifteen. A) Where there are actions arising from investigations into inpatient suicides and homicides the action plans should automatically be made a standing agenda item at the relevant Clinical Governance Committee(s).
B) Clinical Governance Committees should, as part of their terms of reference, include an examination and review of any newly ratified Trust policies and procedures. An audit process should be in place to ensure that the policies and procedures are subsequently audited with involvement with clinical staff that are at the point of patient care.

Recommendation Number Sixteen. The current nursing practice assessment visits should continue on an annual basis. The terms of reference for the visits should be reviewed and amended in light of the findings of this, and any other ongoing, Independent Investigations.

Recommendation Number Seventeen. The terms of reference for structured investigations and Board Level Inquiries should include an examination and assessment of compliance with Trust Policy and Procedure which includes:

- Care Programme Approach;
- Risk Assessment and Management of Harm framework;
- Clinical records standards.

Recommendation Number Eighteen. NHS London, the London Strategic Health Authority, should engage in discussions with the Metropolitan and City Police Forces to ensure that

the Memorandum that is concerned with service user homicides can be implemented effectively.

5. Incident Description and Consequences

14 April 2006

On the 14 April 2006 Mr. RT carried out an arson attack on a shop in Tulse Hill in South London. A witness described a man who was seen to be carrying a paint kettle of about two and a half litres in size. The man was then seen to light the paint kettle, and once this kettle was aflame, he was observed throwing it into the shop. Once this had been done the man was seen walking away to the north along Tulse Hill.

Witnesses describe the fire taking hold in the shop very rapidly. A shop worker sustained a fracture to a bone in his hand, and a customer sustained first degree burns that required two separate skin grafts to his calves[4].

20 April 2006

On the 20 April 2006 Mr. RT carried out a second arson attack at a food and wine shop in Portland Road. A witness described a large man who carried an object that looked like a bottle. The man was seen to throw the object into the shop. Another witness who saw the bottle land inside the shop stated that a fire broke out in 'milliseconds'. One person sustained a partial thickness burn to his left forearm extending to the palm of his left hand[5].

27 April 2006

On the 27 April 2006 Mr. RT carried out a third arson attack at a food and wine shop in the Clapham Road. At around 3.30 in the afternoon a shop worker in the store heard what he thought to be breaking glass. A small explosion followed rapidly and flames were seen to spread across the floor. There were four shop workers in the store that day, of which two were able to escape from the fire. The two other workers were to die later of their injuries[6].

Mr. H1 died as the result of the inhalation of fire fumes. Mr. H2 also died as the result of the inhalation of fire fumes[7].

As a result of the fire on the 27 April 2006 one other member of the general public was injured and another suffered substantial damage to his property.

Mr. A lived in the top floor flat above the shop. Following his rescue by the fire brigade he was sent to hospital suffering from the effects of smoke inhalation[8].

Mr. M, a neighbouring shopkeeper, had his shop severely damaged by the fire. The effects of the fire meant that he had to replace the whole shop front and roof of his property. Fortunately he and his family escaped uninjured[9].

Subsequent Events

Mr. RT was charged with two counts of murder and three counts of arson with intent to endanger life[10]. The psychiatric report prepared by Dr. C in February 2007 stated the opinion that Mr. RT was suffering from paranoid schizophrenia at the time of the offences[11].

In July 2007, it was ordered that Mr. RT be detained under Section 37/41 of the Mental Health Act 1983 at Broadmoor Hospital indefinitely, after he pleaded guilty to three counts of arson with intent to endanger life on the grounds of diminished responsibility. He also pleaded guilty to a further count of arson at a Tulse Hill newsagent. Judge Peter Beaumont ordered Mr. RT to be detained for an indefinite period[12].

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

The Health and Social Care Advisory Service was commissioned by NHS London (the London Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance EL (94)27, LASSL(94) 27, 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*".

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.

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 minimize 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.

The role of the 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 would 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 organizations at the time of the incident.

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 fully investigated by an impartial and Independent Investigation Team.

7. Terms of Reference

The terms of reference for the Independent Investigation into the care and treatment of Mr. RT were developed by NHS London and Lambeth Primary Care Trust. They are set out in full below.

The Independent Investigation Team should undertake all the tasks listed below in order to produce a detailed report on the care and treatment Mr. RT received and make recommendations to help ensure that any mistakes made will not be repeated in the future.

Stage 1

Following a review of clinical notes and other documentary evidence the Team will:

- review the Trust's Internal Investigation and assess the adequacy of its findings, recommendations and action plan;
- review the progress that the Trust has made in implementing the action plan;
- agree with the Primary Care Trust any areas (beyond those listed below) that require further consideration.

Stage 2

a) To examine the mental health care received by Mr. RT in the context of his life history, taking into account any issues raised by cultural diversity which appear to be relevant in order to obtain a better understanding of:

- the extent to which Mr. RT's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC (90) 23 and local operational policies;

- the extent to which Mr. RT's prescribed care plans were effectively drawn up, delivered and complied with by Mr. RT;

- the appropriateness and quality of any assessment, care assessment plan and supervision having regard to his past history to include:

- medication;
- staff responses to service user and carer concerns;
- involvement of Mr. RT and his family in the drawing up and appropriateness of his care plan;
- the range of treatments and interventions considered;
- social care interventions;
- the reliability of case notes and other documentation.

- his assessed risk of potential harm to himself and others by compiling a comprehensive chronology of the events leading up to the homicide. This should specifically include:

  - the risk of Mr. RT harming himself or others;
  - the training of clinical staff in risk assessment;
  - the systems and procedures in place during the period of Mr. RT's contact with services.

b) Consider the effectiveness of interagency working, including communication between the mental health services and other agencies, with particular reference to the sharing of information for the purpose of risk assessment.

c) Involve the perpetrator and his family as fully as is considered appropriate.

d) Involve the victim's family as fully as is considered appropriate.

e) Review and assess compliance with local policies, national guidance and statutory obligations including (where relevant) the appropriateness of use of the Mental Health Act 1983 regarding admission, discharge and the granting of leave, and compliance with Human Rights legislation.

f) Consider any other matters arising during the course of the Independent Investigation which are relevant to the occurrence of the incident or might prevent a re-occurrence.

g) Use root cause analysis as appropriate for the purpose of enabling lessons to be learned.

h) Ensure that any action plan and recommendations take full account of the progress that health and social care services have made since the completion of the Internal Investigation report.

i) Consider such other matters as the public interest may require.

j) Prepare an Independent Investigation Report for the Primary Care Trust.

k) Work with the Primary Care Trust in the period between the delivery of the Investigation Report and its formal publication.

8. The Independent Investigation Team

This Investigation was undertaken by the following panel of healthcare professionals who are independent of the healthcare services provided by the South London and Maudsley NHS Foundation Trust.

Investigation Team Leader

Dr. Androulla Johnstone	Chief Executive, Health and Social Care Advisory Service

Investigation Team Members

Dr. David Somekh	Medical member
Mr. Jim Mc Donald	Nurse member
Mr. Charles Holloway	Health and Social Care Advisory Service Associate. Lay Member
Mrs. Tina Coldham	National Development Consultant, Health and Social Care Advisory Service. Service User Member

Support to the Investigation Team

Mr. Christopher Welton	Investigation Manager, Health and Social Care Advisory Service

Independent Advice to Panel

Mr. Ashley Irons	Solicitor, Capsticks
Mr. Paul Grey	Independent Management Consultant, service user and advisor on cultural diversity issues

9. Investigation Methodology

In May 2008 NHS London commissioned the Health and Social Care Advisory Service to conduct this Independent Investigation under the Terms of Reference set out in section seven of this report.

Consent

At the inception of this investigation Mr RT was written to by NHS London in order to obtain his consent for the Investigation Team to access his clinical records. A letter was sent out to him on the 15 July 2008.

Following this letter being sent by NHS London numerous telephone calls were made by the Health and Social Care Advisory Service to Broadmoor Hospital to ascertain whether or not Mr RT would be in a position to give his consent. The offer was made on several occasions for members of the Investigation Team to meet informally with Mr RT to explain the process to him and to provide him with the opportunity to ask any questions that he may have. Over a period of eight weeks no response was received from Mr RT.

On the 4 September 2008 a letter was sent from the Investigation Team to Mr RT to enquire whether he had come to a decision regarding giving his consent. The offer to visit him in Broadmoor Hospital was re-stated.

The Investigation Team Leader continued to communicate with Broadmoor Hospital regarding Mr RT's view to consent. On speaking to Mr RT's RMO on the 24 September 2008 the Investigation Team Leader was informed that Mr RT had decided to withhold his consent for the Investigation Team to access his clinical records.

On the 25 September 2008, after careful discussion with NHS London, a letter was sent to Mr RT explaining that the Investigation Team would have to make a Data Protection Application directly to the South London and Maudesley NHS Foundation Trust, the Lambeth Primary Care Trust and the West London Mental Health NHS Trust in order to access the records that they held on his behalf. It was explained to Mr RT and his solicitors that this application had to be made in the public interest. The Investigation Team stated once again that the offer to visit him in Broadmoor would stand, and that he could request a visit from the Investigation Team at any time so that the nature of the investigation could be explained to him in full if he so required.

At this time letters were sent out to the Caldicott Guardians of the South London and Maudsley NHS Foundation Trust, the Lambeth Primary Care Trust and the West London Mental Health NHS Trust to request access to Mr RT's records. The records were duly examined by the Trusts and Mr RT's notes were released in due course to the Investigation Team. At this stage the Investigation was able to commence.

Communications continued between the Investigation Team and Mr RT's solicitors. An invitation was made to Mr RT to meet with the Team in order for him to give the Investigation his own personal views on the care and treatment that he received. It was stressed that this meeting would not be confrontational and would not seek to criticise Mr RT in any way, but that it was an opportunity for him to tell the Team what he considered his needs to have been prior to the events of April 2006 and how he would have liked to have been supported by health care services at the time.

On the 26 of January 2009 Mr RT communicated via his solicitors to inform the Investigation Team that he would not feel able to meet with the Team at this stage. Mr RT whilst wanting to be engaged with the ongoing investigation felt an overriding concern for his family and the stress that the publication of the report could visit upon them. At the time of writing this report Mr RT had not met with the Investigation Team.

Communication with Victims

At the inception of this Investigation no prior contact had been made with the victims' families or the survivors of the events of April 2006 by any NHS organization. The Investigation Team were able to liaise with a Detective Inspector who had worked on the case in order to trace victims' families and survivors. At the time of writing this report only one survivor was able to be contacted, an appropriate series of communications then occurred between the survivor, the Investigation Team Leader, the Trust and the SHA.

Communication with the Perpetrator's Family

The Investigation Team wanted to arrange a series of conversations with the family of Mr RT. The Team felt that this would be important in order to ascertain how well the family felt that they had been supported during the time that Mr RT was receiving his care and treatment from the South London and Maudsley NHS Foundation Trust.

Communications were sent to Mr RT's family via the South London and Maudsley NHS Foundation Trust on behalf of the Independent Investigation Team. At the time of writing this report no response had been received from them.

Communication with the South London and Maudsley NHS Foundation Trust

On the 25 June 2008 a letter was sent from the Investigation Team Leader to the Trust Chief Executive Officer (CEO). The purpose of this correspondence was to commence introductions and to arrange for an initial meeting to take place. The Trust promptly responded by identifying a liaison person.

On the 22 September 2008 meetings were arranged with the Senior Management Team of the Trust's Lambeth Directorate. The purpose of the meeting was to clarify the Independent Investigation process and to address any concerns or questions that the Management Team may have had.

A workshop was also held on this day to which all potential witnesses for the Independent Investigation were invited. The Investigation Team Leader was present and accompanied by a Solicitor from Capsticks. The purpose of the workshop was to ensure that the investigation process would be as fair and transparent as possible. All potential witnesses were given a verbal briefing and briefing packs, a question and answer session was also held.

On the 2 October 2008 two members of the Independent Investigation Team visited the Trust Headquarters and photocopied all extant copies of Mr. RT's clinical records. On this occasion a meeting was held between the Investigation Team Leader and the Trust CEO.

Witnesses Called by the Independent Investigation Team

A total of nineteen witnesses were interviewed by the Investigation Team. All witnesses were written to four weeks in advance of their interviews detailing the terms of reference for the Investigation, the areas that the Investigation Team would be questioning them about, and the operational process and timeline of the work. All witnesses were encouraged to bring either a colleague or a trade union representative to their interviews for support. All witnesses were offered the opportunity to speak to the Investigation Team Leader for any further clarification that they may have required prior to their interview taking place. Each Interview was recorded and a transcript prepared. The transcript was forwarded to each individual in order for it to be checked for accuracy and also for any

additional information to be added to it. It is the amended versions that have been used as evidence in this Investigation.

Table One

Witnesses Interviewed by the Investigation Team

Date	Interviewee	Interviewers
20 November 2008	• Non Executive Director, Chair of Board Level Inquiry • Ms. J, Care Coordinator • Ms. A, Care Coordinator (interview conducted via teleconference) • Mr. AM, Manager	Dr. Androulla Johnstone Dr. David Somekh Mr. Jim McDonald
21 November 2008	• Dr. NS, Consultant Psychiatrist • Ms. H CMHT • Mr. C, Manager • Ms. T, OPD Nurse • Ms. D, Social Services Manager	Dr. Androulla Johnstone Dr. David Somekh Mr. Jim McDonald
24 November 2008	• Trust CEO • Trust Director of Nursing • Trust Deputy Director of Patient Safety • Dr. B, Internal Investigation Team • Ms. FJ, Internal Investigation Team • Ms. S, Internal Investigation Team • Trust Borough Director Lambeth • Trust Clinical Director Lambeth • Dr. F, Board Level Inquiry • Dr. EI, Consultant Psychiatrist	Dr. Androulla Johnstone Dr. David Somekh Mr. Jim McDonald Mr. Charles Holloway

The Independent Investigation Team were not able to interview all of the individuals involved in the care and treatment of Mr. RT. Due to the passage of time some of the witnesses that the Team would have liked to have called were either living abroad or were no longer contactable. Every effort was made to contact everyone who comprised Mr. RT's clinical care team between 1999 and the date of the events of April 2006.

Independent Investigation Team Meetings:

The Investigation Team met on a total of seven occasions.

18 September 2008: First Team Day. This day consisted of a full briefing regarding the case and the Investigation process.

20 November 2008: Witness interviews were held.

21 November 2008: Witness interviews were held.

24 November 2008: Witness interviews were held.

11 December 2008: Second Team Day. This day consisted of collating evidence and discussing findings.

7 January 2009: Third Team Day. This day was a root cause analysis day whereupon the data was considered in a systematic fashion as explained in the section directly below.

23 February 2009: Fourth Team Day. This day ensured that all findings and conclusions were set out in full accordance with the Investigation Team's wishes.

Additional meetings were held with the Trust on the following dates:

10 December 2008: Independent Investigation Team Leader meeting with the Trust Director of Nursing.

13 March 2009: The Independent Investigation Team Leader together with the medical and nurse members of the Team held a meeting with the Trust Clinical Governance Team to discuss findings and recommendations.

A meeting was held between the Independent Investigation Team Leader, a member of the Metropolitan Police Service and Mr. JRD, a survivor of one of the arson attacks on the 16 June 2009.

Root Cause Analysis

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 the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service.

The ethos of RCA is to provide a robust model that focuses on 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 organizational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learned 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. This 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.
2. **Causal Factor Charting.** This is the process whereby an investigation begins to process the data that has been collected. A timeline is produced and a sequence of events is established (please see Appendix 1). From this potential causal factors or critical issues can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This Investigation utilised the Decision Tree and the Fish Bone. (Details of the Decision Tree and the Fish Bone can be accessed from the National Patient Safety Agency website).
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

When conducting a RCA the Investigation Team avoids generalisations and seeks to use 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.

Salmon Compliant Procedures

The Investigation Team adopted Salmon compliant procedures during the course of their work. This is 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) that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organization or anyone else they wish 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.

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.

10. Information and Evidence Gathered (Documents)

During the course of this Investigation some 7,000 pages of documentary evidence were gathered and considered. The following documents were actively used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. South London and Maudsley NHS Foundation Trust clinical records for Mr RT, 1999 - 2006
2. General Practice records for Mr. RT 1999 - 2006
3. West London Mental Health Trust, Broadmoor clinical records (court transcriptions, and forensic reports relating to the events of April 2006 only)
4. The Trust Internal Investigation report and archive
5. The Trust Board Level Inquiry report and archive
6. Trust Electronic clinical record log books
7. Media transcripts and newspaper articles
8. South London and Maudsley clinical risk policy, both risk to self and risk to others (undated)
9. Lambeth Integrated Mental Health Services: A Ten Year Review. September 2003
10. Protocol for bed management when demand exceeds capacity in local adult services. April 2005
11. Safeguarding Children policy and procedures. June 2008
12. Care Programme Approach Policy 2000
13. Incident Policy 2006
14. Lambeth organizational Chart
15. Framework for Clinical Risk Assessment and Management of Harm. Version Three. 2005
16. All other current clinical policies, procedures and strategies that are currently operational within the Lambeth Clinical Directorate relating to adults of working age.
17. Independent Healthcare Commission reports
18. Independent Mental Health Act Commission reports
19. Interview transcriptions x 19
20. Trust RT action planning and implementation reports
21. Trust Board minutes and documentation
22. Memorandum of Understanding between the Association of Chief Police Officers (ACPO) and the NHS Security Management Service

23. 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

24. Guidelines for the NHS: National Patient Safety Agency, Safer Practice Notice, 10, *Being Open When Patients are Harmed*. September 2005

11. Profile of the Mental Health Services (Past, Present and Transition)

A description of the Trust's services in Lambeth between 1999 and 2009
Lambeth Adult Mental Health Services

Introduction
The South London and Maudsley NHS Trust was formed in 1999. In 2006 the South London and Maudsley NHS Foundation Trust (the Trust) was founded under the Health and Social Care Community Health and Standards Act 2003.

The Trust provides the most extensive portfolio of mental health services in the United Kingdom, supported by internationally recognised training and research. The Trust provides a full range of mental health services for people of all ages, from 100 community-based sites across South London as well as units based on three acute sites and three psychiatric hospitals:

- Bethlem Royal Hospital;
- Lambeth Hospital;
- Maudsley Hospital.

The Trust provides mental health and substance misuse services for people living in the London Boroughs of Croydon, Lambeth, Southwark and Lewisham (an approximate population of 1.1 million) and substance misuse services in Bexley, Greenwich and Bromley.

The local community served by the Trust has very high levels of mental health need, in parts amongst the highest in the country. There are also high levels of social deprivation and substance misuse, and a very mobile population including large numbers of refugees.

Other things to note include:

- specialist services are provided to people from across the United Kingdom;
- adult mental health and social care services are fully integrated;
- around 5,000 service users receive inpatient hospital treatment each year;
- around 32,000 service users receive community-based care and treatment from the Trust each year;

- the Trust employs around 4,800 staff;
- the Trust and the Institute of Psychiatry manage the only mental health Biomedical Research Centre in the United Kingdom;
- the Trust's annual turnover is around £358 million.

Services in the London Borough of Lambeth

The London Borough of Lambeth is one of the most densely populated inner London boroughs with a population of around 270,000. Based on the 2001 census, 38% of Lambeth's population are comprised of ethnic minorities, the seventh highest figure for a London borough. Approximately 150 languages are spoken in the Borough. After English, the main languages spoken are Portuguese, Yoruba, French, Spanish and Twi.

The 2007 Index of Multiple Deprivation (IMD) places Lambeth as the fifth most deprived borough in London and the 19th most deprived in England. 11.4% of the population are aged over 60, whilst 19.9% are aged under 18 (2006 Mid-Year Estimate).

Outline of the Lambeth Directorate

The Adult Mental Health Directorate shares the same boundaries as the local authority and provides joint health and social care services. Other services, including those for older adults, children, adolescents, substance misuse specialist needs and learning disabilities are shared across the Trust with some bases in the Borough.

In January 2006 Lambeth Adult Mental Healthcare was reorganised so that services are aligned to GP practices. There are now three locality community mental health teams; North, South West and South East each providing an Assessment and Treatment Service and a Recovery and Support Service. Added to this is a borough-wide Assertive Outreach Service which is centrally based in Brixton.

Alongside the generic team are specialist rehabilitation, forensic and early onset teams, which also have ward and community-based teams. These also provide additional services, for instance, supported housing, vocational services and day services, which are run either by the Trust or in conjunction with the voluntary sector.

Services in the London Borough of Lambeth between 1999 and 2003

Following the creation of the South London and Maudsley NHS Trust in 1999, the two East sectors in Lambeth (Brixton and Norwood) and three West sectors (Streatham, Clapham and Kennington) combined to form a single Lambeth Borough-based mental health service. Each of the five sector services at that time had the following three functional teams:

- Assessment and Treatment Teams, which provided the gateway to services. They accepted referrals from GPs to assess people and either provide brief treatment or referral on to more appropriate care.
- Rapid Assessment Teams, which provided an urgent referral service to GPs for people who were in crisis.
- Case Management Teams, which provided intensive community treatment to people with severe and enduring mental ill health. Case management teams operated a zoning system, which gave service users with the greatest levels of need the highest levels of care.

In addition there were community-based Borough forensic services (which took referrals from courts or prison), and rehabilitation services which provided a range of inpatient, supported housing and day care facilities.

In 2003 the first Home Treatment Team was set up in Lambeth. The Home Treatment Team provides intensive support to patients in their home, immediately after discharge from hospital or in order to prevent their admission to hospital.

The 10-Year Review

In September 2003 the Lambeth Adult Mental Health Directorate launched a review of services in Lambeth. This was the most comprehensive review of Lambeth Mental Health Services in a decade. There had been many developments over ten years and it was time to take stock and agree a new strategy and direction for the service and the changes required to improve services.

This review involved a wide ranging consultation of stakeholders and service users and looked at both hospital and community services. This programme included:

Inpatient Services:

- The conversion of Nelson Ward at Lambeth Hospital from an acute inpatient unit into a Challenging Behaviour Unit (CBU).

- A reduction of bed numbers by 16 following expansion of the Home Treatment Team, and introduction of Dove House, a Women's Crisis House.
- The creation of single sex hospital wards in order to promote privacy and dignity for patients who are admitted.
- The development of the role of Lloyd Still Ward at St. Thomas' Hospital to deliver care for people with both physical and mental health problems.

Community Services:

- The alignment of the Community Mental Health Teams [CMHTs] to GP practices so that existing Primary Care Trust (PCT) structures and boundaries are mirrored.
- Expansion of the Lambeth Early Onset Service - LEO.
- Development of an Assertive Outreach Team for the whole Borough, for those patients with severe and enduring mental illness who present with an ongoing significant risk to themselves or others and whom other community services have found difficulty in engaging.
- Development of Recovery and Support teams in each locality. The existing Case Management Teams changed into a Recovery and Support Service. They provide specialist community-based treatment and care to those people who have severe mental health problems and who have some willingness to engage with services.
- Changes to the utility of out-patient services, to improve waiting times and efficiency.
- Work to improve attitudes and respect. For service users from ethnic minorities whose experiences have historically been poor in this area, Spektra, (the Trust's cultural consultancy service) works in areas of cultural consultancy and mediation, to improve the experience of individual service users and the relationships they have with staff.

Service disinvestment

Between 2006 and 2008 a number of services were closed. These included the Hopton Road long stay rehabilitation beds, the Dove House Women's Unit, and the Emergency Clinic at the Maudsley Hospital.

Going forward - Joint Commissioning Strategy 2007-2012

Following the disinvestment, Lambeth PCT has made mental health a key priority in its five year commissioning strategy to 2012 and has agreed to increase investment in mental health services. The Local Authority has also committed to a radical programme of

enhancing commissioning capabilities and personalising care services. There are three priority areas for Adult Mental Health services set out in the Joint Commissioning Strategy for Adult Mental Health 2008-11:

- Primary Care. This focuses on the management of common mental illness in primary care settings. The strategic challenge is to increase investment in evidence-based interventions, such as talking therapies.
- Severe Mental Illness. The strategic challenge is to embrace systematically a recovery model of support and intervention.
- Social Inclusion and Well-being. A more strategic focus is needed on improving health and well being, integrating plans for adults with mental health problems to other work across age groups.

In order to support the three commissioning priority areas, a number of improvements to the way services are commissioned are being developed. These include a comprehensive needs assessment framework, service redesign to fit defined care pathways, development of user, carer and community engagement, and development of personalised care and carer support strategy. This work has been brought together under the remit of the Lambeth Mental Health Improvement Programme.

In the last year, there has been a total investment of £8.45m to improve community (£3.45m) and inpatient mental health services (£5m) in Lambeth.

Achievements to date - Community Services

- Improved access to talking therapies and psychology services, through an expanded service with local GP practices, and recruitment of Primary Care Mental Health Graduate Workers. - *£1m*

- Improved access to Primary Care and Secondary Care Services, through the recruitment of three Gateway Workers. - *£150K*

- Improved access to services for people from Black and Ethnic minority communities through the recruitment of three Community Development Workers. - *£175k*

- Community Support packages for people with severe mental illness, including those with complex needs, for an additional 50 people, through Umbrella Services. This service delivers personalised care/support packages designed to help people with

Serious Mental Illness to live comfortable and meaningful lives in their own homes. - *£300k*

- Extra posts created within the Home Treatment Team. - *£430k*

- Investment in Vocational Matters, a user-led service which provides people with advice on accessing employment and benefit entitlement. - *£40k*

- Investment in Occupational Therapists within the Community Mental Health Teams. The OTs in three sector community teams are the first port of call for people who want support to access vocational choices in the community. The OTs will work closely with the existing vocational providers network. - *£150k*

Achievements to date - Inpatient Services

- In January 2009 inpatient services previously based at St Thomas' Hospital were relocated to a new £4.2m ward at Lambeth Hospital.

Lambeth Forensic In-patient services

- In August 2006 Bridge House opened at a cost of £10m. This is a Medium Secure Unit of 24 beds on the Lambeth Hospital site. This development, returned patients to their local area from out of area placements.

- In 2008, River House was opened on the Bethlem Royal Hospital site in Beckenham. River House is an 89 bed, £33m new build scheme which provides medium secure beds for patients from Lambeth, Southwark and Croydon. It includes a women's unit, an acute ICU, a dangerous and severe personality disorder unit and a rehabilitation unit.

- In August 2008 a new 12-bed Forensic Rehabilitation Service, with facilities to accommodate four female and eight male residents, was opened at Hopton Road in Streatham. One of the aims of this service is to enable patients to be discharged from Bridge House who no longer need to receive MSU care.

Prison services

- In 2008 The Trust (as part of a consortium) won a contract to provide mental health services in Brixton prison including an in-reach team, management of the health care wing and the drug treatment service.

Changes planned for 2009/10

Community Services

- Lambeth PCT have commissioned an Improving Access to Psychological Therapies (IAPT) Service.

- Lambeth Adult Mental Services are participating in a national pilot to develop Integrated Care Pathways based on an Integrated Assessment Tool. This work will be part of the pilot for payment by results [PBR] feeding into a London-wide programme.

Inpatient Services

- Proposed changes to inpatient services at the Maudsley Hospital are taking place as part of the strategy to provide adult acute mental health services for Lambeth residents at Lambeth Hospital. The changes will also enable the Trust to relocate inpatient services currently provided at Guy's Hospital to the Maudsley.

- Inpatient adult services for female Lambeth residents will in future be provided at Lambeth Hospital rather than the Maudsley Hospital. This involves a £600k refurbishment of Nelson Ward at Lambeth Hospital.

- Overall, there will be a total of 267 adult inpatient beds for Lambeth residents, compared to 274 at the moment [out of a total of 1,100 beds provided by the Trust]. The reduction in the number of inpatient beds is offset by the increase in the provision of community services.

12. Chronology of the Events

This Forms Part of the RCA First Stage

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 incident occurring. It also gives a greater understanding of some of the external factors that may have impacted upon the life of Mr. RT and on his care and treatment from the mental health services. As it was not possible to speak directly to Mr. RT or to his family during the course of this Investigation, the information below has been taken from his clinical records and other relevant documentation. It is as accurate as this information will allow.

Background Information

Mr RT is reported as coming from an African Ghanaian family. Mr RT was born in Ghana in 1974, the youngest of four siblings. At the age of 11 he came to the United Kingdom with his family. Mr RT left school at the age of 15 and worked as a painter and decorator for a brief period[13].

Mr RT said he was married in 1995 and was separated in 1998. However his mother reported to the Trust that he had never been married. The oral history that he gave to his doctor at Broadmoor Hospital advised that he had no children. However this is contradicted by the clinical records held by South London and the Maudsley NHS Foundation Trust which state that he is the father to a little girl probably born in 2001[14].

24 September 1992. Mr. RT was convicted of allowing himself to be carried on a conveyance taken without authority, contrary to the Theft Act 1968 section 12(1), He was fined £50 and asked to pay £20 in costs. Mr. RT's driving license was endorsed[15].

28 July 1994. Mr. RT was convicted of driving whilst disqualified. He was given a Community Service Order of 60 hours and was disqualified from driving for 12 months. Mr. RT was also asked to pay £35 in costs and his license was endorsed. On the same occasion he was convicted of having no insurance. He was fined £180 and his driving license was endorsed[16].

1996. Various psychiatric reports by the Lambeth Adult Mental Health Team refer to an arrest during 1996 for theft. Mr. RT refused to elaborate upon this[17].

May 1996. Mr. RT punched an Asian man in the stomach. On this occasion he pulled out a gun from the waistband of his jeans and pointed it at the man stating 'I am going to kill you star'. The victim was assisted by members of the public. Mr. RT hit one of the men with the handle of the gun over the back of the head. Mr. RT ran away but was apprehended at his home. When the police searched Mr. RT's home they found a large brown handled gun propped up against a suitcase[18].

23 September 1996. Mr. RT was convicted of the possession of a replica firearm with the intent to cause fear of violence contrary to the Firearms Act 1968 section 16A. Mr. RT was imprisoned for 18 months. He was also convicted of possession of a firearm without a certificate contrary to the Firearms Act 1968 section 1(1)(a). He was imprisoned for six months concurrently[19].

25 September 1998. A witness statement provided for a police investigation described Mr. RT punching a shop worker following an altercation after Mr. RT had spat on the shop floor. On this occasion he was seen to take a bottle of liquid, believed to be petrol, out of his pocket before threatening to set light to the store. The fluid was splashed over the face and clothes of the shop worker during the incident[20].

27 September 1998. Mr. RT returned to the same shop two days later during which time a witness reported a scuffle. On this occasion Mr. RT was arrested. The police classified this as a racist attack[21].

February 1999. The first concerns regarding Mr. RT's mental health were raised following his father's death in February 1999. Mr. RT attended his father's funeral in Ghana. During this visit to Ghana Mr. RT was involved in a fight with a cousin who hit him over the head with a baseball bat. Mr. RT was kept in hospital overnight for observation and required sutures to a head wound[22].

10 February 1999. Mr. RT was convicted of common assault contrary to the Criminal Justice Act 1988 section 39 in relation to his above listed activities. He was imprisoned for 14 days consecutively. He also received three months in prison consecutively for using threatening, abusive, insulting words or behaviour with intent to cause fear or provocation or violence, contrary to the Public Order Act 1986 section 4(1) (a)[23].

19 August 1999. Mr. RT was referred by his GP to the Duty Psychiatrist at the Brixton Road Community Mental Health Resource Centre at the Trust. Mr. RT presented to his GP as being nervous and agitated, he also had thoughts about harming his mother with whom he shared a flat. Mr. RT explained that he felt aggressive towards his mother but that he had not actually harmed her. The GP stated that in his view 'this patient needs urgent specialist care'[24]. This was Mr. RT's first referral to mental health services.

20 August 1999. Mr. RT was first seen by a Senior Registrar, Dr. SK, at the South London and Maudsley NHS Trust in response to the GP referral. Mr. RT described intrusive thoughts of throwing boiling water over his mother. It was thought by the psychiatrist that Mr. RT was mildly depressed. Both Mr. RT and Dr. SK felt that no further psychiatric input would be neccessary[25].

27 August OR 2 September 1999 (there is an identical letter in Mr. RT's clinical folder which is headed by two separate dates). Mr. RT was assessed by Dr. S another psychiatrist, in the presence of a community psychiatric nurse, who could find no evidence of a worsening mental state. There would appear to be some missing documentation in the clinical file as this visit appears to have been at Mr. RT's home in the presence of his mother and brother. No explanation is given as to why this visit took place. The Doctor wrote in a letter to Mr. RT's GP that the mother was clearly frightened of her son. The Doctor could find no reason why Mr. RT's mother was afraid of him, but wrote that Mr. RT would require further follow up. The plan was to keep Mr. RT on the Trifluoperazine 5 mg (an anti-psychotic medication) which had been previously prescribed by the GP as Mr. RT felt that he was 'doing well on it' [26].

7 September 1999. A follow up appointment was made for Mr. RT on the 16 September 1999 as recommended by Dr. S. A file note in Mr. RT's records stated the following:

'*Phoned reception to leave message that he does not wish to be seen again…as there is nothing wrong with him*'[27]
It would appear that no further attempt was made to follow Mr. RT up at this stage by the secondary care mental health services.

11 November 1999. Mr. RT's GP referred him to Dr. P, a different psychiatrist at the Trust because he appeared to be very tense and agitated. The GP made this specific referral as he knew that this particular doctor had contact with another member of Mr.

RT's family. The GP had further prescribed Trifluoperazine 5 mg at night and Chlorpromazine 25 mg three times a day. The GP stated his concern that Mr. RT may be suffering from a mild schizophrenia[28].

17 January 2000. Dr. A reviewed Mr. RT at his home on the 17 January 2000 in the presence of a community psychiatric nurse. Mr. RT denied any psychotic thoughts and admitted that he was not compliant with his medication. Mr. RT felt that 'things had calmed down a lot'. However during the course of the meeting his answers were described as becoming 'more vague'. Mr. RT could not say whether or not he lived with his mother, and stated that his wife was in his bedroom and that he also had a girlfriend. The clinical impression formed from the meeting was that Mr. RT presented minimal evidence of thought disturbance. However it was felt that there was evidence of the onset of a functional illness. It was noted that there was a family history of schizophrenia. The Doctor felt that it was appropriate to manage Mr. RT with an antipsychotic and that his mental state would need to be carefully monitored.

Risperidone 2mg *nocte* was prescribed, rising to 4 mg in two days. The intention was to discuss Mr. RT with the Early Onset Team and to review him in four weeks time[29].

17 February 2000. Mr. RT was convicted of possessing an offensive weapon in a public place contrary to the Prevention of Crime Act 1953 section 1. He was imprisoned for three months[30].

17 March 2000. A note in the Community Trust-held record stated that Mr. RT was in Belmarsh Prison having been sentenced for six weeks for the possession of an offensive weapon. The file note said that Mr. RT was due for release in two weeks time. This information had been taken from Mr. RT's sister. A prison contact number appears in Mr. RT's clinical record, but this number does not appear to have been called[31].
14 April 2000. Dr. JA tried to contact Mr. RT's sister by telephone.

2 May 2000. Dr. JA spoke to Mr. RT's mother who said that he appeared to be a lot calmer.

4 May 2000. A letter was written to Mr. RT from Dr. JA, a member of the Assessment and Treatment Team, offering a 'further appointment'. It would appear that Mr. RT had not attended an earlier appointment with the service. [32].

11 May 2000. Dr. JA made a home visit but Mr. RT was not in.

17 May 2000. Dr. JA wrote to Mr. RT's GP. Apparently Mr. RT had been referred to him in March. He stated that he had given Mr. RT two appointments but that Mr. RT had not attended. Dr. JA had also been to visit Mr. RT twice at his flat but found he was not in. On the two occasions that Dr JA visited Mr. RT's home he spoke to his brother twice and to his mother once asking for them to pass a message on to Mr. RT. Neither of them informed Dr. JA that Mr. RT was, or had been, in prison. Dr. JA understood that Mr. RT was not collecting his medication from the GP surgery. Dr. JA stated in his letter 'I will be sending him one more appointment'[33].

1 July 2000. Dr JA wrote to Mr. RT offering him an appointment for the 4 July 2000[34].

26 July 2000. Dr. JA wrote to Mr. RT. Dr. JA was concerned because it was clear that Mr. RT had not collected any medication from the GP surgery since January (both pre and post dating his prison sentence). Dr. JA explained in this letter that Mr. RT could contact him if he was concerned about his medication and also to make another appointment to see a doctor if he would like to do so. Mr. RT had apparently also missed all of his appointments with the Assessment and TreatmentTeam[35].

Dr. JA wrote to Mr. RT's GP to explain the situation and to also inform the GP that Mr. RT would be discharged if the Assessment and Treatment Team heard nothing from him within the next six weeks[36]. It would appear that Mr. RT was discharged.

12 October 2000. Once again a referral was made by Mr. RT's GP to Dr. P. The GP stated that Mr. RT had a family history of schizophrenia, and had himself a history of being thought disordered and paranoid since February 2000. The GP explained that Mr. RT had not been compliant with his medication and neither had he kept any appointments. It is not recorded in the notes made available to the Independent Investigation Team what specifically raised the GP's concern on this occasion[37].

27 October 2000. A letter was sent to Mr. RT inviting him to attend an appointment on the 11 December 2000 with Dr. P[38].

11 December 2000. Mr. RT failed to keep his appointment with Dr. P. Dr. P wrote to Mr. RT's GP asking whether or not a home visit would be a sensible thing as Mr. RT had failed to attend his appointment[39].

25 December 2000. The GP wrote to Dr. P regarding Mr. RT's failure to keep the appointment. The GP letter stated that the family only accessed health input in a crisis, and that the family now felt growing concern about Mr. RT. The GP felt that Mr. RT was not taking his medication and he wanted him followed up as swiftly as possible. It was recognised by both Dr. P and the GP that the issue of non compliance and non attendance would be a significant one[40].

31 January 2001. Mr. RT's mother contacted Dr. P stating that Mr. RT had been attacking her and that she was too frightened to remain living at home with him. A full mental health assessment was arranged for the following Friday. It was noted that Mr. RT had a history of refusing to engage. It was also noted that a history of violence to family members was recorded, but that no forensic history was known[41].

7 February 2001. As a result of the assessment conducted by Dr. P Mr. RT was admitted under the care of Dr. A2 because of his risk of violence towards his family members and deteriorating mental state. Mr. RT was admitted on a Section 2 of the Mental Health Act (83) directly to the psychiatric intensive care unit. He was described as being grandiose with delusions and as having no insight.

Mr. RT was also described as unpredictable and elated with no insight or understanding of his circumstances. He was deemed to be a high risk of both aggression and absconding. The plan was to stabilise his mood and minimise the risk of aggression, and to commence a treatment programme[42].

8 February 2001. Mr. RT was seen on the ward by Dr. M who was a Specialist Registrar. It was noted that Mr. RT's mental state remained the same. He was angry and irritable towards the staff and demonstrated no insight and maintained that there was nothing wrong with him[43].

9 February 2001. Mr. RT was seen on the ward by Dr. A2. Mr. RT displayed signs of grandiose thinking and remained lacking in insight. Mr. RT refused to take his medication[44].

12 February 2001. Mr RT made a formal request for a Mental Health Review Tribunal to appeal against his section status[45].

15 February 2001. Mr. RT was seen at ward round and commenced on Quetiapine 50 mg (an atypical anti-psychotic) BD which he refused to take[46].

21 February 2001. Mr. RT continued to deny that he had any mental health problems and stated that he was being held illegally. A Mental Health Review Tribunal was held. The Tribunal was told that Mr. RT had a history of violence towards both his mother and his sister. It was also noted that Mr. RT was deluded and had grandiose ideas in that he was preoccupied with witchcraft, religion and politics. It was stated that Mr. RT's mother was so afraid of her son that she had moved out of the home that they both shared over the Christmas period to live with her daughter. Mr. RT did not take the concerns of his family seriously. It was agreed that Mr. RT had a psychotic illness and that he would not consent to remain in hospital unless his section status remained. The Tribunal found that the nature of his disorder was of a nature and degree to justify detention[47].

22 February 2001. Dr. M made a Mental Health Act (83) Section 3 recommendation. At the ward round Mr. RT was very argumentative and demanded that he should be discharged. His delusions appeared to be of a religious nature.

Mr. RT's mother called the ward to find out the outcome of the Mental Health Review Tribunal. She stated that she felt her son needed treatment and that she was feeling unwell. Mr. RT had telephoned her and was very angry, blaming her for putting him hospital.

Mr. RT continued to be angry, threatening and deluded[48].

5 March 2001. Mr. RT was placed on a Section 3 of the Mental Health Act (83) due to being aggressive, a risk to others, grandiose and having no insight[49].

7 March 2001. A formal request was made by Mr. RT to appeal against his section[50].

8 March 2001. At the Ward Round it was felt that Mr. RT was deteriorating, he was still refusing his oral medication. The plan was that if Mr. RT continued to refuse oral

medication it would be administered to him via an intramuscular injection (IM) as Mr. RT had been on the ward untreated for four weeks.

At 3.00 pm Mr. RT became increasingly hostile and was restrained using the control and restraint method and given 10 mg Haloperidol and 2 mg Lorazepam IM. He remained aggressive and had to be given 15 mg Diazepam intravenously (IV)[51].

9 March 2001. Mr. RT's medication was prescribed for 20 mg Olanzapine. It was noted that Mr. RT remained reluctant to take oral medication. IM medication was to be administered if he failed to be compliant[52].

25 March 2001. It was noted in the clinical record that Mr. RT was making no improvement with regard to his mental state. However he was recorded as being less aggressive and hostile. His delusions remained strong. He also complained of headaches[53].

3 April 2001. This date was set for a Mental Heath Review Tribunal for Mr. RT to appeal against his Section 3. Although some improvement had been noted it was acknowledged that Mr. RT had no insight and that he remained aggressive. At a Managers Hearing it was stated that Mr. RT had been causing concern for some time and that his compliance with his hospitalisation would cease if his section was rescinded. His appeal to the managers was turned down[54].

12 April 2001. At the ward round Mr. RT was described as making steady progress. He had had some escorted leave and continued to take his medication. While his views were held as strongly as before he could discuss them without becoming angry. The plan was to progress to unescorted leave and to transfer him to an open ward. Soon afterwards Mr. RT was transferred to Nelson Ward under the care of Dr. P.

18 April 2001. Section 17 Leave was granted to Mr. RT until the 26 April 2008. This consisted of 45 minutes of unescorted leave per shift[55].

25 April 2001. Section 17 leave was granted to Mr. RT until the 2 May 2008. This consisted of two hours of unescorted leave daily. The condition for this was that Mr. RT would take his medication[56].

27 April 2001. Mr. RT was discharged from his Section 3 of the Mental Health Act (83) following a Mental Health Review Tribunal despite his Responsible Medical Officer stating

that without a section he was a danger to others. Mr. RT was unwilling to remain on the ward informally, but was seemingly compliant with attending ward reviews. He left the ward on extended leave and was prescribed Olanzapine 20 mg. Mr. RT was allocated a Community Psychiatric Nurse at the Brixton Road Community Centre. The plan was to assess Mr. RT's mental state on a daily basis[57].

8 May 2001. Dr. D (Dr. P's SHO on Nelson Ward) wrote a letter to the Brixton Road Community Mental Health Centre requesting follow up for Mr. RT. This letter stated that Mr. RT had been treated on a Section 3 of the Mental Health Act (83) but that his Section had been discontinued by a Mental Health Review Tribunal. The Doctor explained that Mr. RT would not remain an informal patient on the ward but that he still attended for weekly reviews and to collect TTO medication. The letter asked the Centre to review Mr. RT urgently so that his care could continue in the community[58].

13 May 2001. Mr. RT was discharged from Nelson Ward[59]. There is no mention in his clinical record as to the level of the Care Programme Approach that he was placed on at this juncture.

15 May 2001. Mr. RT was reviewed in the ward round and it was noted that he was getting on better with his mother and that he was compliant with his medication[60].

22 May 2001. The Community Mental Health Team deemed Mr. RT suitable for case management. This entry is made by Ms. A, Mr. RT's allocated Care Coordinator[61].

15 June 2001. Ms. A visited Mr. RT at his home. Mr. RT appeared at first to be well and not to be experiencing any psychotic symptoms. However on further questioning Ms. A found him to be quite deluded. Ms A also spoke to Mr. RT's mother who was currently living next door with her daughter instead of in her own home that she shared with her two youngest children, Mr. RT being one of them. Mr. RT's mother said that she could not cope with living with her sons as the place was always a mess and that she was embarrassed by Mr. RT's behaviour. She was also frightened of him. Mr. RT's mother reported that he drank, smoked cannabis and was not compliant with his medication. His mother mentioned his head injury resulting from the fight two years before at his father's funeral. Ms. A said that she would enquire into the progress of Mr. RT's brain scan which had previously been requested. A visit was scheduled for a social worker to visit Mr. RT on the 20 June 2001 regarding rehousing[62].

20 June 2001. Mr. RT was seen at his home on this day. It is noted that the Social Worker was not able to attend due to sickness. Ms. A reported that Mr. RT remained very much the same as before on her previous visit[63].

5 July 2001. A visit was made by Dr. EI with a member of the Team who was covering for Ms. A whilst she was on annual leave. Mr. RT said that he was well and compliant with his medication. Dr. EI felt that Mr. RT looked well and that his mental state gave no cause for concern. Dr. EI did note that some of Mr. RT's ideas were grandiose but did not feel that this was an important issue at that time. They agreed to meet again in four weeks time[64].

13 July 2001. Mr. RT was seen at home (it is not stated by whom). His mental state was reported as remaining unchanged. Mr. RT said that he wanted to move out of his present accommodation. A review meeting was planned to discuss this three to four weeks into the future[65].

23 July 2001. Mr. RT's allocated Community Mental Health Nurse and Care Coordinator wrote to both Mr. RT and to his GP inviting them to attend a Care Programme Approach meeting on the 31 July 2001[66].

31 July 2001. Ms. A made a telephone call to Mr. RT's mother to find out whether or not she was planning to attend the Care Programme Approach meeting. Mr. RT's mother explained that she was not feeling well and so wouldn't attend. She reported that Mr. RT was a little better and only became aggressive when he drank or smoked cannabis[67].

17 August 2001. Ms. A visited Mr. RT at his home. She reported that he appeared to be stable. She wrote that she would be planning a Care Programme Approach review 'ASAP'[68].

22 August 2001. Ms. A made a home visit to Mr. RT. His mental state appeared to be stable. He did however complain of experiencing headaches which he felt were a direct result of taking his medication[69].

3 September 2001. A letter was sent, (it is not clear from the clinical record who the author was or who the recipient was) summarising that Mr. RT's mother would not be attending the Care Programme Approach meeting (set for that same day) as she was feeling unwell. Mr. RT's mother reported some minimal improvement in his condition in

that he was only aggressive after drinking or smoking marijuana. It was also clear from this letter that there were attempts being made to have him rehoused. The letter also implies that the Care Coordinator had met with Mr. RT on the 31 July 2001, the date of the last planned CPA review[70].

12 September 2001. Ms. A made a home visit to Mr. RT. Mr. RT appeared to be sleepy and said that he had not taken his medication for two weeks as he had not collected it from the pharmacy. Ms. A noted that Mr. RT had grandiose thoughts however she found it difficult to understand whether these were relevant or not as he appeared to be so lucid and rational. Mr. RT complained that he continued to have headaches. Ms. A continued to chase the appointment for his scan. She wrote in the notes that she would visit Mr. RT again in two weeks time and that she would arrange for a Care Programme Approach review 'ASAP'[71].

19 September 2001. The Care Coordinator wrote to Mr. RT and also to his sister to inform them that a Care Programme Approach review was scheduled for the 28 September 2001. There is no record that this event was attended[72].

15 October 2001. At this stage Mr. RT was allocated a new Care Coordinator, Ms. J. The new Care Coordinator wrote to Mr. RT confirming that the next review would be set for the 18 October 2001. It would appear from the clinical events log that Mr. RT attended this meeting; however no record appears to have been made regarding the review[73].

19 October 2001. A letter was sent by the Care Coordinator inviting Mr. RT to attend a CPA review on the 18 October 2001[74].

October 2001. An undated letter was sent from the Care Coordinator to Mr. RT thanking him for letting her know that he had not been able to keep his last CPA appointment. The letter also stated that the next CPA meeting would take place at Mr. RT's home on the 2 November 2001[75].

2 November 2001. A note in the electronic record shows that Dr. El and Ms. J visited Mr. RT at his home. Mr. RT's mother and brother were also present. This note refers the reader to the Care Programme Approach summary which is no longer available and which could not be accessed by the Independent Investigation Team.

Dr. EI reported that there was a clear scent of cannabis in the flat. Mr. RT's mother was present but is described by Dr. EI as being forced into the background by Mr. RT. Mr. RT stated that he did not want to have any further contact with mental health services and that he had stopped taking his medication. Mr. RT was described as being well kempt and it was noted that he acted in a calm and cordial manner unless his mother made an attempt to speak whereupon he would become angry.

Dr. EI's impression was that Mr. RT remained stable, despite hearing that he had stopped taking his medication, and that he had no active psychotic symptoms. Dr. EI decided that there would be no further plans made at that stage other than pursuing the CT scan so that the cause of Mr. RT's headaches could be explored[76].

15 November 2001. Mr. RT came to Brixton Road to collect a sickness certificate. Whilst there he said that he was no longer taking his medication[77].

13 December 2001. A home visit was made to Mr. RT but no access was gained[78].

19 December 2001. A home visit was made to Mr. RT by Ms. J and another member of the Community Team. Mr. RT was reported as being very cooperative, but preoccupied by religious ideas and moral beliefs. Mr. RT wanted to know when he would be discharged from mental health services as he did not believe that he had a mental illness. Mr. RT said he would be amenable to further meetings and that he would contact the team if he experienced any problems[79].

23 January 2002. Ms. J telephoned Mr. RT's mother as she had left a telephone message enquiring as to the results of Mr. RT's brain scan. His mother said that he was sometimes restless and agitated and would punch the wall. Mr. RT's mother informed Ms. J that he now had a six week old daughter, and that the baby's mother lived in north London, and that Mr. RT was trying to establish his role as a father. No arrangements appear to have been made for a Safeguarding Children assessment[80].

1 February 2002. Dr. EI and Ms. J made a home visit but Mr. RT was not at home when they called. Dr. EI and Ms. J went next door to see whether Mr. RT's sister was in. She was not, but a cousin reported that Mr. RT had become very aggressive towards his sister recently following consuming alcohol. Mr. RT phoned the Centre later the same day and arranged to come in for an appointment[81].

5 February 2002. Mr. RT attended an appointment at Brixton Road Centre as previously arranged on the 1 February 2002. Dr. EI informed him that his brain scan results were normal. Mr. RT stated once again that he did not want to continue his involvement with mental health services. Dr. EI invited Mr. RT to continue to see him in Outpatients. Mr. RT said he would consent to this if medication was not involved. Dr. EI noted that Mr. RT still had grandiose thoughts. The action from the meeting was that Dr. EI was going to consider discharging Mr. RT formally from the Care Programme Approach. Ms. J telephoned Mr. RT's sister to inform her of the outcome of the meeting[82].

14 March 2002. Mr. RT's mother telephoned Dr. EI expressing her concerns about him. Dr. EI visited Mr. RT at his flat. Mr. RT appeared to be well kempt and was surprised that his mother had called. He denied being aggressive towards her and said that the disagreement had been about a passage in the Bible. Mr. RT continued to manifest his delusional beliefs and said that his continued contact with mental health services would prevent him from being able to communicate with the United Nations[83].

21 March 2002. Mr. RT's mother telephoned to request a meeting with Dr. EI. She explained that Mr. RT always behaved well when services called and visited him at home. Mr. RT's mother claimed that Mr. RT had kicked his sister's boyfriend and he was generally argumentative and restless. She believed that he was smoking cannabis and drinking alcohol. Mr. RT was also refusing to take his medication and was becoming preoccupied with his grandiose ideas[84].

4 April 2002. Mr. RT's mother telephoned Ms. J to say that she had called the police to the house because Mr. RT had been noisily knocking on the door and disturbing the neighbours. He was also reported to have assaulted his cousin. The police interviewed Mr. RT and warned him not to enter his mother's house. They did not arrest him at her request. Mr. RT's mother asked that a mental health assessment be carried out[85].

5 April 2002. Ms. J and a doctor from the Community Team spoke to Mr. RT's elder brother regarding their mother's concerns about Mr. RT. Mr. RT apparently had a fight with his male cousin on the evening of the 3 April. The cousin was staying with Mr. RT's mother at the time. Mr. RT's girlfriend's brother was also present and separated Mr. RT from his cousin and called the police. The family were concerned that Mr. RT was becoming increasingly irritable due to his drinking and cannabis habit which had escalated

over the past few months. (There is no mention as to whether the girlfriend and their baby were present during this fight).

When Ms. J and the doctor spoke to Mr. RT in private he had a different account of the events and said that there was only a minor argument between him and his cousin. Mr. RT expressed many grandiose ideas which included religious elements. He maintained the belief that he was not mentally ill. Ms. J and the doctor informed Mr. RT that they would inform the police if an incident such as this was reported to them again. Ms. J and the doctor advised Mr. RT's mother to call the police if he became violent again. Ms. J and the doctor felt that on balance Mr. RT was not detainable at that time. The plan was to discuss with Dr. EI. No risk assessment was undertaken[86].

10 April 2002. Mr. RT's sister telephoned Ms. J. She said that there had been no concerns over the weekend. The sister explained that she had a good relationship with her brother and that he only got angry when he smoked cannabis. She said that he was good with children and that he spent all of his money on his baby daughter.

Ms. J discussed this with Dr. EI and a date for a meeting was set for the 30 April 2002[87].

23 April 2002. A letter was sent by the Care Coordinator to Mr. RT inviting him to meet with herself and Dr. EI on the 30 April 2002[88].

26 April 2002. Ms. J discussed the appointment that had been for the 30 April 2002 with Mr. RT's brother over the telephone and sent a letter to Mr. RT. The clinical record notes that Ms. J had also spoken to Mr. RT's elder brother regarding an incident that had occurred on the 23 April 2002 when Mr. RT pushed a friend who was visiting the family. Mr. RT's brother implied that the family felt Mr. RT should be receiving treatment. Ms. J explained that the Team could not treat Mr. RT without his consent and that they were trying to maintain contact and engage with Mr. RT[89].

1 May 2002. The clinical record states that:
'*after further calls from the family regarding two further episodes of aggression we met Mr. RT and his mother yesterday*'.

The Care Coordinator accompanied by a doctor from the clinical team met with Mr. RT's mother and Mr. RT. Mr. RT had no insight into his behaviour and denied being aggressive

with a family friend. Mr. RT was very concerned about his headaches even though his scan had shown negative results. Mr. RT was very deluded. A sickness certificate was given to him for paranoid psychosis which he refused to accept. The doctor and the Care Coordinator considered Mr. RT at this stage to be an increasing risk to his family. They made a recommendation that a Section 3 under the Mental Health Act (83) be applied.

Following this meeting the Care Coordinator, together with the Doctor who had accompanied her on the visit made to Mr. RT, met with Dr. EI, Mr. RT's Consultant Psychiatrist, who agreed that a Section 3 under the Mental Health Act (83) was necessary. Mr. RT's sister and mother were contacted to this effect and a message was left with Mr. RT's GP[90].

7 May 2002. The Care Coordinator spoke to Mr. RT's sister over the telephone. Mr. RT's sister said that he was continuing to take his medication but was experiencing bad headaches. He was also sleeping a lot[91]. **There is no further mention in the clinical record regarding the events of the 1 May 2001. There is no mention of any further follow up or why the decision not to proceed with the Section 3 occurred.**

13 May 2002. The Care Coordinator telephoned Mr. RT's mother and spoke to Mr. RT's sister instead, who told her that Mr. RT was much calmer and that he was taking his medication. It was unclear whether or not Mr. RT understood that the medication he was taking was prescribed for his mental state. The medication had been prescribed by the Team Consultant Psychiatrist[92].

20 May 2002. An entry was made by the Care Coordinator. A telephone call was taken from Mr. RT's sister stating that he didn't want to collect his medication any longer, but that she would be happy to do so. Mr. RT's sister said that he was taking his medication and appeared to be better as a result[93].

31 May 2002. Mr. RT's mother was contacted by telephone by the Care Coordinator. She said that he appeared to be stable. Mr. RT was not being aggressive and was taking his medication. Ms. J recorded that 'she [Mr. RT's mother] is basically keeping out of his way[94]'.

17 June 2002. The Care Coordinator made a telephone call to Mr. RT's mother. She was told that Mr. RT appeared to be well and that Mr. RT's mother was 'keeping a low profile'

with him. She was also told that Mr. RT's sister continued to give him his medication and provided him with support[95].

21 June 2002. Letter was sent from Dr. JR to Mr. RT's GP. In this letter Dr. JR explains that Mr. RT had a long history of delusions and that he had on several occasions assaulted several friends of the family. Mr. RT's mother had been concerned about a possible brain haemorrhage and therefore a CT scan was ordered to rule out any organic pathology. Mr. RT however continued to complain of headaches. Mr. RT was taking 10 mg Olanzapine Nocte.

24 June 2002. Mr. RT's mother was contacted by telephone by the Care Coordinator. She stated that Mr. RT was doing well and was taking his medication[96].

2 August 2002. The Electronic record shows that a call was made to Mr. RT's mother who said that she had no concerns about him at the present time, but that she was still unable to move back into her own flat as this would make the situation difficult. She was informed that a new Care Coordinator, Mr. DG, would be taking over the case. Mr. RT was reported to be taking his medication[97].

6 August 2002. A letter was sent from Mr. RT's GP to Dr EI stating that Mr. RT had long standing delusions and that he refused to accept that he had problems and was not compliant with his Olanzapine. The GP also stated that he was very concerned that Mr. RT would relapse and requested that Dr EI review him[98].

26 August 2002. An electronic entry in Mr. RT's Trust clinical record states that a call was made to Mr. RT's sister to arrange an introductory visit. This note does not state by whom the visit would be made or who wrote the entry[99].

On this date Mr. DG filled in a mini risk assessment to ascertain whether or not Mr. RT met the criteria for a full risk assessment (although it is not clear that he had yet met with Mr. RT). It was decided no further action was required[100].

2 September 2002. Mr. DG, describing himself as 'the' Care Coordinator wrote to Mr. RT's GP stating that Mr. RT was reluctant to see staff from the Trust and that he was in the process of trying to negotiate a home visit to meet with Mr. RT and his sister who was described as being his main carer. This letter explained that Mr. RT's medication was

prescribed and then collected from the pharmacy at the Lambeth Hospital by a member of Mr. RT's family on a fortnightly basis. The prescription was for Olanzapine 10 mg *nocte*. Mr. DG wrote that he found it hard to ensure that Mr. RT was compliant and that his medication had been left uncollected on occasion. Mr. DG further explained to the GP that he would be in touch if there was a further change in Mr. RT's condition[101].
Mr. RT's Trust electronic record records an entry stating that a call had been made to the pharmacy to ascertain whether Mr. RT's medication was being collected by a family member on a fortnightly basis. It was positively confirmed that this was the case[102].

20 September 2002. A letter was sent from Dr. W, Mr. RT's GP, thanking Mr. DG for his letter dated the 2 September 2002. The GP letter stated that Mr. RT had told him that he was on no medication, and that he had no psychiatric disorder. The GP stated that he tried to talk to Mr. RT and explain that he had schizophrenia and that if he did not take his medication he would relapse. The GP also stated that this was a long standing issue and that he did not believe there was anything else that could be done[103].

22 November 2002. Dr. NS wrote to Mr. RT explaining that he had taken over from Dr. EI and that he would like to arrange a meeting between Mr. DG, Mr. RT and himself[104].

7 December 2002. A Care Programme Approach review conducted on this date noted that there had been no contact between secondary care mental health services and Mr. RT. The review recorded that the family continued to collect his medication and that Mr. RT had no insight into his condition. It is clear from the record that no one appears to have been invited to this review, or indeed attended it. A Ms. W completed the review form stating that she had never met Mr. RT and that he had never had a CPA review. It was stated in the review summary that Dr. NS was aware of the situation and that he would pursue contacting the family.

No mention is made on the CPA form what level of CPA Mr. RT was on or who his Care Coordinator was at this time or why Ms. W, and not either Mr. DG, or Ms. J (both appearing to be acting as his Care Coordinators at this time according to Mr. RT's clinical records) had completed the documentation[105].

28 March 2003. Mr. RT and his sister did not attend for a Care Programme Approach review. The documented plan was to contact his sister and to discuss a way forward. A telephone message was left for Mr. RT's sister[106].

17 July 2003. Dr. NS and Ms J visited Mr. RT. He had been unwilling to have any contact with mental health services for several months. Mr. RT's sister was collecting all of his medication from the Lambeth Hospital pharmacy. Mr. RT appeared rational but did hold a few delusional ideas. It was agreed that Mr. RT would be discharged from case management but that Dr. NS would continue to prescribe his medication for him. Mr. RT's sister was written to to this effect[107].

21 July 2003. A letter was sent to Mr. RT's sister explaining that Dr. NS was closing the case but that he would continue to prescribe for Mr. RT. The letter explained that if the family grew concerned over Mr. RT they could contact services and the number for the Rapid Response Team was given[108].

25 July 2003. Ms. J wrote a summary report stating that Mr. RT appeared to be stable and that there were no concerns about his behaviour from his family. His risk behaviours were noted as being aggression towards his mother and a cannabis smoking habit. The summary mentioned his 18 month prison sentence in 1995, but this appeared to be dismissed as irrelevant as Ms. J repeated the explanation that Mr. RT had given of 'finding the gun in the street'. This explanation had been rejected by the Crown Court. The summary also records that although Mr. RT lived with his mother, she was still living next door with her daughter. It was noted that Mr. RT had a baby daughter with whom he had contact. No safeguarding children assessment was conducted[109].

A contingency plan was developed for Mr. RT's family to contact services should they have any concerns. It was noted that Mr. RT had no insight and had been aggressive towards his family members. It was noted that intensive family support had been offered and that this had worked in the past to keep Mr. RT well[110].

Ms J filled out a mini risk assessment to ascertain whether or not a full risk assessment was required. The risk assessment that Ms. J selected only looked at Mr. RT's risk towards himself regarding suicide. Out of the five fields present in the mini risk screen only two were filled in as known. No mini risk assessment was used to ascertain Mr. RT's potential violence towards others. It was decided by Ms. J that no further risk assessment was required because:

'risk is likely to be low and inquiry would be inappropriate'[111]

3 February 2004. Mr RT's clinical record notes that his medication was being collected on a regular basis and that he was due for a review in August 2004. This review does not appear to have taken place[112].

2 February 2005. Mr. RT attended Brixton Road requesting the Centre to tell his GP that he had been discharged from the Centre. Mr. RT was reported as being pleasant and polite[113].

20 January 2006. Ms. T, an Outpatient nurse, wrote to Mr. RT's sister explaining that Dr. NS had moved to a different area and that he wished to meet with her to discuss Mr. RT's care. The letter points out that Mr. RT had not been seen by a psychiatrist for two years even though Mr. RT's sister continued to collect his medication from the Trust pharmacy. The letter pointed out that the prescription was due to expire in February 2006. The letter arranged for a meeting to be held on 2 February 2006 at the Outpatient Department. Ms. T wrote that Dr NS was no longer Mr. RT's RMO as he was now working with a different team[114].

30 March 2006. Dr. NS was present at the Outpatients Department on this date to see Mr. RT's sister. Mr. RT's sister did not attend. The plan for the future was that if Mr. RT's sister made contact with secondary care services she would be given the number of the Brixton Road Centre.

At this time Mr. RT had not been seen by a doctor for three years. He had refused to come to the Outpatient Department. Dr. NS had been prescribing Olanzapine 10mg *nocte* during this entire period[115].

14 April 2006. On the 14 April 2006 Mr. RT carried out an arson attack on a shop in Tulse Hill. A witness described a man who was seen to be carrying a paint kettle of about two and a half litres in size. The man was then seen to light the paint kettle, and once this kettle was aflame, he was observed throwing it into the shop. Once this had been done the man was seen walking away to the north along Tulse Hill[116].

20 April 2006. On the 20 April 2006 Mr. RT carried out a second arson attack at a food and wine shop in Portland Road. A witness described a large man who carried an object that looked like a bottle. The man was seen to throw the object into the shop. Another

witness who saw the bottle land inside the shop stated that a fire broke out in 'milliseconds'[117].

27 April 2006. On the 27 April 2006 Mr. RT carried out a third arson attack at a food and wine shop in the Clapham Road. At around 3.30 in the afternoon a shop worker in the store heard what he thought to be breaking glass. A small explosion followed rapidly and flames were seen to spread across the floor. There were four shop workers in the store that day, of which two were able to escape from the fire. The two other workers were to die later of their injuries[118].

1 May 2006. Mr. RT was arrested on suspicion of arson and murder[119].

July 2007. At the Central Criminal Court the Judge ordered that Mr. RT be detained at Broadmoor Hospital indefinitely after he pleaded guilty on the grounds of diminished responsibility to three counts of arson with intent to endanger life on the grounds of diminished responsibility[120].

13. Timeline and Identification of the Critical Issues

RCA Second Stage

Timeline

The Investigation Team formulated a Timeline in table format and also a chronology in a narrative format in order to plot significant data and identify the critical issues and their relationships with each other. This represents the second stage of the RCA process and maps out all of the emerging issues and concerns held by the Independent Investigation Team.

Critical Issues Arising from the Timeline

On examining the timeline the Independent Investigation Team initially identified critical junctures that rose directly from the care and treatment that Mr. RT received from the South London and Maudsley NHS Foundation Trust. These critical junctures are set out below.

1. Delays occurred from specialist secondary care services when conducting assessments of Mr RT's mental state following repeated urgent referrals by his General Practitioner in the autumn and winter of 1999.

2. Mr. RT did not receive the care and treatment that he required from specialist mental health services between January and July 2000. During this period Mr. RT was supposed to have been assessed and monitored by the Brixton Road Community Mental Health Resource Centre. However he was discharged from their caseload due to non- engagement. This 'non-engagement' was partially due to the fact that Mr. RT was serving a three month prison sentence for carrying an offensive weapon. The implications of Mr. RT's prison sentence do not appear to have impacted upon any clinical plan that was offered to him.

3. Mr. RT was detained on a Section 2 of the Mental Health Act (83) on the 7 February 2001. Mr. RT refused to take medication. On the 5 March 2001 he was placed on a Section 3 of the Mental Health Act (83). On the 8 March 2001 Mr. RT received his first medication. It is unclear why Mr. RT remained untreated for so long when he was clearly unwell, aggressive and lacking insight.

4. On the 1 May 2002 the clinical team treating Mr. RT decided that he required detention under Section 3 of the Mental Health Act (83). An assessment visit was made and a recommendation was agreed by the visiting team members, however no action ensued and no section was arranged.

5. On the 17 May 2003 at a CPA meeting it was decided that Mr. RT would be removed from case management but that Dr. NS would follow him up in Outpatients and would continue to prescribe although it was accepted that he was unlikely to ever attend. In effect Mr. RT was moved from enhanced to standard CPA at this time. It was agreed that the family would be written to by Dr. NS giving contact numbers for the sister or other family members if problems were to arise. This decision appears to have been made on the basis that Mr. RT was judged to be a low risk, the assumption was made that he was settled. Mr. RT was an uncooperative patient and there was nothing to indicate that Mr. RT was a risk at this time. However Mr. RT was non-compliant with medication, and his family had not been involved in the decision.

The five critical junctures listed above are incorporated under the relevant headings listed directly below. They are examined in detail under these headings in section 14 of this report.

Critical Issues Arising from the Review of other Data

The Investigation Team found other critical issues that were not immediately apparent from analysing the timeline and the chronology. These issues are set out below under the key headings of the Independent Investigation Terms of Reference.

1. **Management of Clinical Care and Treatment.** The Investigation Team could not identify a coherent and robust care and treatment plan for Mr. RT. The emphasis for this finding is based on the fact that Mr. RT did not receive basic components of care and treatment.

2. **Diagnosis and Medication.** Mr. RT was given Olanzapine whilst an inpatient and no one subsequently ever checked whether it was the most appropriate medication or whether it was effective. No robust checks were undertaken to ensure that Mr. RT was compliant with his medication and there are good grounds to suggest that Mr. RT's condition between 2000 and 2006 was partially treated at best.

3. **Clinical Risk Assessment and Forensic Risk History.** There was no evidence to suggest that Mr. RT had been subject to a sound clinical risk assessment process. Mr. RT had a significant forensic history which included three terms in prison. All three prison terms were for acts of violence. The Independent Investigation noted that Mr. RT's forensic history was never discussed or explored in such a way as to ensure that he presented no further risk to the general public.

4. **Care Programme Approach.** It was evident from Mr. RT's clinical records that Care Programme Approach meetings were being arranged on a regular basis. However the Independent Investigation Team could find no evidence to support the notion that the Care Programme Approach was being implemented in a thoughtful manner in keeping with both national and local policy, particularly between 2001 and 2003 when he was on enhanced CPA.

5. **Carer Assessments and Carer involvement in Care Planning.** Throughout the examination that the Investigation Team gave to the review of the care and treatment of Mr. RT, no evidence could be found to suggest that Mr. RT's mother had been offered a formal carer assessment. Nor was there evidence of any face to face meetings with Mr. RT's sister to ascertain her views regarding his mental illness, despite the fact that she was relied upon as the principal agent for ensuring that he received and took his medication.

6. **Service User Involvement in Care Planning.** It is perfectly obvious that Mr. RT was a non-compliant patient who had limited or no insight into his mental condition and the need for treatment. Nevertheless, he was sometimes willing to meet with healthcare professionals and have discussions about his situation. These discussions did not lead to the development of a holistic care and treatment plan.

7. **Cultural Diversity.** It would appear that assumptions were made regarding Mr. RT's behaviour in the light of his cultural background. These assumptions were not tested or discussed with either Mr. RT or with his family.

8. **Safeguarding Children.** Despite Mr. RT's well-reported acts of violence in a domestic setting no safeguarding children assessment was made with regard to his baby daughter in line with extant Trust policy guidance.

9. **Interagency Communication and Working.** There is no evidence that services made any attempt to contact either the police or the probation service regarding Mr. RT's past criminal record.

10. **Organizational Change Management.** Between 2001 and 2006 the South London and Maudsley NHS mental Health Trust underwent a high degree of organizational change. This change encompassed the merging of corporate services, the development of local Lambeth services and a Trust-wide adoption of new electronic clinical records systems. These events undoubtedly impacted upon the care of this patient, e.g. frequent changes of care staff in the Community Team particularly, which impacted on communication exacerbated by the parallel use of paper and rudimentary electronic records.

11. **Adherence to National and Local Policy Guidance.** The Trust was found to have sound policies in place at the time of the incident. However the Investigation Team did not find evidence to demonstrate that these local policies were adhered to by clinical staff on a day to day basis regarding the care and treatment of Mr. RT. This statement is made with particular regard to all aspects of risk assessment and CPA.

12. **Documentation.** The overall quality of Mr. RT's clinical record was found to be poor by the Independent Investigation Team. Written evidence of risk assessment and care planning were virtually non existent. The bulk of the clinical record, both paper and electronic, is presented in the case of Mr. RT as that of a 'cardex system' which is a fairly primitive form of clinical note keeping and not compatible with basic minimum practice standards. Another key documentation issue included an information management technology problem that had inadvertently changed key data in the electronic record. This meant that the Investigation Team could not ascertain with any clarity from reading the records certain key patient related information.

13. **Clinical Supervision.** The practice and process of both clinical and caseload supervision could not be tracked by the Investigation Team during their review.

14. **Clinical Governance processes.** The Investigation Team found significant issues regarding non-adherence to both the Trust care programme approach and risk assessment policies. The Investigation Team also found significant issues relating to

the effectiveness of the Trust electronic record. It is apparent that audit processes in place between 2001 and 2006 were not able to detect potential clinical governance weaknesses in these areas.

The above fourteen critical issues were identified by the Independent Investigation Team as requiring an in-depth review. It must be stressed that critical issues in themselves do not necessarily have a direct causal bearing upon an incident.

The Independent Investigation Team also conducted a review into the South London and Maudsley NHS Foundation Trust Internal Investigation process, reporting, and action planning implementation outcomes. This is explored in section 16 below.

14. Further Exploration and Identification of Causal and Contributory Factors and Service Issues

RCA Third Stage

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. key causal, contributory and service issue factors.

In the interests of clarity each critical issue is set out with all the factual evidence relevant to it contained within each subsection. This will necessitate some repetition but will ensure that each issue is examined critically in context. This method will also avoid the need for the reader to be constantly redirected to reference material elsewhere in the report. The terms 'key causal factor', 'contributory factor' and 'service issue' are used in this section of the report. They are explained below.

Key Causal Factor. The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team have concluded had a direct causal bearing upon the deterioration of Mr. RT's mental state, which subsequently may have led to the homicides that occurred in April 2006. 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 care and treatment that a service user receives and any subsequent homicide perpetrated by them.

Contributory Factor. The term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown in Mr. RT's mental health and/or the failure to manage it effectively.

Service Issue. The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of April 2006, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvement to services made.

14.1. Critical Issue Number 1. Management of Clinical Care and Treatment

This section examines the general management of Mr. RT's overall care from when he came to the notice of mental health services in August 1999 to the time of his arrest for major offences in May 2006.

14.1.1. Description of Events between 18 August 1999 and 15 May 2001

Mr. RT's GP wrote a referral letter dated 19 August 1999 to the Brixton Road Community Mental Health Resource Centre. This letter reported Mr. RT had attended the surgery that day with symptoms dating from the time of his father's unexpected death in a road traffic accident in February 1999. Prior to this event Mr. RT said that he had been well. He now presented with feelings of depression, not sleeping and having violent thoughts, particularly towards his mother. His brother was known to mental health services and was being treated for a chronic psychotic disorder[121].

Mr. RT was assessed at Brixton Road Mental Health Resource Centre on 20 August, when he reported 'thinking too much' following his father's death. He described an incident in Ghana around the time of his father's funeral when he was assaulted by a cousin with a baseball bat, leading to overnight observation in hospital and suturing of scalp wounds. He reported no loss of consciousness. Following his return to the United Kingdom he said that his mood gradually deteriorated, his sleep became fitful and approximately one week previous to the assessment he developed thoughts of pouring boiling water on his mother, with whom he lived, causing him to become preoccupied and anxious[122].

At interview on 20th August Mr. RT was described as co-operative and somewhat low in affect. There was no evidence of psychotic thought processes. The Specialist Registrar, Dr. SK of the Assessment and Treatment Team, advised the GP that his impression was that Mr. RT suffered from a mild depressive disorder. He had been given advice regarding his anxieties and it was understood that the GP was providing a hypnotic for the sleep problem[123].

However, a further letter from Dr. SS a Specialist Registrar from the Community Psychiatry team dated 27 August 1999 implies that there had been a home visit following concerns expressed by the patient's mother that she was frightened of him. The Community Team notes indicate that Mr. RT's mother had rung, requesting an urgent visit saying that her son was aggressive and threatening towards her to the point that she was too frightened to go back to the home that they both shared[124].

At interview Mr. RT appeared 'appropriate' although described as anxious, hyper vigilant and guarded. Nevertheless he denied experiencing any psychotic phenomena. The visiting staff concluded 'we could find no evidence of a worsening mental state, and we had no concerns, as he was interacting well with the other man in the house [this man being his brother]. We are unclear of his mother's worries, but he will need closer follow-up'. It was understood that he was taking some Trifluoperazine, which he believed to be an antidepressant and he was advised to continue with this as he said that he felt that it was helping him. It was agreed that the Assessment and Treatment Team would continue follow-up[125].

A follow up appointment was made for Mr. RT on the 16 September 1999 as recommended by Dr. S. A file note in Mr. RT's records states the following:

'Phoned reception to leave message that he does not wish to be seen again…as there is nothing wrong with him'

It would appear that no further attempt was made to follow Mr. RT up at this stage by the secondary care mental health services[126].

On 11 November 1999 Mr. RT's GP referred him to Dr. P, a different psychiatrist at the Trust, because he appeared to be very tense and agitated. The GP made this specific referral as he knew that this particular doctor had contact with another member of Mr. RT's family. The GP had further prescribed Trifluoperazine 5 mg at night and Chlorpromazine 25 mg three times a day. The GP stated his concern that Mr. RT may be suffering from a mild schizophrenia[127].

The next entry in Mr. RT's Community Trust held record was made on 19 January 2000, when there was a further domiciliary visit and a letter to, and telephone discussion with, the GP. In a letter dated 25 January 2000 the Specialist Registrar of the Assessment and Treatment Team, Dr. CA states that Mr. RT said that things had calmed down a lot. He still thought too much sometimes. He denied depression or any psychotic symptoms or illicit drug use. He said that his relationship with his mother was much better now. He admitted that he was not taking his medication, because he felt that it made him restless[128].

'*As the interview progressed he became more vague in his responses, his thoughts were rather muffled (sic - presumably 'muddled'), he was becoming suspicious and guarded. He said his wife was in the bedroom, we asked if we could talk to her, he went into the bedroom and came out saying she does not want to talk to us. He then added that he had a girlfriend who comes to the house to see him. He said his wife did not mind. His mother had told our colleague in the past that Mr. RT was not married. He said he spent 18 months in prison 5 years ago for carrying a replica firearm. He was also arrested for theft 4 years ago. He said he would take his medication if it would help him sleep.*[129]'

'*The impression was of… a man with minimal evidence of disturbance in his thought processes associated with some paranoia. He is quite guarded and lacks insight. This could well be the onset of a functional illness. There is a family history of schizophrenia. He has so far not been compliant with medication…please commence Risperidone and we will discuss his suitability with the early onset team. He will be reviewed in four weeks*'[13]

Trust Community held clinical records on 7 February 2000 confirm that Mr. RT was not accepted by the Lambeth Early Onset Team. When followed up on 17 March 2000 it was noted that he was currently in Belmarsh Prison serving a three month sentence for possession of an offensive weapon. He had been charged with this offence four months previously. There is no record of any interagency communication regarding this matter and neither is there any evidence that Mr. RT's clinical risk was assessed in the light of this offence[131].

The Specialist Registrar Dr. JA wrote to the GP on 17 May 2000 stating that since taking over the case in March he had been trying to see the patient without success. He understood that medication was not being collected from the surgery. This letter does not mention the fact that Mr. RT had been in prison during this period and it is unclear whether or not Dr. JA understood this to be the reason why Mr. RT had not collected his medication or kept his appointments. However the notes indicate that Mr. RT's mother had been spoken to on 2 May 2000 and she reported that her son was 'calmer' and 'OK' indicating that Mr. RT was presumably out of prison by this date[132].

On the 26 July 2000 Dr. JA wrote to Mr. RT's GP stating that he had failed to attend an appointment that had been arranged for the 18 July. Dr. JA explained that unless he heard from Mr. RT within six weeks he would discharge him from the Brixton Road caseload[133].
Mr. RT was technically discharged from follow-up in September 2000.

Mr. RT was soon re-referred to services by his GP in October 2000. Mr. RT was offered two outpatient appointments in November and December by Dr. P but failed to attend[134]. By December it was clear that Mr. RT's family were growing increasingly concerned about his mental health. The GP wrote once again to Dr. P requesting advice and suggesting that Mr. RT required following up as swiftly as possible[135].

An urgent assessment was requested for Mr. RT on 31 January 2001 following a telephone call from his mother to Dr. P. She stated that Mr. RT had been attacking her. This led to a Mental Health Act assessment at his home, attended by health staff, police and an ambulance. The patient refused them entry. His sister then spoke to staff indicating that he became violent at times when he drank alcohol, and that he had assaulted her in the past and that he often wrote letters to world leaders in Africa about convening peace. The patient was admitted to Eden Ward (Intensive Care Unit) on Section 2 (Mental Health Act 1983) on 7 February 2001 after his mother had indicated that she had moved out of the flat that she shared with Mr. RT because of his increasing violence towards her[136].

Mr. RT was treated on Eden Ward by Dr. A2 and her team. When seen by her on 9 February 2001 he complained about being admitted to hospital, and was judged to be manifesting grandiose delusions, some irritability and a lack of insight. He was in denial about his family's concerns. It was explained to him that he had been admitted for assessment following a perceived deterioration in his mental state[137].

It was felt that Mr. RT had probably been suffering from untreated schizophrenia prior to admission, he was offered oral anti-psychotic medication and the plan was to treat him under Section 3 of the Mental Health Act (83) in due course as he was refusing medication. This remained the plan for the next three weeks. During this time his family visited him regularly, his sister brought him in meals as he was unwilling to eat the hospital food. He continued to complain about being admitted, to pursue his grandiose ideas (which included making nuisance telephone calls to Westminster Abbey and writing frequent letters to the United Nations) and was occasionally hostile but not physically aggressive. He was seen at a Mental Health Review Tribunal on 21 February 2001 and was not discharged on the basis that he was suffering from an untreated psychotic illness and that there was risk to others, specifically the patient's mother and sister[138].

Mr. RT was regraded to a Section 3 of the Mental Health Act (83) on 5 March 2001. As well as having a preoccupation with major land projects in Ghana, he was expressing ideas about killing homosexuals, ridding the world of sin and converting other religions to Christianity. He was still refusing psychotropic medication. The Specialist Registrar Dr. M wrote of checking 'co-informant history' but in fact no detailed history appears to have been collected from the family, nor were the details of his past offending verified (e.g. his recent prison sentence, noted in the outpatient records, is not even referred to in the later report to the Mental Health Review Tribunal). The question of imminent use of medication by injection having been raised at the ward round of 8 March 2001 led later that day to an outburst from the patient that required control by restraint (control and restraint techniques) and rapid tranquillization with intravenous diazepam[139].

Mr. RT required a further injection the following day and then began to accept oral Olanzapine, once he recognised that the alternative was further medication by injection. It was noted on 17 March 2001 that although the patient was now consistently pleasant and was accepting oral medication, his abnormal beliefs were still very much in evidence and he seemed to be trying to divide the clinical team by suggesting that some nurses agreed with him and only the medical staff thought that he had a mental health problem. Information from the social worker was that the family was split over their view. One brother thought that it was a medical problem whereas others thought that it was related to ‘bad luck’ resulting from his father's death[140].

At a ward round on 22 March 2001, attended by Mr. RT’s mother, the events leading to admission and the current diagnosis (schizophrenia) were discussed. Mr. RT’s mother explained that she felt pressured by her son to write letters saying he was all right and that she didn't feel confident about facing him and challenging his beliefs in the ward round. It was evident that she was frightened of him. In the ward round Mr. RT became angry when his mother would not accept his viewpoint telling her that what she said did not make sense and eventually the interview was terminated by the Responsible Medical Officer. Nevertheless, Mr. RT was noted next day as being relaxed and not hostile to staff. By the ward round on 12 April 2001 he was seen as making steady progress. He had had some escorted leave and continued to take his medication. While his views were held as strongly as before he could discuss them without becoming angry. The plan was to progress to unescorted leave and to transfer him to an open ward[141].

Mr. RT was transferred to Nelson ward on 12 April 2001. At the ward round on 25 April 2001 Dr. P the Responsible Medical Officer agreed to periods of unescorted leave. Mr. RT was seen as settled and appropriate but still deluded and without insight. A CT scan was agreed to because of his persistent headaches. At a further Mental Health Review Tribunal on 27 April 2001 Mr. RT was discharged from Section on the grounds that he said that he was willing to accept medication on a voluntary basis even though he did not believe that he was mentally ill. Later that day it was agreed that he would come in daily to take medication and he went home on leave. When his case was reviewed on 15 May 2001 he was described as managing well at home, getting on well with his mother and complying with medication. There is no record of a formal mental state examination on that day. He was discharged to the care of the Case Management Team at Brixton Road as of 15 May 2001[142].

14.1.2. Findings and Analysis by the Independent Investigation Team for the Period of Mr. RT's Care and Treatment between 18 August 1999 and 15 May 2001

At the time of Mr. RT's discharge he had been under the care of the inpatient services for a period of 13 weeks. In contrast to some service users in this situation, he had strong family links and both his mother and his sister regularly visited the ward and spoke to staff.

There are four main issues of concern arising from this period of care and treatment that Mr. RT received.

1. **Initial GP Referrals**

Dr. W, Mr. RT's GP, made an urgent referral to secondary care services on the 19 August 1999. Mr. RT was first seen by the Trust on the 20 August 1999 whereupon it was felt that no further psychiatric input would be necessary. However we know that he was visited at his home on the 27 August for an assessment by two psychiatrists, the clinical records do not record why this change to the 20 August plan was made. The plan on the 27 August was that Mr. RT would require 'follow up'. However this did not occur.

Dr. W once again referred Mr. RT to secondary care services on the 11 November 1999. It took nine weeks for Mr. RT to be seen on the 17 January 2000. Directly following this period it would appear that Mr. RT went to prison. Mr. RT was not seen again until his GP made the next referral.

Dr. W referred Mr. RT once again to secondary care services on the 12 October 2000. It took until the 7 February 2001 for Mr. RT to actually be seen by a member of the Trust clinical team, whereupon he was admitted to Eden Ward.

Between 19 August 1999 and 7 February 2001 Mr. RT was only seen three times by secondary care services despite three referrals from Mr. RT's GP. Secondary care services did not follow Mr. RT up in accordance with their own recorded plan and did not appear to take into consideration the concerns of both the GP and Mr. RT's family. This period of time represents an early opportunity to have assessed and treated Mr. RT's psychiatric condition. It is one that was missed.

2. History Taking

The Independent Investigation Team found that the quality of the history taking in the case of Mr. RT to be poor. For example, the account of his background given in the first report for the tribunal dated 13 February 2001(one week after his admission) is reproduced apparently without alteration in the discharge summary of 25 May 2001. Although Mr. RT's mother's conversations with nursing and medical staff are recorded from time to time in the notes, there seems to have been no attempt to interview the family systematically to get their account of historical facts. Mr. RT's own version of his background history was taken as being entirely factual despite the fact that he was clearly deluded at the time.

Some of the Background history accounts are contradictory and it would appear that the clinical team did not confirm or correct the information that they were recording. It may not be relevant whether there were two brothers or one, or whether Mr. RT had been married or not (both areas where entirely different information is recorded), but an independent history of his childhood, his reaction to his father's death, the family's reaction to previous offending, which both predated and postdated his father's death, their attitude to mental illness given his brother's diagnosis of schizophrenia must surely all have been potentially useful and information not too difficult to obtain. It is important to note Mr. RT's father's occupation was a politician, his elder brother is a civil engineer, one sister a fashion designer, the other an accountant: all important factors in understanding Mr. RT's social context.

This lack of engagement with the family of Mr. RT ensured that both his social and cultural context was not fully understood.

3. Therapeutic Engagement with Mr. RT

This apparent lack of curiosity on the part of the clinical team appeared to also extend to their interaction with Mr. RT. During his weeks under their care, staff frequently attempted to persuade him that his beliefs regarding land in Ghana were unrealistic as they were judged to be delusional, but there seems to be no record of a primary or other nurse (or anyone else) talking to him about his father's death, his interests outside land in Ghana, his friends, his attitude to his brother's illness, and his hopes for the future.

Even if it was felt that getting a rounded picture of the person was not realistically manageable in the busy environment of Eden Ward. The aetiology of his previous criminal record should have been explored. His views that homosexuals should be shot or that other religions were partly to blame for world catastrophes should also have been explored. When Mr. RT mentioned these beliefs they seemed to be handled as 'inappropriate comments' and he was 'counselled' about them. However, this was a patient with a working diagnosis of schizophrenia who was known to act on his delusions, in that he spent a lot of time making telephone calls and writing letters pursuing his ideas and beliefs. Delusions, by definition, cannot be altered by argument or counselling. Mr. RT's delusions were never considered in a risk context and were never assessed as possibly contributing to any risk prone behaviours.

Mr. RT was placed in hospital under a Section 2 of the Mental Health Act (83) in order for an assessment to be made regarding his mental state. This did not take place in that no comprehensive history was taken, no rigorous risk assessment was conducted and no coherent plan of care was drawn up with a view to managing his condition in either the short or the long term.

4. Multi Agency Communication

A serious concern regarding the management of Mr. RT's clinical care during this period is that of the failure to engage and liaise with other agencies such as with the police and the probation service. The sharing of information with other services is crucial in order to provide the best management of a patient's clinical care.

During this admission period, when Mr. RT had been detained on both a Section 2 and a Section 3 of the Mental Health Act (83), no attempt was made to understand the nature of his past forensic history which was entirely relevant to both his care and treatment needs at the time and also to the events that occurred in April 2006.

The history taken by the clinical team during Mr. RT's inpatient stay mentions almost in passing the fact that Mr. RT had previously been in prison for a firearms offence in 1996 and that he had also been arrested for theft on another occasion. It is also mentioned in this history that Mr. RT had no previous history of assault charges[143]. This was not true.

The Independent Investigation Team knows that the Community Team caring for Mr RT in March 2000 was aware that he was in prison during this period for possessing an offensive weapon[144]. With the evidence available to Mr. RT's clinical team at the time communication should have been pursued with both the police and possibly the probation service to be able to ascertain precisely the facts surrounding Mr. RT's forensic history, this was not done. **This is the first significant point at which mental health services began to lose control of Mr. RT's care.**

If this had been done the decision to release Mr. RT from his section, once he was an inpatient a year later, may have been played out differently and Mr. RT would most certainly have been in receipt of a comprehensive risk assessment. If a risk assessment had been conducted at this stage, with all of Mr. RT's previous forensic history known, a more precise prediction could have been made with regard to his future likely offending behaviours. **This is the second significant point at which mental health services began to lose control of Mr. RT's care.**

14.1.3. Description of Events between 15 May 2001 and 1 May 2002

The account that follows regarding contact with Mr. RT between 15 May 2001 and 1 May 2006 is based on the printouts of the Electronic Patient Journey System. This contemporaneous data appears to be the most comprehensive available for the period.

The first recorded visit to Mr. RT following his discharge was on 15 June 2001, the patient was visited by Ms. A his Care Coordinator. Although there is no recorded written evidence the Independent Investigation Team was told that Mr. RT was at this time on Enhanced CPA[145].

At the meeting held on 15 June 2001 Mr. RT presented well, but further questioning confirmed the continued existence of his delusional beliefs. His mother was also spoken

to. She was living next door, at the flat occupied by her daughter and her eldest son as she did not feel comfortable being in her own flat with Mr. RT and her other son at that time. She said that they had made a mess in the flat; that Mr. RT often shouted, embarrassing her with the neighbours, and it was because he had been acting strangely that she had originally initiated the hospital admission. She was skeptical that he was compliant with his medication. The issues identified to be dealt with were getting a CT scan for the patient as previously agreed, and getting him rehoused. A risk assessment was not conducted[146].

By 17 August 2001 Mr. RT had been visited five more times and there had been some telephone contact with his mother. Mr. RT claimed that he was compliant with medication, his mental state was judged to be stable, he remained 'cooperative and polite' at interview but had decided that he didn't want to move to a new flat for the time being[147].

At a visit to his home on 22 August 2001 Mr. RT reported a faint which he ascribed to his medication. Asked if he would continue to take his medication daily, he agreed to do so. The CT scan was to be chased up. A call to the pharmacy was made on 3 September 2001 that confirmed that Mr. RT's medication had not been collected on 10 August 2001 or 21 August 2001 indicating that he may well have been medication free for a month during this period[148].
When visited on 12 September 2001 Mr. RT admitted that he had not taken his medication but said he would take what was then offered, although reiterating that he did not think it gave him any benefit. He appeared lucid and rational and asked the visiting case manager about causes of mental illness and about hearing voices. However, when asked directly about his own experiences, he denied hallucinations[149].

There was a visit on 2 November 2001 for the purposes of a care programme approach (CPA) review, by the case manager Ms. J and the Responsible Medical Officer (RMO) Dr. I. The latter noted that Mr. RT appeared to be intimidating his mother and prevented her from making contributions to the discussion. Nevertheless, the RMO felt that Mr. RT's mental state had not deteriorated since he had stopped taking medication. 'Although he was guarded, it seemed to me that he wanted to talk more about his beliefs, almost trying to check with us, and be reassured that they were not delusional'. The CPA was concluded with the decision to further pursue the CT scan, but there were no further plans made as

'there are no active psychotic symptoms, and his delusional beliefs are not, at the moment, putting himself or others at risk of harm'[150].

When Mr. RT visited Brixton Road on 15 November 2001 to collect a sick certificate, he said that he was not taking any medication at that time. The completed Lambeth Early Onset research report showed Mr. RT 'continued positive and negative symptoms, with poor insight'. A further home visit took place on 19 December 2001 whereupon no changes to his condition were noted. Mr. RT wanted to be discharged from care as he was not taking any medication and he did not believe he suffered from mental illness. He did agree however to further meetings taking place[151].

A telephone call from Mr. RT's mother on 23 January 2002 relayed that he was sometimes restless, agitated and talking aloud and sometimes punched the walls. He believed that people were against him but he did not express ideas about harming others. His mother now reported that he had a six week old daughter, who lived with her mother in North London. After a failed home visit the patient agreed to meet at the Brixton Road Community Resource Centre on the 5 February 2002[152].

When Mr. RT attended the Resource Centre on 5 February 2002 he was shown that his CT scan result was normal. Mr. RT said that he still had severe headaches and a referral to a neurologist was agreed. He still didn't want to be involved with mental health services and would agree to outpatient follow-up only if this was not linked to medication[153].

There then followed a series of home visits triggered by distress calls from Mr. RT's mother on 14 March 2002 (after aggression to sister's boyfriend), 5 April 2002 (after Mr. RT's mother had had to call the police after agitated behaviour and a minor assault on a cousin) and 1 May 2002 (after two further minor episodes of aggression within the family). There had been telephone conversations with both Mr. RT's sister and elder brother where they seemed to be agreeing that treatment was necessary. After seeing him on 1 May 2002 when the CPA was due, the Care Coordinator Ms. J, who was accompanied by the Specialist Registrar, recorded that they considered him an increasing risk to the family as a result of his delusions and that they had made a recommendation for a Section 3 assessment. The entry was countersigned by the Specialist Registrar[154].

14.1.4. Findings and Analysis by the Independent Investigation Team

The Independent Investigation Team found a puzzling gap in the available records for this period. After an apparently logical decision to seek admission for Mr. RT, the next entry in the clinical record a week later refers to a telephone call to the sister who stated that she had been to the pharmacy, given the patient medication and that he was now calmer. The comment at the end of the entry dated 7 May 2002 was that this would be discussed with Dr. I in the clinical review meeting. No mention is made of the decision on the 1 May 2002 to seek detention for Mr. RT. There is no record in existence which documents an assessment, a clinical team discussion, or most importantly of all, a formal Mental Health Act Assessment (83) meeting with the service user. None of the witnesses interviewed could explain what occurred at this time or why it was not recorded[155]. One clinical witness remembered at interview that the Section 3 was not proceeded with because Mr. RT's family had plans to take him to Brighton and were reluctant to proceed with the Mental Health Act. This should not have been sufficient reason for a clinical decision to be reversed if it was felt that Mr. RT required detention under the Act.

The Independent Investigation Team identifies this as being the third significant point at which mental health services lost control of Mr. RT's care. He had persistently demonstrated that he was noncompliant with medication, and that although he could present well at interview he showed disturbed behaviour within the family setting, which belied his settled presentation at interview. Although the family regularly raised the alarm, when family meetings were arranged, they never attended. Here was an opportunity for a 'second bite at the cherry' via a Section 3 Mental Health Act (83) admission, with the family's backing. It did not happen.

A number of healthcare witnesses who attended this Investigation confirmed the existence of a 'community team file' where the results of weekly team review meetings at the Community Mental Health Centre were entered. This file appears to have disappeared. It is likely, according to witnesses, that this was also where CPA documentation was routinely filed. Without the information within this file it can only be speculation as to why certain actions did not take place following the events of the 1 May 2002. Equally, the electronic record fails to record any face to face meeting between the clinical team and Mr. RT or his sister at this stage. We cannot know whether such a meeting is recorded in the community team file. It has to be assumed that such a meeting did not occur. The Independent Investigation Team does not think that this was a satisfactory resolution of a crisis situation.

14.1.5. Description of Events between 2 May 2002 and April 2006

All contact between the clinical team and the family was by telephone between 7 May 2002 and the end of September 2002. During this period medication was prescribed by the RMO and medication was collected from pharmacy, apparently by Mr. RT's sister. When Mr. DG took over as the Care Coordinator in August 2002, he wrote to the GP on 2 September 2002:

'[he] *is reluctant in the extreme to see staff from this service and I am…trying to negotiate a home visit with his sister...who is the primary carer….Clearly it is hard to gauge Mr. RT's actual compliance with medication*' [156]

The GP wrote back on 30 September 2002:

'he tells me that he is on no medication, and that as far as he is concerned he has no psychiatric disorder…I suppose under the circumstances there is very little we can do.[157]'

At the end of September there was a change of RMO and Dr. NS wrote to the family introducing himself and asking to set up a meeting. The patient and family members failed to attend for CPA meetings scheduled for December 2002 and March 2003. Medication continued to be prescribed and (usually) collected. A note confirms some telephone contact with Mr. RT's sister prior to mid-December 2002 but none further prior to July 2003. Contact with the family between May and December 2002 had suggested that the family was not unduly worried by Mr. RT's behaviour[158].

Dr. NS made his sole face to face contact with the patient in the company of Ms. J (then acting care coordinator) on 17 July 2003. This amounted to the last recorded CPA review prior to the Outpatient Department Nurse writing to the family to say that Dr NS was being reallocated to a different area from 23 January 06. On 17 July 2003 Mr. RT was, as always, pleasant in initial presentation but still obviously deluded. It was proposed that he would be removed from case management but that Dr. NS would follow him up in the Outpatient Department and continue to prescribe Mr. RT's medication, although it was accepted that he was unlikely to ever attend. It was agreed that the family would be written to by Dr NS giving contact numbers for the sister or other family members if problems were to arise. No copy of this letter was available to the Independent Investigation Team[159].

In early 2006, as he was due to move on, Dr NS attempted to set up a meeting with Mr. RT's family to discuss his future care. The family failed to attend, although the Outpatient Department Nurse had, in addition to letters, spoken to the family on two occasions. On one of those occasions, Mr. RT's sister had said that he had not taken medication for one

or two weeks and a new prescription was issued. It is impossible to say whether Mr. RT had taken medication at all for the two months prior to the first arson offence on 14 April 2006.

14.1.6. Conclusions

No direct attempt appeared to have been made by the clinical team to visit Mr. RT between early May 2002 and July 2003. Yet it was acknowledged that compliance could not be confirmed. Mr. RT's sister had been designated 'primary carer' without a face to face discussion regarding contingencies or her view of his condition. The main Care Coordinator at the time (there were three personnel changes within a 12 month period) gave the Independent Investigation Team evidence that she did not ever feel threatened by him and that this substantially affected her decision making as to whether he should be seen as a priority. She also stated that this impression was based on her risk assessment of him, however no record of this risk assessment was documented. The former RMO, Dr. I, told the Independent Investigation Team that he had never had a plan to stop seeing the patient and was struck mostly by Mr. RT's ambivalence, not his hostility. Yet the 'default position' decided in July 2003 was to all intents and purposes in place by May 2002.

The Trust Internal Investigation Report and the Trust Board Level Inquiry into the care and treatment of Mr. RT concluded there were problems with the effective use of risk screens and that there was pressure on the case management team and a perceived lack of available care options for a complex, non-compliant patient with a chronic psychotic disorder.

The Trust Internal Investigation Team stressed the following:

- failure to communicate information at change points;
- pressures due to under-staffing and organizational change;
- undue reliance on the family without a face to face meeting;
- not taking the decision to discharge to the GP;
- irregularities in operating the CPA.

The Independent Investigation Team would concur with these findings. However the Independent Investigation Team also concludes that there were underpinning weaknesses in the clinical management of Mr. RT's care and treatment that were exacerbated by a series of mistaken assumptions.

In relation to the clinical care that Mr. RT received there are at least four instances where false assumptions ('factoids') seem to have been operating in a way that influenced subsequent events:

Factoid 1. An adequate history was taken on admission

The care that Mr. RT received between February 2001 and April 2006 was largely predicated on the initial history that was taken following his first admission. This history was taken by the Senior House Officer and was countersigned by the Responsible Medical Officer. This history was then passed down through time as a statement of fact, no one appears to have gone back to check it for accuracy. The perception of Mr. RT's clinical risk was largely based upon it. However no formal interview with Mr. RT's family about past events, including his forensic history, took place. Therefore, despite a thirteen week admission, Mr. RT remained an unknown quantity, other than that he was known to have delusions.

Factoid 2. He might be some risk to his family, but not a serious one, and that he was no risk to the general public

From the outset the clinical team appeared to place a high degree of credence upon the word of Mr. RT, often to the detriment of his mother, who was quite clearly afraid of her son and whose pleas for help were often ignored or dismissed. A carer assessment was never conducted to ascertain Mr. RT's mother's own personal requirements for support or her levels of personal risk. This should have been considered as a matter of some urgency as she shared her flat with her two schizophrenic sons.

The clinical team were convinced that if Mr. RT's family were worried about his mental health then they would alert services. This did in fact occur, but the arrangement failed to take into account the times when the family were not available to monitor Mr. RT, or when they disagreed between themselves as to the appropriate way to manage him.

The details of Mr. RT's past offending were never examined carefully. The potential risk he posed in the context of his diagnosis was likely to have been considered much higher than was recognised. It would not be unreasonable to assume that Mr. RT would have been placed in the 'red zone' (please see the section on risk assessment below) regarding his risk and would therefore have been subject to a different care and treatment regime.

Factoid 3. The family was very engaged and supportive

It was assumed by the clinical team that Mr. RT's sister was willing to take on the 'primary carer' role. This never appears to have been subject to a formal discussion. The likely reality was that the family was deeply ambivalent. What Mr. RT's sister actually thought her brief was has never been verified. It was in fact Mr. RT's mother that was present during most of his face-to-face visits with the clinical team; it is not clear why his Care Coordinator did not continue to make contact with her. Mr. RT's sister did not turn up for face to face meetings, despite repeated requests over more than a five year period. Mr. RT's sister, if the clinical record is correct, is depicted as a busy professional woman. No member of the clinical team actually discussed with her the issues involved in caring for her two schizophrenic brothers.

Factoid 4. The patient was not engaging; therefore it was logical to effectively discharge him from case management in July 2003.

Mr. RT was known to lack insight into his condition and to be noncompliant with his medication. The assumption was that Mr. RT presented no kind of risk either to himself or to others and that he could be cared for in the community with minimal contact from mental health services. If so, of course, he should have been discharged to the care of his General Practitioner.

Mr. RT's reluctance to engage with services was seen to be a key reason behind discharging him from active case management. At no time was it considered to adopt a different approach to either Mr. RT or his family, it would appear to have been 'an all or nothing' type of package being offered. The clinical team themselves disengaged from active contact with Mr. RT following the failure to activate the Section 3 Mental Health Act (83) in May 2002. This happened in spite of the fact that the Trust had a clear policy on how staff should manage those patients who did not engage with services.

It is the view of the Independent Investigation Team that the Trust Internal Investigation Review identified many important issues in their report. It is also the Independent Investigation Team's view that underpinning the weaknesses in the clinical management of Mr. RT's care and treatment were a series of mistaken assumptions.

Care and treatment in the case of Mr. RT was provided by the Trust over a seven-year period. It is never a simple or straightforward task to determine causality to an action or omission by a mental health Trust and a homicide perpetrated by a service user. However the Independent Investigation Team concludes that there was an absence of basic building blocks that would normally form part of the clinical management of the service users'

treatment and care from the outset of Mr. RT's initial contact with services between 2000 and 2001. After careful consideration the Independent Investigation Team concludes that these omissions triggered a clinical management plan that ultimately failed to treat Mr. RT's mental illness effectively. This mental illness was judged in court to have a direct bearing on the events of April 2006.

- ***Key Causal Factor Number One. The failure to manage the ongoing assessment, care, risk and treatment needs of Mr. RT meant that his mental illness was at best partially treated. His Honour Judge Peter Beaumont ruled that Mr. RT's mental state had a direct bearing on the events of April 2006***

14.2. Critical Issue Number 2. Diagnosis and Medication

This section will examine two specific issues in the context of the very detailed description of Mr. RT's overall care contained in section 14.1. above.

14.2.1. Findings

Diagnosis

Following Mr. RT's initial presentation in August 1999 he was identified as having a 'mild depressive disorder'. In January 2000 he was thought to possibly show early signs of a 'functional illness' and it was noted that his brother had an established diagnosis of schizophrenia.

At the Mental Health Review Tribunal of 21 February 2001, after he had been an inpatient under Section 2 for two weeks, it was agreed that he suffered from an untreated psychotic illness characterized by irritability, grandiose ideas and a preoccupation with witches and with religion. His admission had been initiated following concern from his family about threatening and uncontrollable behaviour towards them.

The Specialist Registrar, having stated up until then that the clinical impression was consistent with schizophrenia, confirmed the diagnosis in writing on 8 March 2001 as paranoid schizophrenia. It appears that this was the diagnosis explained to Mr. RT's mother at the ward round of 22 March 2001. Certainly at the Managers Hearing of 3 April 2001 their conclusion was 'he is still suffering from a paranoid schizophrenic illness, requiring treatment in hospital'.

At the Mental Health Review Tribunal on 27 April 2001 they found that Mr. RT was suffering from a schizoaffective disorder, but that neither the nature nor the degree of the illness made it appropriate for him to be detained.

On the discharge summary from Dr. P's team, dated 26 July 2001 the section headed 'diagnosis' is left blank. Nevertheless, the GP, in letters dated 30 September 2002 and 2 June 2006 makes it clear that his understanding is that the diagnosis was schizophrenia.

In the electronic records covering Mr. RT's management in the community between May 2001 and April 2006, there is no mention anywhere of a diagnosis, other than a comment from the case manager on 1 May 2002 that she had offered him a sickness certificate for 'paranoid psychosis' and that he had refused it.

Following Mr. RT's arrest in May 2006, he was assessed by Dr. SO'C from the Lambeth Forensic Services who concluded on 25 August 2006 'he is suffering from a severe mental illness characterized by the presence of grandiose and persecutory delusions.' When assessed for Broadmoor, the conclusion of the assessing team on 6 October 2006 was 'if investigations (for organic brain syndrome) turn out to be normal, then the diagnosis would indeed be of a chronic paranoid schizophrenia with an insidious onset, a tendency to relapse and prominent affective symptoms'. After ten weeks of admission to Broadmoor, the conclusion of his RMO Dr. AP on 27 January 2007 was that he fulfilled the criteria for a diagnosis of paranoid schizophrenia as defined in the ICD-10.

There is a particular reason for going into this degree of detail. First, it may well be that the case management team felt that it was either insensitive to the patient or to his family to mention a diagnostic label, other than to talk about his 'illness' and whether he showed active evidence of psychosis (consistently stating he did not, even when persistent delusions were elicited) or a deterioration in his mental state. Was a diagnostic label then of no relevance to the treatment plan or a consideration of choice of medication or other approaches? Was the treatment plan set in stone in mid March 2001 (when the diagnosis appeared to be schizophrenia), never to be reviewed?

Second, there is the apparent paradox that at interview with the Independent Investigation Team, the senior clinician on the Trust Board Level Inquiry, Dr. SF and Dr. I, who had been his RMO in the community for at least 15 months, both insisted that the diagnosis was not schizophrenia but 'delusional disorder'.

Dr. SF felt that the phenomenology was difficult to assess, therefore the latter diagnosis was more appropriate. Dr. I stated that for him the diagnosis was 'clear-cut'. 'Mr. RT had clear delusional beliefs which were persistent, as far as we could know in the absence of other major perceptual abnormalities'. He went on to clarify 'we have not got many diagnoses of psychosis to put it under - schizophrenia - schizoaffective disorder - and delusional disorder. I think he fitted the (last mentioned) category. With schizophrenia one would expect….development of some negative thinking at some stage as well, whereas with delusional disorder that is preserved in some ways'.

Commentary: does this apparently academic difference in use of terminology make any difference to the effective management of the case? Perhaps not, given the way care was delivered for Mr. RT. Both diagnoses imply potentially intractable conditions where the likelihood of more or less complete resolution of symptoms with vigorous treatment is less than 50%. Nevertheless both diagnostic labels imply a) very careful assessment of the exact nature of the mental abnormality (which would be problematic if the patient was routinely concealing or denying certain symptoms) and b) giving the patient an adequate trial of medication, to test effectiveness.

With the advantage of hindsight it seems very likely to the Independent Investigation Team that this patient did actively conceal symptoms. There are distinct indicators in Mr. RT's clinical records to confirm this. Equally, what this case perhaps illustrates is a commonplace about the presentation of severe psychotic illness which unfortunately tends to be forgotten by some practitioners, namely Bleuler's teaching on what he called schizophrenic autism.

The point is this. Severely ill patients may consciously deny or conceal symptoms, especially if they have paranoid elements in their presentation. But in addition a significant aspect of their mental state is that they are withdrawn from the world in a way that makes some of their abnormal ideas largely unavailable for communication. How this is strikingly illustrated is that not infrequently with severely ill patients it is only after some treatment with antipsychotic medication, that the full range of their abnormal beliefs becomes accessible.

Medication

The discussion above regarding Mr. RT's diagnosis leads naturally to a consideration of the use of medication in his case. It has already been accepted here, as is not uncommon with young people with severe mental illness, Mr. RT could not accept that he was ill and therefore was unwilling to take medication. What the care team appear to have failed to notice, was that the patient was discharged on Olanzapine 20 mg, but before the end of 2001 Mr. RT had persuaded them that his dosage was 10mg, and this is what was prescribed subsequently.

In other words, in conjunction with the observation, above, that there is no evidence that the medication prescribed when he was first prescribed was ever reviewed (in terms of its effect being evaluated) it is reasonable to argue that Mr. RT's condition was never adequately treated, nor did this fact appear to have been noticed. Had effectiveness of treatment, the need to try other pharmacological options etc. been nearer to the surface in the collective consciousness of the care management team, the opportunity that the potential admission under Section 3 in May 2002 presented might have been grasped more firmly.

Commentary: there has been substantial advice given in recent years about the value of atypical antipsychotic medication in the treatment of severe mental illness, particularly in relation to avoiding the development of long term Parkinsonian side-effects. However, what this may have led to is a tendency for clinical teams to turn away from use of depot medication, even when it is indicated. Again, the die was cast at a very early stage, when the decision was made in March 2001 to offer the patient Olanzapine, rather than e.g. a test dose of Risperidal. As has already been identified, the other opportunity to instigate a trial of the use of depot in a non-compliant, relapsing patient with severe mental illness, in May 2002, was not taken advantage of.

14.2.2. Conclusion

Mr. RT's care and treatment plan never appeared to have been adequately considered in the light of his diagnostic context. A diagnosis of schizophrenia was made but no active care planning ensued for either Mr. RT or his family to ensure that a holistic assessment of his condition was made and a treatment plan developed and implemented. Mr. RT was given Olanzapine whilst an inpatient in 2001. This medication was never reviewed in the light of either its effectiveness or Mr. RT's compliance. There are good grounds to suggest

that Mr. RT's condition was only partially understood and therefore only partially treated between 2000 and 2006.

- ***Key Causal Factor Number Two. Mr. RT's care and treatment plan never appeared to have been considered in the light of his diagnostic context. The appropriateness and effectiveness of Mr. RT's medication and treatment regime were never effectively reviewed. The subsequent partial treatment of his condition had a direct bearing on his mental state. His Honour Judge Peter Beaumont ruled that Mr. RT's mental state had a direct bearing on the events of April 2006.***

14.3. Critical Issue Number 3. Risk Assessment and Forensic Risk History

14.3.1. Context

Safety is at the heart of all good healthcare. There has been an implied requirement under the Health and Safety at Work Act for risk assessments to be carried out since 1974[160]. No mental health organization can afford not to have a programme that actively seeks to reduce and eliminate risk, not only because of financial consequences, but more importantly, solid risk management programmes can significantly improve patient care.

The South London and Maudsley NHS Foundation Trust has comprehensive risk management policies available[161]: Risk Management and Assurance Policy (July 2006) and their local strategy for clinical risk management[162]: "Framework for Clinical Risk Assessment and Management of Harm" which was ratified in 2001, reviewed in 2003 and further reviewed in 2005. These policies reflect national guidance. The clinical risk assessment and management policy outlines the clinical risk management process, risk assessment, risk management in care planning, within teams and services, procedures and monitoring arrangements. The local Care Programme Approach policy[163] "Towards Integrated CPA and Care Management" also gives comprehensive guidance on the assessment of risk.

Risk assessment and management is an essential and ongoing element 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.

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.

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 service users' risk is assessed and managed to safeguard their health, well being 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.
Clinical risk assessment supports the provision of high quality treatment and care to service users. It supports the provision of the Care Programme Approach and is a pro-active method of analysing the service users past and current clinical presentation to allow an informed professional opinion about assisting the service users recovery.

It is essential that risk assessment and management is supported by a positive organizational strategy and philosophy as well as efforts by the individual practitioner. It is recognised in Trust policy[164] that the issue of risk management includes the need to consider "responsible risk taking" and that "clinicians are often faced with difficult dilemmas for which there are often no single or simple solution. The Trust Board accepts the need for staff (and service users and carers) to arrive at these often high risk decisions and that not every decision taken has a successful or expected outcome. It supports the right and need for those decisions to be made."

"Best Practice in Managing Risk" (DoH June 2007)[165] 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.

"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."

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 and unclear.

14.3.2. Findings

There is evidence that the implementation of robust risk assessment and management procedures failed repeatedly in respect of the care and treatment of Mr. RT. The evidence suggests that Mr. RT did not at any time have a thorough risk assessment and management plan completed and documented. Good risk assessment depends on having a good knowledge of the service user; the evidence suggests that the services did not know Mr. RT sufficiently well.

It is the opinion of the Independent Investigation Team that a number of opportunities were lost that could have positively affected the pathway of Mr. RT's care and treatment, and that if good clinical procedures had been followed, Mr. RT would have had a more accurate risk profile and management plan.

First Admission to Hospital: Mr. RT was first admitted to hospital in February 2001, he was detained under Section 2 of the Mental Health Act 1983 (Assessment Order). This was subsequently converted to a Section 3 (Treatment Order) on the basis that he was a risk to others. He was subsequently discharged from his liability to detention under Section against the Consultant Psychiatrist's advice in April 2001 whereupon he became an informal patient with extended home leave.

The subsequent discharge letter documents his history but omits mention of a clear diagnosis. There is no risk formulation and no firm plans for follow up other than "an application was made for case management in the community[166]. Mr. RT was contacted by Ms. A, a Community Psychiatric Nurse based at Brixton Road Community Mental Health Centre, following which he was discharged from the ward. This is despite the fact that, according to policy and practice guidance, Mr. RT should have had a documented Section 117 meeting and should automatically have been referred for Enhanced CPA.

At that time the following risk related information was available to the clinical teams caring for Mr. RT:

- **1995**: Mr. RT received an 18 month custodial sentence in Belmarsh Prison for the possession of a replica firearm, no one appeared to have considered this a lengthy or significant sentence or looked into this history further.
- **1996:** RT was arrested for theft.
- **August 1999:** Mr. RT expressed thoughts of throwing boiling water over his mother, it is not documented if anyone asked him why or further clarified the possible nature of the risk to his mother at this time other than to say he had never acted on the thoughts.
- **January 2000:** Mr. RT's non compliance with medication is highlighted; this was to be a recurring theme throughout his contact with mental health services.
- **February 2000**: Mr. RT was convicted of possessing an offensive weapon and assault and was sentenced to three months in Pentonville Prison. The community-based Consultant wrote this information in the clinical record. No attempt was made to review Mr. RT or contact the police or probation services following his discharge from prison.
- **2000:** Mr. RT failed to attend several appointments for his Care Programme Approach review and there were significant issues regarding his lack of engagement with services.
- **December 2000 / January 2001:** Mr. RT was reported to be verbally aggressive towards his mother, he was reported to be attacking her and she was too frightened to remain living at home with him.
- Mr. RT was known to smoke cannabis and abuse alcohol which the family claimed exacerbated his condition.
- There was a family history of schizophrenia.

- **February 2001:** Mr. RT was detained in hospital under Section 2 the Mental Health Act (83) because of the risk of violence towards his family and his deteriorating mental state.
- **Hospital Admission:** Mr. RT's mental state was characterised by religious and grandiose delusions and lack of insight. His behaviour was characterised by anger, hostility, being argumentative, and refusal to accept medication, he was agitated and disruptive requiring restraint, rapid tranquillisation and one to one observations on one occasion. It is recorded that his mother reported that Mr. RT had telephoned her, was very angry and blamed her for putting him in hospital.

This profile was not deemed problematic enough by the Trust to merit a detailed clinical risk assessment to be conducted for Mr. RT.

Mental Health Act Assessment May 2002: In April 2002 Mr. RT was thought not to be detainable under the Mental Health Act 1983 after two telephone calls from his mother who was concerned that he was aggressive. It is recorded that Mr. RT had assaulted a cousin, and his mother also had to call the police to the house on the night of the 3 April 2002 because of Mr. RT's behaviour[167].

A visit took place at Mr. RT's home on the 5 April 2002. Ms. J his Care Coordinator and a Doctor from the community team attended. This visit reviewed the incidents of the night of the 3 April, the assault of a cousin, the increased consumption of alcohol and cannabis, the uncertainty over living arrangements, and the fact that there had been an increase in Mr. RT's aggressive outbursts towards his family, driven by delusional beliefs (although it was questioned if these could have had some basis in reality). It was decided that on balance Mr. RT was not detainable under the Mental Health Act.

Mr. RT's sister phoned five days later (there is no evidence of other follow up in between times) to report that there had been no further concerns since the weekend. During that conversation Mr. RT's sister reported that he got on well with children, often spent his money on his baby daughter and that a neighbour often left her ten year old twins with him[168]. This information does not appear to have prompted any Child Safety concerns.

Mr. RT was assessed again under the Mental Health Act (83) on 1 May 2002 after further phone calls from the family regarding two further episodes of aggression when Mr. RT assaulted a family acquaintance, and tried to grab his sister's boyfriend after misinterpreting horse play with a neighbour's child at the family home[169].The assessment

concluded that Mr. RT was considered an increasing risk to his family as a result of his delusions, that his mental state would deteriorate without treatment and a recommendation was made for detention under Section 3 of the Mental Health Act (83). The Care Coordinator tried to contact Mr. RT's mother to inform her of their decision but she was not available, she spoke to Mr. RT's sister who "*sounded as if she agreed with plans (to detain Mr. RT in hospital under Section)*".

This recommendation was not followed up and it is unclear as to why this was the case. There is certainly no rationale given in the clinical records. Evidence given at the Independent Investigation Team interviews suggested that the family didn't want Mr. RT admitted and this contradicts the documented discussion with Mr. RT's sister and family. It also raises the question of why the clinical judgement of a team of mental health professionals was not upheld in the face of any possible family disagreement, given that the Mental Health Act has inbuilt safeguards to protect the patient in the event of dissent regarding the decision to detain in the form of the Managers Panel Hearing, a process with which Mr. RT was familiar from his 2001 admission.

It is also of considerable concern that Mr. RT's mental state and progress were not re-assessed on a regular basis by the clinical team after the concerns expressed about his mental ill health which were characterised by increasing acts of aggression. The next documented contact was by telephone six days later[170]. From the records Mr. RT was not personally seen again by a member of the mental health services until July 2003, over one year later.

Risk Assessment Documentation: Risk assessment documentation cannot replace good clinical practice and judgement, they can however supplement practice and provide a valuable framework within which to work.

Mr. RT had contact with the mental health services since 1999. In his file there were no complete risk assessment documents, no formulation of risk and just two South London and Maudsley NHS Foundation Trust Brief Risk Screens. These were completed in 2002 and 2003 and are both incomplete. These Brief Risk Screens also only sought to determine his risk to self, not to others[171].

The first part of the Brief Risk Screening tool has five questions relating to suicide risk, three of the replies on one form were filled in as "Don't Know" and four replies on the

second form were filled in as "Don't know" – the correct answers to these screening questions were available.
The second part of the Brief Risk Screening tool addressed violence (please see Appendix Two). In guiding the practitioner as to how to proceed, this tool provides the following question:

"no screen should be done because risk is likely to be low and inquiry would be inappropriate – agree / disagree".

Despite the fact that Mr. RT had a well-documented history of violence and a detailed forensic history, both times that the questionnaires were used the practitioner decided that no further in depth risk screen was required.

This illustrates two essential elements of good clinical risk assessment practice: risk assessment is only as good as the information available, and it is only as good as the person conducting it. The Independent Investigation Team holds the view that clinical practice fell short of what would be expected at a basic minimum level.

Care Programme Approach: This has been dealt with comprehensively under a separate section below (14.4.). **However it is worth noting here that if the Trust CPA risk assessment guidelines had been followed, this would have highlighted several key clinical indicators for risk of violence. For example:**

- "Previous history of violence"
- "Alcohol and drug misuse associated with violence, or offending"
- "Poor compliance / relapse"
- "Poor engagement with services"
- "Altercations with the police"
- "Key relationships where another person might be considered at risk"
- "Recent changes in mental state and a reduced ability to engage in services as a result"

Risk Reducing Interventions: Because no formulation of risk had been completed, the need to consider therapeutic risk reducing interventions was never formally considered or documented. Good practice would dictate that the services should have been move assertive in their efforts to engage with Mr. RT, to work on his insight and medication

compliance, this was a recommendation following a Care Programme Approach review on the 2 November 2001[172]. The clinical team should also have worked more closely with the family as they were essentially being given the responsibility for managing Mr. RT's care and risk. Mr. RT does not appear to have ever been offered the opportunity to do some educational work regarding his alcohol and drug use.

Attitude to Risk: The impression gained from conducting the interviews during the Independent Investigation was that there appeared to have been a culture of risk minimisation (down playing, understating risk) and risk complacency. The Independent Investigation Team formed the impression that some of the staff involved in Mr. RT's care had no sense of the risks he might pose because they did not personally feel threatened by him. Risk appeared to have been a comparative issue, measured against the perceived risks presented by other patients on their caseload rather than being an individually considered concept. It also appeared to be an issue dependent on how the staff member felt in his presence rather than a professional assessment based on objective evidence which took into consideration the opinions and views of others.

The Independent Investigation also heard much about the concept of positive risk taking during interviews with witnesses but were concerned that this concept appeared to be misunderstood and used as an explanation as to why some risk decisions are not taken formally by clinical teams. Trust practice guidance dictates that risk decisions should be collaborative, based on evidence and documented. The Investigation Team accepts that some members of the clinical team did discuss the issue of risk relating to Mr. RT informally, but the Independent Investigation Team are of the opinion that best practice guidelines were not followed and that further staff training needs to be undertaken regarding the concept of positive risk taking and also the dynamic nature of risk. The Independent Invesitgation Team would like to point out that there is no evidence that this is a Trust-wide practice, and may have been unique to the staff group/team that provided care and treatment to Mr. RT.

Zoning System of Risk Monitoring

In the Trust's clinical risk assessment and management policy there is a section on 'risk management within teams and services'. This has a subsection on 'communication' where there is mention of the practice of 'zoning'. This refers to the option the CMHT's have of adopting the zoning system as a way of 'recognising the fluidity of risk with clients' and it

allows for prioritising and ensures those considered the highest risk are discussed more frequently. It also helps monitor practitioner caseloads.

There was much discussion about zoning during the interviews with witnesses that this Investigation held. The Investigation Team found the system confusing and lacking in clear guidelines in terms of the basis on which patients would move in and out of 'zones'. The Independent Investigation Team was also of the opinion that it was not helpful to have a system that was not used by all practitioners. The Independent Investigation Team was concerned following discussions that we held with witnesses that Mr. RT would probably not have made it in to the 'red zone' (the zone of highest risk) because of the apparent lack of appreciation of his risk potential and the fact that he had not been seen by mental health professionals for substantial periods of time.

14.3.3. Conclusions

Contributing Factors: There were a number of factors that the Independent Investigation Team believe contributed to the failure of the Trust to institute the correct processes regarding risk assessment. They are as follows:

- there was a high degree and level of organizational change especially around the time of Mr. RT's first admission and subsequent period in the community;
- there was a culture of risk minimisation and complacency;
- there were distinct pressures of work within the community teams coupled with a perceived need amongst staff to move patients 'off the books if possible', this allowed a culture of risk minimisation to develop;
- there was poor supervision coupled with a lack of clarity regarding the supervision process and at what forum issues relating to clinical practice standards should be dealt with;
- there were difficulties with the Electronic Patient Journey System which made accessing and using computer based technology difficult on a day-to-day basis;
- there was a lack of continuity within the clinical team;
- the Trust used a high number of bank and agency staff during this period;
- there is no evidence to suggest that the risk assessment and management process was audited during this time so that poor practice could be identified and eradicated and good practice championed.

It is the view of the Independent Investigation Team that the implementation of robust risk assessment and management processes failed during the time that Mr. RT was in contact with the mental health services, and fell short of both local and national expectations.

There was a significant degree of information available to the clinical team about Mr. RT during the time of his first admission. The culture and processes within the service allowed the importance of this risk relevant information to be minimised. **The clinical teams who provided the care and treatment for Mr. RT had in their possession enough information to know that he was a potentially very dangerous man.** At the time of his first admission he had been sentenced to three prison terms for possessing offensive weapons and for serious assault. These were not his only offences. The inexplicable thing is that the Trust already knew about two of these prison sentences at the time of his first admission and did not do enough to protect Mr. RT, his family and the general public in the light of his potential for future violence as set within the context of his diagnosis. It is the view of the Independent Investigation Team that a forensic psychiatry opinion should have been sought prior to his discharge in 2001 from inpatient services and that liaison should have been instigated with the police. It is important to note that if Mr. RT's offences had occurred after 2001 they would have been considered severe enough to have met the requirements of the Multi-Agency Public Protection Arrangements (MAPPA). Had the Trust acted upon the information that was within its possession, although technically Mr. RT was not subject to MAPPA, it would have understood the severity of his past crimes within the new public protection arrangements and could have risk assessed and planned accordingly.

If risk assessment and management processes had been operationalised effectively, they would have ensured that Mr. RT had a comprehensive risk assessment documented and regularly updated. This in turn would have helped to ensure that he was followed up more assertively and that his family would have been more engaged with and supported by services. As a result Mr. RT fell through the safety net of care.

- ***Contributory Factor Number One. The failure of the Trust to ensure a risk assessment was conducted that took full account of Mr. RT's personal, psychiatric and forensic history ensured that he fell through the safety net of care.***

14.4. Critical Issue Number 4. The Care Programme Approach

14.4.1. Context

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[173]. Since its introduction it has been reviewed twice by the Department of Health[174]: in 1999 (Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach) to incorporate lessons learned about its use since its introduction and again in 2008[175] (Refocusing the Care Programme Approach).

"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 the specialist mental health services[176]." (Building Bridges; DoH 1995) This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more that one agency is likely to be involved, but to *all* patients.

The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework which can help achieve those positive outcomes for service users by enabling effective co-ordination 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.

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.

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 key worker 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.

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.

Local Care Programme Approach Policy

The South London and Maudsley NHS Foundation Trust and its partner agencies had a comprehensive policy for the delivery of the Care Programme Approach (Care Programme Approach Policy – Towards Integrated CPA and Care Management; April 2000) which reflected national policy guidelines during the time that Mr. RT received his care and treatment[177]. It described two levels of CPA: Standard and Enhanced. Every person offered interventions by the mental health services (health and social services) must be "subject" to one of these two tiers of CPA. The policy described the levels of CPA as follows:

Standard CPA: Those people covered by Standard CPA (DOH) will be likely to:

- require the support or intervention of one agency or discipline or;
- require low key support from more than one agency or mental health worker;
- be more able to self manage their mental health problems;
- have an informal support network;
- pose little danger to themselves or others;
- be more likely to maintain contact with services.

Enhanced CPA: Those people covered by enhanced CPA will be likely to:

- fulfil the criteria for Section 117 aftercare and will be automatically included on enhanced CPA (i.e. service users who have been detained in hospital under Section 3, 37, 37/41, 47/49, 48/49 of the Mental Health Act 1983).

For those not subject to Section 117 aftercare the following are the criteria for enhanced CPA:

- a diagnosis of severe and persistent mental illness;
- a requirement for multi-agency involvement and co-ordination.

Plus any of the following:

- individuals with a history of repeated relapse of their illness due to a breakdown in their medical and / or social care in the community;
- individuals with severe social dysfunction or major housing difficulties as a consequence of their illness;
- a history of suicide risk, self harm, severe self neglect, violence or dangerousness to others consequent on their illness, which the responsible clinicians judge to be relevant in view of the service user's current or likely future mental health, taking into account their past history.

This Trust policy also clearly outlined the care co-ordination process including referral, assessment, assessment of risk, contingency and crisis plans, support for service users and their wider families, the care coordinator role, moving people between types of CPA (standard and enhanced), transfer of responsibility of care, loss of contact and refusal to maintain contact.

The successful implementation of the Care Programme Approach is fundamental to the delivery of effective mental health care in the community.

14.4.2. Findings

The Independent Investigation Team found evidence to suggest that the implementation of the Trust Care Programme Approach policy significantly failed with regard to the care and treatment of Mr. RT. The evidence suggests that none of the key elements of the Care Programme Approach had been properly or successfully implemented. In the Team's opinion if the CPA process had been implemented properly then Mr. RT would have received a more structured assessment both of his needs and of any potential risk that he might have posed to other people. He would have had a more relevant plan for his care

after leaving hospital and going forward, and a sensible contingency plan would have been put in place.

Clinical Records. The Trust has a duty to ensure that clinical records are accessible and readily evidence key clinical information. Each practitioner has a responsibility to maintain detailed clinical and practice records to document the patient's assessment, care plan and the review process. Clinical records should always record outcomes particularly in the case of the application of the Mental Health Act and the Care Programme Approach. The Independent Investigation Team found the standard of record keeping in general to be poor, particularly in relation to the Care Programme Approach.

Bearing in mind that Mr. RT was known to mental health services since 1999[178], was admitted to hospital under the Mental Health Act in 2001, and was assessed under the Mental Health Act in 2002[179], in the records available to the Investigation Team we could only locate three documents relating to the CPA process. These are listed in detail below.

1. There is a document recording Mr. RT as being on Standard CPA on the 7 December 2001, no Care Coordinator is identified on this record[180]. This document is dated seven months after Mr. RT had been discharged from a period in inpatient care on Section 3 of the Mental Health Act 1983. According to Trust policy and national guidelines, he should have had an immediate Section 117 meeting to ensure all aspects of his aftercare had been considered and addressed and he should have automatically been on enhanced CPA. Witnesses to the Independent Investigation did state that they believed Mr. RT to have been placed on enhanced CPA hence his being held on the CMHT caseload. However this is not demonstrated by the extant documentation. There is no evidence of assessment or care planning having taken place within this documentation.
2. There is documentation dated 17 July 2003 that refers to a CPA review[181]. This documentation identifies Mr. RT's CPA level as being Standard and also identifies his Care Coordinator. The electronic event record however states that this review was in fact held on the 28 March 2003 and that Mr. RT and his "relative" did not attend for the CPA. There is no actual record regarding the review itself and the ensuing decisions made with regard to Mr. RT's care and treatment plan.

3. There is a document dated 25 July 2003 that includes a Summary of Need, an Action Plan, and a Contingency and Crisis Plan[182] – these are the *only* documents of

this nature in Mr RT's file despite the length of time he had been in contact with the service and the complexity of his care needs. These documents do not appear to be have been comprehensively developed.

Assessment of Needs. There is no evidence that a systematic and thorough assessment of health and social care needs was undertaken either to meet Mr. RT's immediate or longer term requirements, this is in spite of the fact that the clinical team had concluded his mental state was likely to deteriorate.

There are a number of qualitative concerns regarding the one and only set of documents relating to Summary of Need, Action Plan, and Contingency and Crisis Plan documentation (25 July 2003). They are as follows:

- they do not state the level of CPA Mr. RT was on;
- there was no discussion of the presentation of Mr. RT's mental state when unwell;
- there was no record of when his last mental state examination took place, the evidence is that this had not been undertaken by a mental health professional for some time;
- there was no record of Mr. RT's aggression towards his mother, it is the view of the Independent Investigation Team this is minimised by referring to it as a "strained relationship". There is no mention of concern that Mr. RT's mother had moved out of her home because she was frightened of him;
- it was documented that Mr. RT had a baby daughter but no comment was made as to whether or not safeguarding children issues had been considered;
- the section on "daytime activities" refers to Mr. RT spending 'his time exploring various projects which had to do with poverty and voluntary / political bodies'. There is no reference to the fact that these activities are intrinsically related to his delusional beliefs. There was no proposed plan to help Mr. RT gain employment or to identify what his actual needs in this area were;
- there were multiple references to, 'Mr. RT tells us', regarding a variety of information and this appears to have been accepted at face value;
- under the "physical health" section there was no reference to the fact that when Mr. RT was unwell he could complain of somatic symptoms;
- the risk assessment made no reference to a number of issues of concern e.g. non compliance, lack of engagement and lack of insight;

- the action plan set out an intervention (which was not discussed and agreed with the service user or his carers) to review his mental state every three months at the Outpatient Department, knowing that he would not attend;
- there was no reference to the importance of the family and the need to maintain and develop a close working relationship, or to consider undertaking a carer assessment;
- the crisis plan stated that 'in the past intensive family support and outreach from case management has been adequate in addition to family support to Mr. RT from extended family'. There is no evidence in the case files that this was in fact the case.

The above list demonstrates a number of issues, the primary one being that the team did not know their patient sufficiently well, this is evident when reading the clinical files. Decisions, assessments and actions regarding the patient were not formulated and systematically recorded. No workable care plan was agreed between the relevant professional staff together with the patient and his carers and recorded in writing.

Care Coordinator Role. The patient was allocated a number of care coordinators over a period of time whose specific job was to keep in close contact with the patient, to maintain an agreed programme of care, to make sure it was delivered and to take immediate action if it was not.

The records show that the patient was not seen for long periods of time and that services were not aware of his mental state. There is no evidence to demonstrate that regular reviews of the patient's progress or his health and social care needs were undertaken. There was no extant evidence of any formal processes used to transfer his care between coordinators and indeed it was difficult at times to identify exactly who Mr. RT's care coordinator was.

There is some evidence that services made efforts after Mr. RT's initial detention to hold a CPA review. Several CPA meetings were scheduled[183]: 31 July 2001, 3 September 2001, 28 September 2001, 18 October 2001 and the 26 October 2001, it would appear that neither Mr. RT nor his family attended any of these events. A meeting was finally held on 2 November 2001.

The electronic event record logs that a CPA / Section 117 meeting was held at Mr. RT's address on the 2 November 2001 (6 months after he was discharged from hospital) and that Mr. RT's 'mother was there too, but was forced by him to stay in the background'[184].

The assessment letter discussed options for further engaging Mr. RT although there is no recorded care plan from this meeting. Another CPA meeting was scheduled for 1 February 2002 but was cancelled as Mr. RT was not at home.

After Mr. RT's assessment under the Mental Health Act in April and May 2002, the extent of follow up by the Care Coordinator over the next fourteen months was a number of phone calls to the family, there is no evidence that they attempted to meet and personally support the family, and they did not see Mr. RT again until July 2003[185].

Supporting Carers / Families. It is the opinion of the Independent Investigation Team that there was an over reliance on Mr. RT's family to alert the team to any concerns without any concerted effort on the part of services to build a working relationship with the family. The family were invited to CPA meetings and brief contact was made over the telephone but no one appears to have sat down with the family and discussed Mr. RT's illness, what they should look out for, and when to contact someone for help.

No carer assessment was undertaken, there is no evidence that this was offered.

There was no evidence that contingency or planning arrangements were in place to prevent or respond to a crisis, the family were left with the responsibility to ensure Mr. RT took his medication and alert mental health staff if there were any problems. It should be borne in mind that Mr. RT's family had on a number of occasions been the victims of his aggression and his mother was fearful of him.

Refusal to Maintain Contact. Trust policy clearly stated that where a service user refuses to engage the issue should be:

'*rapidly discussed within the Multidisciplinary Team and communicated to the GP. An assessment of the risks that the service user presents to him/her self (including risks of self neglect), or others should be undertaken and plans made accordingly … Consideration should be given to carrying out a mental health assessment …. In all cases, an action plan should be set out following discussion within the team and where appropriate family members and other carer(s). The action plan should be clearly documented in the medical case notes.*'

While the Independent Investigation Team accepts that members of the team did have informal discussions regarding Mr. RT, these are not recorded and there is no evidence that any of the above issues were formally considered or actioned. In April and May 2002 the clinical record states that Mr. RT was considered to be an increasing risk to his family and that at that time detention under Section 3 of the Mental Health Act (83) was considered appropriate. However this concern was not followed up by the clinical team and dealt with appropriately.

14.4.3. Conclusions

Contributing Factors. There were a number of factors that the Independent Investigation Team believe contributed to the breakdown of the Care Programme Approach process during the period of time in which Mr. RT received his treatment and care. They are as follows:

- the amount and level of organizational change especially around the time of Mr. RT's first admission and subsequent period in the community;
- the pressure of work with the perceived need among staff to move patients off the books if possible;
- high use of bank and agency staff;
- two different cultures coming together: health and social services;
- poor supervision coupled with a lack of clarity regarding the supervision process and at what forum issues relating to clinical practice standards should be dealt with;
- the number of staff in "acting up" positions e.g. Mr. RT's Care Coordinator was also an acting team leader;
- changes to national legislation and guidance;
- lack of continuity within the clinical team;
- there was a culture of CPA non-adherence;
- there was also a culture of resistance among staff to what was seen as overwhelming expectations of them to absorb far reaching organizational change they felt ill prepared for;
- there was no evidence that the CPA process was audited at the relevant time so that poor practice could be eradicated and good practice championed;
- electronic records were in the early stages of introduction between 2001 and 2003. Records may have been lost because of IT problems. There was lack of clarity as to whether paper records should also be kept, and problems with accessing computers for staff.

It is the view of the Independent Investigation Team that the implementation of the care programme approach within the South London and Maudsley NHS Foundation Trust failed during the time that Mr. RT was in contact with the mental health services, and that it fell short of both local and national expectations.

Following a period of inpatient care on section 3 of the Mental Health Act (83), Mr. RT should have automatically have been discharged on enhanced CPA which, if operationalised effectively, would have ensured that he received assessment of his health and social care needs which would have included a comprehensive risk assessment. Mr. RT and his family should have been in receipt of a copy of his care plan. This may have occurred, but there is no evidence to suggest within the clinical record that any appropriately prepared CPA documentation ever existed.

A Care Coordinator should have been assigned clear responsibilities and tasks agreed in the care plan. The service user should have had a regular review which addressed such things as risk, contingency planning and long term care planning, for as long as was deemed appropriate and the issues around his lack of engagement should have been more actively pursued. It is not clear from the existing clinical record how Mr. RT's care programme approach was managed. On interviewing witnesses it became clear to the Independent Investigation Team that even the people assigned as being Care Coordinators for Mr. RT were unclear regarding their roles. Witnesses could not clarify in their minds when interviewed whether they were actually acting as Mr. RT's Care Coordinator or not[186]. This is clearly an unsatisfactory state of affairs.

Nowhere in the clinical record does the word 'enhanced' appear. The Independent Investigation Team were told that Mr. RT was 'probably' on enhanced CPA because his care was being managed by the Brixton Road Community Resource Team. Whether this was the case or not, aside from rudimentary CPA reviews, Mr. RT did not appear to have benefited from an enhanced CPA package. Mr. RT should have been on enhanced CPA and should have been subject to everything that this should have entailed. This did not occur and Mr. RT fell through the safety net of care.

- ***Contributory Factor Number Two. The failure of the Trust to provide Mr. RT with a comprehensive package under an enhanced level of the Care Programme Approach led to Mr. RT falling through the safety net of care.***

14.5. Critical Issue Number Five. Carer Assessment and Carer Involvement

14.5.1. Context

The recognition that all carers, especially those 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[187]. It also provided for carers who give a substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. It also provides that services take into account information from a carer's assessment when making decisions about the cared for persons type and level of service provision required.

Further to this, The Carers and Disabled Children Act 2000 gave local councils mandatory duties to support carers by providing services directly to carers[188]. It also gave carers the right to an assessment independent of the person they care for.
In addition 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[189]. Also that it facilitated co-operation between authorities in relation to the provision of services that are relevant to carers.

In particular regarding mental health, Standard Six of the NHS National Service Framework for Mental Health (1999) states 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.

As Mr. RT was under the care of a multi-disciplinary mental health team within a mental health trust, it should have been possible as part of the assessment and review process within the Care Plan Approach to identify if Mr. RT had any carers who warranted an assessment and possibly help in their own right. It is the view of the Independent Investigation Team, especially in the light of the fact that Mr. RT's brother also suffered from schizophrenia that Mr. RT's mother should have been in receipt of a Carer Assessment.

14.5.2. Findings

It is recognised that Mr. RT was hard to engage by mental health services. Due to his unwillingness to be engaged, Mr. RT had little or no involvement in his care planning. This also meant that Mr. RT's family had no involvement in his care planning other than being relied upon by mental health services to collect the prescriptions for Mr. RT, a key component of the care that he did receive.

It is not evident from the available clinical record whether or not Mr. RT's family had been able to fully discuss their domestic situation or how much support was provided to Mr. RT by them. When Mr. RT's GP wrote to Dr. P in mental health services, he stated that Mr. RT had a family history of schizophrenia in that he had a brother who was also diagnosed and being treated for schizophrenia[190]. It is noted on at least one occasion that Mr. RT's mother could not attend appointments with Mr. RT due to her own ill health.

There is no record of a carer's assessment being offered or completed at any time. The issue that perhaps makes the absence of a carer assessment and carer involvement of most concern is the fact that Mr. RT lived with his mother and his schizophrenic brother in the same flat. It is reported on many occasions that Mr. RT's mother was too afraid to remain living at her home and that she had to move into her daughter's flat, which happened to be next door. No assessment was made or concern regarding her safety was raised.

Mr. RT's family asked for help from mental health services on 31 January 2001 and also in April 2002. The former occasion resulted in Mr. RT being admitted under Section 2 of the Mental Health Act (83), and the latter in a recommendation that Mr. RT ought to be detained under the Mental Health Act (83).

During 2002 Mr. RT's family were principally contacted by mental health services by telephone. Speaking to Mr. RT's Mother or Sister on the telephone was the main form of contact that was made at this time even though significant concerns had been raised regarding Mr. RT's mental health. During this period Mr. DG (one of Mr. RT's Care Coordinators) wrote to the GP. In this letter he states that Mr. RT's sister was his main carer. After this date it appears that the sister was treated as the main point of contact for Mr. RT. She was invited to CPA meetings and was relied upon to collect Mr. RT's medication from the hospital pharmacy. There is no explanation as to why Mr. RT's sister

became the main carer at this stage when prior to this time Mr. RT's mother had been the main point of contact and had also attended all of the clinical meetings that had been held with her son. Mr. RT's sister did not attend a single meeting that she was invited to.

On 17 July 2003 Dr. NS and Ms. J visited Mr. RT. It was decided then that Mr. RT would be discharged from case management and that Dr. NS would manage Mr. RT's care in the Out-patient Department. Mr. RT's sister was informed of this in writing on 21 July 2003. Mr. RT continued to be prescribed medication from the Lambeth Hospital pharmacy.

On 20 January 2006 that Mr. RT's sister was written to inviting her to meet with Dr. NS on 2 February 2006 as he had moved to another workplace and wished to discuss Mr. RT's future with her. In the electronic Trust record dated 30 March 2006 it was noted that Dr. NS had been trying to meet Mr. RT's sister since January 2006 to review his care, but that his sister had not attended any meetings. It was therefore decided that if the sister did want to make contact in the future that she be given the telephone number of the Brixton Road Centre. No other contact was made by or to services until Mr. RT was arrested on suspicion of murder and arson, in May 2006.

Since July 2003, even though Mr. RT's sister was acknowledged as being his main carer, very little was done to stay in contact with her or with Mr. RT himself by mental health services. It was not possible to find out what Mr. RT's family thought of the level of service that was offered to them between 1999 and 2006 as the Independent Investigation Team were not able to engage them during the Independent Investigation process.

14.5.3. Conclusions of the Independent Investigation Team

As stated above, the involvement of Mr. RT's family was not acknowledged by services except in the role they played in informing them of any deterioration in Mr. RT's health, being available for telephone conversations to update services on Mr. RT's condition, and to collect Mr. RT's prescriptions for him.

Mr. RT was at times unwilling to take medication. When he was living at home either with or next door to his family, his mother and/or sister were relied upon by mental health services to ensure that he took his medication. Apart from them stating he was taking it, there is no evidence provided by service records that he indeed did.

There are numerous occasions between 1999 and 2002 where Mr. RT was recorded as being either violent or aggressive within his family and domestic context. These occasions are listed below.

1. Mr. RT was first referred to mental health services by his GP on 19 August 1999 stating that Mr. RT was nervous and agitated and had thoughts of harming his mother.

2. Mr. RT failed to attend an appointment on 11 December 2000 with Dr P, a Consultant Psychaitrist with the Trust. Mr. RT's family had become increasingly worried about him as he was becoming verbally aggressive towards his mother.

3. On 31 January 2001 Mr. RT's mother contacted Dr. P as Mr. RT had been physically attacking her and she claimed to be too frightened to remain living with him at home. Mr. RT was subsequently admitted under a Section 2 of the Mental Health Act (1983) on 7 February 2001.

4. On 22 February 2001 it was reported that Mr. RT had telephoned his mother in a very angry state, blaming her for putting him in hospital.

5. Mr. RT was placed on a Section 3 of the mental Health Act (83) on 5 March 2001 due to being aggressive, and a risk to others. He also had grandiose ideas and no insight.

6. On 8 April 2001 Mr RT became increasingly hostile and was restrained and given medication against his will.

7. On 27 April 2001 a Mental Health Review Tribunal discharged Mr. RT's from his Section 3 (MHA 1983) despite the Responsible Medical Officer stating in his opinion that Mr. RT was a danger to others.

8. On the 14 March 2002 Mr. RT's mother telephoned Dr. I expressing her concerns about him stating that he had been aggressive.

9. On the 21 March 2002 Mr. RT's mother telephoned Dr. I requesting a meeting as Mr. RT had attacked his sister's boyfriend.

10. On the 4 April 2002 Mr. RT's mother telephoned Ms. J, Mr. RT's Care Coordinator to say that she had had to call the police to the house due to Mr. RT's violent and threatening behaviour. He was reported to have attacked his cousin on this occasion.

11. On the 5 April Ms. J and a doctor from the community team spoke to Mr. RT's elder brother who said that the family were growing increasingly concerned about Mr. RT's behaviour which was made worse by both his drug and alcohol misuse.

12. On the 23 April 2002 Mr. RT's brother reported another incident where Mr. RT had attacked a family friend. Once again Mr. RT's brother stated that the family felt Mr. RT should be receiving some kind of care and treatment.

13. On 1 May 2002 Ms. J and Dr. JR met with Mr. RT and his mother. Mr. RT denied being aggressive with a family friend. However Dr. JR considered Mr. RT to be an increasing risk to his family, and a recommendation for a Section 3 was made.

14. On 31 May 2002 although Mr. RT's mother stated that he appeared stable, was taking his medication and was not being aggressive, she had decided to not return to the home that she shared with him and that she tried to avoid her son.

15. A subsequent telephone conversation on 17 June 2002 between the Care Coordinator and Mr. RT's mother reported that she was 'keeping a low profile with him', and that his sister was administering his medication. At this stage Mr. RT's mother had still not returned to her own home.

16. In a letter to Mr. RT's GP, Dr. JR said that Mr. RT had on several occasions assaulted friends of the family.

During this period as has been discussed in detail above, Mr. RT only received the most rudimentary of risk assessments.

Following the 1 July 2002 it must be noted that Mr. RT was only ever seen again on two occasions.

No risk assessments were made regarding Mr. RT's risk to his own family. It would appear that only two mini risk assessments were made throughout the period that he was in contact with services, and these only assessed his own risk to himself and did not consider any risk that he presented to anyone else. Mr. RT was at times hostile and aggressive towards mental health staff and was reportedly both verbally and physically aggressive towards his mother who most of the time appeared to avoid him. Mr. RT was also aggressive towards other family members and to friends of the family.

During the period between 1999 and April 2006 no carer assessment was conducted and no real attempt was made to engage with the family. Whilst it is noted that the Trust clinical services attempted to maintain contact with Mr. RT and his family, the Independent Investigation Team do not believe that this constituted meaningful engagement. It is without a doubt that Mr. RT's mother was placed at substantial risk during this period. The Trust failed to provide robust care and treatment in line with national policy expectation.

The Independent Investigation Team does not believe that the lack of carer assessments necessarily constituted a direct contributory factor to the events of April 2006. However if the family had been directly engaged it may have been possible for them to have alerted services more robustly regarding Mr. RT's mental state.

However the lack of carer assessment in this context could be viewed as a near miss. It is clear that Mr. RT's mother was placed at considerable risk between 2000 and 2006.

- ***Service Issue Number One. No carer assessment was conducted.***

14.6. Critical Issue Number Six. Service User Involvement in Care Planning

14.6.1. Context

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*'[191].

In particular the National Service Framework for Mental Health (DH 1999) states in its guiding principles that 'people with mental health problems can expect that services will involve service users and their carers in planning and delivery of care'. It also states that it will 'deliver continuity of care for a long as this is needed', 'offer choices which promote independence' and 'be accessible so that help can be obtained when and where it is needed.

14.6.2. Findings

The period of contact with secondary care mental health services provided by the South London and Maudsley NHS Foundation Trust regarding Mr. RT's mental health began in August 1999 and ended in May 2006 on his arrest. This constituted a period of some seven years. During this period Mr. RT refused to accept his diagnosis, and at times his medication. Mr. RT was very reluctant to engage actively in any aspect of his care and treatment. At times his health deteriorated as a result. The occasions when he appeared well seem to coincide with the times that he was possibly accepting medication, but even then he was not engaging actively with services as his medication was being collected and given to him by family members.

The conclusion can be reached that Mr. RT was successful at avoiding meaningful contact with mental health services when he was in the community. Mr. RT constantly failed to attend appointments at the team base. Although attempts were made to see Mr. RT at his home address, which were successful on few occasions, he avoided contact, unless detained on a ward under a section of the Mental Health Act 1983. Even then Mr. RT wanted to be discharged, applying to the Mental Health Review Tribunal and at times being argumentative and hostile or aggressive.

The fact that Mr. RT was difficult to engage with begs the question as to whether an alternative approach could have been used to counter this. It may be that Mr. RT could have been considered a suitable candidate for assertive outreach.

In a letter from Mr. RT's GP to Dr. P on 25 January 2000, the GP stated that the family only accessed health input in a crisis. It may be that Mr. RT was used to a family culture of reluctance to seek medical help and that his reticence to be in mental health services could have partly stemmed from this.

Mr. RT's involvement with his care plan. Mr. RT appears to have had very little involvement in his care planning. During the period up to his first admission on 7 February 2001, Mr. RT constantly failed to keep appointments and was non-compliant with any medication that he was being prescribed. He was discharged from services in August 2000 only to be referred back again in October 2000. When he was first on the ward from February 2001 he constantly refused all medication and stated that he was being kept illegally. During this time Mr. RT was also restrained and given medication forcibly. At no time between August 1999 and April 2001 was there any real attempt made to get to know Mr. RT. There appears to have been no attempt made to work with him in order to understand how services could best engage with him.

In May 2002 Mr. RT was seen again as his mental health was deteriorating. He refused to accept a sickness certificate with 'paranoid psychosis' on it and was subsequently recommended for admission to the ward on a Section 3 of the Mental Health Act (83), although this appears not to have happened. After this Mr. RT did not have any meaningful direct contact with mental health services regarding his care and treatment. This lack of involvement was made particularly difficult by Mr. RT's longstanding disengagement from services.

Compliance with Medication. The main component of Mr. RT's care and treatment was medication. Mr. RT repeatedly refused to accept that he had a diagnosed mental health problem and therefore reportedly also refused to accept taking medication consistently throughout his contact with primary and secondary services.

Attempts to help Mr. RT understand that he had a mental health problem had not resulted in him fully accepting help from services, or indeed a fuller understanding of his diagnosis. It is conjecture as to how much Mr. RT actually accepted the need to take his prescribed medication.

- ***Contributory Factor Number Three. Mr. RT was not actively involved in any aspect of his care planning by his clinical team. This lack of involvement may have exacerbated Mr. RT's inclination to disengage from services.***

14.7. Critical Issue Number 7. Cultural Diversity

14.7.1. Context

Black and Minority Ethnic (BME) individuals often appear to be subject to a paradoxical effect when accessing mental health services. The paradox is that many BME groups actively avoid mental health services and yet these same groups are represented by a significantly high presence within the mental health system. Research informs us that current mental health services within the United Kingdom have been based on a westernised model of psychiatry. It is a fact that some cultures accept the notion of mental illness more readily than others, these cultures will access mental health services and accept treatment programmes. Other cultures may be reluctant to consider the notion of mental illness with issues such as cultural stigmatisation, fear of the unknown and basic communication and language difficulties becoming barriers to accessing help[192].

Over the past six years a considerable amount of literature has been published regarding the needs of BME individuals, and their families, who require access to mental health services. This literature includes the Government's response to the death of David Bennett in 1998. David Bennett was a 38-year-old African-Caribbean patient who died on 30 October 1998in a medium secure psychiatric unit after being restrained by staff[193]. The Independent Inquiry into David Bennett's death raised many issues and identified failures regarding mental health services failing to understand cultural diversity.

It was stated within the Department of Health's *Delivering Race Equality in Mental Health Care* (2005) action plan that healthcare organizations must challenge discrimination, promote equality and respect human rights, and that organizations must enable all members of the population to access services equally[194]. The Government's expectation for the future of mental health services is set out below.

The vision for Delivering Race Equality is that by 2010 there will be a service characterised by:

- *less fear of mental health services among BME communities and service users;*
- *increased satisfaction with services;*
- *a reduction in the rate of admission of people from BME communities to psychiatric inpatient units;*
- *a reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units;*

- *fewer violent incidents that are secondary to inadequate treatment of mental illness;*
- *a reduction in the use of seclusion in BME groups;*
- *the prevention of deaths in mental health services following physical intervention;*
- *more BME service users reaching self-reported states of recovery;*
- *a reduction in the ethnic disparities found in prison populations;*
- *a more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective;*
- *a more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and*
- *a workforce and organization capable of delivering appropriate and responsive mental health services to BME communities.*

14.7.2. Findings

Mr. RT received his care and treatment from the Trust between 1999 and 2006, it has to be noted that the earliest part of this period fell prior to the Government advice as listed above. Mr. RT was difficult to engage with and at all times denied that he had any form of mental illness. As has been set out above, the family of Mr. RT was divided regarding the notion of his mental illness. Some members of his family thought he was unwell and needed psychiatric treatment, others felt that Mr. RT's problems stemmed 'from bad luck' as a result of his father's death[195]. Mr. RT himself expressed his belief in witchcraft[196]. These concerns regarding 'bad luck' and witchcraft were never explored by the clinical team in the light of a possible cultural belief system. Because this exploration did not take place no real understanding was gained as to relevance of these beliefs held by Mr. RT and his family regarding the care and treatment of his mental health condition. This lack of exploration meant that no culturally appropriate advice, education or support was given to either Mr. RT or his family.

Mr. RT himself expressed concerns that his contact with mental health services would prevent him from working with overseas Governments and particularly the United Nations[197]. This concern of Mr. RT was never actually explored by his clinical care team, however it would not be unreasonable to deduct from this that he was expressing a belief that a diagnosis of mental illness would be stigmatising. This probable belief may well have been central to his subsequent rejection of all psychiatric care and treatment. Mr.

RT placed a great deal of emphasis on his headaches which he believed to be a direct cause of his problems. Mr. RT did not appear to be reluctant to explore a neurological rather than a psychiatric explanation for his condition and experiences[198]. It is relatively common for individuals from BME communities to somatise their psychiatric condition. Somatisation is the manifestation of mental health problems as physical symptoms[199]. It is possible that Mr. RT was presenting in this manner and that the whole issue of stigmatisation was overlooked by the clinical care team.

Between 1999 and 2006 Mr. RT was offered medication as the principal part of his care and treatment. At no time was any psychological therapy treatment offered to him. It cannot now be known what Mr. RT's attitude to, or compliance with, a psychological therapy approach would have been. The issue here is that none was at any time considered or offered. This tends to be the experience of individuals from BME backgrounds. Although the quote below comes from research data relating to Asian service users the findings would appear to have a degree of resonance with Mr. RT's experience.

'For the Asian patients who are diagnosed with schizophrenia or psychosis, intervention is addressed exclusively through medicines and the social problems associated with the condition are not dealt with.[200] *'*

(Sashidharan, 1999)

Mr. RT's clinical records evidence both his cannabis use and the fact that he had a past criminal history. The Independent Investigation Team asked the clinical witnesses who were called to interview why these two aspects were not critically examined particularly with regard to risk assessments. There was a distinct feeling amongst the clinical witnesses that Mr. RT somehow conformed to the standard behaviours of other service users currently on their books and that none of this raised any particular concern. It was clear from Mr. RT's care and treatment plan that his cannabis use was never discussed with him, even though his family were very concerned about it and recognised that it had a direct bearing on his mental state[201]. It would appear that Mr. RT was not treated as an individual and that various assumptions were made about the appropriateness of his behaviours. The Independent Investigation Team is of the impression that cultural assumptions were made about Mr. RT and his lifestyle and that no appropriate interventions were made or discussed with him.

The final issue in this section examines the degree of cultural awareness and management of diversity practice that is present within the current Lambeth Community Mental Health Team. The Independent Investigation Team asked clinical witnesses how cultural diversity issues were managed on behalf of service users. The response was that the Community Mental Health Team was comprised of individuals from many different cultures and that this ensured that cultural diversity issues were considered at all times. This response did not detail how exactly this approach worked. Whilst the Independent Investigation Team acknowledges that an ethnically diverse Community Mental Health Team will possibly engender a culture where the management of diversity can flourish, no evidence was brought forward by clinicians in the Trust as to how the needs of service users would actually be met in accordance with the *Delivering Race Equality* action plan as set out above.

14.7.3. Conclusions

The Independent Investigation Team is of the impression that cultural assumptions were made about Mr. RT and his lifestyle especially regarding his cannabis usage and his past forensic history. Clinical witnesses told the Independent Investigation that Mr. RT fitted the profile of many of their service users in the area and that he did not appear as a cause of concern to them. The impression that the Investigation was left with was that Mr. RT fitted the clinical team's expectations of young black African and Afro-Caribbean men. The fact that Mr. RT's family profile fitted that of the professional middle-classes and that they had expressed concerns relating to his lifestyle and subsequent behaviours should have been taken more seriously. Mr. RT's assessment and treatment should have been managed on an individual basis rather than a comparative one.

The issues around Mr. RT's own particular cultural belief system were never explored or understood by his clinical team. The ambivalence displayed by Mr. RT's family and his own outright rejection of a psychiatric diagnosis lay at the heart of how events played themselves out between 1999 and 2006. Mr. RT did not engage with mental health services, possibly due to his fear of the unknown and his perceived concerns about stigmatisation. Mr. RT's notions regarding the aetiology of his condition were never explored by his clinical team. The concepts of 'bad luck' and witchcraft were never discussed with him in the light of his rejection of mental health services. This was a missed opportunity and Mr. RT was allowed to disengage with services and no attempt was made to understand the possible cultural aspects of this disengagement.

Contributory Factor Number Four. The services that were offered to Mr. RT and his family were not culturally sensitive and did not provide him appropriate assessment, care and treatment options.

14.8. Critical Issue Number 8. Safeguarding Children

14.8.1. Context

One in four adults will experience mental health problems. Many of these people will be parents, parents-to-be, grandparents, other family members, or will have regular access to children[202]. Parental mental illness in particular can have a detrimental effect on the health and well being of a child. The Department of Health and the Royal College of Psychiatry advise that systems should be in place to ensure timely assessment, review and support[203].

The National Service Framework for Mental Health (1999) provides a framework that expects all mental health practitioners to:

- *'**Promote mental health and engage in earlier intervention/prevention (Standard one)**.*
  Knowing which patients are parents will enable appropriate steps to be taken for the patient as parent and for her/his children'[204]

There is a significant legislative framework in place to both protect and safeguard children. There is also a significant series of Inquiry recommendations and Department of Health Guidance relating to both the protection and safeguarding of children, much of which was in place during the time that Mr. RT was receiving his care and treatment from the Trust.

Since 2003 the Trust has had specific Child Protection and Safeguarding Children polices in place. The 2005 policy was made available to the Independent Investigation Team, it stated that:

'A child is defined under the Children Act 1989 as anyone under the age of 18 years. Staff should remember, young children, including babies, may be particularly vulnerable and in need of protection, and also that child protection concerns for the unborn may need to be considered during pregnancy'

And that

'For staff working with adults or older adults, this may become relevant when considering the impact of the adult's mental state and behaviour on their own children

and grandchildren who they may care for and any other children they may have regular contact with'[205]

The Trust 2005 policy is comprehensive and understands fully that safeguarding children is not simply a matter of protecting against emotional, physical and sexual abuse, but is about promoting wellbeing and ensuring that children thrive in situations where mental illness afflicts family members.

14.8.2. Findings

On the 23 January 2002 Ms. J, Mr. RT's Care Coordinator, telephoned Mr. RT's mother. His mother said that he remained somewhat restless and agitated and would at times punch the wall. During this telephone conversation Mr. RT's mother informed Ms. J that he now had a six week old daughter, that the baby's mother lived in north London, and that Mr. RT was trying to establish his role as a father. No arrangements appear to have been put into place for a Safeguarding Children assessment at this stage[206].

On the 25 July 2003 Ms J wrote a summary report stating that Mr. RT appeared to be stable and that there were no concerns about his behaviour from his family. His risk behaviours were noted as being aggression towards his mother combined with a cannabis smoking habit. The summary mentioned his 18 month prison sentence in 1995, but this was dismissed as irrelevant as Ms. J recorded the explanation that Mr. RT had given of 'finding the gun in the street'. This explanation had been rejected by the Crown Court. The summary also records that although Mr. RT lived with his mother, she was still living next door with her daughter. It was noted that Mr. RT had a baby daughter with whom he had regular contact. No safeguarding children assessment was considered neccessary[207].

14.8.3. Conclusions

The Independent Investigation Team understands that Child Protection and Safeguarding Children issues came to the forefront of both the general public and healthcare professionals' attention in 2002 following the Laming Inquiry into the death of Victoria Climbie. In 2002 most Mental Health Trusts were only just putting into place the kinds of safeguarding policies that are commonplace today. It would be unfair to judge the lack of safeguarding procedures that occurred between 2002 and 2003 by the standards that would be expected at the current time. However it is clear that the clinical team did not work within the spirit of the *National Service Framework for Mental Health* (1999) to ensure that Mr. RT's daughter was not placed at risk due to her father's mental health condition.

It became apparent during the Independent Investigation interviews that any risk to Mr. RT's baby daughter was not considered due to the fact that she did not live with him but with her mother in North London. The Independent Investigation Team retains a sense of unease that this kind of thinking is still present within the current Community Mental Health Team. Mr. RT did have regular contact with his daughter and was known to be consistently violent within a domestic context. The fact that the baby did not live at the same address as him ought not to have been cited as a valid reason for not conducting a safeguarding assessment.

The Independent Investigation Team is at pains to state that they do not believe that Mr. RT was a specific risk to his baby daughter. However parental mental illness can have a detrimental effect on the health and well being of a child and this potential was not taken into account. The Independent Investigation Team does not believe that the lack of a Safeguarding Children assessment was a contributory factor to the events of April 2006. However the lack of such an assessment highlights a particular service management issue during the period of Mr. RT's care and treatment with the Trust.

Service Issue Number Two. No Safe guarding Children assessment was conducted.

14.9. Critical Issue Number 9. Interagency Communication and Working

14.9.1. Context

'Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion.'[208]

Jenkins *et al* (2002)

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.

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and have a history of criminal offences cannot be met by one agency alone[209]. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticises agencies for not sharing information and not liaising effectively[210]. The Department of Health *Building Bridges* (1996) sets out the expectation that agencies should develop policies and procedures to ensure that information sharing

can take place when required. This level of expectation was firmly in place during the time that Mr. RT first came to the attention of mental health services in Lambeth.

14.9.2. Findings

During the course of this investigation it became evident that two distinct areas of interagency working failed to take place as effectively as it should have done.

First, between 1992 and 2000 Mr. RT was convicted of six criminal offences. Three of these offences were of a violent nature and resulted in custodial prison sentences ranging from between three to eighteen months. Mental health services were aware of least three of these offences and these three offences are referred to in Mr. RT's clinical records. In the spring of 2002 Mr. RT's family had to call the police out to the family home on several occasions. The Community Mental Health Team was aware of this.

It is unclear as to whether or not the police were aware of Mr. RT's mental health condition. However it is clear that Mr. RT's clinical team were aware of some aspects of his forensic history. No attempt was made at any stage by Mr. RT's clinical team to understand the nature of Mr. RT's forensic history.

Second, it is evident from the GP held records that minimal communication and working occurred between the secondary care and primary care interface. It would appear that most of the communication was initiated by Mr. RT's General Practitioner.

14.9.3. Conclusions

It is perfectly clear to the Independent Investigation Team that Mr. RT was an individual with a forensic history of a nature that required significant interagency communication and liaison. This did not occur. It is the view of the Investigation Team that the clinical team who provided the care and treatment for Mr. RT should have made attempts to understand his past offending history once they understood that he was actually serving a custodial sentence whilst under their care in the spring of 2000.

Multi-Agency Public Protection Arrangements (MAPPA) were issued in 2001 by the Ministry of Justice. The aim of MAPPA is to ensure that a risk management plan is drawn up for the offenders of serious violent crime, benefiting from the information, skills and resources provided by the individual agencies who are involved with the offender, this includes mental health services. Mr. RT's offences occurred prior to these arrangements being

issued in 2001, therefore he was not automatically subject to them. The point is however, that Mr. RT's offences were of a serious enough nature to meet these criteria if the arrangements had been issued at an earlier time. Interagency communication guidelines were in place prior to MAPPA that could have ensured that vital information was obtained about Mr. RT if his clinical team had thought to operate within them. However his previous offences were never explored, his full level of risk never understood, and public protection arrangements were therefore not put into place.

Contributory Factor Number Five. The Trust did not instigate appropriate interagency communication, particularly with the police which, meant that significant information regarding the risk Mr. RT posed to the general public was never understood.

14.10. Critical Issue Number 10. Documentation

14.10.1. Context

'The Data Protection Act gives individuals the right to know what information is held about them. It provides a framework to ensure that personal information is handled properly.
The Act works in two ways. ... it states that anyone who processes personal information must comply with eight principles, which make sure that personal information is:

- *Fairly and lawfully processed*
- *Processed for limited purposes*
- *Adequate, relevant and not excessive*
- *Accurate and up to date*
- *Not kept for longer than is necessary*
- *Processed in line with your rights*
- *Secure*
- *Not transferred to other countries without adequate protection*[211]*'*

All NHS Trusts are required to maintain and store clinical records in accordance with the requirement of the Act. All records should be archived in such a way that they can be retrieved and not lost. All records pertaining to individual mental health service users should be retained by NHS Trusts for a period of 20 years from the date that no further

treatment was considered necessary; or eight years after the patient's death if the patient died while still receiving treatment.

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 professional 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 [212]*'*
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 litigatious environment, the means by which it may be judged. The record is the clinician's main defence if assessments or decisions are ever scrutinised[213]*'*

14.10.2. Findings
During the course of this investigation several issues regarding documentation came to light. They are as follows:

1. **Issue Number One: Location of Records.** The Trust could not locate Mr. RT's complete clinical record archive for the use of the Independent Investigation Team;

2. **Issue Number Two: Completeness of Records.** The standard of clinical record keeping appeared to be poor. Mr. RT's clinical record did not contain full Care Programme Approach documentation, risk assessment documentation or care plan documentation;

3. **Issue Number three: Inadvertent Alteration of Records.** Mr. RT's clinical record appeared to contain unintentional alterations as a direct result of the Trust electronic record system undergoing revision and modernisation processes.

Issue Number One. The Independent Investigation Team found that Mr. RT's clinical records did not appear to be as complete as would normally be expected for a service user who had been an inpatient and also subject to a period of enhanced CPA, for example, there was virtual absence of CPA documentation. The Investigation team needed to enquire as to whether some of the notes had possibly been lost, or whether they had never been created in the first place.

The Trust, after a rigorous search, could not locate any additional records pertaining to Mr. RT for the use of the Investigation Team. Clinical witnesses were interviewed and were asked to explain why Mr. RT's clinical record appeared to be incomplete. The Investigation Team were given two explanations as to why this was the case.

The first explanation given by the witnesses who directly provided care and treatment to Mr. RT was that the clinical record system between 2000 and 2006 was fraught with difficulties as the Lambeth Directorate piloted a new electronic records system. During this period clinical teams maintained both electronic and paper systems. The electronic system during this period was considered by clinicians to be slow and access to computers was limited. The Investigation Team were told that Multi Disciplinary Team clinical meeting folders were kept to record CPA meetings and reviews. This parallel system appears to have been in place for a period of several years. Clinical witnesses were certain that Mr. RT's CPA reviews would have been recorded in this clinical meeting folder. However this paper record appears to exist no longer and it was not possible for the Investigation Team to understand exactly how Mr. RT's care and treatment was managed as virtually nothing relating to Mr. RT's CPA was present in the extant electronic record. Witnesses also referred to social workers keeping separate social work folders instead of integrating their inputs within the patient's individual electronic journey system. Two out of three of Mr. RT's Care Coordinators were social workers and described this practice as being in operation up until 2005. The effect of this practice was that essential information was not shared with the rest of the clinical team. In the absence of this information the clinical witnesses struggled to remember events as they pertained to Mr. RT's care and treatment. [214].

The second explanation offered to the Independent Investigation Team came from a Trust Board Director. This Director was of the view that if the records were not available to the Independent Investigation it was because they had never been created in the first place [215].

The Investigation Team were presented with two different explanations as to the incomplete nature of Mr. RT's clinical records. As the two accounts would appear to conflict one with the other there can be no certainty as to whether this is a record location issue or a professional clinical record maintenance issue. The Investigation Team believe that both explanations are probably correct. It is likely that a team file was used to record meetings and has subsequently been lost. This would concur with the evidence of the clinical witnesses. It is also entirely reasonable to consider that these simple notes could not be regarded as a complete individualised patient record that would meet with professional regulatory bodies' expectation thereby concurring with the view of Trust Board Director Witness. The fact remains that these records, rudimentary or not, cannot now be located by the Trust.

Issue Number Two. Mr. RT's clinical record did not contain complete CPA documentation, risk assessment documentation or care planning documentation. The record contains what can at best be described a simple 'cardex system'. A cardex system is one whereby a chronological running record only is kept based upon clinical contacts and interventions. This kind of system is usually devoid of care planning and practical case management.

Neither Mr. RT's paper records nor his electronic records contained any evidence of coherent case management. It is not possible to understand from the extant clinical record exactly what the clinical team was trying to achieve with him. There is no evidence that any holistic assessment of his needs ever took place, no formal risk assessments are recorded and no care plans were formulated.

The Independent Investigation Team were told by clinical witnesses that many discussions did in fact take place regarding Mr. RT's care and treatment. However these discussions are described as having been informal rather than formal, and do not appear to have been recorded anywhere in such a manner that would meet professional regulatory standards.

It became clear when clinical witnesses were interviewed that the embryonic electronic patient record system was fraught with difficulties between 2001 and 2006. Computers were in short supply and the system was slow. These circumstances were given as being a key reason as to why there was a virtual absence of CPA documentation in Mr. RT's record. Whatever the reason, the fact remains that Mr. RT's clinical record is incomplete. This begs the question, was his care and treatment also incomplete? No evidence can be brought forward to suggest otherwise?

Issue Number Three. The Independent Investigation Team noted some key discrepancies within Mr. RT's electronic clinical records. The Team was initially confused by the information recorded at the top of each electronic clinical record sheet. The documents appeared to record the names of Mr. RT's 2006 clinical team as having also been his clinical team from 2001, this information was incorrect. The information on the header of each sheet appeared to contradict the information within the narrative context of each sheet. The main confusion was with regard to Mr. RT's CPA status and the name of his Care Coordinator.

After full consultation with Trust senior personnel the discrepancies were explained. Apparently every time an electronic record was printed off, the system instantly transposed the most recently inputted header information onto all historic record sheets.

It was established that this was a system error within the Electronic Patient Journey System. This system error has now been fully rectified by the Trust.

14.10.3. Conclusions

The issue regarding the failure to locate clinical records is a serious one. Every NHS Trust is required to archive patient records in a secure environment. This is a challenge when systems evolve from paper-based records to electronically-held records. It is clear that in this case not all paper-based records were archived successfully at the South London and Maudsley NHS Foundation Trust. The team files containing clinically sensitive information compiled by the North-West Lambeth Community Mental Health Team cannot now be found.

The fact that clinical team meeting files were in used in the first place is another issue of concern. Meeting folder recordings of Care Programme Approach reviews and meetings does not represent best practice regarding individualised patient care planning and management. However the Independent Investigation Team could understand that meeting folders were used to record the decisions made in meetings in a 'paper light' clinical situation where paper patient document folders no longer existed. What the Team could not understand was why this information was not appropriately recorded at a later date in the individualised electronic patient record together with the appropriate recording of all assessment and care planning documentation.

It is the view of the Independent Investigation Team that individual clinicians did not operate within the expectation of either local Trust policy or national expectation regarding the recording of clinical information. This has had the effect of ensuring that crucial information about Mr. RT was never recorded and communicated effectively from one clinical team member to another over a period of five years. The lack of coherent documentation meant that the Independent Investigation Team could find no evidence to support the notion of the existence of a coherent Care Programme Approach, risk assessment or care planning process. The old adage has to be upheld here, 'if was not recorded, then it never happened'.

It is also the view of the Independent Investigation Team that the Trust did not successfully oversee the management of the transition from paper-based to electronically-held clinical records. It should have been possible during the pilot stage of the implementation of the electronic records system within the North-West Lambeth team to detect the flaws within the new system that proved an immense frustration to clinicians in the field. Clinical witnesses described to the Independent Investigation Team a 'chaotic system' between 2001 and 2006 where services were being integrated and policies and procedures rationalised[216]. This chaos also appears to have been exacerbated by the practice of keeping clinical records in a variety of different folders and note books.

Contributory Factor Number Six. Individual clinicians did not produce and maintain Mr. RT's clinical records to a professional standard. Local team management systems and corporate-led audit both failed to detect these shortcomings.

14.11. Critical Issue Number 11. Clinical Supervision

14.11.1. Context

The NHS Management Executive defined clinical supervision in 1993 as:

'….a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations'[217]

Clinical supervision is used in counselling, psychotherapy and other mental health disciplines. Supervision provides the opportunity to discuss case work and other professional issues in a structured manner. In the United Kingdom clinical supervision has been seen by both the Department of Health and the statutory healthcare professional regulatory bodies as an integral part of professional health and social care practice since the early 1990's.

Throughout the entire period that Mr. RT received his care and treatment from the Trust sound clinical supervision guidelines were in place. The 2002 Trust guidelines differentiated clearly between clinical supervision and managerial supervision and gave clear definitions for both. Clinical Supervision was described in the following way;

'It is a key component of quality improvement as it provides an opportunity for practitioners at all levels to review practice in a regular and systematic way. Therefore, "clinical supervision" could be seen to be "at the heart of clinical governance' [218]

Managerial supervision was described thus:

'It is a planned process, establishing the accountability of the worker in the organization, ensuring tasks are carried out to a satisfactory, safe standard in line with organizational objectives and promoting the workers professional development...It involves... implementation of government, local and Trust policies.'[219]

The Trust 2002 guidelines suggested that clinical supervision should occur no less than once a month for a duration of no less than one hour.

14.11.2. Findings

The Independent Investigation Team found examples of sub-standard clinical practice particularly with regard to basic history taking, record keeping, risk assessment and the implementation and management of the care programme approach. It is the view that some of the poor practices identified by this investigation could have been identified by clinical supervision. The Trust guidelines that were in place from 2002 stated clearly that one of the main objectives of supervision was to ensure that practitioners adhered to Trust policy and procedure. It would appear that these guidelines were not able to ensure that this occurred. It is possible that supervision took time to be fully incorporated into the Trust practice and culture. This view is supported by the evidence below.

In the context of the Trust Board Level Inquiry it was evident that Dr. NS was in his first Consultant position when on the 17 July 2003, after discussion with Mr. RT's Care Coordinator, he made the decision to discharge Mr. RT from Case Management. This in effect removed Mr. RT from enhanced CPA and placed him on standard CPA. When interviewed Dr. NS informed the Independent Investigation Team that he had had reservations about this decision at the time, but that he had deferred to the opinion of his colleague Ms. J as he felt that she knew Mr. RT well. Dr. NS was at pains to state that he took full responsibility for the decision, nevertheless his reservations about this decision was part of his rationale for not discharging Mr. RT back to the direct care of his GP[220].

It was evident that Dr. NS had no mentor and that he did not seek advice about the case simply because this was not consistent with the prevalent culture of the Trust. The Trust Board Level Inquiry commented that case management team caseloads were well monitored but that Consultant activity in the Outpatient Department was not. At the current time the Trust is trying to establish where doctors are getting their supervision from. The Trust Medical Director informed the Independent Investigation Team that attempts are being made to understand what kind of approach would be the most effective[221]. It has to be noted that supervision arrangements were not in place in July 2003 for Dr. NS and that instead of being able to discuss his decision regarding Mr. RT with a peer or senior colleague he chose the option of out-patient care. It is clear that Dr NS felt uncomfortable about his decision. It is not possible to state that had Dr. NS had access to clinical supervision the events of April 2006 would not have taken place. However the experience of Dr. NS highlights the day-to-day dilemmas that many clinicians face and the need for the opportunity to reflect, that clinical supervision affords.

The experience of Mr. RT's Care Coordinator regarding clinical supervision demonstrates that in 2003 neither clinical nor managerial supervision was actually an embedded practice within the Lambeth Directorate. When specifically asked about clinical supervision and the role that it played within her practice Ms. J told the Independent Investigation Team that, *'yes, my line manager would have been there for me to talk to, but I cannot recall what we discussed. I think the day care and issues and concerns, I would probably discuss it more with the medical staff. That was more the pattern we had within the team.*[222]*'*

The situation that Ms. J found herself in was compounded by the fact that from the summer of 2002 she was acting up as a Team Leader for the Community Mental Health Team. Clinical Witnesses including the Head of Social Care felt that it was entirely possible that Team Leaders would have had no access to supervision at this time even though they would have held small caseloads in conjunction with their management roles. Unfortunately no witness could remember what the supervisions arrangements were or could provide evidence for the arrangements during the time in question.

No evidence could be found to support the notion that the Trust clinical supervision guidelines were being implemented during the period that Mr. RT was receiving his care and treatment from the Trust.

14.11.3. Conclusions

Set against the background of organizational change, service integration and systems management changes (such as the electronic patient record) and high staff turnover,

clinical supervision guidelines may have been regarded at the time as one more challenge to implement.

It is entirely possible that had both clinical and managerial supervision been embedded within the Lambeth Directorate Community Mental Health Teams at the time when Mr. RT was receiving his care and treatment then issues regarding the standards of clinical practice could have been identified, monitored and improved as part of a local management accountability framework.

Although, as has been stated above, the absence of supervision may not have had a direct bearing upon the events of April 2006, it is evident that no formal process was in place that could have provided an opportunity for reflection and support to a staff group that were experiencing a high degree of organizational turbulence.

Key Contributory Factor Number Seven. Clinical supervision was not available to the health and social care professionals providing the care and treatment to Mr. RT. This ensured that poor adherence to Trust policy and procedure went undetected.

14.12. Critical Issue Number 12. Adherence to National and Local Policy and Procedure

14.12.1. Context

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.*[223]' 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.

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their 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 14.14 below.

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.

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 polices or procedures or to raise any implementation issues as they arise with immediate effect.

14.12.2. Findings

The Independent Investigation Team examined a comprehensive list of Trust policies and procedures. The policies and procedures most pertinent to this investigation were those pertaining to risk assessment, CPA, clinical supervision, and record keeping. It was the view of the Independent Investigation Team that these policies and procedures were comprehensive and reflected both national guidelines and best practice.

The finding of the Independent Investigation Team is that whilst the Trust policies and procedures were fit for practice and purpose between 2000 and 2006 they were not implemented. Had these policies been properly implemented they should have allowed for Mr. RT to have received effective care in the community. It is not clear why these policies and procedures were not implemented. It would appear that all healthcare staff received training to support clinical policy implementation. It was evident from clinical witness interviews that a great deal of reliance was placed on 'gut instinct' when reaching clinical decisions. Policies and procedures did not appear to have a central position in the hearts and minds of some of the people that were interviewed by this Investigation Team. Although it is not possible to generalise, it may be that this played an important part in the non-adherence to Trust policy and procedure that was evidenced by the care and treatment that Mr. RT received. It is certain that Mr. RT did not cooperate and was difficult to engage with, and this has to be taken into consideration when understanding the challenges faced by the clinical team.

14.12.3. Conclusions

The Trust policies and procedures have much to commend them, however it is clear that during the period in which Mr. RT was receiving his care and treatment they were not

being implemented, to the detriment of patient care. The implementation of policy and procedure presents a challenge to all healthcare providers. Implementation requires clear dissemination, training, audit and clearly defined clinical supervision arrangements. It is apparent that between 2000 and 2006 patient care was delivered against a backdrop of organizational change and service system transformation. It is difficult to understand exactly the circumstances that the community mental health team in Lambeth found itself working within, however clinical witnesses describe a chaotic environment. It is also apparent that clinicians appeared to define their own working parameters which often circumnavigated corporate processes. The section directly below will explore the Trust Clinical Governance processes which should have been able to detect this non-adherence to Trust policy and procedure, but which did not.

Contributory Factor Number Eight. Clinical practice within the Trust did not conform to internal policies and procedures.

14.13. Critical Issue Number 14. Clinical Governance Processes

14.13.1. Context

'Clinical governance is the system through which NHS organizations 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'[224]

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.

Prior to, and during, 2006 the South London and Maudsly NHS Foundation Trust had a Clinical Governance and Risk Management sub committee that reported to the Trust Board. This sub committee represented an integrated approach to clinical governance and risk management which was in line with national expectation and guidance. During the period in which Mr. RT received his care and treatment from the Trust the Commission for Health Improvement, and subsequently the Healthcare Commission, externally monitored the Trust and provided independent ratings for its performance.

14.13.2. Findings

During the period that Mr. RT received his care and treatment from the Trust it was evident that several systems failed to work effectively, particularly with regard to CPA, risk assessement and documentation. As has been stated above, the Trust had sound clinical policies and procedures in place. It is evident from independent Clinical Negiligence Scheme for Trusts (CNST) assessments and reviews by the Healthcare Commission that clinical staff were receiving the appropriate training and development in these areas in order to facilitate full implementation of Trust policy and procedure.

During the course of the Independent Investigation the Team accessed the external reports authored by the Healthcare Commission. These reports confirm that the Trust had sound clinical governance processes in place. For example for the year 2002/2003 the Trust was rated a '5' for its CPA systems implementation. A 5 signified that the Trust was performing significantly above the national average in this area[225]. Other more recent independent reports from the Healthcare Commission also confirm that the Trust has a consistently high level of service performance with all of the required checks and balances in place within the system.

The Trust has always instituted a robust series of clinical audits as evidenced to the Independent Investigation Team. During the course of this Investigation over 1,000 pages of documentary evidence was considered by the Team which was relevant to the issue of the Trust clinical governance systems. However it is clear that in the case of Mr. RT aspects of his care and treatment did not meet internal Trust standards and were not detected via Trust clinical governance processes.

14.13.3.Conclusions

When conducting an Investigation of this kind it has to be remembered that the care and treatment of a single service user is being examined. This examination no matter how detailed can only yield a certain degree of insight into the workings of an organization that treats nearly 40,000 service users each year. On examination the Trust clinical governance processes between 1999 and 2006 were found to be perfectly adequate by this Independent Investigation Team, this finding takes into account the many external reports that examined the Trust's systems during this period.

It is a salutory lesson that all health related agencies need to consider that sometimes systems may be excellent but cannot demonstrably be effective 100% of the time. When reviewing why the Trust clinical governance systems did not appear to work effectively in

this particular case the Independent Investigation Team had to consider the following possiblities:

- team culture;
- 'the exception that proves the rule';
- the effect of Mr. RT falling away from the Trust's 'radar system'.

Team culture. It was evident from clinical witness interviews that a great deal of reliance was placed on 'gut instinct' when reaching clinical decisions. Policies and procedures did not appear to have a central position in the hearts and minds of some of the people that were interviewed by this Investigation Team. Although it is not possible to generalise, it may be that this played an important part in the non-adherence to Trust policy and procedure that was evidenced by the care and treatment that Mr. RT received. It may also be possible that this culture affected the rigor with which audit data was collected, analysed and then acted upon.

The exception proving the rule. Between 1999 and 2006 most Trusts would not automatically audit every single case file when determining the effectiveness of a system, it is entirely possible that Mr RT's case file was never subject to audit. It is possible that Mr. RT's case file depicts a general state of affairs that exisited within the Lambeth Directorate, but this is not bourne out by Trust audit data. There will always be a small percentage of cases that do not reflect best clinical practice and it is possible that Mr. RT was simply one of these.

The effect of Mr. RT falling away from the Trust 'radar system'. Mr. RT did not receive an adequate clinical assessement at the inception of his period of care and treatment. The failure to instigate this basic building block of care ensured that Mr. RT was able to gradually disengage from services over a period of time. Mr. RT was not assessed as being a risk, this ensured that he never became the subject of caseload supervision or management review. This had the effect of preventing his case from ever coming under any degree of clinical scrutiny. The absence of this scrutiny allowed the systematic flaws in his care and treatment to remain undetected.

The Independent Investigation Team concludes that the clincial governance systems within the Trust were sound during the period that Mr. RT was receiving his care and treatment even though they failed to detect key clinical service issues in the management of his case.

15. Findings and Conclusions

The backdrop of organizational change

The South London and Maudsley NHS Foundation Trust is a large organization, representing the amalgamation into one working unit of several mental health services within a geographical area of South London. Inevitably, as the Trust began establishing its new corporate identity from 1999 onwards, there were numerous re-organizational processes, not the least those associated with the successful bid to become a Foundation Trust, which was attained in 2006. In parallel, there was the move towards integration of health and social care within mental health, which was happening nationally. Another major process change during the period that Mr. RT was receiving his care and treatment was the move from a paper-based record keeping system towards an electronic patient record.

It is a matter of speculation as to the degree to which these process changes impacted on the turbulence that affected the Lambeth Directorate and the clinical effectiveness of their work. However organizational change is usually recognised as being a disruptive process to operational services and the findings regarding the care and treatment that Mr. RT received from the Trust have to be understood in this context.

Root Cause Analysis

In order to ensure that the findings are understood within the root cause analysis methodology each finding is placed within one of the three categories below. These categories are as follows:

1. **Key Causal Factor.** The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team have concluded had a direct causal bearing upon the mental state of Mr. RT. In the realm of mental health service provision it is never a simple or straightforward task to unconditionally identify a direct causal relationship between the care and treatment that a service user receives and any subsequent homicide perpetrated by them.

2. **Contributory Factor.** The term is used in this report to denote a process or a system that that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown in Mr. RT's mental health and/or the failure to manage it effectively.

3. **Service Issue.** The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of April 2006, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvement to services made.

Key Causal Factors

The Independent Investigation Team has found two key causal factors relating to the care and treatment of Mr. RT and the subsequent events of April 2006. The key causal factors identified by this Investigation had a direct bearing on the breakdown of Mr. RT's mental health. His Honour Judge Peter Beaumont ruled that Mr. RT committed his offences on the grounds of diminished responsibility as a direct result of his paranoid schizophrenia. .

- ***Key Causal Factor Number One. The failure to manage the ongoing assessment, care, risk and treatment needs of Mr. RT meant that his mental illness was at best partially treated. His Honour Judge Peter Beaumont ruled that Mr. RT's mental state had a direct bearing on the events of April 2006.***

- ***Key Causal Factor Number Two. Mr. RT's care and treatment plan never appeared to have been properly considered in the context of diagnosis and its implications. The appropriateness and effectiveness of Mr. RT's medication and treatment regime were never effectively reviewed. The subsequent partial treatment of his condition had a direct bearing on his mental state. His Honour Judge Peter Beaumont ruled that Mr. RT's mental state had a direct bearing on the events of April 2006.***

Contributory Factors

The Independent Investigation Team found eight factors that contributed to the less than effective care and treatment package that Mr. RT received.

- ***Contributory Factor Number One. The failure of the Trust to ensure a risk assessment was conducted that took full account of Mr. RT's personal, psychiatric and forensic history ensured that he fell through the safety net of care and contributed to undetected breakdown in Mr. RT's mental health, and thereby to the events of April 2006.***

- ***Contributory Factor Number Two. The failure of the Trust to provide Mr. RT with a comprehensive package under an enhanced level of the Care Programme Approach led to Mr. RT falling through the safety net of care.***

- ***Contributory Factor Number Three. Mr. RT was not actively involved in any aspect of his care planning by his clinical team. This lack of involvement may have exacerbated Mr. RT's inclination to disengage from services.***

- ***Contributory Factor Number Four. The services that were offered to Mr. RT and his family were not culturally sensitive and did not provide him appropriate assessment, care and treatment options.***

- ***Contributory Factor Number Five. The Trust did not instigate appropriate interagency communication, particularly with the police, this meant that significant information regarding the risk Mr. RT posed to the general public was never understood.***

- ***Contributory Factor Number Six. Individual clinicians did not produce and maintain Mr. RT's clinical records to an appropriate professional standard. Local team management systems and corporate-led audit both failed to detect these shortcomings.***

- ***Key Contributory Factor Number Seven. Clinical supervision was not available to the health and social care professionals providing the care and treatment to Mr. RT. This ensured that poor adherence to Trust policy and procedure went undetected.***

- ***Contributory Factor Number Eight. Clinical practice within the Trust did not conform to internal policies and procedures.***

Service Issues

The Independent Investigation Team found two service issues.

- ***Service Issue Number One. No Carer Assessment was conducted.***
- ***Service Issue Number Two. No Safe Guarding Children assessment was conducted.***

Conclusions

The care and treatment that Mr. RT received between 1999 and 2006 did not provide a comprehensive package that treated his condition effectively and adequately monitored him with regard to relapse.

The Trust had excellent policies and procedures during this period of time, but they were not adhered to. Despite the presence of robust clinical governance systems the inadequacies of Mr. RT's care and treatment were not identified or rectified. This ensured that as the years went by Mr. RT was able to completely disengage from mental health services. Despite the presence of significant risk indicators and evidence that suggested Mr. RT's psychosis was only partially treated, secondary care services allowed him to slip through the safety net of care.

It is the case here that, despite excellent policies and procedures and sophisticated clinical governance systems, the basic building blocks of clinical practice which form the most essential components of patient care were not respected. Nothing can take the place of a detailed patient history set within the context of a sound and ongoing relationship with the service user. The notion of rapport building and engagement are fundamental to the provision of safe and effective care.

It is the conclusion of the Independent Investigation Team that had Mr. RT's full history been appropriately explored, based on the knowledge available to the Trust early in 2001, his case would have been managed entirely differently. Whilst it is impossible to say that the events of April 2006 could have been avoided, it is possible to say that Mr. RT's care and treatment plan could have been managed more effectively and that his mental illness could have been assessed and monitored more robustly.

16. South London and the Maudsley NHS Foundation Trust's Response to the Incident and the Internal Investigation Process

The following section sets out the Trust response to the events of April 2006.

16.1. The Trust Serious Untoward Incident Process

The Trust has a robust serious untoward incident policy. This policy clearly sets out the required procedure following an incident and also sets out the responsibilities of all Trust personnel[226]. The policy details clear instructions for the support of service users and their carers, victims and their families, and staff.

The most serious events are graded as being either class A, B or C incidents. A class A incident is one that results in a death and can include acts of homicide or suicide. The events of April 2006 perpetrated by Mr. RT were graded collectively by the Trust as being a class A incident and was managed accordingly.

The Trust sets out a three-stage investigation process for class A incidents. It is as follows:

1. **Level One- Fact Finding Report.** This is completed within 48 hours of the incident occurring. This report includes details of those involved in an incident and contains a brief chronology of the antecedents of the events.

2. **Level Two – Internal Investigation (Structured Investigation Report).** This is a full investigation using structured investigation methodology. This second-stage investigation can be conducted at either a departmental or directorate level. It can also be internally commissioned as an independent internal investigation which can be conducted outside of the department or directorate where the incident occurred. This was the chosen option for the Mr. RT case.

3. **Level Three – Board Level Inquiry (BLI).** This is a full investigation such as is found at level two of the process but with an additional review from the Trust Board. The purpose of the BLI is to take a broader view of the incident and to ensure full Trust Board scrutiny occurs.

4.

16.2. The Trust Internal Investigation (Structured Investigation Report)

This was internally commissioned by the Assistant Director Patient Safety and Clinical Governance, and the Lambeth Service Director, on the 6 May 2006[227]. The Investigation Team comprised a Consultant Psychiatrist, a Nurse Advisor, and an Investigation Facilitator.

The scope of the Investigation was to:

'...review and investigate the circumstances giving rise to the incident. To involve the family in the investigation process if possible. To review policy and practice in relation to the incident. To identify good practice and care management problems. To identify the root causes of any identified care management problems. To agree an action plan designed to reduce the risk of recurrence of a similar incident. To produce a report which would fully assist further scrutiny of the event preceding this incident including Coroner's Inquest and Independent [public]Inquiry[228].

The Internal Investigation also sought to specifically address the issues of care planning and medication and risk assessment.

Findings of the Trust Internal Investigation (Structured Investigation Report)

The Internal Investigation Team found the primary problem regarding the provision of care and treatment that Mr. RT received was that no coherent risk assessment had been conducted. The Internal Investigation found what they described as 'root causes to the primary problem'. They are as follows:

1. There was a lack of planning for discharge from inpatient services.
2. There was management of the risks that Mr. RT presented with following his relapse and assessment under the Mental Health Act (83). The brief risk screens that were utilised did not allow for a full clinical consideration of risk.
3. Too much responsibility was given to the family of Mr. RT.
4. Irregularities were found in the CPA documentation. No Section 117 meeting appeared to have taken place at the time of Mr. RT's discharge from inpatient services. Community documentation did not comprise contingency or crisis plans and no care programme was formulated.
5. The case management team were under pressure and no assertive outreach was available between 2001 and 2003.
6. Mr. RT's compliance with medication and mental state were not monitored by mental health professionals and possible relapse indicators were not identified.

The Independent Investigation Team's findings concur with those of the Internal Investigation Team in most respects. However there is one main area that the Independent Investigation Team felt was overlooked by the Internal Investigation Team and that is the area of the known forensic risk history and resulting risk that Mr. RT presented with. The fact that Mr. RT could not engage with the CMHT in the spring of 2000 was because he was in prison and this was not picked up by the Internal Investigation. The fact that Mr. RT's clinical record documented two custodial sentences was not explored. Mr. RT's forensic history was significant and highly relevant and should have been subject to detailed consideration from the Internal Investigation. This aside, it is the view of the Independent Investigation Team that the Internal Investigation was sound and conducted in accordance with both national and internal guidelines, policy and expectation.

The Internal Investigation Report was completed on the 4 August 2006.

16.3. The Trust Board Level Inquiry

The Trust held a Board Level Inquiry on the 24 August 2006. The Panel comprised a Non-Executive Director who acted as the Inquiry Chair, the Deputy Director of Nursing, and a Clinical Director. In attendance to the Inquiry was the Trust Board Level Inquiry Coordinator.

The Board Level Inquiry addressed and reviewed the following:

1. The Internal Investigation Structured Report.
2. Staff support and debrief.
3. The role and functioning of the Case Management Team.
4. Mr. RT's transfer from the Case Management Team to the Outpatient Department.
5. Family involvement and carer responsibilities. The Panel also questioned whether a carer assessment had been conducted.
6. Mr. RT's compliance with medication.
7. Crisis contingency and care planning.
8. Risk assessment and documentation.
9. The Care programme approach.
10. Child protection.
11. Police Involvement.

It is the view of the Independent Investigation Team that the Board Level Inquiry identified a comprehensive range of issues. However not all of these issues were satisfactorily addressed by the Board Level Inquiry Panel. The Independent Investigation Team noted that the issues of Child Protection and Carer Assessments, for example, should have received a more in depth analysis. The Board Level Inquiry accepted what could be interpreted as a rather superficial range of explanations from the clinical witnesses which required a more in-depth exploration. As a result Child Protection and Carer Assessments were not highlighted as areas in which the Trust could learn lessons and ensure an increased rigor regarding patient and public safety.

Another key issue that was not adequately explored was that of CPA. It is clear that the evidence brought forward to the Board Level Inquiry regarding Mr. RT's CPA status was incorrect. This internal inquiry did not identify the problems that the migration of clinical records into the EPJS system had caused. Once again this represents a missed opportunity for the Trust to ensure that internal systems and processes were running in an effective and efficient manner.

On the whole both the Internal Investigation and the Board Level Inquiry focused on the last four years of Mr. RT period of contact with the Trust. It is the view of the Independent Investigation Team that this rather narrow view did not reveal the full picture regarding all aspects of Mr. RT's condition, history and risk. The Board Level Inquiry commended the care and treatment that both Ms. J and Dr. NS provided to Mr. RT. It is the view of the Independent Investigation Team that the general quality of the care and treatment that Mr. RT received throughout his period of contact with the Trust consistently fell below both local policy standards and national expectation. It is the view of the Independent Investigation Team that the internal Trust investigation processes should have been able to provide a more critical analysis of the care and treatment that it provided to Mr. RT in the interest of learning the lessons.

The Board Level Inquiry endorsed the recommendations made within the Structured Investigation Report. It concluded that that Mr. RT was a complex and challenging individual with whom it had been difficult to engage. The BLI recommended that some additional points were incorporated into the Structured Investigation recommendations. These are set out below in section 16.6.

16.4. Being Open

The National Patient Safety Agency issued the *Being Open* guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006[229]. 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[230].

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.

The Independent Investigation Team understands that the Trust did not work with either the perpetrator's family, the families of the deceased, or with the surviving victims of the events of April 2006 in the spirit of the *Being Open* guidance. The reason for this is in the main part due to the understanding that the Trust had that the Metropolitan Police Force had advised them not to make contact with the above mentioned parties because of the ongoing police investigation.

Another reason that the families of the deceased and the surviving victims of the events of April 2006 were not communicated with in the spirit of the guidance is that the details of these people were not known to the Trust. It is only as a result of the Independent

Investigation that the Trust has been made aware of the numbers of individuals that were affected by the actions of Mr. RT and the resulting events of April 2006.

The Trust published a *Being Open* Policy in September 2008. The Trust acknowledges that further clarity is required about how it should engage with the families of the victims of alleged homicide in situations where the Police are involved in concurrent criminal investigations.

The Metropolitan Police has been able to offer exceptional support to the Independent Investigation Team. The Trust has now been able to make arrangements to meet with Mr. JRD, a survivor of one of the fire bomb attacks, in order to address any outstanding issues and to be able to offer what support it may be appropriate to give even after such a long period of time between the incident and the present day.

The Independent Investigation Team has noted that despite the 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, there remains a high degree of uncertainty as to how to implement the guidance. It is the view of the Independent Investigation Team that NHS London, as the Strategic Health Authority, should work with the Metropolitan and City Police Forces to ensure that the Memorandum of Understanding is reviewed regarding its implementation in London. There is a recommendation to this effect in Section 19 below.

16.5. Staff Support

The Trust Board Level Inquiry noted the following regarding the Trust Internal Investigation Processes:

'The panel were concerned to hear that staff did not receive any support following the notification of the incident. The panel wished to remind all management staff that whatever the route, time lapse, or staff designation, all staff involved in an incident should receive and have access to support. As such the panel recommend that the Borough Directors ensure that mechanisms and systems are in place to enable this to happen.'[231]

The Trust worked with the Independent Investigation Team to ensure that all clinical witnesses were supported throughout the process and that all Scott compliant processes were followed. The Trust is in the process of arranging a full feedback session with all of the clinical witnesses who contributed to the Independent Investigation.

16.6. Trust Internal Investigation/ Board Level Inquiry Recommendations

The Trust Structured Investigation Report set out the following recommendations:

1. *It is recommended that the value of the Brief Risk Screen be reviewed in the imminent review of the Trust's Framework for Clinical Risk Assessment and Management of Harm.*
2. *The Trust framework for Clinical Risk Assessment and Management of Harm recommends that risk assessments should be reviewed where there is any change in the patients' circumstances. It is recommended that an audit is commissioned within the Directorate to review compliance with a view to improvement of practice or policy change.*
3. *The Trust's Care Programme Approach Policy (2002), which is under review, describes the level of assessment and care planning required for carers. It is recommended that the CPA Policy review and implementation should emphasise the importance of this responsibility to carers/families and that future CPA training should also emphasise the Trust's responsibilities to families/carers.*
4. *The Trust Care Programme Approach Policy (2002) requires that carers/families are involved in assessments for care programmes 'where appropriate'. It is recommended that families/carers who take on direct responsibilities for the care/treatment of a patient should be involved in formulation of plans as a matter of course and if not the reasons should be clearly documented and this should be considered in the policy review.*
5. *Non engaging patients would not now be transferred to outpatients from case management as the Assertive Outreach would be the most appropriate team to manage them. It is recommended that if there are no risk concerns they should be discharged to the care of their GP.*
6. *It is recommended that the Trust Medicines Management Committee consider how long it is advisable for medication to be prescribed without a review of the patient and that this is made explicit in future review of the Trust Medicines*

Management Policy. It is also recommended that an audit of repeat prescribing should be considered[232].

The Trust Board Level Inquiry recommended that the Structured Investigation considered the following:

- *In terms of recommendation one the panel agreed that the value and role of the risk screen should also be taken into consideration as part of the Trust's framework for Clinical Risk assessment. Consideration should also be given to ways in which the risk assessment documentation can be changed to prompt further fact finding and /or discussion.*
- *In addition to the list of points made in the second recommendation outlining when a risk assessment should take place, the panel would also like the investigation team to consider including an additional category, advising that risk assessment should be undertaken periodically, particularly where a patient has missed appointments and as such may have been seen for some time.*
- *In addition to the points raised in recommendation five, which centred around the engagement of patients. The panel agreed that local teams and outpatients departments should also have a documented care and contingency plan, detailing treatment and action to be taken when a patient has not been seen.*
- *The panel were concerned to hear that staff did not receive any support following the notification of the incident. The panel wished to remind all management staff that whatever the route, time lapse, or staff designation, all staff involved in an incident should receive and have access to support. As such the panel recommend that the Borough Directors ensure that mechanisms and systems are in place to enable this to happen.*
- *The panel...recommend that the EPJs steering group consider ways in which the system can generate automatic messages to alert staff of a patient's non attendance.*
- *The panel were given to understand that a review of the Risk assessment policy and documentation was underway and as such would like to recommend that the working group consider the inclusion of substance misuse as a factor in the brief risk screen*[233].

16.7. Progress against the Trust Internal Investigation Action Plan

The implementation of the action plan arising from the Mr. RT Internal Investigation has been conducted using the established processes for all serious untoward incidents (SUIs) in Lambeth and in other Trust Directorates.

SUI panels are established in each Trust Division and Directorate. The panels meet at a minimum on a quarterly basis to review incidents and the investigation reports within their service area. The findings of investigations and the recommendations arising from these are scrutinized and agreed at the panel. Recommendations are put into an action plan, which is monitored at the Directorate Clinical Governance Committees.

The local Clinical Governance Committees, which are chaired by the relevant Clinical Directors, endorse the recommendations from the SUI Panels and monitor the action plans arising from these recommendations. All recommendations are then added to the Directorate action plans.

The action plans are active documents which identify the context of change, clear goals and implementation plans, for example timescales and the names of staff delegated to lead the changes. The action plans are owned by the Clinical Governance Committees and it is the responsibility of the committees to ensure regular review through to completion.

A recent development (2008) is that Trust-wide recommendations are reviewed and discussed at the quarterly Trust Clinical Risk Committee (CRC). The CRC is also responsible for allocating actions and monitoring the implementation of the recommendations. The action plan arising from this is then circulated to the Directorate Clinical Governance Committees for information.

Furthermore actions arising from the investigations and inquiries into SUIs are raised and/or monitored as necessary by other means and in other forums:

- The analysis of SUI data frequently identifies themes which are then subject to wider initiatives, not specific to any single recommendation. Some of these are identified in the annual SUI report to the Trust Board.

- The Trust is subject to external scrutiny and sends reports and responses to organizations such as the National Patient Safety Agency and the Care Quality Commission.

- Increasingly the Trust is asked to provide information to commissioning Primary Care Trusts and the Strategic Health Authority - NHS London. The Trust welcomes the involvement of these organizations as a means of ensuring transparency and enhancing opportunities to improve services and reduce risks to patient safety.

In the case of Mr. RT the action plan arising from the Internal Investigation and the Board level Inquiry was monitored and reviewed at the Lambeth Clinical Governance Committee. The Lambeth Clinical Governance Committee is chaired by the Lambeth Clinical Director and meets on a monthly basis. The Clinical Director has also taken the lead in overseeing and monitoring the implementation of the action plans. A number of actions were completed not only as a result of the interventions of the Clinical Governance Committee but were also assimilated into the natural cycle of policy development, for example, the review of the Trust Care programme Approach Policy and the Trust Framework for Clinical Risk Assessment and Management of Harm Policy.
Because of the fact that there were several patient related homicides in Lambeth in a relatively short time a decision was made in April 2007 to amalgamate the action plans arising from all Lambeth homicide investigations. It was agreed that the Mr. RT action plan was reviewed jointly with another case as a standing item at the Clinical Governance Committee in June 2008. This decision was reached to help ensure that information was shared about the progress of the investigation and where necessary any clinical matters raised by the investigation teams could be dealt with promptly.

Specific progress against the Mr. RT Internal Investigation recommendations and action plan implementation

1. **It is recommended that the value of the Brief Risk Screen be reviewed in the imminent review of the Trust's Framework for Clinical risk Assessment and Management of Harm.**

Implementation of recommendation 1.
A policy review took place during 2008. The policy review included a review of the brief risk screen which was changed from a risk screen requiring yes/no answers, to a structure of similar questions to those now in the full screen, which requires more free text. The

policy was also changed to emphasise the importance of the sharing of risk information. The revised Policy on the Framework for Clinical Risk Assessment and the Management of Harm was published in October 2008.

2. **The Trust's Framework for Clinical Risk Assessment and Management of Harm recommends that risk assessments should be reviewed where there is any change in the patient's circumstances. It is recommended that an audit is commissioned within the directorate to review compliance with a view to the improvement of practice or policy change.**

Implementation of recommendation 2.

A rolling programme of nursing practice assessment visits is established. All clinical teams throughout the Trust are visited annually by a review team of Senior Nurses who systematically assess compliance with Trust policy and procedure, this also includes compliance with risk screen and Care Programme Approach requirements.

3. **The Trust Care Programme Approach Policy describes the level of assessment and care planning required for carers.**

Implementation of recommendation 3.

The Trust's Care Programme Approach Policy was reviewed during 2008 in light of new Department of Health Guidance. A revised Trust Care Programme Approach Policy was published in September 2008. The policy contains details of the Trust response to the needs of carers. The revised policy was publicised to staff through line management channels, and Directorate Clinical Governance Committees.

4. **It is recommended that the CPA Policy review and implementation should emphasise the importance of this responsibility to carers/families and that future CPA training should also emphasise the Trust responsibilities to families /carers.**

Implementation of recommendation 4.

"Making CPA More Meaningful" and the "Carers Awareness" in-house training courses both include an exploration of family and carer involvement. The Trust also has a Family and Carers Strategy. Recent family and carer related activities include the Family and Carers Listening day held for all stakeholders in February 2009.

5. **It is recommended that if there are no risk concerns about a patient they should be discharged to the care of their GP.**

Implementation of recommendation 5.
This was previously noted by the Trust as being a poorly worded recommendation in that absence of risk should clearly not in itself automatically lead to discharge of a patient to primary care. This recommendation was circulated via the Consultants committee. The Care Programme Approach Policy gives clear guidance about the thresholds for the discharge of patients.

6. **It is recommended that Medicines Management Committee consider how long it is advisable for medication to be prescribed without a review of the patient and whether this should be Trust policy.**

Implementation of recommendation 6.
The Medication Management Policy (March 2008) explicitly states that medication should be prescribed for no longer than three months without a review of the patient. This point has been publicised through pharmacists and the Trust medicines management committee.

7. **It is also recommended that commissioning of an Audit of repeat prescribing should be considered by the committee.**

Implementation of recommendation 7.
The Trust's Pharmacy department are regulating repeat prescribing tightly. Prescribing practice through out the Trust has been subject to a programme of Prescribing Observatory in Mental Health POMH-UK audits. There is good evidence that subsequent action plans designed to improved practice have had a positive effect in improving prescribing practice.

8. **BLI Recommendation: The panel were concerned that Mr. RT's care, whilst in outpatients, was solely dependent on the follow up of the Consultant and that there did not appear to be contingency plans in place to identify possible relapse indicators. Although the panel acknowledge that this is an unusual case they do recommend that the Boroughs consider the impact and ways in which the monitoring and review can be maintained following transfer of care. Furthermore that this is monitored by way of audit on a periodic basis.**

Implementation of recommendation 8.
Outpatient letters are routinely sent to GPs. The existing outpatient arrangements ensure that DNAs are discussed with the consultant.

9. **BLI Recommendation: The value and role of the risk screen should also be taken into consideration as part of the Trust's Framework for Clinical Assessment. Consideration should also be given to the ways in which the risk assessment documentation can be changed to prompt further fact finding and / or discussion.**

Implementation of recommendation 9.
See response to recommendation 1.

10. **BLI Recommendation: In addition to the list of points made in the second recommendation outlining when a risk assessment should take place, the panel would also like the Investigation Team to consider an additional category, advising that risk assessments should be undertaken periodically. Particularly where a patient has missed appointments and as such may not have been seen for sometime.**

Implementation of recommendation 10.
The Framework for Clinical Risk Assessment and the Management of Harm outlines the requirement to make risk assessment an active process for example reviewing risk when patient's circumstances change or when there are risk events. The Lambeth directorate uses zoning as a tool to ensure that risk is monitored particularly when patients are in crisis. During 2008, community practice assurance visits were undertaken to all Trust sites. The assurance visits systematically assessed compliance with Trust policy and procedure in particular compliance with risk screen and Care Programme Approach requirements.

11. **BLI Recommendation: Outpatients should have a documented care and contingency plan which details treatment and action to be taken when a patient has not been seen.**

Implementation of recommendation 11.
The new Trust CPA policy covers the action to be taken when a patient has not been seen.

12. **BLI Recommendation: The panel were concerned to hear that staff did not receive any support following notification of the incident. The panel wished to remind all management staff that all staff involved in an incident should receive and have access to support. As such the panel recommend that the Borough Directors ensure that mechanisms and systems are in place to enable this to happen.**

Implementation of recommendation 12.
In September 2008 a 'Supporting staff involved in incidents, claims and complaints' policy was ratified and has been publicised throughout the Trust. Staff will receive a staff support leaflet at the point of incident, claim or complaint notification. The policy was developed in response to recommendations arising from investigations, observing good practice elsewhere and National Health Service Litigation Authority requirements. Lambeth Adult Services also have helpful local guidance on debriefing staff produced by the Head of Lambeth Clinical Psychology in August 2007.

13. **BLI Recommendation: The panel were pleased to hear that a DNA audit was planned, but also recommend that the PJS Steering Group consider ways in which the system can generate automatic messages to alert staff of a patient's non-attendance.**

Implementation of recommendation 13.
There is a facility within the IRS system which enables the monitoring of 'patients not seen' at Team and Directorate level.

14. **BLI Recommendation: The panel were given to understand that a review of the Risk Assessment Policy and documentation was underway, and as such would like to recommend that the working group consider the inclusion of substance misuse as a factor in the brief risk screen**

Implementation of recommendation 14.
A policy review took place during 2008. The policy review included a review of the brief risk screen. The revised Policy on the Framework for Clinical Risk Assessment and the Management of Harm was ratified in September 2008. The brief risk screen was deliberately amended to generalise it and encourage consideration of all risks. Substance misuse is not a specific prompt unless it is regarded as a factor contributing to an unstable

mental state. Substance misuse is covered in detail in the full risk screen. The Policy for the Care and Treatment of Service Users with Dual Diagnosis which was published in August 2008 also outlines the risk factors associated with this patient group. Specialist dual diagnosis staff also provide support and training to the Lambeth adult mental health teams.

The Independent Investigation Team can verify that the Trust has implemented in full the action plan that resulted from their Internal Investigation processes. The resulting service effectiveness will require monitoring as the new processes become embedded within the organization. Audit and monitoring forms part of the Independent Investigation Recommendations set out in section 19 below.

17. Notable Practice

During the course of the Independent Investigation several areas of notable practice were identified. It is the view of the Independent Investigation Team that other Mental Health Trusts could benefit from the work that has been undertaken by the South London and Maudsley NHS Foundation Trust.

17.1. The Electronic Patient Journey System (PJS)

The Patient Journey System (PJS) is a web browser enabled electronic clinical record application. The system was originally developed in 2003 with a commercial partner. The aim was to support the implementation of a newly standardized clinical process (the Patient Journey) across Trust services and to enable the interim enhancement of the Trust's existing patchwork of electronic information systems prior to the arrival of the all encompassing National Care Record Service in 2010.

The vision was for a single electronic application to be used across the Trust by all clinical and administrative staff to improve the co-ordination of care, reduce clinical risk and enable the information needs of the Trust to be met more effectively as well as assist transition to the National Care record Service at some point in the future.

Prior to PJS, a multiplicity of legacy systems existed across the Trust, together with the use of paper records and no single source of operational clinical information was available.

The implementation of PJS allowed the rationalisation of over five existing electronic systems and ensured that the primary source for all clinical documentation was now accessible from within one system across all 200 geographical locations within the responsibility of the Trust.

The PJS contains a range of content including the ability to document not only demographic details, but also assessment, care planning, risk assessment, outcome measures, clinical noting, Mental Health Act administration, National Treatment Agency recording and specialised Child and Adolescent Mental Health Service documentation.
PJS links directly with the Trust's pharmacy, contracting and bed state systems to provide real time integration with the Trust's business and administrative applications.

PJS underpins the Trust's reporting framework, IRS, enabling a range of activity and performance measures to be directly linked to the Trust's front-line clinical processes.

In addition, the PJS is now the source of clinical data for use by the Trust's research partners at the Institute of Psychiatry. In a groundbreaking application annonymised PJS clinical data can now be interrogated by research staff, enabling significant improvements in research processes.

PJS has now been implemented across all Trust services. Some key facts include:

- PJS now contains nine million documents;
- it is used on a daily basis by 2,500 individual staff;
- 110,000 system transactions are undertaken by staff users over a 24 hour period;
- at peak periods 195 separate transactions, on average, are undertaken every minute, and 1,120 logins are, on average, concurrently active at any one time.

PJS is now widely used in ward rounds and for clinical supervision. In Child and Adolescent Mental Health services a PJS audit tool is used to measure completion and quality of the clinical record.

Given the delays with the national NHS Information technology programme, PJS will continue to be developed by the Trust. Exciting developments are planned for PJS over the next few years, building on the clinical, research and business needs of the Trust. It would appear that no other current application can match the functionality of the PJS.

17.2. The Integrated Reporting Solution (IRS)

The Trust's Integrated Reporting Solution (IRS) is a computer information system that provides Trust staff and Primary Care Trusts with access to a wide range of information on clinical activity, finance and human resources. The information in the IRS is extracted from the PJS, and the human resource and finance systems. The IRS does not replace these systems which are needed to support operational processes, it simply extracts data from them and stores it in a format from which it can be reported on easily. These reports provide clinical teams with a wide range of information to manage their clinical activity, finances and staff resources more effectively. IRS plays a vital role in enabling the Trust to undertake extensive data mining of its information and using it to support continuous

service improvement. It is one of three major information technology investments made by the Trust, the others being PJS and the new digital data network.

There are several different ways in which the IRS provides information. These are:

- the Trust's IRS Intranet site, an important information route for Trust staff;
- the Trust's Primary Care Trust Extranet (for PCTS);
- the development of specific reports by staff located in the information department and the Directorates.

Summary reports are available to all staff who are able to log into the Trust's network. For ease of use, these have been divided into a number of logical groups which can be accessed via a series of menus. Summary reports show the current position at any given time and are updated weekly. There is no restriction on access to these. All summary reports can be printed out if required.

Managers and clinicians at different levels in the organization are able to monitor activity and access clinical records at individual, team, directorate and Trust-wide levels through IRS. Summary reports currently include:

- brief risk screens;
- child need and risk screens (compliance with completion);
- service user employment status;
- service user CPA reviews;
- data quality, e.g. GP, NHS Number etc. details;
- patient not seen in three months flags;
- service user physical/nutritional health screens (compliance with completion).

The Independent Investigation Team found that the IRS system was able to evidence the Trust's current compliance with both local policy and national expectation. The reports that the system is able to yield is impressive. **The system allows for an in-depth interrogation of most facets of the Trust's clinical functioning in a very thorough and immediate manner.**

17.3. Trust Policies, Procedures and Guidelines

It is the view of the Independent Investigation Team that the Trust had a comprehensive suite of policies, procedures and guidance which was current, clear and evidence-based.

In recent times the Trust has made a determined effort to ensure that new policies, procedures and guidelines are introduced to the organization in conjunction with training events and information.

The training session, 'Making CPA More Meaningful' provides a clear and professional approach that sets out both Trust statutory duty and individual healthcare professional responsibility. The programme is service user focused and supports the recovery approach.

17.4. Lambeth Carers Strategy

The Lambeth Carers Strategy is a new approach which was introduced into the Trust in 2008, the training for which is currently being implemented. This strategy was developed in full consultation with local Voluntary Groups, the Local Authority and NHS partners. The strategy is easy to understand and based on thorough research and understanding of the Borough of Lambeth. **The independent Investigation Team commend this strategy to any other NHS organization that may consider undertaking the review of an existing strategy, or the development of a new one.**

18. Lessons Learned

The South London and the Maudsley NHS Foundation Trust is a large organization that provides care and treatment to nearly 40,000 service users each year. The Trust has a well-deserved reputation as being both a sound service provider and a proven research-based innovator.

The findings within this report conform to those of most other Independent Investigations conducted in recent years. Issues raised regarding risk assessment, the Care Programme Approach, clinical supervision, the quality of documentation and organizational change are all common factors to be found in the Independent Investigation Report literature across the country.

The key lesson to be taken away from this particular case is simple. It was the omission of a basic building block of care that led to Mr. RT's care and treatment being planned and implemented in the way that it was. The failure to elicit an adequate history that was factually accurate and incorporated everything that was then known about this individual ensured that Mr. RT's condition remained partially treated and his full potential risk never understood.

The failure to take Mr. RT's *full* history at the outset of his contact with mental health services is not the kind of thing that would normally be detected by clinical audit, no matter how robust. This kind of factor is probably something that could best be described as being at 'sub-audit' level in most organizations. Clinical audit often assumes that some actions are so basic and fundamental to clinical practice that the audit standards do not necessarily detect their absence or measure their full effectiveness.

If the family of Mr. RT had been engaged with appropriately, and had the Trust clinical team followed up on all of the information known to them at the time of Mr. RT's first contact with them, a full history would have been taken. The key lesson is that clinical governance, no matter how sophisticated, can often fail to detect a basic omission in a clinical team's practice and that the fundamental building blocks of care should never be underestimated regarding their importance to the long term clinical outcomes for each patient.

19. Recommendations

The Independent Investigation Team worked with the South London and Maudsley NHS Foundation Trust and NHS Lambeth (the Primary Care Trust) to formulate the recommendations arising from this inquiry process. The events of April 2006 occurred over three years ago. It is evident that the Trust has been able to develop many processes and strategies since the dates on which the serious untoward incidents occurred that have either partially or fully addressed many of the issues identified by the Independent Investigation.

The recommendations that the Independent Investigation Team have developed in response to its inquiry are set out below under a brief synopsis of each finding. The progress that the Trust has already made has been taken into account. As a result the recommendations developed by the Independent Investigation Team are intended to support the Trust's strategic direction and take into full consideration the fact that all of the Internal Investigation actions have already been implemented.

19.1. Recommendations Relating to Key Causal Factors One & Two, and Contributory Factors One, Two, Six and Eight

To recap: Key Causal Factors One and Two, and Contributory Factors One, Two, Six and Eight are set out below. These factors directly relate to all aspects of patient assessment, care planning and general case management.

- **Key Causal Factor Number One.** The failure to manage the ongoing assessment, care, risk and treatment needs of Mr. RT meant that his mental illness was at best partially treated. His Honour Judge Peter Beaumont ruled that Mr. RT's mental state had a direct bearing on the events of April 2006.

- **Key Causal Factor Number Two.** Mr. RT's care and treatment plan never appeared to have been considered in the light of his diagnostic context. The appropriateness and effectiveness of Mr. RT's medication and treatment regime were never effectively reviewed. The subsequent partial treatment of his condition had a direct bearing on his mental state. His Honour Judge Peter Beaumont ruled that Mr. RT's mental state had a direct bearing on the events of April 2006.

- **Contributory Factor Number One**. The failure of the Trust to ensure a risk assessment was conducted that took full account of Mr. RT's personal, psychiatric and forensic history ensured that he fell through the safety net of care.

- **Contributory Factor Number Two.** The failure of the Trust to provide Mr. RT with a comprehensive package under an enhanced level of the Care Programme Approach led to Mr. RT falling through the safety net of care.

- **Contributory Factor Number Six.** Individual clinicians did not produce and maintain Mr. RT's clinical records to an appropriate professional standard. Local team management systems and corporate-led audit both failed to detect these shortcomings.

- **Contributory Factor Number Eight.** Clinical practice within the Trust did not conform to internal policies and procedures.

The recommendations are as follows:

Recommendation Number One. A number of the findings relate to core practice that would be expected and required of community staff, for example, developing a therapeutic relationship, managing and undertaking thorough risk assessments, completing clinical documentation and completing forensic risk histories. The Trust should develop core competencies for community staff, including medical staff, which will include the requirements for staff to work to established policy and procedure and to specify what actions need to be undertaken. The core competencies should be completed with care coordinators as part of the appraisal process. Team managers should also work towards core competencies which ensure that they know what is expected of them as part of their management role.

Recommendation Number Two. The potential of the Trust IRS system should be maximised to ensure that it delivers a focussed breakdown by team and by care coordinator to be available on the:

- completion of Care Programme Approach reviews;
- completion of risk assessments;
- completion of child in need risk screens;
- frequency that carer assessments are offered.

Recommendation Number Three. A policy review took place during 2008. The policy review included a review of the brief risk screen. The revised Policy on the Framework for Clinical Risk Assessment and the Management of Harm was ratified in September 2008. The Trust should conduct a full audit following the publication of the Independent Investigation Report to ensure that the revised policy is operating effectively and that any further revisions are made as necessary.

Recommendation Number Four. The Trust's Care Programme Approach Policy was reviewed during 2008 in light of new Department of Health Guidance. A revised Trust Care Programme Approach Policy was published in September 2008. The policy contains details of the Trust response to the needs of carers. The revised policy was publicised to staff through line management channels, and Directorate Clinical Governance Committees. The Trust should conduct a full audit following the publication of the Independent Investigation Report to ensure that the revised policy is operating effectively and that any further revisions are made as necessary.

19.2. Recommendations Relating to Contributory Factor Number Three

To recap: Contributory Factor Number Three is set out below:

- **Contributory Factor Number Three.** Mr. RT was not actively involved in any aspect of his care planning by his clinical team. This lack of involvement may have exacerbated Mr. RT's inclination to disengage from services.

The Recommendation is as follows:

Recommendation Number Five. The potential of the Trust IRS system should be maximised to ensure that it delivers a focussed breakdown by team and by care coordinator, evidence that service users have signed their care plans, and received full copies of their CPA documentation. In the event that a patient shows significant and consistent non-compliance and lack of insight, it is essential that staff are supported by agreed protocols that allow them to continue to engage with the patient and attempt to address their treatment needs, rather than collude with the patient via disengagement.

Please also see Recommendation Number One which sets out actions that are relevant to this contributory factor.

19.3. Recommendations Relating to Contributory Factor Number Four and Service Issue Number One

To recap: Contributory Factor Number Four is set out below:

- **Contributory Factor Number Four.** The services that were offered to Mr. RT and his family were not culturally sensitive and did not provide him appropriate assessment, care and treatment options.
- **Service Issue Number One**. No carer assessment was conducted.

The Recommendations are as follows:

Recommendation Number Six.

A) The Trust should revise and further develop its existing policies and procedures to ensure that an appropriate consideration is made regarding each individual service user's ethnicity when developing care and treatment plans. The capacity, role and functioning of Spectra (the Trust Cultural Consultancy Service) should be incorporated into this review.

B) Due to the complex BME demography of Lambeth the Trust should develop a comprehensive audit to be conducted on an annual basis, based on the Department of Health's *Delivering Race Equality in Mental Health Care* (2005), and formally reported to NHS Lambeth and disseminated widely throughout the Directorate.

Recommendation Number Seven. The Lambeth Carer Strategy is a new approach which was introduced into the Trust in 2008. This strategy was developed by local Voluntary Groups, the Local Authority and NHS agencies. The strategy is easy to understand and based on thorough research and understanding of the Borough of Lambeth. This strategy has made a robust attempt to engage with ethnic minority groups within the Borough to ensure its relevance and success. The Trust should conduct an audit against the effectiveness of this strategy on the publication of this report and make any necessary revisions. The audit should as a basic minimum:

- determine how many carer assessments have been offered;
- determine how many carer assessments have been accepted;
- determine the ratio of carer assessments taken up by BME carers;
- determine the quality and effectiveness of the resulting care plans.

19.4. Recommendations Relating to Contributory Factor Number Five

To recap: Contributory Factor Number Five is set out below:

- **Contributory Factor Number Five**. The Trust did not instigate appropriate interagency communication, particularly with the police, this meant that significant information regarding the risk Mr. RT posed to the general public was never understood.

The Recommendation is as follows:

Recommendation Number Eight. Existing policies and procedures regarding police liaison should be reviewed in the light of the lessons learned from the Mr. RT case and revised accordingly.

19.5. Recommendation Relating to Contributory Factor Number Seven

To recap: Contributory Factor Number Seven is set out below:

- **Key Contributory Factor Number Seven.** Clinical supervision was not available to the health and social care professionals providing the care and treatment to Mr. RT. This ensured that poor adherence to Trust policy and procedure went undetected.

The Recommendation is as follows:

Recommendation Number Nine. The existing clinical supervision policy should be reviewed and an audit conducted to ascertain its effectiveness. Any necessary revisions should then be made.

19.6. Recommendation Relating to Service Issue Number Two

To recap: service Issue Number Two is set out below:

- ***Service Issue Number Two. No Safeguarding Children assessment was conducted.***

The Recommendation is as follows:

Recommendation Number Ten. All active Lambeth cases should be reviewed regarding the current Trust Safeguarding Children Policy to ensure that children are identified appropriately and that plans are in place to promote both their wellbeing and safety.

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19.7. Recommendations Relating to the Trust's Internal Investigation and Learning Lessons Processes

The following recommendations have been developed jointly between the Independent Investigation Team and the Trust.

Recommendation Number Eleven. The Trust acknowledges the far reaching nature of the Independent Investigation and the opportunity that this provides for organization-wide learning. The Trust should arrange learning feedback sessions to enable the findings of this investigation to be raised with a wide audience and to help ensure that lessons are learnt.

Recommendation Number Twelve. The Trust should develop strategies to ensure that condolence, support and advice are offered to the families / loved ones of the victims of homicide without this endangering the police investigation and judicial processes.

Recommendation Number Thirteen. Structured investigations and Board Level Inquiry reports should be thoroughly examined to ensure that the recommendations are SMART. Examination should take place prior to the report's submission to the Serious Untoward Incident (SUI) Panel, at the SUI Panel and at any Board Level Inquiry. The Board Level Inquiry should routinely have an examination of the recommendations as a routine part of the inquiry terms of reference.

Recommendation Number Fourteen. The findings of the Independent Investigations should be raised and discussed at:

- forthcoming Child Safeguarding conferences;
- in Trust newsletters and Patient Safety Bulletins;
- Police Liaison Committees.

Recommendation Number Fifteen. Where there are actions arising from investigations into inpatient suicides and homicides the action plans should automatically be made a standing agenda item at the relevant Clinical Governance Committee(s).

Clinical Governance Committees should, as part of their terms of reference, include an examination and review of any newly ratified Trust policies and procedures. An audit process should be in place to ensure that the policies and procedures are subsequently audited with involvement from clinical staff that are at the point of patient care.

Recommendation Number Sixteen. The current nursing practice assessment visits should continue on an annual basis. The terms of reference for the visits should be reviewed and amended in the light of the findings of the independent investigations.

Recommendation Number Seventeen. The terms of reference for structured investigations and Board Level Inquiries should include an examination and assessment of compliance with Trust Policy and Procedure which includes:

- Care Programme Approach;
- Risk assessment and management of harm framework;
- Clinical records standards.

19.8. Recommendation for NHS London

It was apparent during the course of this investigation that the 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, was not clearly understood by either the Trust or the Police Service. A high-level discussion needs to take place to avoid further confusion in the future and to ensure that victims' families are communicated with in a timely and helpful manner.

Recommendation Number Eighteen. NHS London, the London Strategic Health Authority, should engage in discussions with the Metropolitan and City Police Forces to ensure that the Memorandum can be implemented effectively.

Glossary

Aetiology	The cause of a disease or illness
Cardex system	An old fashioned system of keeping a chronological entry log to record a patient's progress. This system traditionally does not include an active plan of care.
Care Coordinator	This person is usually a health or social care professional who co-ordinates the different elements of a service users' care and treatment plan when working with the Care Programme Approach
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user centred manner
Case management	The process within the Trust where a patient is allocated to a Care Coordinator that 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
Control and Restraint	Control and Restraint techniques are used as a last resort in order to bring a violent patient under control
CT Scan - Computerised Tomography	A way of taking images of the body, and the brain
Delusion	A delusion is a belief that is clearly false and that indicates an abnormality in the affected person's content of thought
Delusional disorder	Delusional disorder is a psychiatric diagnosis denoting a psychotic mental illness that involves holding one or more bizarre delusions
Diazepam (Valium)	This is a drug used for the short-term relief of symptoms related to anxiety disorders
Early Onset Team	The aims of this service are to improve clinical and social outcomes through early identification, assessment, treatment and support of people with psychosis using a multi-disciplinary framework. The service is usually provided for people aged between 16 and 35 years of age
Enhanced CPA	This was the highest level of CPA that a person could be placed on prior to October 2008. This level requires a robust level of supervision and support

Electronic Patient Journey System (EPJS)	The Trust electronic clinical records system
Factoid	A factoid is a spurious—unverified, incorrect, or fabricated—statement formed and asserted as a fact, but with no veracity
Grandiose	This refers to an exaggerated sense of one's own importance, power, knowledge or identity
Haloperidol	Haloperidol is a major tranquilizer used to treat psychoses
IM (Intramuscular)	Usually denotes drug administration that requires an injection into the muscle
IV (Intravenous)	Usually denotes drug administration into a vein
Lorazepam	A sedative and anti anxiety drug
Mental Health Act (83)	The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition[234]
Mental Health Act Tribunal	A tribunal decides whether or not it is necessary to detain a patient under the Mental Health Act (83). The tribunal will decide when requested whether a section under the Mental Health Act should be terminated or not
National Treatment Agency	The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England
Olanzapine	A psychotropic drug used orally and intramuscularly in the treatment of schizophrenia, bipolar disorder, and acute psychosis
Paranoid Schizophrenia	This causes its victims to lose touch with reality. They often begin to hear, see, or feel things that aren't really there (hallucinations) or become convinced of things that simply aren't true (delusions). In the paranoid form of this disorder, they develop delusions of persecution or personal grandeur[235]
Phenomenology	Phenomenology is the study of structures of consciousness as experienced from the first-person point of view
Primary Care Trust	An NHS primary care trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commission them from other providers, and are involved

	in commissioning secondary care, such as services provided by Mental Health Trusts
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place
Quetiapine	a drug used to treat severe mental disorders like schizophrenia
Risk assessment	A formal process to determine a patient's risk behaviours. This is the precursor stage to a clinical management plan
Risperidone	Risperidone is usually used to help treat illnesses or conditions such as psychosis, schizophrenia and hypomania
RMO (Responsible Medical Officer)	The role of the RMO is defined in law by the Mental Health Act (1983) referring to patients receiving compulsory treatment[236]
Schizophrenic autism	Defined as a detachment from reality associated with a rich fantasy life[237]
Schizoaffective disorder	It describes an illness that is defined by recurring episodes of mood disorder and psychosis
Section 2 Mental Health Act (83)	Section 2 of the Mental Health Act allows compulsory admission for assessment, or for assessment followed by medical treatment, for a duration of up to 28 days.
Section 3 Mental Health Act (83)	Section 3. Admission for treatment for up to 6 months initially
Section 17 leave	Allows a responsible Medical Officer to grant a detained patient under their care the permission to leave the mental health hospital premises where are currently being detained
Section 117	This applies to all patients who have been detained under a Section 3 of the MHA (83) once they have been discharged from hospital. The Section 117 ensures that robust aftercare is provided in a community context
Service User	The term often preferred by users of mental health services instead of the word patient
SHO (Senior House Officer)	A grade of junior doctor between House officer and Specialist registrar in the United kingdom
Specialist Registrar	A Specialist Registrar or SpR is a doctor in the United Kingdom and Republic of Ireland who is receiving advanced training in a specialist field of medicine in order to eventually become a consultant

Standard CPA	Denotes a lower level than enhanced CPA that requires lower levels of input from the Care Coordinator
Stelazine (Trifluoperizine)	This is an antipsychotic medication that also treats anxiety
Thought disordered	This is one of the symptoms of psychotic illness where thoughts and conclusions do not follow logically one from the other
TTOs	A prescription which is prepared for a patient to take out or away. Literally medication 'to take out'

Notes

1. HSG (95) 27
2. Investigation Clinical Archive. Broadmoor file. PP. 1 & 22
3. Investigation Clinical Archive. Broadmoor file. P. 21
4. Investigation Clinical Archive. Broadmoor file. P. 22
5. Investigation Clinical Archive. Broadmoor file. P. 22
6. Investigation Clinical Archive. Broadmoor file. P. 22
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12. http://www.irr.org.uk/2002/november/ak000008.html
13. Investigation Clinical Archive. Broadmoor file. P. 8
14. SLaM Electronic Trust Records. P.33
15. Investigation Clinical Archive. Broadmoor file. P. 17
16. Investigation Clinical Archive. Broadmoor file. P. 17
17. Investigation Clinical Archive. Trust Clinical File 1 (B). P. 361
18. Investigation Clinical Archive. Broadmoor file. P. 24
19. Investigation Clinical Archive. Broadmoor file. P. 17
20. Investigation Clinical Archive. Broadmoor file. P. 23
21. Investigation Clinical Archive. Broadmoor file. P. 55
22. SLaM Internal Investigation File 1. P. 30
23. Investigation Clinical Archive. Broadmoor file. P. 17
24. Investigation Clinical Archive. Early Records. P.39
25. Investigation Clinical Archive. GP Records. P.32
26. Investigation Clinical Archive. Early Records. P.36
27. Investigation Clinical Archive. Early Records. P. 35
28. Investigation Clinical Archive. Early Records. P.34
29. Investigation Clinical Archive. Early Records. PP. 26-27
30. Investigation Clinical Archive. Broadmoor File. P. 17
31. Investigation Clinical Archive. Early records. P. 10
32. Investigation Clinical Archive. Early Records. P. 37
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110. Investigation Clinical Archive. Clinical File 1(A). P. 72
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Appendix One

South London and the Maudsley NHS Foundation Trust Brief Risk Screen

Framework for Clinical Risk Assessment and Management of Harm(ratified 2005)

Version 3

'Brief risk screen

The expectation is that this should be completed for all persons who come into contact with, or are currently in contact with, mental health services. An exception is noted, particularly with regard to the assessment of the risk of violence.

The Brief Risk Screen includes a brief list of questions regarding factors associated with increased risk. These should support the assessor in identifying risks and making the decision as to whether a further, more detailed risk assessment is indicated or not.

It is not designed as a scoring system; there is no suggestion that a specific number of 'YES' ticks indicate that a full assessment is required. The screen is designed to assist the clinician in making a judgement'. PP 11-12

'BRIEF RISK SCREEN (Patient Journey Version) (See Appendix 1)

The expectation is that this should be completed for ***ALL clients*** *who come into contact with or are currently in contact with mental health services. An exception is noted, particularly with regard to the assessment of the risk of violence; we recognise that there are patients in whom the risk is likely to be very small and where inquiry is judged to be inappropriate or potentially offensive. The Risk Screen should be repeated when it is felt necessary, that is, when it is felt that the potential for risk has changed because of a change in circumstances or because new information has come to light. PP. 11-12*

The Risk Screen includes a brief list of questions regarding factors associated with increased risk. These should support the assessor in identifying risks and making the decision as to whether a further, more detailed risk assessment is indicated or not. It is not designed as a scoring system; there is no suggestion that a specific number of 'YES' ticks indicate that a full assessment is required. The screen is designed to assist the clinician in making a judgement'.

Taken from Appendix One of the Trust 2005 Risk Policy

Brief Risk Screen:

Risk to Self

- Suicide
- Deliberate self harm
- Accidental self harm
- Self neglect
- Wandering or falls
- Level of mobility

Risk to Others

- Physically violent
- Threats of violence
- Verbally violent
- Sexually inappropriate
- Driving

Vulnerability from Others:

- Financial abuse
- Physical abuse
- Emotional abuse
- Sexual abuse
- Falls
- Social isolation

Unstable mental State/Compliance Problems

- Mental health liable to deteriorate quickly or unpredictably
- Compliance problems with medication
- Compliance problems with services
- Compliance problems with allowing access to home

Risks to or from carer

(Specify)

Appendix Two

Timeline for the Independent Investigation

of the

Care and Treatment of Mr. RT

Date	Event	Source
24.September 1992	Mr. RT was convicted of allowing himself to be carried on a conveyance taken without authority, contrary to the Theft Act 1968 section 12(1), He was fined £50 and asked to pay £20 in costs. Mr. RT's driving license was endorsed.	Investigation Clinical Archive. Broadmoor file. P. 17
28 July 1994	Mr. RT was convicted of driving whilst disqualified. He was given a Community Service Order of 60 hours and was disqualified from driving for 12 months. Mr. RT was also asked to pay £35 in costs and his license was endorsed. On the same occasion he was convicted of having no insurance. He was fined £180 and his driving license was endorsed.	Investigation Clinical Archive. Broadmoor file. P. 17
1996	Mr. RT was arrested for theft	SLaM Clinical records.
May 1996	Mr. RT punched an Asian man in the stomach. On this occasion he pulled out a gun from the waistband of his jeans and pointed it at the Asian stating 'I am going to kill you star'. The victim was assisted by members of the public. Mr. RT hit one of the men with the handle of the gun over the back of the head. When the police searched Mr. RT's home they found a large brown handled	Investigation Clinical Archive. Broadmoor file. P. 24

	gun propped up against a suitcase.	
23 September 1996	Mr. RT was convicted of the possession of a replica firearm with the intent to cause fear of violence contrary to the Firearms Act 1968 section 16A. Mr. RT was imprisoned for 18 months. He was also convicted of possession of a firearm without a certificate contrary to the Firearms Act 1968 section 1(1)(a). He was imprisoned for six months concurrently	Investigation Clinical Archive. Broadmoor file. P. 17
25 September 1998	A witness statement described Mr. RT punching a shop worker following an altercation after Mr. RT had spat on the shop floor. On this occasion he was seen to take a bottle of liquid, believed to be petrol, out of his pocket, before threatening to set light to the store. The fluid was splashed over the face and clothes of the shop worker during the incident.	Investigation Clinical Archive. Broadmoor file. P. 23
27 September 1998	Mr. RT returned to the shop two days later during which time a witness reported a scuffle. On this occasion Mr. RT was arrested. The police classified this as a racist attack.	Investigation Clinical Archive. Broadmoor file. P. 55
10 February 1999	Mr. RT was convicted of common assault contrary to the Criminal Justice Act 1988 section 39. He was imprisoned for 14 days consecutively. He also received three months in prison for using threatening, abusive, insulting words or behaviour with intent to cause fear or provocation or violence, contrary to the Public Order Act 1986 section 4(1)(a).	Investigation Clinical Archive. Broadmoor file. P. 17
February 1999	Mr. RT's father died in a car accident in Ghana. Mr. RT attended the funeral in Ghana	SLaM Internal Investigation File 1. P. 30
19 August 1999	A GP referral was made to mental health services because Mr. RT was nervous and agitated and had thoughts about harming his mother.	Early records P. 39

20 August 1999	Mr. RT was first seen by a psychiatrist following concerns regarding intrusive thoughts of throwing boiling water over his mother (he never acted any of this out). It was thought by Dr. SK that Mr. RT was mildly depressed and that no further action needed to be taken by secondary care services.	Early records P.32
27 August 1999	Mr. RT was assessed by Dr. S, a psychiatrist, who could find no evidence of a worsening mental state. The plan was to keep Mr. RT on Stelazine as he appeared to be doing well on it. There appears to be some missing documentation from the file as it is unclear why the Trust decided to see Mr. RT again following their decision of the 20 August 1999.	Early records P. 36
7 September 1999	Dr. S made a further appointment for Mr. RT to be seen on the 16 September 1999. However Mr. RT's clinical record noted that he did not wish to engage and he was not seen on the 16 September. This may not have been a sensible decision as Mr. RT remained unwell.	Early Records. P. 35
11 November 1999	The GP referred Mr. RT to Dr. P, a Consultant Psychaitrist at the Trust, as he appeared to be very tense and agitated. The GP had prescribed stelazine 5 mg nocte and largactil 25 mg three times a day. The GP wrote that he felt Mr. RT may be suffering from a mild schizophrenia.	Early records P. 34
17 January 2000	Mr. RT was reviewed at his home by Dr. A1 and started on 2 mg nocte Risperidone rising to 4 mg in 2 days time. The view was that Mr. RT may have the onset of functional illness. The plan was to review him in four weeks time. It would appear that it took the Trust nearly ten weeks to action the GP referral made on the 11 November 1999.	Early records PP 26-27
17 February	Mr. RT was convicted of possessing an offensive weapon in a public place contrary to the	Investigation Clinical

2000	Prevention of Crime Act 1953 section 1. He was imprisoned for three months.	Archive. Broadmoor file. P. 17
17 March 2000	A note was made in Mr. RT's Community Clinical record that he was in Belmarsh Prison. This information was taken from Mr. RT's sister. A contact number was placed in the clinical records for Belmarsh Prison Healthcare Centre. It would appear that this number was not rung. There is no mention in the clinical records that any liaison took place.	Early Records. P. 10
14 April 2000	Dr. JA got no response when he contacted Mr. RT's sister by telephone, however a message was left with Mr. RT's brother's girlfriend.	Early Records. P. 10
2 May 2000	Dr. JA spoke to Mr. RT's mother on the telephone, she stated that Mr. RT appeared to be a lot calmer. Dr. JA left a message with his mother for him to call back.	Broadmoor file. P. 11
4 May 2000	Dr. JA wrote to Mr. RT to offer him a further appointment, implying that there had been one earlier that had not been attended.	Early records PP. 11 and 37
11 May 2000	A home visit was made by Dr. JA but no one was in. Dr. JA left a message with Mr. RT's brother	Broadmoor file. P. 11
17 May 2000	Dr, JA wrote to Mr. RT's GP. Mr. RT had been referred to him in March. He stated that he had given Mr. RT two appointments but that he did not attend. Dr. JA had also been to visit Mr. RT twice at his flat but he was not in. Dr. JA understood that Mr. RT was not collecting his medication from the GP surgery. It was possible that Mr. RT had been in prison for the whole of this period as he was given a three month custodial sentence even though the family had stated he was only in prison for six weeks.	GP notes P. 28
1 July 2000	Dr JA wrote to Mr. RT offering him an appointment for the 4 July 2000. There is no record	Investigation Clinical

	whether or not this appointment was kept or not.	Archive. Early Records. P. 31
26 July 2000	Dr A3 wrote to Mr. RT's GP stating that he had failed to attend his appointment of the 18 July 2000 and that that if he heard nothing further from him he would discharge him from the Brixton CMHT centre within two weeks.	Trust Community File
12 October 2000	A referral was made by Mr. RT's GP to Dr. P. The GP stated that Mr. RT had a family history of schizophrenia, and had himself a history of being thought disordered and paranoid since February 2000	GP notes P.26 Clinical File 1 (B). P.372
27 October 2000	A letter was sent to Mr. RT inviting him to an appointment on the 11 December 2000 with Dr. P.	GP notes P.23
11 December 2000	Mr. RT failed to keep his appointment with Dr. P. Mr. RT's family became increasingly worried about his mental health as he was becoming verbally aggressive towards his mother. Dr. P wrote to Mr. RT's GP asking whether or not a home visit may be a sensible thing as Mr. RT had failed to attend. Once again it would appear that there had been a nine week delay period between the original GP referral and an appointment being offered to Mr. RT.	Investigation Clinical Archive. GP Records. P. 24
25 December 2000	Mr. RT's GP wrote to Dr. P regarding his failure to keep a follow up appointment. The GP letter stated that the family only accessed health input in a crisis. The GP felt that Mr. RT was not taking his medication and he wanted Mr. RT followed up as swiftly as possible	GP notes P.23
31 January	Mr. RT's mother contacted Dr. P stating that Mr. RT had been attacking her and that she was too	Clinical File 1 (B). P.

2001	frightened to remain living at home with him. A full mental health assessment was arranged for the following Friday. It was noted that Mr. RT had a history of refusing to engage.	322
7 February 2001	Admitted under the care of Dr. P because of his risk of violence towards his family members and deteriorating mental state. Admitted on a Section 2. Grandiose delusions with no insight. Mr. RT was described as unpredictable and elated with no insight or understanding of his circumstances. The plan was to stabilise his mood and minimise the risk of aggression, and to commence a treatment programme. There was a total of a four month delay between the original GP referral and Mr. RT being seen by secondary mental health services.	GP Notes P. 6, 13, 15 Clinical File 1 (A). P. 110
8 February 2001	Seen on the ward by Dr. Dr. M Specialist Registrar. Mr. RT remained the same	GP Notes P. 18
9 February 2001	Seen on the ward by Dr. A2. Mr. RT remained the same. Mr. RT refused all medication. Mr. RT was angry and hostile and stated that he was being kept on the ward illegally. He had pressure of speech and grandiose delusions.	GP Notes PP. 18-19 Clinical File 1 (A). P. 108
12 February 2001	Mr. RT made a formal request for a mental health Review Tribunal to appeal against his section status.	Clinical File 1 (B). P. 296
15 February 2001	Mr. RT was seen at ward round and commenced on Quetiapine 50 mg BD.	Early Records. P. 51

21 February 2001	A Mental Health Review Tribunal was held and it was decided to keep Mr RT on his Section. It was decided that Mr. RT had a mental health disorder and that he was a risk to others.	GP Notes P. 19 Clinical File 1 (B). P. 289
22 February 2001	Dr. M made a section 3 recommendation. At ward round Mr. RT was very argumentative and demanded that he should be discharged. His delusions appeared to be of a religious nature. Mr. RT's mother called the ward to find out the outcome of the Mental Health Review Tribunal. She stated that she felt he needed treatment and that she was feeling unwell. Mr. RT had telephoned her and was very angry, blaming her for putting him hospital.	GP Notes P. 19
5 March 2001	Mr. RT was placed on a Section 3 due to being aggressive, a risk to others, grandiose and with no insight	GP Notes P. 19 & 22
7 March 2001	A formal request was made for Mr. RT to appeal against his section	Investigation Clinical Archive. Clinical File 1 (B). P. 281
8 March 2001	At the Ward Round it was felt that Mr. RT was deteriorating, he was still refusing his oral medication. The plan was that if Mr. RT continued to refuse oral medication it would be administered to him IM as Mr. RT had been on the ward untreated for 4 weeks At 3.00 pm Mr. RT became increasingly hostile and was restrained and given 10 mg Haloperidol and 2 mg Lorazepam IM. He remained aggressive and had to be given 15 mg Diazepam IV.	GP Notes PP. 19-20

9 March 2001	Medication was set at 20 mg Olanzapine. It was noted that Mr. RT remained reluctant to take oral medication. IM medication was to be administered if he failed to be compliant.	GP Notes P. 20
25 March 2001	It was noted in the clinical record that Mr. RT was making no improvement with regard to his mental state. However he was noted to be less aggressive and hostile. His delusions remained strong. He complained of headaches	Clinical File 1 (A). P. 109 Clinical File 1 (A). P.114
1 April 2001	A referral was made requesting a social services assessment	Clinical File 1 (A). P. 80
3 April 2001	This was the date set for a MHRT for Mr. RT to appeal against his Section 3. He appeal was turned down.	Clinical File 1 (A). P. 87
12 April 2001	At the ward round Mr. RT was described as making steady progress. Mr. RT was prepared for a transfer to Nelson Ward	
18 April 2001	Section 17 Leave granted until the 26 April 2008. This consisted of 45 minutes of unescorted leave per shift	Clinical File 1 (B). P. 247
25 April 2001	Section 17 leave granted until the 2 May 2008. This consisted of 2 hours of unescorted leave daily. The condition for this was that Mr. RT would take his medication	Clinical File 1 (B). P.245
27 April 2001	Mr. RT discharged from his Section 3 following a MHRT despite his RMO stating that without a section he was a danger to others. He was unwilling to remain on the ward informally, but was compliant with attending ward reviews. He was continued on Olanzapine 20 mg. He was allocated a CPN Ms. A at the Brixton Road Community Centre. The plan was to assess Mr. RT's mental state on a daily basis.	GP Notes P. 20 Clinical File 1 (B). P. 242

8 May 2001	Dr. D (Dr. P's SHO) wrote a letter to the Brixton Road Community Mental Health Centre requesting follow up for Mr. RT. Dr. D was writing regarding Mr. RT who was on extended leave from Nelson ward. This letter stated that Mr. RT had been treated on a Section 3 of the Mental Health Act (83) but that his Section had been discontinued by a Mental Health Review Tribunal. The Dr. explained that Mr. RT would not remain an informal patient on the ward but that he still attended for weekly reviews and TTO's. The letter asked the Centre to review Mr. RT urgently so that his care could continue in the community	Clinical File 1 (B). P. 234
13 May 2001	Mr. RT was discharged from the ward. It does not appear that a section 117 meeting was held.	GP Notes P. 19
15 May 2001	Discharged with a diagnosis of schizophrenia. At the ward round it was noted that Mr. RT was getting on better with his mother and was managing well at home.	GP notes P.6 Clinical File 1 (A). P.117
22 May 2001	The Community Mental Health Team deemed Mr. RT suitable for case management.	Electronic Records. P.51
15 June 2001	Home visit made to Mr. RT by Ms. RA. Appeared stable but with some grandiose ideas.	Investigation Clinical Archive. Electronic Records. P.51
20 June 2001	Home visit made to Mr. RT by Ms. A. Appeared stable but with some grandiose ideas.	Investigation Clinical Archive. Electronic Records. P.50
5 July 2001	Home visit made to Mr. RT by Ms. A and Dr. I. He appeared stable but with some grandiose	Investigation Clinical

	ideas.	Archive. Electronic Records. P.50
13 July 2001	Mr. RT seen at home his mental state remained unchanged	Investigation Clinical Archive. Electronic Records. P.50
23 July 2001	A letter was sent from Ms. A inviting Ms. CS the social worker to Mr. RT's CPA review on the 31 July 2001 A letter was also sent to Mr. RT's GP inviting him to the same CPA review Mr. RT was also written to inviting him to attend his CPA review	Clinical File 1 (A) P. 9 Clinical File 1 (A) P. 10
31 July 2001	Ms. A telephoned Mr. RT's mother. She reported that he was a little improved but that he was smoking cannabis and this made him aggressive.	Investigation Clinical Archive. Electronic Records. P.49
17 August 2001	Mr. RT was visited at home,. He remained stable.	Investigation Clinical Archive. Electronic Records. P.49
22 August 2001	Mr. RT was visited at home. He complained of headaches	Investigation Clinical Archive. Electronic Records. P.48
3 September 2001	A letter was sent (not clear to whom, or from whom) summarising that Mr. RT's mother would not be attending the CPA review (set for 3 September 2001) as she was feeling unwell. Mr. RT's	Clinical File 1 (A). P.34

	mother reported some minimal improvement in his condition in that he was only aggressive after drinking or smoking marijuana	
12 September 2001	Mr. RT was visited at home by Ms. A he informed her that he had not been taking his medication. Mr. RT still had grandiose ideas and headaches	Investigation Clinical Archive. Electronic Records. P.48
19 September 2001	Ms. A wrote to Ms. CS inviting her to attend Mr. RT's CPA review on 28 September 2001 A letter was also sent to Mr. RT informing him of the next CPA review on the 28 September 2001. A separate letter was also written to Mr. RT's sister	Clinical File 1 (A). P.31 Clinical File 1 (A). PP. 32-33
15 October 2001	Letter sent by Ms. J inviting Mr. RT to attend a CPA review on the 18 October 2001	Clinical File 1 (A). P. 30
19 October 2001	Ms. J wrote to Mr. RT writing to confirm that his next CPA meeting would be held on 26 October 2001	Clinical File 1 (A). P. 28
19 October 2001	A letter was written by Ms. J to Mr. RT thanking him for letting her know that he had not kept his last CPA appointment. The letter also stated that the next CPA meeting would take place at Mr. RT's home on the 2 November 2001	Clinical File 1 (A). P. 29
2 November 2001	Dr. EI and Ms. J visited Mr. RT at his home for a CPA review. Mr. RT's mother was present. Mr. RT appeared to be stable and it was the view of the Doctor that his mental health had not deteriorated.	Investigation Clinical Archive. Electronic Records. PP. 47- 48
15 November	Mr. RT visited the Brixton Road Centre to collect a sick certificate. He reported that he was not	Investigation Clinical Archive. Electronic

2001	taking his medication.	Records. P.47
13 December 2001	A home visit was made but access was denied	Investigation Clinical Archive. Electronic Records. P.47
19 December 2001	Normal results were received from a CT scan regarding Mr. RT's severe headaches. A joint home visit was made and the meeting recorded by Ms. J. Mr. RT was described as being cooperative. Mr. RT expressed the desire to no longer be seen by mental health services.	GP notes P.14
23 January 2002	Ms. J spoke to Mr. RT's mother who expressed concerns regarding Mr. RT becoming agitated. She also mentioned that Mr. RT now had a six week old daughter.	Investigation Clinical Archive. Electronic Records. P.46
1 February 2002	Dr. EI and Ms. J visited Mr RT at home, but they spoke to his cousin who told them that Mr. RT had been aggressive towards his sister. Mr. RT was telephoned and asked to visit Brixton Road for his next appointment.	Investigation Clinical Archive. Electronic Records. P.46
5 February 2002	Mr. RT attended Brixton Road as arranged on the 1 February 2002. It was clear that Mr. RT was smoking cannabis and that he still had no insight into his illness.	Investigation Clinical Archive. Electronic Records. P.46
14 March 2002	Mr. RT's mother called Dr. EI on the telephone. Dr. EI visited but Mr. RT denied there being any problem	Investigation Clinical Archive. Electronic Records. P.46
21 March 2002	Mr. RT's mother rang the Centre to request a meeting with Dr. I as she continued to be concerned about her son.	Investigation Clinical Archive. Electronic Records. P.45

4 April 2002	Mr RT's mother rang the centre to say that the police had been called out because of Mr. RT's behaviour. The police had warned him not to enter his mother's place of residence again.	Investigation Clinical Archive. Electronic Records. P.45
5 April 2002	Ms. J and a doctor from the Community Team visited Mr. RT and also spoke to Mr. RT's older brother. The brother said that Mr. RT had been involved in a fight with his cousin and that the police had been called. Mr. RT did not think that anything very serious had occurred. Ms. J and the visiting doctor felt that there was an escalation in Mr. RT's behaviour.	Investigation Clinical Archive. Electronic Records. PP.44-45
10 April 2002	Mr. RT's sister rang the Centre to say that the weekend had been peaceful and that nothing had occurred.	Investigation Clinical Archive. Electronic Records. P.44
23 April 2002	A letter was sent by Ms. J to Mr. RT inviting him to meet with herself and Dr. I on the 30 April 2002	Clinical File 1 (A). P. 27
26 April 2002	Ms. J had a conversation with Mr. RT's older brother who explained that there had been further fighting, this time between Mr. RT and a family friend.	Investigation Clinical Archive. Electronic Records. P.44
1 May 2002	After phone calls from the family of RT prompted by him being aggressive Ms. J and Dr. JR met with Mr. RT's mother and Mr. RT. Mr. RT had no insight into his behaviour and denied being aggressive with a family friend. Mr. RT was very concerned about his headaches even though his scan showed up with negative results. Mr. RT was very deluded. A sickness certificate was given to him for paranoid psychosis which he refused to accept. Dr. JR considered Mr. RT at this stage to be an increasing risk to his family. And made a recommendation for a Section 3	Clinical File 1 (A). P. 67

	Following this meeting Ms. J met with Dr. I and Dr. JR who agreed that a section 3 was necessary. Mr. RT's sister and mother were contacted to this effect and a message was left with the GP. No formal admission took place. No record regarding this decision exists in Mr. RT's clinical record.	Clinical File 1 (A). P. 68
7 May 2002	Ms. J spoke to Mr. RT's sister over the telephone. Mr. RT was continuing to take his medication but was experiencing bad headaches. He was also sleeping a lot.	Clinical File 1 (A). P. 66
13 May 2002	Ms. J telephoned Mr. RT's mother and spoke to Mr. RT's sister who told her that Mr. RT was much calmer and that he was taking his medication. It was unclear whether or not Mr. RT understood that the medication he was taking was for his mental state. The medication was prescribed by Dr. I.	Clinical File 1 (A). P. 64
20 May 2002	Entry made by Ms. J. A telephone call was made by Mr. RT's sister stating that he didn't want to collect his medication, but that she would be happy to do so. Mr. RT was taking his medication and appeared to be better as a result.	Clinical File 1 (A). P. 63
31 May 2002	Mr. RT's mother was contacted by telephone. She said that he appeared to be stable. Mr. RT was not being aggressive and was taking his medication. Mr. RT's mother avoided him. It is not clear who made this entry	Clinical File 1 (A). P. 62
17 June 2002	A telephone call was made to Mr. RT's mother. She said that Mr. RT appeared to be well and that she was 'keeping a low profile with him'. She stated that Mr. RT's sister continued to give him his medication. It is not clear who made this entry.	Clinical File 1 (A). P. 61
21 June 2002	Letter from Dr. JR to Mr. RT's GP. In this letter Dr. JR explains that Mr. RT had a long history of	GP notes P. 14

	delusions and that he had on several occasions assaulted several friends of the family. Mr. RT's mother had been concerned about a possible brain haemorrhage and therefore a CT scan was ordered to rule out any organic pathology. Mr. RT however continued to complain of headaches. Mr. RT was taking 10 mg Olanzapine Nocte	
24 June 2002	Mr. RT's mother was contacted by telephone, She stated that Mr. RT was doing well and was taking his medication. It is not clear who wrote this entry	Clinical File 1 (A). P. 60
1 July 2002	Letter was sent from the GP to the Consultant neurologist seeking an opinion regarding Mr. RT's headaches.	GP Notes. P.13
2 August 2002	The Electronic record shows that a call was made to Mr. RT's mother who said that she had no concerns about him at the present time, but that was still afraid to move back into her flat. She was informed that Mr. D G was taking over the case. Mr. RT was taking his medication. The person entering this did not give a name	Clinical File 1 (A). P. 58
6 August 2002	Letter from GP to Dr. I. stating that Mr. RT had long standing delusions and that he refused to accept that he problems and was not compliant with his Olanzapine. The GP also stated that he was very concerned that Mr. RT would relapse and requested that Dr. I review him.	GP notes. P. 12
26 August 2002	An electronic entry states that a call was made to Mr. RT's sister to arrange an introductory visit. (does not state with whom or who wrote the entry) Mr. DG filled in a mini risk assessment to ascertain whether or not Mr. RT met the criteria for a full risk assessment. It was decided no further action was required.	Clinical File 1 (A). P. 57 Clinical File 1 (A). P. 75
2 September	Mr. DG, Care Coordinator wrote to Mr. RT's GP stating that Mr. RT was reluctant to see staff	GP notes P.11

2002	from the Trust and that he was in the process of trying to negotiate a home visit to Mr. RT with Mr. RT's sister (described as being his main carer). This letter explained that Mr. RT's medication was prescribed and then collected from the pharmacy at the Lambeth Hospital by a member of Mr. RT's family on a fortnightly basis. The script was for Olanzapine 10 mg nocte. Mr. DG wrote that he found to hard to ensure that Mr. RT was compliant and that medication had been left uncollected. Mr. DG further explained to the GP that he would be in touch if there was a further change in Mr. RT's condition. Electronic Records show an entry stating that a call had been made to pharmacy to confirm that Mr. RT's medication was being collected by a family member on a fortnightly basis	Clinical File 1 (A). P. 56
20 September 2002	Letter was sent from Dr. W, Mr. RT's GP, thanking Mr. DG for his letter dated the 2 September 2002. The GP letter stated that Mr. RT told him he was on no medication, and that he had no psychiatric disorder. The GP stated that he tried to talk to Mr.RT and explain that he had schizophrenia and that if he did not take his medication he would relapse. The GP also stated that this was a long standing issue and that he did not believe there was anything else that he could do.	GP notes P.10
22 November 2002	Dr. NS wrote to Mr. RT explaining that he had taken over from Dr. I and that he would like to arrange a meeting with Mr. DG and himself	Clinical File 1 (A). P. 17
7 December 2002	A CPA review showed that there had been no contact between services and Mr. RT. The review stated that the family continue to collect his medication and Mr. RT had no insight into his condition. Ms. W completed the review form stating that she had never met Mr. RT and that he had never had a CPA review. Dr. NS was aware and would pursue contacting the family.	Clinical File 1 (A). P.14

28 March 2003	An electronic record states that Mr. RT and his sister did not attend the CPA review and that a message was left for them to contact services	C Trust Electronic Record. P. 42 & Clinical File 1 (A). P. 55
17 July 2003	Dr. NS and Ms. J visited Mr. RT. He had been unwilling to have any contact with mental health services for several months. Mr. RT's sister collected all of his medication from the pharmacy. Mr. RT was rational but did hold a few delusional ideas. It was agreed that Mr. RT would be discharged from case management but that Dr. NS would continue to prescribe his medication for him. Mr. RT's sister was written to this effect.	Trust Electronic Record. P. 41
21 July 2003	A letter was sent to Mr. RT's sister explaining that Dr. NS was closing the case but that he would continue to prescribe for Mr. RT. The letter explained that if the family grew concerned over Mr. RT they could contact services and gave the number for the Rapid Response Team	Clinical File 1 (B). P.315
25 July 2003	Ms. J wrote a summary report stating that Mr. RT appeared to be stable and that there were no concerns from his family. His risk behaviours were noted as being drug and alcohol abuse misuse and deliberate self harm. The contingency plan was for Mr. RT's family to contact services should they have any concerns. It was noted that Mr. RT had no insight and had been aggressive towards his family members. It was noted that intensive family support had been offered and that this had worked in the past to keep Mr. RT well.	Clinical File 1 (A). P. 70 Clinical File 1 (A). P. 72-73

	Ms. J filled out a mini risk assessment to ascertain whether or not a full assessment was required. It was decided that no further assessment was required.	Clinical File 1 (A). P.74
3 February 2004	Mr. RT's medication was noted as having been collected on a regular basis and that he was due for a review in August 2004	Trust Electronic Record. P. 41
2 February 2005	Mr. RT attended Brixton Road requesting the Centre to tell his GP that he had been discharged from the Centre. Mr. RT appeared pleasant and polite.	
20 January 2006	Ms JT wrote to Mr. RT's sister explaining that Dr. NS had moved to a different area and he wished to meet with her to discuss Mr. RT's care. The letter points out that Mr. RT had not been seen by a psychiatrist for two years even though Mr. RT's sister collected his medication from the Trust pharmacy. The letter pointed out that the prescriptions were due to expire early February 2006. A meeting was set for 2 February 2006 at the Outpatient department. Ms JT writes that Dr NS was no longer Mr. RT's RMO as he was now working with a different team	Clinical File 1 (B). P. 314 Clinical File 1 (A). P. 44
30 March 2006	Mr. RT had not been seen by a doctor for three years. He had refused to come to outpatients. Dr. NS had been prescribing Olanzapine 10mg nocte. This meeting had been planned since January 2006 with his sister to review Mr. RT's care, several meetings were planned but none kept by his sister. Dr. NS was present at Outpatients to see Mr. RT's sister. Mr. RT's sister had not confirmed that she would be attending the appointment. Plan: if Mr. RT's sister made contact for her to be given	Trust Electronic Record. P.41

	the number of the Brixton Road Centre.	
14 April 2006	Mr. RT undertook an arson attack	
20 April 2006	Mr. RT undertook an arson attack	
27 April 2006	Mr. RT undertook an arson attack	
1 May 2006	Mr. RT was arrested on suspicion of murder and arson	Investigation Clinical Archive. Broadmoor file. P. 22