PSYCHOLOGICAL APPROACHES CIC

Independent review of progress since an incident of domestic homicide in 2012 by Mr R, a service user at South West London and St George's Mental Health NHS Trust

Confidential

Independent review under HSG (94) 27

Case number:	32877 / SWLStG
Initials of service user:	Mr R
Incident type:	Domestic homicide
Report prepared by:	Dr Anne Aiyegbusi
Review team:	Dr Anne Aiyegbusi (chair) Dr Deborah Brooke Mr Paul Ralph Dr Julia Blazdell

PSYCHOLOGICAL APPROACHES COMMUNITY INTEREST COMPANY (CIC)

Our Ethos and our Team

Psychological Approaches CIC is a not for profit community interest company. We focus on work with individuals with complex mental health needs – often associated with a history of offending and social exclusion for whom services may be difficult to access or sometimes poorly equipped to meet their needs.

Our ethos is one of collaboration and partnership with other organisations. We are able to support the workforce with a focus on development in the following areas:

- Commitment to the task
- Competence and confidence in service delivery
- Containment of emotional states to support staff wellbeing

We attend to the evidence base for best practice, and in doing so, we help organisations to review and evaluate series to achieve best outcomes.

We understand how important it is to focus on improved quality of care, delivered in ways to maximise efficiency and impact.

Our independent serious incident review team comprises five senior practitioners from a multi – disciplinary background with many decades of experience in mental health including forensic mental health services and clinical governance. We adopt a whole team approach to independent serious incident reviews, with an emphasis on peer review and ratification of findings.

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1.1 INTRODUCTION

1.2 DETAILS OF THE INCIDENT

On the 27th December 2012, Mr R killed his 86 year old mother, Mrs R who was also his main carer. He killed her in the kitchen of her home, hitting her over the head with saucepans and cutting her throat with a knife.

Mr R has a long history of schizophrenia and was receiving care and treatment from his local CMHT at South West London and St George's Mental Health NHS Trust (SWLStG) at the time of his offence. He lived in independent accommodation and his landlord was Viridian Housing. He attended Wandsworth Mind to add structure to his day and increase opportunities for socialisation. He was receiving outpatient medical care at St George's Hospital for diabetes.

According to psychiatric reports, Mr R was not assessed as psychotic at the time of the offence. However in the days and weeks that followed, he presented as increasingly psychotic.

1.3 THE REVIEW PROCESS

The team employed a multiple methods approach with a focus on triangulation to validate information regarding current practices.[1] Methods included individual and team interviews, document reviews, service visits and a focus group with service users and carers. We conducted a review of the evidence base regarding perpetrators of a domestic homicide offence who have a diagnosis of severe and enduring mental illness (usually schizophrenia) and who are under the care of community health teams at the time of the offence. A peer review of findings and recommendations took place within Psychological Approaches.

1.4 FINDINGS FROM PREVIOUS REVIEWS

The following is a summary of relevant findings from two reviews that followed the offence. The first was a Root Cause Analysis (RCA) by the Trust and the second was a Domestic Homicide Review (DHR):

His mother, Mrs R, was not included in the care planning process, nor was she assessed in terms of the level of risk she

[1] This means we collected information from a number different sources in order to increase confidence in the accuracy of our findings and conclusions

may have been exposed to. Mrs R was invited to have a carer's assessment by Mr R, who then reported that she had declined. This was never followed up.

A lack of continuity of care and therapeutic relationships due to temporary staffing and frequent changes of care co-ordinators was found. This occurred in the context of a lot of organisational change. Mentioned were team amalgamations, team base moves, changes to structures and systems and lack of stability in local leadership and management suggesting a lack of support for care co-ordinators.

There were conflicting conclusions about Mr R's mental state at the time of the offence. The RCA concluded that no root cause was found to lead to the incident and no clinical evidence to indicate that the patient's mental health presentation had changed in the two weeks leading up to the incident. The DHR concluded that Mr R was very mentally unwell at the time of the index offence.

The Trust was criticised for poor communication with other agencies involved in Mr R's care and treatment, notably Viridian Housing, Wandsworth Mind and his GP. Poor communication was described in terms of not initiating dialogue with these other agencies. Lack of communication was also identified with regard to risk issues and in a failure to foster close working relationships with other agencies.

The Trust was found to have implemented a narrow, medical model perspective in terms of understanding Mr R and informing the care provided. There was found to be an absence of psychological treatment as recommended by NICE guidance for the management of schizophrenia. There was insufficient evidence of a holistic recovery plan including recovery goals in Mr R's Care Programme Approach (CPA) care plan.

Both reviews concluded that the incident was neither predictable nor preventable.

1.5 FINDINGS OF THE CURRENT REVIEW

Mr R had not used cannabis for many years and was not identified as misusing alcohol and therefore was not receiving support or services for substance misuse at the time of the offence. Drugs and alcohol were not factors in his index offence.

A high proportion of the CMHT service users misuse substances. The Trust has an up to date dual diagnosis policy, which is dated September 2016 and due for review in September 2018. There is

concern about the ability to implement the policy. Addiction services within the Trust have been decommissioned and in Wandsworth this happened on April 1st 2015. Care co-ordinators do not feel skilled to work with dual diagnosis.

The implementation of the Care Act of 2014 means that carers are directly approached and invited to have a carer's assessment. Some examples of good practice in carer engagement with the business of the Trust were found but not in the day-to-day support and engagement with care. The process of receiving a carer's assessment was experienced as unwieldy.

Good implementation of safeguarding practice was identified within the Trust including some areas of excellence.

The Trust had undergone tremendous organisational change and upheaval in recent years and this would be expected to impact on the experience and performance of staff. We found the Trust to be in the beginnings of bringing about positive stability and organised systems of governance.

The difference in opinions about Mr R's mental health at the time of his offence can be explained by the fragile hold on his illness achieved by medication, the difficulty in assessing his mental state and the rapidity of his relapse.

We found that there continues to be challenges to communication between the CMHT, housing and Mind amid a number of changes across all these agencies. Joint mental health and physical care services have been developed and in Wandsworth are provided by Primary Care Plus.

Despite the Trust having a number of excellent services and impressive professional expertise available, this is not reflected in the service delivered by care co-ordinators who struggle with the acuity and complexity of service user needs. We identified a number of underlying factors. One of the consequences is a dearth of available psychologically informed care for a service user population with complex needs.

1.6 CONCLUSIONS

The Trust has undergone some considerable turmoil due to repeated change and turnover of professionals at all levels of the organisation in recent years, which has left its impact. We found the Trust to be in the process of a positive turnaround. In regard to the service users who present in the way Mr R did at the time of the index offence, we were struck by the gap between the areas of excellence we observed within the organisation and the

quality of care delivered on the front line by care co-ordinators. We found a common thread running through the areas requiring improvement. That thread could be described as integration and is what informs our recommendations.

1.7 RECOMMENDATIONS

Develop quality improvement programmes around the following areas:

1. The role of the care co-ordinator: Ensuring it is more fit for purpose in terms of ability to deliver optimal care to a complex population
2. Carer engagement: To address day – to – day support and the provision of information for role
3. Interagency working: producing and implementing a protocol for partnership working to support the delivery of integrated care to service users and carers

2. REPORT OF THE INDEPENDENT REVIEW

2.1 INTRODUCTION

This is the report of an independent review commissioned by NHS England – London under HSG (94) 27 concerning the case of a domestic homicide committed by Mr R in 2012 while he was receiving care provided by the Central Wandsworth and West Battersea Community Mental Health Team (CMHT) at South West London and St George's Mental Health NHS Trust (SWLStG).

The review has taken account of the entirety of care provided to Mr R by SWLStG. That is, since his first contact with the Trust in 1989, through to the care he is currently receiving at a medium secure unit (MSU).

The review considers the domestic homicide, which resulted in the death of Mrs R who was the mother of Mr R. As a result of this offence, Mr R was convicted of manslaughter on the grounds of diminished responsibility and detained in medium secure care under section 37/41 of the Mental Health Act (MHA). He remains in medium secure care at the Trust.

In keeping with the terms of reference for this review, the circumstances surrounding the index offence were considered in order to gain an understanding of Mr R's mental health at the time of the incident in relation to the Trust's internal report which concludes that there were no concerns about Mr R's mental health and the report of the Domestic Homicide Review which highlights an extract from the court papers stating that Mr R was *"at the time extremely ill."*

The main focus for this review was to establish assurance about actions taken by the Trust to learn lessons and mitigate the risk of similar incidents occurring. As a result, the following principles have been applied throughout the review process:

- Recognition that Mr R meets many of the criteria for a specific cohort of men with severe and enduring psychosis who commit an offence of homicide within the family while in receipt of community mental health services. The review has been framed with the needs of this cohort in mind

- Appreciation of the importance of care co-ordination in meeting the needs of service users in the community who present as Mr R did at the time of the index offence, and the support and development needs of staff employed in

this important role

- Emphasis on the present day and current practices at SWLStG and other stakeholders providing care to patients receiving community mental health services

- The relevance of interagency and partnership working

- Sensitivity to the emotional impact on professionals of serious incidents and subsequent reviews

We hope the report will be helpful and supportive to all who were involved in the incident and this review, including Mr R, service users and carers and staff from all the services and agencies who contributed.

2.2 ACKNOWLEDGEMENTS

We would like to thank all the people who contributed to the production of this report. We appreciate that there were a number of sensitivities and complexities surrounding the review. In particular, the passage of time between the incident and this review, which meant that for some, revisiting the events surrounding the index offence was difficult. We are particularly grateful to Mr R in this regard.

Also due to the passage of time, it was challenging to try to track details of organisational functioning and change from the time of the offence to the time of this review. However, it is hoped that the report and recommendations will be of value in supporting its future progress.

2.3 THE REVIEW TEAM

Dr Anne Aiyegbusi (Chair), consultant nurse and psychotherapist with extensive experience of nursing leadership, working in challenging contexts, staff support for working with complex needs, governance of risk, the recovery approach and service user and carer experience.

Dr Deborah Brooke, trained in general practice, then in psychiatry and addictions. Dr Brooke has 20 years of consultant experience in forensic psychiatry during which she had educational and management roles within her NHS Trust.

Mr Paul Ralph, a mental health social worker with extensive experience in forensic and community mental health services. He also has experience of holding managerial responsibility for the joint commissioning of health and social care.

Dr Julia Blazdell (facilitator of the service user and carer focus group) is an education consultant with considerable experience in consulting to mental health services and providing interventions as an expert by lived experience.

2.4 METHODOLOGY

The team used multiple methods with a focus on triangulation of data gathered in order to establish as accurate a picture as possible regarding current services and practices. The following were included:

Staff invited to meet with the review team were contacted in writing and provided with information about the review. They were made aware in the letter that if they so wished, they could be accompanied.

A full review of Mr R's clinical records and correspondence held on Mr R, as provided by the Trust from the time of his first contact with it in 1989.

Case summary of the metropolitan police report of the offence.

Court report prepared for the Crown Prosecution Service dated 11th July 2013.

Review of relevant Trust policies and other documents.

Interviews with key Trust clinicians and managers.

Focus group with SWLStG service users and carers (transcript can be found in Appendix C).

Service visits to and interviews with key staff from other agencies providing care to service users also receiving care at SWLStG, including Westminster and Wandsworth Mind (previously Wandsworth Mind), Wandsworth Carers' Centre and Optivo Housing (previously Viridian Housing).

Interview with Mr R who was accompanied by his current social worker from the medium secure unit.

Visit to the Trust Recovery College.

Central Wandsworth and West Battersea Community Mental Health Team (CMHT).

Telephone conversations and correspondence with local GP

services.

The victim and perpetrator are members of the same family. That is, the victim Mrs R was killed by her son, Mr R. There are no relatives currently living in England. At the time of writing it is unclear whether the extended family living abroad will wish to have contact with the review team.

We met with representatives from the CCG.

A review of the evidence base regarding homicide of a family member by perpetrators who have a diagnosis of severe and enduring mental illness (usually schizophrenia) who are under the care of CMHTs at the time of the offence (the full paper can be found at Appendix B).

Peer review of findings and recommendations within Psychological Approaches CIC team.

2.5 BACKGROUND TO THE CASE

Mr R's Mental Health History

Mr R was born in Glasgow in 1963. The family moved to London during his early childhood and settled there. He was his parents' only child. His father was from Scotland, and his mother was from Spain. Mr R reported that his father was an alcoholic and violent to both Mr R and his mother when intoxicated. His father became paranoid if his mother spoke to him in Spanish. At this time his mother was unable to speak English. Therefore Mr R was left with nobody to speak to. In order to communicate, he and his mother did so using sign language.

Mr R's father had tried to kill him when he was 14 years old by attempting to throw him out of the window of a block of flats where the family were living at the time. Mr R's father was arrested for this, and his mother made it her son's choice whether to press charges. When he was in his early 20's Mr R's mother was described as emotionally dependent on him.

Mr R was first referred to psychiatric outpatients in 1989 when he was 26 years old. He was given a diagnosis of schizoid personality disorder, and referred to the day hospital. His first hospital admission was in February 1991. He described that the television said things to him, that "they must be putting thoughts into my mind". He said he could read his parents' minds, and it was as if they wanted him to kill them.

Mr R believed that his parents could read his mind. He disclosed

that in childhood, he had thoughts of being "beamed away by aliens". His mother provided the history that he was threatening and abusive towards his parents, he was drinking alcohol, and had been "thrown out" several times. He was treated with depot medication and discharged in April 1991.

Mr R's illness responded to depot for the first ten years, with brief admissions to hospital in 1994 and 1998. Cannabis use was implicated in his relapses during the earlier years of his illness.

Mr R had a relationship for five years with a woman who gave birth to twins in 1998. Due to the stress of looking after the twins, Mr R ended the relationship. The children were later removed from their mother's care and adopted within her family.

After his father's death in 2001, Mr R's illness pursued a more treatment-resistant course with eight admissions between 2002 and 2011, some of which were under the MHA. His mother was his main carer. There are references to his making threats to his mother, and to others, when unwell, and records of assaults against patients and staff, although charges were not pressed. Relapses were associated with changes in medication in the later years. It was recognized that Mr R could be difficult to assess, as he did not always disclose his symptoms.

Mr R suffered from some physical health problems. These were; type two diabetes, which was diagnosed in 2006, cholesterolemia, which was diagnosed in 2007 and psoriasis.

In May 2012, his depot was reduced at his request because of his experiences of side effects.

He killed his mother in the kitchen of her home on the 27th December 2012. He was convicted of manslaughter on the grounds of diminished responsibility for this offence and was detained in conditions of medium security under a hospital order with restrictions (Section 37/41 of the MHA) in September 2013. Overall he was detained in conditions of medium security from January 2013 until he was conditionally discharged into hostel accommodation in August 2015 following a Mental Health Tribunal.

Once transferred to the hostel, Mr R then requested a change of depot, again because of side effects. He then relapsed over the Christmas period of 2015. He was recalled to hospital under the section 37/41 as a result of this.

Since his recall in January 2016 Mr R has remained detained in

conditions of medium security.
With regard to the children he had with his former partner, Mr R had been in receipt of annual letters about the children's progress. The children were informed about the index offence and since then have been clear that they do not wish to have any form of communication from Mr R or any members of his extended family.

When Mr R was interviewed as part of this review, he was keen to assist the panel. However, he showed a lack of fluency in his thoughts and incongruity of affect, consistent with his history of long-term schizophrenia.

Summary of Mr R's Mental Health Problems

Mr R's childhood was characterized by his father's alcoholism and domestic violence towards him and his mother. These experiences are associated with anxiety and difficulty in trusting authority figures. Similarly, the experience of domestic abuse is associated with unassertiveness in accessing services, and so his mother may have also had difficulties in seeking help.

All parties involved with his care agree that Mr R has schizophrenia, an enduring mental illness, and that his mental state can be difficult to assess. He himself has described that his mental state can deteriorate very quickly.

The frequent admissions during the decade preceding the homicide, and the history of relapse in response to changes in medication, suggest that only fragile control had been maintained over his illness.

The pattern of rapid relapse following medication change was repeated again in 2015 when he was conditionally discharged from medium security to hostel accommodation. This was despite the psychological work and the multidisciplinary interventions of the team at the MSU. It is noted that he once again relapsed with no warning at a Christmas period after a change in depot medication.

2.6 FINDINGS OF THE PRESENT REVIEW

The following section relates to the specific terms of reference.

2.6.1 Understanding of services and support Mr R was receiving for the management of his substance misuse of cannabis and alcohol and how practice has changed since the index offence

Mr R has been described in his clinical records as using cannabis during the early years of his illness. He does not appear to have used cannabis for many years and it has been recorded that Mr R had reported a belief that cannabis use triggered his mental illness. During our interview with him, Mr R himself described using cannabis as a teenager and not since.

With regard to Mr R's alcohol use, it has been recorded that Mr R stated his heavy use of alcohol in his twenties was in an attempt to drown out the symptoms of his illness. It is recorded that he had reported drinking a bottle of wine and a few cans of strong lager each night. His drinking at that time was severe enough to cause problems at his place of work. Mr R told us that he had consumed alcohol as a teenager but did not feel he ever had a drinking problem. Mr R's responsible clinician at the time of this index offence confirmed that Mr R's drinking had not been problematic for a number of years. It is recorded that after his index offence, Mr R reported to an SPR that he had drunk alcohol infrequently at about once a month during the previous year. However, he reported drinking a large volume on these occasions, usually a large bottle of vodka in one bout. There is no collateral evidence to verify this.

There is no indication in the records that alcohol misuse was a contributory factor in his index offence. He does not appear to have presented as having an alcohol misuse problem in the time prior to his index offence although he may have consumed large amounts of alcohol intermittently, which he reported retrospective to committing the offence.

Mr R does not appear to have used cannabis for many years. He did not present to services as misusing alcohol. For that reason he was not in receipt of support for this or engaged with substance misuse services. Retrospective to his index offence he disclosed what appears to be bout drinking though there is no record of this being identified as directly associated with his struggle to cope with his mental health problems at this time.

Mr R was not in receipt of any services for substance misuse treatment in the years leading up to the index offence. Also, we found it was not possible to identify substance misuse practice at the Trust at the time of the index offence. We are however able to report on practices at the current time.

With regard to practice within the Trust, there is an up to date Dual Diagnosis policy, which is dated September 2016 and due for review in September 2018.

A high proportion of service users at the CMHT have complex

needs including comorbid psychosis and substance misuse problems. The service users we met with recognised that substance misuse is commonplace amongst service users and understood it as an attempt to numb psychological pain in lieu of formal therapeutic interventions. We learnt there are concerns about whether the dual diagnosis policy can be realistically implemented. The Trust is no longer contracted to provide addiction services Decommissioning in Wandsworth occurred on 1st April 2015 and resulted in a loss of considerable resource and professional expertise from within the organisation.

Staff felt there were limited resources available to work with service users who have dual diagnosis. The reality of life on the front line of community care delivery was described to us as that of being in constant crisis with substance misusing service users who often do not want to engage in the substance misuse services that are available to them, now that these are not provided by the Trust.

Care co-ordinators do not feel they have the skill set to work with the service users who are typically reluctant to access the commissioned addiction services. This is a dilemma because it is the role of care co-ordinators to ensure appropriate care is received through the CPA framework. We learnt that specialist training has been provided in the past but the trend has been for benefits to be quickly lost due to the high turnover of staff in the care co-ordinator role.

2.6.2. Explore how practice has changed regarding carer's assessment/safeguarding since the index offence

A development that has occurred since the index offence is that the Care Act (2014) initiated some key changes and stipulations regarding Trusts' approach to carers and safeguarding. A finding from previous reviews was that Mr R's mother was invited to have a carer's assessment indirectly, by Mr R. He reported back that she had declined. The Care Act (2014) would require Mrs R to have been offered a carer's assessment directly by professionals.

There is a mixed picture regarding the SWLStG approach to carers. Wandsworth Carers reported that their organisation and carers in general are engaged and embedded in service delivery at the Trust and attend various forums such as the Clinical Reference Group (CRG). They experience the Trust as receptive to carers needs and perspectives and committed to working in partnership with carers.

A Wandsworth Carers' Centre representative was involved in

staff selection and development for Primary Care Plus. Carers also co-produce and co-deliver groups and courses provided by the Recovery College.

While there are carer's forums in place, there are marked inconsistencies within the CMHT regarding how carers are identified and signposted towards support. Wandsworth Carers outlined that this is often dependent on individual teams and the care co-ordinators within the teams. Teams with a good understanding of the issues affecting carers tended to have high response and referral rates with more examples of good practice. However, the carers we spoke to described negative experiences, particularly in relation to accessing carer's assessments, which they described as a long and poorly designed process, which involved major barriers to communication. This picture was consistent with that presented by Wandsworth Carers. Some care co-ordinators were perceived by Wandsworth Carers to block rather than facilitate communications with carers. The removal of social workers from the CMHT had resulted in a decline in feedback and information regarding referrals for carer's assessments.

The removal of a carer participation officer position and the absence of an up to date carers strategy are deficits in terms of implementing the Triangle of Care. The Triangle of Care is a best practice guide for carer engagement in mental health care. It emphasises a triangular therapeutic alliance between service user, carer and professional. Thus carers are included as active participants in the care process.[2] The current carer strategy which is posted on the Trust website is dated 2010 and was never implemented. However, we felt the current Director of Nursing who is the executive lead for carers, was aware of issues and committed to addressing deficit areas.

We reviewed how safeguarding issues were taken up prior to the 2014 Care Act being implemented and in particular in 2012 when the index offence occurred. The Trust had a vulnerable adults policy in place at the time of the homicide. However, Mr R and his mother were never subject to its scrutiny. It is hypothetical as to whether the policy was robust enough or had the information support requirements required to activate a response but it is felt unlikely to have had any noticeable impact.

The Trust response to the 2014 Care Act has led to improvements in the support and protection of vulnerable adults. The current safeguarding lead was initially seconded

[2] Carers Trust (2013) The Triangle of Care. Carers Included: A Guide to Best Practice in Mental Health Care in England. Second Edition.

from the local authority as a senior safeguarding coordinator in 2011. The introduction of the Care Act widened the scope, significantly improving procedures and understanding of safeguarding within the Trust.

We met with the Trust safeguarding lead and raised safeguarding procedures and practices with interviewees and other agencies. We reviewed the Trust annual and quarterly safeguarding reviews, its safeguarding policy, procedures and practices and staff leadership and training. We found all to be robust and that the organisational understanding and implementation of safeguarding and its reporting culture are of a good standard. We also found active executive level leadership for safeguarding.

We identified some areas of excellent practice such as the Quality Matters Group (QMG), the Making Safeguarding Personal Group(MSPG) which is a service user led safeguarding group set up in response to service user concerns following the publication of the Lampard Report (2015)[3] and the course which is informed by the work of the MSPG, entitled 'understanding how to live safely' which was co-produced and is co-delivered by service users and staff and available through the Trust Recovery College. The QMG is a weekly patient safety meeting attended by representatives of all disciplines, governance staff and senior representatives from all service lines. Safeguarding alerts and their management is part of the core business of the QMG.

There has been a loss of expertise from the Trust in terms of day- to-day safeguarding practice due to the disaggregation of social workers following the rescinding of the section 75 agreement with the local authority. The main negative impact is seen as getting feedback from the local authority about progress following alerts and enquiries. This was supported by CMHT staff who reported their team and service expertise in safeguarding felt weaker due to the loss of readily available advice and input previously provided by their social work colleagues. Care co-ordinators reported a relentless pressure on their time and there is evidence to suggest that they do sometimes underreport. However, this is monitored and picked up on Ulysses, the Trust electronic incident management system and referred to the Clinical Lead for management at team level.

When reflecting on the homicide, the safeguarding lead was confident that in the present day, aspects of Mr R's history such

[3] Department of Health (2015) Themes and Lessons Learnt from NHS investigations into matters relating to Jimmy Savile

as an unprovoked assault on a patient in September 2007 and verbal abuse directed at his mother in February 2008 when she requested to leave the ward as a result, and Mr R's subsequent verbal and physical hostility would have been clearly registered as safeguarding alerts on Ulysses, the Trust's incident management system. More importantly the safeguarding lead demonstrated that the Trust now has mechanisms, such as the weekly QMG, which has the capability to identify risks that may not have been picked up by clinical teams. These systems, which operate independently of the clinical teams and are not reliant on RiO recordings, would have offered an extra layer of scrutiny, prompting further review of Mr R's risk to his mother.

2.6.3. Explore **current** staffing levels and capacity of staff

The index offence occurred in 2012. Due to managerial changes and turnover of personnel between then and now, we found it was impossible for the Trust to locate details of staffing and capacity at the time of the offence or the years following. Although we were not able to establish a 2012 baseline against which to review subsequent staffing levels we were able to establish that the Trust has suffered from staffing problems for a number of years. These have been characterised by recruitment difficulties and problems with retention reflected in high turnover and use of temporary staffing. The highest vacancies have been for mental health nurses, who along with occupational therapists are the most difficult staff group to recruit, impacting on the care co-ordinator role.

Some of the recruitment and retention problems can be explained in terms of national austerity and a shortage of mental health nurses. There is also a more local context in that SWLStG is a London Trust and is impacted by the high cost of living in conjunction with competition between London Trusts for a limited pool of available candidates for jobs. Additionally, as more specialised mental health services come on line, services such as generic CMHTs have become less popular workplaces.

A number of important measures are in place. SWLStG has a comprehensive recruitment and retention strategy. A Board sub committee provides workforce oversight. We have had sight of the very detailed workforce monitoring spreadsheet. The Director of Nursing is proactively engaging potential candidates for positions at the Trust including through local schools and meeting with nursing students during their first year of training. The Director of Nursing is working in a partnership with the Directors of Nursing at two other South London Trusts to establish consistent standards of recruitment, work opportunities and development for candidates. Improvements

have been realised with turnover for nurses reducing from 21% in February 2016 to 14% in February 2017. However, this is an area that requires constant intense effort for progress to be maintained.

When we visited Central Wandsworth and West Battersea CMHT we were informed that the team was well staffed for the first time in a number of years during which time there has been very high turnover within the team and high use of temporary staffing. There were two locum staff working in the team, one was the consultant psychiatrist and the other was a CPN. There was 1 care co-ordinator vacancy. The team had in place a permanent manager having previously experienced approximately 10 different managers within a period of 7 years.

In terms of pressures on care co-ordinators' capacity, these were mainly located with the complexity and acuity of service user needs and size of caseload (average 35 service users). In terms of complexity, service users typically presented with co-morbidity, especially in relation to psychosis and substance misuse, poor engagement and reluctance to engage with specialist addiction services. The team did not feel skilled to work with the complexity presented by the service user group. With regard to acuity, zoning, a traffic light or RAG rating system is used for identifying the level of support required by service users according to their risk and acuity. A high proportion of service users are in the red zone, which represents the highest level of acuity at any time and service users typically fluctuate in and out of the red zone. Community psychiatric nurses (CPNs) are the care co-ordinators who are likely to bear the greatest burden of acuity in terms of managing caseloads with high numbers of service users zoned red.

Care co-ordinators feel pressured further because of the loss of expertise in the teams due to the disaggregation of social workers from the team which happened when the section 75 agreement with the local authority was rescinded with social workers relocated with the local authority. Furthermore, joint working with social workers is now more stressful due to not having the previous level of support that had been achieved through working together as part of the same team.

We heard that the CMHTs are underfunded and also that reductions in service provision within other areas of the wider system due to austerity measures, left unmet needs which are now being picked up by care co-ordinators. Care co-ordinators themselves felt they were overstretched and that if there were some junior staff employed to undertake administrative functions, this would free them up to deliver more clinically

skilled aspects of the care co-ordinator role.

With regard to underfunding, a benchmarking exercise, across the community care pathway is planned to commence in January 2018. The benchmarking exercise has been jointly commissioned by SWLStG and the South West London Clinical Commissioning Group. In addition to identifying funding gaps, the findings of this exercise will be used to inform commissioning requests at subsequent business planning rounds.

In terms of support and development for staff, a weekly team reflective practice group is provided and facilitated by a consultant psychotherapist. According to the records we had sight of, the team were 100% compliant with the supervision requirements with all team members in receipt of supervision against 69% compliance Trust-wide. The team were 92% compliant with staff appraisal and 68.72% compliant with mandatory training. They were 8.33% compliant with the RATE mandatory risk assessment training. However, we note that this training was only made mandatory in June 2017 and that the Trust has an improvement trajectory.

Retention rates for psychologists are very high. The CMHT has 2 psychologists who are accessible and offer care co-ordinators support with service users who have complex needs but there is often a delay between the request being made and the support being provided on account of psychologists' capacity. Due to the acute inpatient psychology resource being given up as a cost saving a number of years ago, CMHT based psychologists are required to deliver into the inpatient services for 10% of their time.

SWLStG has considerable expertise within its senior nursing team and offers excellent training and development in partnership with Kingston University for psychosocial interventions for working with service users with psychosis but this is markedly under subscribed by care co-ordinators. There is good evidence for the effectiveness of psychosocial interventions for preventing relapse and improving symptom management and self care in psychosis. It is also in line with current NICE guidelines for schizophrenia and psychosis and has been identified as providing core tools for front line staff working with people diagnosed with schizophrenia and psychosis.

Care co-ordinators who have been invested in with regard to training to provide psychosocial interventions and dual diagnosis training tend to move on in keeping with the high staff

turnover. Therefore when investment in skills development within teams has taken place, it tends not to have been sustained but rather to have been lost to the organisation.

Reasons for the undersubscribing of important staff development include a predominately medically driven model of care delivery and a tendency for care co-ordinators to fall into adopting a reactive approach to their work. The long term consequences on teams of chronic staff retention problems, large caseloads, systemic pressures brought about by austerity impacting on their role and high complexity and acuity of service users compound this picture, leading to the washout of skills from the organisation.

Service users and carers we spoke to described a fragmented experience. Although examples of positive experiences with care co-ordinators were described, they found these to be few and far between and short lived. A constant turnover of staff was described which negatively impacted their experiences of care. Service users and carers have come to associate staff changes with imminent discharge with little or no follow up.

We found a number of inter related factors to be associated with high turnover of staff. These were:

- A high level of strain in the care co-ordinator role
- A national shortage of mental health nurses
- Small pool of talent and high levels of competition between London Trusts
- Care co-ordination in generic CMHTs becoming less popular in the light of speciality areas coming on stream
- The impact of chronic, repeated organisational change

For further details of strain in this role, please see Page 31, 2nd paragraph in this report.

2.6.4 Understand the mental health of Mr R at the time of the incident. This is in relation to the Trust internal report which concludes there were no concerns about Mr R's mental health and the DHR report which highlights an extract from the court papers stating that Mr R was *"at the time extremely ill"*

The fragile control of Mr R's psychosis achieved by medication, the difficulty in assessing his mental state and the rapidity of his relapse explain the difference in the opinions relating to his mental state at the time of the homicide. No symptoms of the imminent relapse were apparent to his usual care team in the days prior to the homicide. After the homicide the first psychiatric assessor found him to be fit for interview. However, prison staff had already noticed that his behaviour was of

concern and he rapidly became sufficiently disturbed to necessitate special precautions by the prison staff when unlocking his cell. He was extremely unwell on admission to the MSU later in January 2013. His own account some weeks later confirmed that he was psychotically ill when he killed his mother.

2.6.5. Explore what changes have been implemented to improve the joint management and support for service users between the CMHT and housing.

Following the domestic homicide, Optivo (then Viridian) housing undertook an internal management review. This resulted in a number of developments within the organisation associated with working with risks related to vulnerable people. Included is a focus on domestic violence and investment in staff awareness, training, development and support in this area.

The internal management review also led to the implementation of an enhanced safeguarding strategy including the identification of a safeguarding lead and the introduction of mandatory safeguarding training for staff.

We learnt that following the publication of the DHR and Trust RCA for this case, there had been stronger partnership working between housing and CMHT, including meetings with a CMHT manager to address mutual remits but when that manager left their post, the meetings and any consequent contact with the CMHT deteriorated. We found no evidence to support improved joint management or support for service users at the time of this review.

Optivo staff reported that they find the Trust exceptionally difficult to work with. In particular, Optivo experience partnership working required for supporting service users to be difficult to establish and maintain with care co-ordinators. The Trust has noted changes within both organisations and it is felt these may explain some of the challenges around joint working, with scope for both agencies to learn lessons and make improvements to their partnership working for the benefit of service users.

2.6.6. Explore and specify the impact of what the 'significant' service changes were and if the introduction of electronic records had an impact on Mr R's care and treatment

It was not possible to track service changes from the time of the index offence to the present day. However we did learn that the

Trust has had numerous restructures over recent years. Indeed, the Trust was undergoing an important management restructure at the time of this review, with the introduction of service lines. For the CMHT, this meant a move from being borough based, to being located within the community service line. Additionally, the Trust has experienced a high turnover of staff from executive level to front-line. Throughout the review we heard about the impact on CMHTs of the local authorities rescinding the section 75 agreement and the consequent disaggregation of social workers from the teams. Although some benefits were mentioned such as social workers having more objectivity regarding safeguarding issues, the feedback was mostly negative with loss of these experienced, well trained professionals keenly felt both in terms of the quality of care available to service users and carers and support to colleagues.

We found no evidence of the introduction of electronic records having a negative impact on Mr R's care and treatment. If anything the electronic records system has been experienced as a positive development. The only drawback being the lack of interface between the Trust RiO system and those used by other agencies.

2.6.7. Review the change in the level of communication between CMHT, Wandsworth and Westminster Mind (previously Wandsworth Mind), Optivo Housing (previously Viridian) and GP practice to establish what improvements have been made

Some collaborative work takes place at a strategic level, for example through the Clinical Reference Group (CRG) which is convened by the Clinical Commissioning Group (CCG) and attended by representatives from the Trust, local authority, service users and carers and non statutory agencies. However much less contact takes place between agencies at the care delivery level.

With regard to Wandsworth and Westminster Mind, there was felt to be an initial improvement with the CMHT following publication of the DHR. However, this reduced with the rescinding of the section 75 agreement and loss of social workers from the CMHT. Communication was described as challenging at the present time. The Trust recognises that transformation and change regarding the delivery of services by both agencies and adult social care too, has contributed to the current position regarding interagency communication.

Wandsworth and Westminster Mind require a comprehensive risk assessment before service users can access their service. A

risk assessment is received from the CMHT at this time. Although informative, these are often also felt to be limited and subsequent updated risk assessments are not forwarded.

There is felt to be communication problems between the CMHT and Wandsworth and Westminster Mind regarding service users. For example, we heard of occasions when Mind had not been informed when service users were admitted to or discharged from hospital.

We heard that the very limited information sharing that does take place occurs when Mind requests it. Therefore it is difficult to keep track of service users' circumstances. Few CPA reviews are attended and Mind reported not being informed about when they are held. Care plans are not always complete and information has to be chased from the CMHT. Emails and telephone messages to care co-ordinators go unanswered even when a service user is in crisis.

The picture described by Optivo was very similar to that of MIND with very poor quality of communication reported. As described, there was an improvement following the DHR followed by a decline when a key member of CMHT staff left. The picture of having to chase care co-ordinators for information and of emails and telephone messages going unanswered was also described by Optivo.

With regard to GPs, there is now an integrated mental and physical health service in Wandsworth. Wandsworth Primary Care Plus aims to improve pathways between primary and secondary care and also improve care and clinical outcomes for people with co-morbid mental health and physical health care needs. It is a multi agency provider, including SWLStG, local GP services, family services and local service user and carer groups.

The service users and carers we spoke to reported experiencing fragmented care with no sense of collaboration or even communication between the different agencies involved.

2.6.8. Review the development and implementation of a shared protocol between Trust and Primary Care Groups, to establish clear shared care arrangements between CMHT's and GPs (as identified by previous homicide in 2010)

Despite considerable searching, we were unable to locate a shared protocol between Trust and primary care. Nobody we met with from any agency knew anything about a shared protocol. However there were CCG commissioned joint mental

health and primary care services in place in all but one of the boroughs served by the Trust.

We were provided with the annual review for the joint mental health and primary care service for the borough of Sutton. An integrated Primary Care Mental Health Service ("Sutton Uplift") launched in July 2015 offering mental health support to the borough's residents. It was developed in partnership between South West London and St George's Mental Health Trust and local voluntary sector organisations. The service offers assessment, psychological therapies, a primary care recovery team (supporting those with severe and enduring mental illness) and a wellbeing service (promoting access to community and vocational opportunities and practical help with money and housing). The annual review showed that Uplift has met a number of Key Performance Indicators while ensuring high levels of service user satisfaction.

As mentioned above, in Wandsworth the joint mental health and primary care service is Primary Care Plus, which aims to improve pathways between primary and secondary care as well as improving clinical outcomes for people with co-morbid physical and mental health conditions.

3. THE EVIDENCE BASE

A recent review of the literature on homicide by perpetrators who have a diagnosis of severe and enduring mental illness (usually schizophrenia) and who are under the care of CMHTs at the time of the offence was carried out in order to locate the findings and recommendations of this review in sound research evidence (The full review can be found in appendix B).

In summary, the killing of family members by patients with schizophrenia is a rare event and difficult to predict; furthermore, although there are some helpful indicators of characteristics which are associated with this type of offence, they are fairly commonly encountered, and the research is not sufficiently robust to suggest that they are specific risk indictors. Factors **associated** with an event, are not necessarily factors that **cause** an event to take place

Nevertheless, the evidence base suggests that male patients with schizophrenia who are single and unemployed, possibly with prior convictions and a history of psychiatric hospitalisation, but more probably with co-morbid substance misuse and prior threats against the potential family victim, should be considered as posing a greater risk.

Family dynamics may well play a part, most particularly if there is evidence that the patient expresses mixed feelings about the family member, or the family member is experienced by the patient as over protective. As might be expected, stopping or reducing medication for the mental illness seems to precipitate the event, with the ensuing development of paranoid beliefs regarding the family member. There is some suggestion that the family member's attempt to protect the patient by minimizing the impact of their illness may expose them to greater risk.

4. THE ORGANISATION

Given the extent and impact of change and restructure over a number of years, we felt it was important to include an overview about our experiences of the organisation, including its culture. Our hope is to further anchor the review. We found the Trust to be an organisation in transition. The impression gained was of there being a history of tremendous pressure brought about by repeated change, over recent years. These changes include restructures, team reconfigurations and closures, service closures, personnel changes throughout all levels of the management structure including at executive level which has also brought changes of philosophy and priorities. In the midst of this, there has been a loss of organisational memory making it difficult to track actions or locate data referring to the past. Indeed with regard to this incident, we found that the Trust was unable to provide satisfactory evidence regarding the implementation of recommendations from the Trust RCA and DHR that followed this domestic homicide. In this regard, the experience was of informality and the vestiges of resistance to learning lessons from serious incidents.

Despite the above, we were pleased to find current senior leaders who were committed to driving through strong systems of management and integrated quality governance within clear structures in place from floor to board. This progress is at a relatively early stage and will require further time to fully embed, especially at the front line of care delivery. It is hoped that this progress will continue, providing a stable and robust context, which supports optimal care delivery.

In terms of further positive observations about the organisation, we found repeated examples of good practice and excellence. The Trust has enjoyed a national profile for excellence in regard to the implementation of the recovery approach and its Recovery College. It has functioned as a national demonstration site for a Department of Health sponsored programme for supporting the implementation of the recovery approach in mental health services in England. The review team visited the

Recovery College and were pleased to hear about the wide range of programmes offered, which were co-produced with service users and carers. We met the Trust recovery lead and were struck by their knowledge, skills and understanding of how to embed this culture into front line care. We also note that according to the CQC community survey, the Trust has the highest employment rate for service users in London, which suggests good recovery implementation.

The Trust also has a profile for its leadership and excellence regarding psychosocial interventions for working with people who have psychosis and their families. We were delighted to meet with the Head of Nursing Education, Practice and Research who we found to have extensive expertise regarding best practice with people experiencing psychosis. This includes how to implement and embed best practice at the front line of care delivery within the care co-ordinator role. We heard about a jointly developed education programme accredited by Kingston University but that this is under subscribed by care–coordinators and even so, skills and knowledge gained from undertaking the training has soon been washed out of the organisation due to staff turnover.

Other areas of good practice we wish to comment upon are:

- Strong and visible executive nurse leadership which has brought renewed professional pride and a focus on the contribution nursing can make to multi disciplinary care

- The weekly QMG which is attended by representatives from service lines, heads of discipline and corporate governance to review all incidents, raising their profile

- A comprehensive system for facilitating learning lessons from incidents. Sound structures are in place to facilitate this. We recognise that it will take further time to embed a learning lessons culture in terms of changing professionals' attitudes and understanding regarding this aspect of patient safety

- Clear floor to board structure for incident management

- The introduction of sound mandatory risk training in June 2017 – Risk Assessment Training and Education (RATE)

- The virtual risk team which provides clinical teams with peer review and support when they require an additional opinion about risk management of service users

- The implementation of sophisticated quality dashboards enabling the monitoring of individual and team performance around the quality of care delivery in real time

- Strong and visible safeguarding leadership and good procedures in place to support front line practitioners

- The service user led Making Safeguarding Personal Group and the co-produced and delivered training emerging from the work of the group which is entitled 'understanding how to live safely'

- Good monitoring of mandatory training, appraisal and supervision

The gap between these examples of excellence and good practice and the delivery of front line care within the CMHT is marked at the moment and must represent an area to focus future service and practice developments. In the context of this review, the challenge will be for existing good practice, excellence and expertise to be reflected in standards of care and performance by care co-ordinators and therefore the quality of service user and carer experience.

We felt it was important for the organisation to consider whether the high turnover of front line staff reflects an institutionalised coping mechanism developed in reaction to stress and exhaustion within their roles. We felt there is likely to be a system of such coping mechanisms at play within the organisation given the intensity and duration of those aspects of its apparently reactive, crisis driven history. We question whether some of our other findings including prior fragmentation within the clinical management and governance of risk, loss of organisational memory, default medical model dominance and difficulties collaborating with non statutory agencies reflect an attempt by staff to manage stress created by wider systemic factors including chronic shortfalls in resources.

5. CONCLUSIONS

We set these conclusions in the context of Mr R's clinical presentation and the wider environmental influences on the delivery of care. We recognise the challenges of holding an individual's initial narrative and developmental history in mind with the passing of decades. This is especially so in the case of long term service users who might not present to professionals with clinical evidence that indicates the initial narrative and developmental history have any bearing on their current relationships or risks. Additionally and in line with the evidence base about perpetrators of domestic homicide who have psychosis and are receiving care by CMHTs, it is very difficult to predict who, of the many service users who present similarly, will enact such an event.

We also recognise the strains of managing large community caseloads at a time of national austerity, huge organisational pressures and multiple other systemic factors beyond the control of clinicians, that nevertheless impact on practice.

In line with the evidence base, we will take the view that, men who present as Mr R did, should be considered as presenting a greater risk than is the norm (see appendix B for our full review). Our conclusions and recommendations are made with this cohort of service users in mind.

With regard to the terms of reference relating directly to Mr R's mental health, we found that the difference between the findings of the RCA and the DHR could be explained by the fragile control of his psychosis achieved by medication, the difficulty in assessing his mental state and the rapidity of the relapse. No symptoms of imminent relapse were apparent to his usual care team in the days prior to the homicide. After the homicide the first psychiatric assessor found him to be fit for interview. However, prison staff had already noticed that his behaviour was of concern and he rapidly became sufficiently disturbed to necessitate special precautions by the prison staff when unlocking his cell. He was extremely unwell on admission to the MSU approximately two weeks later.

With regard to support and services for substance misuse of cannabis and alcohol received by Mr R and how practice has changed since the index offence, first of all Mr R was not receiving any services. It appears that he had not used cannabis for many years and that he was not regarded to have misused alcohol for many years either. He has provided an uncorroborated account of drinking approximately one large

bottle of vodka per month in one bout. Nevertheless, he did not present as someone with an alcohol problem, alcohol misuse was not identified as a factor relevant to his enduring mental health problems or difficulties in living. Neither alcohol nor cannabis use were found to be relevant to the index offence.

The Trust has an up to date, comprehensive dual diagnosis policy but there are concerns about whether it can be realistically implemented. The Trust has recently lost a contract to provide addiction services and this has also led to a loss of professional expertise within the organisation. A high proportion of CMHT service users present with dual diagnosis but care co-ordinators do not feel they have skills to work with this complexity. Their experience is of constantly crisis managing and they find that the service users are reluctant to engage in the available services now that they are not provided by the Trust.

Since the time of the index offence, the Care Act (2014) has been implemented. This has resulted in some key changes which, had they been in place, may have led to a greater recognition of the risks Mrs R was exposed to. These include her being directly offered a carer's assessment and that incidents of aggression towards her by Mr R would have resulted in safeguarding alerts being raised. Additionally, more sophisticated incident monitoring and the weekly QMG provide a level of independent scrutiny where safeguarding risks not picked up by the clinical team would be identified and followed up.

The Trust offers opportunities for carers to be engaged in the business of the organisation at many levels and there is much good practice to be found. However, the day-to-day support for carers that would be facilitated through care co-ordinators appears to be inconsistent and dependent on individual teams and care co-ordinators. The absence of a current, clear strategy and understanding of the care co-ordinator role in relation to carers in some cases appears to underlie this. Carer's assessments are experienced as unwieldy and a cause of dissatisfaction and inefficiency.

There appears to be a vast improvement in the safeguarding of vulnerable adults with well functioning systems in place at the Trust. There was evidence of excellent practices, notably the MSPG and the training evolving from this.

The Trust experiences difficulties recruiting and retaining staff of which nursing presents the greatest challenge. Thus, impacting the care co-ordinator role. At the time of our review, we found the team at Central Wandsworth and South Battersea

to be, for the first time in a long time, well staffed, with a permanent manager and deputy, in receipt of supervision and a weekly reflective practice group facilitated by a consultant psychotherapist. Nevertheless, there were still a number of areas of concern and no reason to assume that the problem of rapid staff turnover was not still problematic.

Systemic factors in the wider health economy combine with internal trust factors to produce a number of negative conditions and we suspect rapid job turnover may be a way for staff in this role to cope with the stress of work. Included in the factors identified as applying strain are;

- National shortage of mental health nurses
- Small pool of talent and high levels of competition between London Trusts
- Underfunding of services
- Care co-ordination in generic CMHTs becoming less popular in the light of speciality areas coming on stream
- The impact of chronic, repeated organisational change
- Disaggregation of social workers from teams
- Loss of Trust addiction services
- Large caseloads
- Acuity and complexity of caseloads
- Lack of skills to work with complexity
- Administrative burden
- Reactivity and crisis management
- Reduction in support from team psychologists due to their requirement to provide to inpatient services
- Washout of training gains

We feel it is important to be aware that deficits and problems in the wider system can become manifest at this point in care delivery, which leaves the role and staff employed within it, vulnerable to becoming the place where fault and blame gets located.

We noted the positive, active recruitment and retention activity led by the Director of Nursing.

In terms of interagency working, including that which involved risk management, we found a similar picture to that described at the time of the index offence. According to both housing and Mind, a slight improvement had been experienced following the index offence before a return to prior functioning. The disaggregation of social workers from CMHTs appears to have been a factor.

Although we found no evidence of a shared protocol with GPs, there has been the development of joint mental health and

primary care services since the index offence. In Wandsworth this is provided by Primary Care Plus.

We found much good practice, expertise and excellence at the Trust and feel a key challenge is for this to be reflected in the care provided by care co-ordinators including multi agency working.

We identify a common thread running through the areas that require improvement. That thread could be described as integration and we target three key areas for recommendations; the role of the care co-ordinator, carers and multi – agency working. We would recommend a quality improvement programme around each of these areas.

6 RECOMMENDATIONS

6.1 **The role of the care co-ordinator**: Develop a quality improvement programme around this role to augment existing good practice. The following should be included:

- An analysis of systemic factors impacting on the care co-ordinator role and address these
- Addressing systemic factors should include actions to address impact of rescinding of S 75 agreement in light of its implications for safeguarding
- Identification of a named individual to provide practice leadership and head the production of a development programme for the care co-ordinator role
- Service user and carer input into the development programme
- Outcomes to include knowledge and skills to match known service user complexity and acuity, including working proactively with psychosis and dual diagnosis and an emphasis on empowerment and self care
- Multi disciplinary input to develop and implement clinical formulations for all service users
- Continue with the improvement trajectory and then maintain improved attendance on RATE training

6.2 **Carers**: Develop a quality improvement programme around working with carers to address the day-to-day needs for support and information. The following should be included:

- Co-produced carer strategy and policy, embedding best practice from the Triangle of Care
- Service user and carer input
- Input from Wandsworth Carers' Centre and address partnership working requirements
- Include a whole family approach to care delivery
- Inform and empower front line staff to provide required support and information for carers

6.3 **Inter-agency working between the CMHT, housing and Mind:** Develop a quality improvement programme: The following to be included:

- Produce, implement and monitor an agreed protocol for inter-agency working
- Service user and carer input
- Input from front line staff
- Representation from all agencies
- Analysis of systemic factors impeding joint working and address these
- Focus on risk management and information sharing
- Ongoing monitoring and reporting to ensure progress is

maintained

Appendix A

Specific Terms of Reference

- To understand what services / support Mr R was receiving for the management of his substance misuse of cannabis and alcohol and how practice has changed since the index offence.

- To explore how practice has changed regarding carers assessment/safeguarding since the index offence.

- To explore current staffing levels and capacity of staff.

- To understand the mental health of Mr R at the time of the incident. This is in relation to the trust internal report which concludes that there were no concerns with Mr R's mental health and the DHR report which highlights an extract from the court papers stating that Mr R was *"at the time extremely ill."*

- To explore what changes have been implemented to improve the joint management and support for service users between the CMHT and housing.

- To explore and specify the impact of what the 'significant' service changes were and if the introduction of electronic records had an impact on Mr R's care and treatment.

- To review the change in the level of communication between MHT, Wandsworth MIND, Viridian Housing and GP practice and to establish what improvements have been made.

- To review the development and implementation of a shared protocol between Trust and Primary Care Groups, to establish clear shared care arrangements between CMHTs and GPs (as identified in previous homicide in 2010).

Appendix B.

What can the published evidence base tell us?

The aim of this section is to review the recent published evidence base on homicide and mental illness. We have reviewed the relevant publications from the past five years, and extracted information which is of potential relevance to this particular inquiry. That is, we have restricted our review to information on perpetrators of a homicide offence who have a diagnosis of severe and enduring mental illness (usually schizophrenia) and who are under the care of community mental health teams at the time of the offence.

The most useful and comprehensive oversight is provided by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH: http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/) . The following data has been extracted from their Annual Report and 20 year review (2016), and is presented in Table 1 for ease of understanding.

The report covers the period 2004-2014, during which time the Inquiry was notified of 6,241 homicide convictions, an average of 567 per year. Of these, 662 (an average of 60 per year) were confirmed patient cases. Out of the 662 patients, 369 homicides were by people with a history of schizophrenia, which is 6% of the total sample and an average of 34 per year. However, the number of those with schizophrenia who were patients at the time of the offence falls to 209, an average of 19 per year.

Table 1. Patient homicide offenders in England (2004-2014) and those with a diagnosis of schizophrenia

RELEVANT FINDING	FREQUENCY & PERCENTAGE
All patients with a mental health diagnosis	**662**
Individual committed homicide 1-4 weeks after their last contact with services	317 (48%)
Individual committed homicide 5-13 weeks after their last contact with services	141 (21%)
Relationship of victim to perpetrator was family member or spouse	222 (38%)
Previous history of convictions for violence	334 (52%)
Known patients with a mental health diagnosis of schizophrenia	**209 (57%)**
Patient had abnormal mental state (psychotic) at the time of the offence	303 (82%)
Non compliant (or non-adherent) patients with drug treatment in the month before the homicide	57 (30%)

Patients who missed their final service contact before the homicide	69 (37%)
Patients who were either non compliant or missed their final contact	106 (57%)
Patients with schizophrenia and co-morbid alcohol or drug dependence/misuse	158 (25%)

A more detailed study of domestic homicide offenders, drawing on the National Inquiry database (Oram and colleagues, 2014) found that 28% of adult family homicide perpetrators had a lifetime diagnosis of schizophrenia of whom 70% were acutely ill at the time of the offence. When this group of offenders were compared with those domestic homicide offenders without a history of mental illness, they were found to be less likely to be employed, and less likely to have a history of alcohol abuse or prior violence.

Patients who are in contact with services and commit a homicide offence are generally judged as low risk by clinicians at their last contact prior to the homicide (NCISH, 2013). A pilot study investigating the quality of risk assessments in these cases found 59% to be of satisfactory quality; diagnoses of personality disorder and alcohol misuse were strongly linked to poor risk assessments.

Raymond and colleagues (2015) published a retrospective study of 40 parricidal (killing a father or mother) patients in a French secure unit over 15 year period. The authors first summarized the published literature on parricide as follows: perpetrators of parricide nearly always have a history of mental illness (if killings for financial gain are excluded); they comprise mostly sons, with an average age of around 30, who tend to be single and unemployed, living with the victim in a 'hostile-dependent' relationship, and with a previous history of violence towards the victim. Active symptoms of psychosis tend to be present at the time of the homicide, and 'persecutory' motivation is often evident. By this, the authors mean that the perpetrator is suffering from paranoid beliefs that others are going to harm them. The offences tend to take place in the victim's house, frequently involving excessive violence. Precipitating factors are abusing substances and stopping psychotropic medication.

The authors go on to describe their own sample of 40 parricidal patients: in their study, they found half had witnessed or been victims of violence as children; at the time of the offence they lived with and were dependent on their victim. Around 40% had previous convictions, and 60 had been previously aggressive towards others. Sixty six per cent had a history of psychiatric hospitalization, most had a diagnosis of schizophrenia, and 80% were known to mental health services prior to the offence; 50% abused substances (mostly alcohol and cannabis). At the time of the homicide, the perpetrators were suffering from symptoms with persecutory, grandiose or religious themes; 70% described the act as one of self defence.

The authors suggested that the majority of the offences lacked premeditation, precipitant often being an argument. As with prior research, not taking medication

and misusing substances were evident, and excessive destructive violence was present in 60% of the homicide events. In this sample, mothers were slightly more at risk than fathers, and mothers were described – after the event – as over protective or authoritarian, with evidence of a hostile dependence from patient. Interestingly a third of victims had apparently refused to acknowledge or had trivialized the existence of mental illness in their child.

Summary

The killing of family members by patients with schizophrenia is a rare event and difficult to predict; furthermore, although there are some helpful indicators of characteristics which are associated with this type of offence, they are fairly commonly encountered, and the research is not sufficiently robust to suggest that they are specific risk indicators. Factors which are **associated** with an event are not necessarily factors which **cause** an event to take place.

Nevertheless, the evidence base suggests that male patients with schizophrenia who are single and unemployed, possibly with prior convictions and a history of psychiatric hospitalisation, but more probably with co-morbid substance misuse and prior threats against the potential family victim, should be considered as posing a greater risk. Family dynamics may well play a part, most particularly if there is evidence that the patient expresses mixed feelings about the family member, or the family member is experienced by the patient as over protective. As might be expected, stopping or reducing medication for the mental illness seems to precipitate the event, with the ensuing development of paranoid beliefs regarding the family member. There is some suggestion that the family member's attempt to protect the patient by minimizing the impact of their illness may expose them to greater risk.

References

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2016). *Making Mental Health Care Safer*: *Annual Report and 20-year Review*. University of Manchester.

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. (2013). *Quality of Risk Assessment prior to Suicide and Homicide: A Pilot Study.* University of Manchester.

Oram, S., Flynn, S. M., Shaw, J., Appleby, L., & Howard, L. M. (2013). Mental illness and domestic homicide: A population-based descriptive study. *Psychiatric Services*, *64*(10), 1006-1011.

Raymond, S., Leger, A., & Lachaux, B. (2015). A descriptive and follow-up study of 40 parricidal patients hospitalized in a French secure unit over a 15 year period. International Journal of Law and Psychiatry, 41, 43-49.

Appendix C

SWLSTG Focus Group – Report

The following report summarises the findings of a service user and carer focus group that was held in SWLSTG on 14th July 2017. Although only two people attended the focus group, both participants identified as having experiences of being both service users and carers in the Trust.

The first part of the session focused on the participants' experiences as service users.

Although the participants highlighted a couple of examples of good practice, for instance, a positive experience of care co-ordination, such experiences were few and far between. Moreover, these experiences were short-lived, such that when the care co-ordinator in question became pregnant and had to take leave, the service user was, in turn, treated as a 'closed case':

> 'I had a good relationship with her [the care co-ordinator] but it was like she just had to close me as a case and there was no follow-up'.

Indeed, both participants reported a constant turnover of staff and spoke of the negative impact this had on their experience of care, highlighting the lack of continuity and consistency this engendered and how changes in staff often heralded imminent discharge with little or no follow up in the community:

> 'The emphasis [then] was on being discharged. I was no longer of importance.'

When participants were referred into other services, for example, to a day hospital, their experiences were generally positive. However, with little or no evidence of robust multiagency working - or even communication between services - the participants felt 'dropped' and 'dumped' by services rather than experiencing a 'joined-up' pathway of care. Thus, when the day hospital was closed, no services were offered for participants to be referred into or to return to.

Similar shortcomings were reported at assessment. Both participants highlighted the lack of a psychologically-informed formulation of their difficulties and care needs. Instead, the assessment focus tended to be upon medication and managing symptoms rather than on, or alongside, a psychological understanding of their complex needs:

> 'I really suffered psychologically when I was working. People in my job were awful to me and there was institutional racism. It seemed that services refused to acknowledge what I was going through. Mental health professionals seem to be in a class of their own. The psychiatrist thought she was an expert on me, but she was not. The racism made me ill but they didn't want to talk about it.'

Experiences of trying to secure Personal Budgets were also identified as problematic with the application process itself described as being long and confusing with poor mechanisms for feedback about outcomes:

> ‘I have sickle cell and other issues and I wanted to use my personal budget to go swimming and to sit in a sauna, especially in the winter. I simply never received it and was never informed as to the outcome.

Both participants spoke of the complex interplay of psychological and social factors that affect their mental health and both highlighted the need for services to address this dynamic if service users are to be supported effectively in the community:

> ‘Professionals underestimate the difficulties service users have with practical matters and especially managing their finances when they are on large amounts of medication or feeling unwell. I used to fear the brown envelopes coming through the letter box.’

> ‘It’s when people are discharged and there is no management of their finances and utilities that things get out of hand. It causes stress and relapses and people are readmitted. They wonder why people want to stay in secondary care!’

Furthermore, both participants addressed the issue of co-morbidity and spoke of how alcohol and drug use is commonplace within the service user population. For the two participants, this was completely understandable since it was viewed as part of a coping strategy in lieu of anything that would effectively attend to the underlying problem:

> ‘They want to numb psychological pain but they do this with alcohol and drugs. It’s the underlying issue that needs to be addressed.’

The second part of the session focused on the participants’ experiences of being carers in the Trust.

Both participants had had experience of carers’ assessments and although the outcomes differed, in that one received a discretionary grant, whilst the other felt that her application had simply been ‘lost’, both highlighted significant problems with the current system.

Both described the process as longwinded and complicated with a series of financial questions which many applicants would find unduly intrusive and off-putting. Both participants agreed that it was very difficult for carers to deal with financial assessments and that this would be especially so if the carers were to have mental health needs of their own.

One participant described the type of support carers get as a postcode lottery, since the quality and extent of the offer depends wholly on the borough in which you live. Moreover, both participants agreed that carers fail to be fully valued and respected by the Trust:

> ‘I am at home with my family but I don’t get respect for looking after my mum and dad.’

One participant gave a moving account of her experience as a carer for a family member and the lack of support she received from services:

> ‘I felt that what I was doing was good. I would wash his clothes. He would come to my house for a shower. But I couldn’t get anyone to help him in his home. It was tiring.’

Despite her concerns for the family member's safety and her explicit requests for him to be kept in hospital, her family member was granted leave and subsequently committed suicide. Although the participant asked repeatedly for information about the circumstances of the family member's care and leave prior to the incident, her requests went unanswered:

> 'It was like a wall of secrecy. I felt they didn't want me to have any information.'

The lack of emotional support following the incident further compounded the participant's sense of being disregarded as a carer. This was echoed by the other participant who highlighted a lack of emotional support for carers across the board.