REPORT OF THE INDEPENDENT INQUIRY TEAM INTO THE CARE AND TREATMENT OF D

COMMISSIONED BY:
Lambeth Primary Care Trust

JUNE 2004

ACKNOWLEDGEMENTS

We acknowledge the help that 'D' and his family gave us at a time of great distress for them. The open, frank and often painful discussions that were held were of great help to the inquiry panel in their investigations.

We also wish to acknowledge the way in which the professionals involved in D's care and treatment, then and now, co-operated with us and commend their candour and commitment to provide information at what was a difficult time for them.

A constructive process is impossible without commitment and we acknowledge the willingness of the South London and Maudsley NHS Trust, Lambeth Social Services and Lambeth Primary Care Trust to share information with us and ensure that we had access to the relevant documents.

Executive Summary

INTRODUCTION

During the night of 25th July 2000 D killed his grandmother. He later pleaded guilty to manslaughter on the grounds of diminished responsibility, and the court ordered that he be detained under what is known as Treatment and Restriction Orders in a medium secure hospital. D had been in receipt of mental health services from the South London and Maudsley NHS Trust (SlaM) having been referred to these services by his GP.

An independent mental health inquiry was formally set up in February 2003, by Lambeth Primary Care Trust, as required by National Health Service Guidance, HSG (94) 27.

The purpose of an inquiry is to thoroughly review the patient's care and treatment in order to establish the lessons to be learnt; to minimise the possibility of a recurrence of similar events, and to make recommendations for the delivery of mental health services in the future incorporating what can be learnt from a thorough analysis of an individual case.

CHRONOLOGY

Early Years - 1977 -1990

D's parents married in 1977. He was born in Carshalton, Surrey on 5th December 1977, an only child with a Russian mother and mixed Jewish and Burmese parentage father. Father is known to have had a history of bipolar affective disorder.

D's parents separated when he was six months old. Mother had custody of D and moved to Brixton where she lived with D and her mother.

Adolescence - 1990 - 1996

In 1992 D started to experiment with illicit drugs. It was reported that D took money from his savings to play on gambling machines and presumably to pay for the cost of drug use.

In December 1995, he was referred privately to a consultant physician about various symptoms D reported. No physical signs were identified to account for them.

Whilst living in Paris - 1997 – February 1999

D went to Paris to undertake a French studies course in 1997. In 1998 D converted to Islam, shaving his head, and growing a beard. He became very strict in his adherence to his understanding of the religion's requirements. It was at this time that he disengaged from his course. Whilst in Paris it seems that D made at least two suicide attempts.

March - May 1999

On 4th March D's mother went to her GP, Dr C, to register concerns about his behaviour since his return from France on vacation. He had been very abusive to his mother and her female colleagues.

She was concerned about his zealous frame of mind, he had become a vegan, and was aggressively opposed to smoking and drinking. He described himself to her as "the Antichrist".

On the morning of the 11th March his mother asked D to go to see the GP, at the time he was cutting string from camping equipment – seemingly in preparation for his intention to camp in central London. As described by his mother "he looked terrible, his eyes were blank and cold, he said 'Mummy, now we play" tied her hands together and started to lead her upstairs in the house. Mother managed to push the panic alarm as she passed it and at that "D snapped out of his blankness and looked confused". Mother ran from the house, freed her hands and went straight to the GP who arranged a joint visit shortly afterwards with the Rapid Assessment Team. The GP (Dr C) recorded in his notes the possibility of "schizophrenia and mood disturbance, some distorted thinking but no major symptoms". He also noted the calmness of D in the afternoon and the dissonance of that with the actions of the morning towards his mother.

This assessment led to D's eventual informal admission to Lloyd Still Ward, St Thomas' Hospital after some difficulty in finding a bed for him. Notes from the assessment suggest that he was flat, sometimes inappropriate in his responses, and malleable. Included in the immediate plan set out by the duty psychiatric SHO, was the potential use of Section 5(2) of the Mental Health Act to prevent him leaving hospital. It was reported by the family that they were not asked to provide information relating to D and the family history.

No regular medication was prescribed during this time. The references in his multidisciplinary working notes describe him at different times as varying in his mood and presentation: being "perplexed and bizarre" in his thoughts. Other entries suggest he was quiet and calm in his moods and behaviour. On the 19th March an entry states that he "expresses ideas of reference", "still thinks that accidents are connected to him when he hears the sirens in the street. Mood is changeable at times, appears elated".

D went on weekend leave just over a fortnight after admission to attend a family gathering, While on home leave, D wrote his mother a note and he left the family home on the Saturday night/Sunday morning. Mother reported D's action to the ward on Sunday 28th March and asked the ward psychiatrist whether she should contact the police but was advised this was not necessary.

D was formally discharged in his absence on Tuesday 30th March.

Remainder of 1999 and until July 2000

Throughout this time D had been living with his mother and was in daily contact with his grandmother. However, D did not keep up with his studies, he appears to have had some fleeting relationships and indulged in some illicit drug usage.

During 2000 it seems that his relationship with his mother became more strained, he appears to have become more self absorbed, preoccupied and, as reported later by his mother, "to talk aggressively to himself, he would slap his face and say 'stop it, stop it, stop it', then tell me. 'it's not me talking, it's him talking'". His self care deteriorated, "his body would twitch, his face would grimace". His mother did not seek help or support for D or herself during this period.

July 2000

On the 4th July D attempted to shoot himself in his bedroom with a shotgun that belonged to his mother. He missed and damaged the ceiling in his room. No professionals were informed of this incident at the time or subsequently.

On the 6th July D went to see his GP. He was seen by a partner, Dr G who referred him by letter directly to Dr D, the sector team consultant psychiatrist, who had been responsible for his care during his admission in 1999. The letter was sent to Dr D's university office base. It would seem that this letter was not picked up for attention by his team while he was on leave at the time.

His mother reports that she followed up the referral with the GP surgery on the 12th July as there had been no response, following D's contact on the 6th July.

Because of her increasing concern about D, his mother visited Dr C on the morning of 17th July. Dr C spoke with Dr D that same day, initially in regard to another patient, and faxed an urgent referral together with Dr G's initial referral letter of 7th July to the Rapid Assessment Team (RAT) for D to be assessed.

Acting on this information, the RAT arranged to see D that same afternoon. D attended the centre with his mother where they were seen together by the RAT psychiatrist (Dr W) on duty that day and Community Psychiatric Nurse K. During this assessment D was seen with his mother present throughout.

The recorded Treatment Options discussed with D and his mother were; the possibility of informal hospital admission which D declined; "some form of talking therapy or counselling"; a future appointment with the sector team at St Thomas' and prescription of an antidepressant, Fluoxetine 20mg, brand name Prozac. The assessment outcome and subsequent treatment proposed was based on a view that D was depressed with suicidal ideation.

On the 24th July D watched the film Gladiator at the cinema. It emerged subsequently that D felt that this film spoke directly to him and told him that "I needed to fight, materialise my demon in this world by killing someone I loved".

Early the following morning he went into his mother's room looking for cigarettes. He went downstairs, but returned shortly after when he lay on his mother's bed, then he started to stroke her and wanted to massage her neck, at which time he put some pressure on her larynx. His mother felt uneasy, got up, dressed and left the house taking the dog to the park. Later she and D's grandmother returned to the house. D's mother reports that D was hostile towards her during the rest of the day; but he was warm and loving towards his grandmother.

As described by his mother "I knew that I couldn't stay, D was fidgeting all the time, standing up, walking around, sitting down, shaking his hands, slapping his face. I felt that D was going to hurt me, so I decided to leave the house for the night and stay at my mother's flat".

Late at night on the 25th/early hours of 26th July D spread flammable liquids around his grandmother's bed and outside her bedroom door. He then set fire to these as she slept in the bed; she tried to get away from the flames, but they struggled in the doorway and on the stairs where D stabbed her repeatedly. A neighbour banged on the front door alerted by the smoke coming from the bedroom upstairs. D responded briefly, then ran from the house, later presenting himself to Kennington police station.

FINDINGS AND RECOMMENDATIONS

March 1999 - Findings

The panel found that the response time in March 1999 was good when he was seen on the day of the referral.

The panel consider that the admission to hospital following the assessment in March 1999 was the right course of action. The panel acknowledge the pressure that Trust inpatient staff were facing in trying to maintain a good quality service when under such pressure as a 140-160% bed occupancy. This may well account for the fact that there is little evidence of any purposeful activity to investigate or understand this young man's mental health problems. This was reflected in the manner of his discharge and can be illustrated by:-

- No evidence that the ward staff took account of the history of D's maternal grandmother or father
- D's father apparently being rebuffed on a unduly narrow and restricted understanding of confidentiality issues
- Staff not being mindful of the contribution that D's carers had to make. D's father would have been able to provide information, ensuring that a much fuller history of his mental state was available
- No evidence that the Care Programme Approach (CPA) process was initiated while D was on the ward, and it would appear that this was a paper exercise after he failed to return from weekend leave
- No evidence that, when the ward staff were informed by mother that D had disappeared, attempts were made to establish where

he was or the risk that he might have presented to himself or others
- The lack of detailed assessment work being completed during this inpatient stay, the only option open on discharge was for D to be placed on Level One CPA and a subsequent outpatient appointment being offered
- The final diagnosis submitted to D's GP of 'unclear' was unhelpful, unsatisfactory and gave no guidance to D's GP about his future care and treatment

That D was placed on the CPA at Level One and followed up by the outpatient appointment only, may reflect the reality of how inner city services cope with the pressures on their services and how they respond to people who present with early symptoms of psychosis. The CPA categorisation is not questioned by the panel on the information amassed by the clinical team at the time. However the absence of any recorded preparation and planning prior to D's self discharge was inadequate.

It is unreasonable to expect inpatient units to work under such a sustained bombardment of pressure as experienced at that time. We know this is a matter of resources and is not entirely controllable by SLaM or PCT management, however this reinforces the need for strong clinical leadership and management systems in order to make clinical interventions and treatment purposeful.

Recommendation 1

The panel recommends that when admissions and discharges are arranged:

- *the purpose of the admission is clarified through assessment and planned engagement in the hospital setting for the clinical team*
- *the patient is informed of the purpose of their admission*
- *the contribution of carers is recognised and encouraged*
- *a carer's legitimate interest in their family member is recognised and also that their support needs are considered*
- *preparation for CPA on discharge, is commenced on admission*
- *clear guidance to GPs is incorporated in discharge information*
- *a proactive approach is taken for patients who fail to return from hospital leave*

July 2000, Assessment and clinical performance - Findings

Although the non urgent referral went astray, when it was eventually brought to Dr D's attention on his return from leave by the GP, the right action was taken promptly and D and his mother were seen the same day. The assessment was multi disciplinary and the doctor and nurse had read the referral letter from Dr G and the second referral fax from Dr C before the assessment was undertaken.

This assessment did not appear to take full account of the known history, the mental state assessment was not comprehensive and the conclusion reached did not appear to correlate with the presenting symptoms. The medication prescribed for a depressive condition in line with the assessment was unlikely, in the panel's view, to have had the desired effect.

No attempt was made to interview D on his own or his mother separately. The panel was surprised to hear that it was standard practice at that time not to interview service users and their carers separately.

The panel has concerns regarding the quality of the assessment and the subsequent outcome management plan in terms of medication management and follow up. It is difficult to see that the recommendation for "talking therapy", for which there was a waiting time following referral, of many months, was realistic in this circumstance.

The panel has considered whether the offence was predictable or preventable. We do not think that the homicide could have been predicted.

We have considered whether the offence was preventable, and if it would have happened if D's assessment and management plan had been based on a diagnosis of a possible schizophrenic or psychotic condition, rather than a depressive illness.

The assessment team were not in possession of the information about D's attempt to shoot himself with a shotgun earlier in July. This is information that might well have raised the awareness of all the professionals involved to the level of risk that D posed to himself and potentially to others. It is possible that such information would have influenced both the assessment outcome and the management plan to contain the level of risk.

Had an assessment of possible schizophrenia or psychosis been made, it seems likely that the management plan might well have been

different, for example hospitalisation or intensive community follow-up, or the use of anti psychotic medication.

We are not suggesting that the homicide was preventable. We are however of the view that a different assessment and management plan might have reduced the risk of violent behaviour by D to himself or others.

Recommendation 2

The panel recommends that so far as it is possible, those engaged in an assessment: -

- *obtain and take into account full background information about the person's previous psychiatric history and social circumstances*
- *the assessment process must enable the individual concerned, members of their family and, as appropriate, informal carers the opportunity to be seen separately as standard practice*

Recommendation 3

On the evidence of the information available to the panel in this case we recommend: -

- *that SLaM review Dr W's clinical performance to ensure its quality in regard to assessment, diagnosis and treatment planning*
- *that Ms K's clinical performance is reviewed to ensure its quality in regard to assessment and treatment planning*

Service configuration and operational practice - Findings

In the view of the panel, in 1999 and in 2000, staff were expected to take on too many roles and responsibilities. This caused uncertainty in lines of accountability for staff and may not have been clearly understood by service users and referring agencies.

In cases where a GP directs a referral letter to a named consultant, there did not appear to be a reliable process for secretarial staff to check mail trays; or pigeon holes; bringing appropriate referral letters to the attention of either the SHO or specialist psychiatric registrar in the absence of the consultant.

Clinical and managerial supervision for non-medical staff in both the A&T and Case Management and Outreach Team were provided on a regular basis by various members of the teams they worked in. Supervision for doctors was provided by the sector senior clinician. It appears that agency nurses were not included as part of the appraisal system even though some staff were long term and worked within the team permanently.

The panel was concerned that record keeping in the RAT and the follow through of management plans seemed ad hoc. The need for formal record keeping and the processes of collating previous records and information is fundamental to the function of all teams, particularly to a disparate team such as RAT was at that time. The Friday review of the week's work meeting does not appear to have had a clear remit to further review, consider and agree treatment options and follow through plans.

This was compounded by the absence of any designated management function in the team and a degree of ambivalence on the role of the consultant psychiatrist in supervision of clinicians rostered onto the team.

Supervision arrangements for doctors in the RAT were incomplete because those with responsibility for clinical supervision were external to that team and therefore not fully apprised of their work and clients being considered. This meant that individuals' medical practice was insufficiently overseen and this aspect of their work not clearly appraised.

At the time of the assessment of D, neither the doctor nor nurse saw D or his mother separately nor was it recognised as the normal process. The panel considered this poor practice as was also the lack of a documented report of the assessment undertaken.

The panel could not determine that the Friday work review meeting was documented and recorded regarding decisions relating to service users, or how these were arrived at. Our view is that this was an inadequate arrangement that created an unstructured review process.

The panel was aware that the Internal Inquiry report stated that there was a delay in the Trust being informed of the incident. It is understood that this has been rectified.

Recommendations 4

The panel recommends that systems and procedures are clearly laid out, accessible and understood by both clinicians, and those who will refer into the teams and work in partnership with them: -

- *that SlaM satisfies itself that the functions and contributions of the different clinical teams (different now to at the time of these incidents) is understood by the referral agencies*
- *that secure arrangements are in place to deal with referrals that may be addressed to individuals/teams not directly responsible are identified and redirected without delay*
- *that in circumstances where clinical staff, of all disciplines, are working in more than one setting their clinical supervision and accountability arrangements are clear and effective*
- *that when there is a long term agency staff member in post, a system must be developed for the clinical service lead managers to satisfy themselves as to the person's competency, and to ensure that these staff are included and encouraged to participate in professional development*
- *that all teams ensure that they have systems in place requiring written notes of any formal team assessments of individual service users with recorded outcomes and purposeful management plans*
- *the impact of excessively high bed occupancy rates on patients and their care, should be understood and included in future service planning and that when occupancy rates reach an agreed threshold over 100% there are processes put in place to deal with this*
- *that staff undertaking assessments, where both the service user and carer are present, provide the opportunity for a separate meeting to take place with each party*
- *that notes are made of all multi disciplinary review meetings which record the discussions and decisions made*
- *That SlaM compiles a checklist of all documents that should be secured following a Serious Untoward Incident. The panel suggests a sample checklist of: -*

    - *Inpatient case notes*
    - *Community case notes to include medical records*
    - *Medical reports for coroner/court*
    - *Relevant policies and procedures current at the time of the incident*
    - *Coroner's report and judgement made at the time*
    - *Staff statements made for the Trust and Police*
    - *Incident forms*
    - *Relevant diary, handover pages and notes of any discussions relating to the patient.*

The inquiry panel would wish to see a proactive programme of actions in relation to these recommendations. The value of an independent inquiry is in identifying key issues with achievable recommendations that will promote improved practice.

1. GENERAL INTRODUCTION

During the night of 25th July 2000 D killed his grandmother. He later pleaded guilty to manslaughter on the grounds of diminished responsibility, and the court ordered that he be detained under what is known as Treatment and Restriction Orders in a medium secure hospital, under Sections 37/41 of the Mental Health Act 1983. D had been in receipt of mental health services from the South London and Maudsley NHS Trust, having been referred to these services by his GP.

An internal review was undertaken by members of the South London and Maudsley NHS Trust (SlaM) in October 2000. This examined the care and treatment of D and made recommendations for action by the mental health services provided by the NHS Trust.

An independent mental health inquiry was formally set up in February 2003, by Lambeth Primary Care Trust, as required by National Health Service Guidance, HSG (94) 27. "Guidance on the discharge of mentally disordered people and their continuing care in the community". This requires an inquiry, independent of the service providers, to be undertaken when a person in receipt of mental health services commits a homicide.

We have been inquiring into events that happened some years ago now, particularly the hospital in-patient episode in March 1999 and the circumstances around the offence in July 2000. Since then changes have been made in the organisation of services in Lambeth.

2. PURPOSE OF INQUIRY

The purpose of an inquiry is to thoroughly review the patient's care and treatment in order to establish the lessons to be learnt; to minimise the possibility of a recurrence of similar events, and to make recommendations for the delivery of mental health services in the future incorporating what can be learnt from a thorough analysis of an individual case.

The process is intended to be a positive one, serving both the individuals involved, and general public needs. It is important that those who have been bereaved are fully informed of the individual

circumstances and are assured that the case has been fully investigated by an impartial and independent inquiry panel.

The Terms of Reference for the inquiry are set out below:

3. TERMS OF REFERENCE

General remit	Beginning with the internal report to examine the relevant circumstances surrounding the treatment and care of D by the mental health and from the criminal justice and social services. To consider other matters as the public interest may require, which might arise during the course of the inquiry.
Treatment and care	The appropriateness of D's treatment, care and supervision in respect of: • his actual and assessed health and social and support needs; • his actual and assessed risk of potential harm to himself and others; • his history of prescribed medication and compliance with it; • his previous psychiatric history and treatment, • his previous forensic history, • the documentation recorded relating to the above.
Compliance	The extent to which D's care corresponded to statutory obligations, particularly the Mental Health Act 1983 and relevant other guidance from the Home Office and Department of Health (Care Programme Approach (HC (9()) 23/LASSL (90) 11) Supervision Registers (HSG (94)5); Discharge Guidance (HSG (94) 27; and local operational policies.
Care plans	The extent to which care plans were effectively drawn up with D, and how these plans were delivered and complied with.
Joint working	To examine the process and style of the collaboration within and between all of the agencies, involved in the care of D and the provision of services to him and his family.
Risk Management	To examine any issues of in-service training that arise in relation to those caring or providing services to D and to consider the adequacy of the risk management and training of all staff involved in D's care and supervision.
Report	To prepare a report and to make recommendations to the Lambeth Primary Care Trust and other relevant agencies.

4. PANEL MEMBERSHIP

This inquiry has been undertaken by the following panel of professionals who were independent of the local mental health services provided by the South London and Maudsley NHS Trust.

Panel Chair	
Nick Georgiou	Formerly Director of Social Services, and with experience as an NHS manager of an inner London mental health service
Panel Members	
Jose Wood	Deputy Director of Nursing, Central and North West London Mental Health NHS Trust. Former CMHT Manager and Senior Practitioner
Dr Ken Craig	Consultant Psychiatrist with previous experience of working in London and now Lead Clinician working in Norfolk Mental Health Care NHS Trust.
Inquiry Manager	
Lynda Winchcombe	Director of a Management Consultancy company which specialises in Serious Untoward Incident reviews.

5. METHODOLOGY

5.1 How the inquiry was undertaken

The inquiry was commissioned by Lambeth Primary Care Trust and was undertaken according to the Terms of Reference on page 13.

Pre-meetings were held with family members and friends, D and the professionals involved in his current care.

Written documentation required was identified by the inquiry. Once these were received each document was indexed and paginated. A chronology of the events was compiled.

Evidence was received from twenty-six witnesses over a period of six days during June and July 2003. Each interview was recorded and the individuals given the opportunity to correct the transcript for accuracy and to add any other information that might be of relevance.

This report has been drafted to include a brief history of D, detailed consideration of key periods in his care and treatment, and the panel's findings and recommendations.

5.2. Documents seen

The following is a list of the documentation that were obtained for the panel to review.

1. South London and Maudsley NHS Trust Internal Review
2. Luke Warm Luke Summary Report – November 1998
3. Daniel Joseph Report- September 2000
4. Wayne Hutchinson Report – November 2001
5. Health Authority/Primary Care Trust documents correspondence
6. Community Mental Health Team notes
7. Information pack – South London and Maudsley NHS Trust
8. Secure Hospital Notes
9. Lambeth Social Services notes
10. Computerised print out of GP notes – Lambeth Walk Group Practice
11. South London and Maudsley NHS Trust – Management Structure
12. Lambeth Borough Structure (2000)
13. South London and Maudsley NHS Trust Action Plan following Board Level Inquiry
14. South London and Maudsley NHS Trust – statement of Strategic Direction
15. GP notes
16. Medium Secure Unit notes – 6 volumes
17. Police Investigation
18. South London and Maudsley NHS Trust General Information
    - Strategy
    - Trust Board

- Locality covered
- Annual Report 01/02

Clinical Services Directory

19. Solicitors documentation
20. Case Management Team Policy
21. Lambeth Acute Bed Occupancy
22. Care Programme Approach Policy Pack
23. Supervision/Appraisal for staff grade doctors
23. Pages from Handover book
24. CPA Documentation
25. Statement from Dr C

6. PROFILE OF SERVICES

6.1 Service profile in 1999 and summer of 2000

In April 1999, the South London and Maudsley NHS Trust (SLaM) was formed, delivering mental health services to the boroughs of Lambeth, Southwark, Lewisham and Croydon. Specialist services were also provided to these boroughs as a whole. The Trust employs 4,400 staff with an annual budget in excess of two hundred and twenty million pounds.

SLaM is described, in their Annual Review Report 1999/2000, as having its own values and vision, working from the same policies and procedures but as having different relationships with different partners from the individual boroughs.

In respect of the Borough of Lambeth; this was divided into five sector services, North, North-east, North-west, South-west and South-east, providing five entry points into Lambeth mental health services. The north sector had access to inpatient facilities at St Thomas' Hospital. The south sector used inpatient facilities provided on wards at Lambeth Hospital.

In each of these sectors there were the following teams: -

- Case Management and Outreach
- Assessment and Treatment

A Crisis/Rapid Assessment Team provided a service to the sector services. The services provided by these teams were health led and not integrated at this time with the Local Authority Social Services Department.

The Assessment & Treatment Team (A&T) was described to the panel as "essentially a gateway into mental health services…for people who were not urgent'. It provided a service to the North and Northwest Sectors of Lambeth operating Monday to Friday 9-00am to 5-00pm. Multi professional in membership they offered assessment and time limited focussed interventions either by the team or referring onto other statutory or non-statutory services. The manager at this time, Ms N, described screening referrals as to their appropriateness and urgency, those requiring urgent assessment were forwarded to the Rapid Assessment Team, (RAT). The Consultant Psychiatrist for the team was Dr D.

Approximately fifty referrals, including re-referrals were received each month. Team members were reported to have been 'very stretched' around the time in question. In April 2000 the North team moved to St Thomas' with some increase in staffing levels which whilst welcomed did little to reduce the overall work load. Team members continued to be rostered into the RAT.

The Case Management and Outreach Teams provided care and treatment to people who experienced severe and enduring mental health needs. The team offered intensive support to people who might otherwise have been lost to follow up. This was a Monday to Saturday service with provision for an out of hours, seven day a week telephone help-line for service users and carers. The North Sector Team was managed by Mr A, the Consultant Psychiatrists were Dr D and Dr R. Caseloads were in the region of seventeen to twenty service users to each case manager. The team was reported to have been 'busy but not overwhelmed', 'stable'. Three of the twelve case managers were long term agency staff in July 2000.

The consultants responsible for these two teams in North Lambeth, but not the Rapid Assessment Team, also had beds on Lloyd Still, the acute admission ward, St Thomas' Hospital. At the time of D's stay on Lloyd Still Ward the panel was told that occupancy rates were in the order of 140-160%.

In 2000 there was the emergence of the Lambeth Early Intervention Service. This was a research project in the early stages of development and provided inpatient care to those service users with signs of early psychosis who met the research criteria for random selection.

The Lambeth Early Onset Team, (LEO), was also established in 2000.

The Rapid Assessment Team (RAT) had membership drawn from the other teams on a rostered basis. It provided a service to the North and Northwest Sectors of the London Borough of Lambeth. The need for this team grew from the high referral rate being experienced by the Assessment and Treatment Team and the increasing time before they were able to offer appointments, at times reported to be in the region of six to nine weeks. It accepted direct referrals from GPs, Assessment and Treatment Team and when necessary the Case Management and Outreach Team.

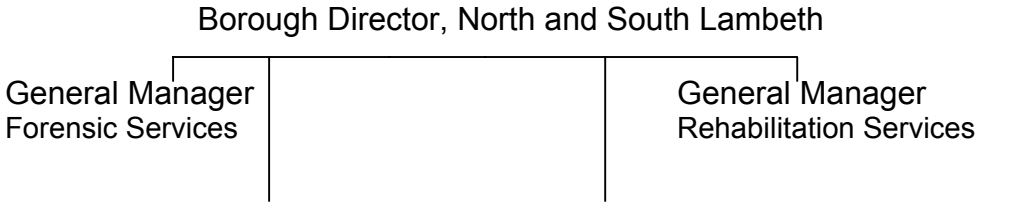
The RAT's function was to respond to urgent referrals within 48 hours, providing a service Monday to Friday 9.00am to 4.00pm. Service users requiring immediate follow-up could be seen by RAT for a maximum two weeks. Reports of referrals in the region of two a day were described to the panel with assessments taking place mainly at the Community Mental Health Centre or at the client's home.

As described to the panel this team was facilitated by Mr A in his coordination role which include the organisation of the staff rota for clinical input from other teams. He did not hold responsibility for managing the team. The doctors and nurses who worked in the team on a sessional basis continued to receive their clinical and professional supervision, in the main, from outside the RAT. The supervising Consultant Psychiatrist for the work of the RAT was Dr P.

The hand over of cases and discussions of concerns regarding individual referrals for each day occurred through twice daily meetings, facilitated by the team coordinator. There was no formal recording process of this meeting, although there was a referrals record book. There was a regular Friday team meeting attended by the Consultant Psychiatrist and the duty staff of the day, at which services users seen that week were discussed, no consistent information was available to the panel as to how this meeting was recorded. Other staff within the team could also attend or leave a written report regarding people they had seen during their duty session in the RAT.

6.2 Service profile now.

Since the offence in July 2000 there have been major changes to the organisation of services in Lambeth. The introduction of these changes is not related to the subject of this inquiry and was being planned during the year 2000 prior to their introduction. Services to North and South Lambeth in July 2003, as described to this panel, are configured as set out below:-



General Manager covers:
3 North sector teams comprising

- Home Treatment *
- 3 inpatient wards
- 3 community teams
- Preventative team
- Liaison psychiatry
- Psychology
- Volunteers

General Manager covers:
2 South Sector teams comprising

- 3 inpatient wards
- 3 community teams
- Intensive care unit
- Early onset service
- Women's services
- Amardeep
- Therapies
- Volunteers

*north and north east sectors only

Each of the five sectors consists of an in-patient unit, Assessment and Treatment Team, Case Management Team and Rapid Assessment Team managed by clinical co-ordinators who span both community and in-patients.

7. CHRONOLOGY

7.1 Early Years - 1977 -1990

D's parents married in 1977. He was born in Carshalton, Surrey on 5th December 1977, an only child with a Russian mother and mixed Jewish and Burmese parentage father. Father is known to have had a history of bipolar affective disorder.

D's parents separated when he was six months old. Mother had custody of D and moved to Brixton where she lived with D, her mother, and the family dogs.

In January 1980 D was referred to the Sir Wilfred Sheldon Paediatric Assessment Centre, as his mother was concerned about delayed development and behavioural problems. He was seen on three or four occasions during the year, when the involved clinician stated that "mother has little time for him in fact or psychologically". On review in December 1980 improvement "with motor, personal, social and non-verbal skills (to) at least age appropriate" was noted.

In 1981 when he was 4 years old, D started at Hill House, an independent boys preparatory school. In 1984, when he was 7 years old, D transferred to the Lycee de France, where he remained until he left school aged 19 years old, in 1997.

In 1994, D and his mother moved to Walcott Square, Lambeth. D's grandmother moved to sheltered accommodation nearby although she remained in more or less daily contact, excepting the time when D was in France.

D experienced various accidents in his childhood, for example, in a swimming pool; being hit by a car; laceration to his leg, but on none of these occasions did he experience significant harm. His medical record shows various minor ailments and treatments, including in 1990 a referral and treatment for pain associated with Osgood Schlatters disease. D appears to have reacted strongly to his mother having relationships with men, and is reported to have been a sensitive child.

7.2 Adolescence - 1990 - 1996

In 1992 D started to experiment with illicit drugs: cannabis, cocaine, LSD, heroin, amphetamines and ecstasy. It was reported that D took money from his savings to play on gambling machines and presumably to pay for the cost of drug use. In 1992 D met his girlfriend who also attended the Lycee de France.

In December 1995, he was re-referred privately to a consultant physician about various symptoms D reported. No physical signs were identified to account for them. At that time it was stated that "He is an introspective person, who is polysymptomatic and I am the third doctor he has seen this year regarding anxiety about his health".

After leaving school he had a number of short-lived student jobs, eg in Boots Chemist, Catering, but did not hold any of them for any length of time.

7.3 Whilst living in Paris - 1997 – February 1999

D went to Paris to undertake a French studies course in 1997, his girlfriend from the Lycee was also a student in Paris. In 1998 D converted to Islam, shaving his head, and growing a beard. He became very strict in his adherence to his understanding of the religion's requirements. At this time he disengaged from his course and became aggressive towards his girlfriend. They stopped being together with the relationship finally breaking up in 1999.

While in Paris it seems that D made at least two suicide attempts, lacerating both wrists, and swallowing rat poison. On no occasion did he seek medical assistance as a consequence of these suicide attempts. During this period he did however meet with a private counsellor he made contact with through a newspaper advertisement, this arrangement appears to have lasted for two months or so. It appears that he was prescribed Valproate shortly before leaving France.

7.4 March - May 1999

On 4th March D's mother went to her GP (Dr C) to register concerns about his behaviour since D's return from France on vacation. He had not returned as expected on 2nd March but appears to have avoided his mother when she went to meet him off the Eurostar at Waterloo and subsequently, when she returned home, found D "behaving in a bizarre fashion". He had been very abusive to his mother and her female

colleagues when he visited her at her college where she was, at that time, a postgraduate student.

Following this D's mother had suggested that D see the GP. She was concerned about his zealous frame of mind, he had become a vegan and was aggressively opposed to smoking and drinking. He described himself to her as "the Antichrist".

On the morning of the 11th March his mother again asked D to go to see the GP, at the time he was cutting string from camping equipment – seemingly in preparation for his intention to camp in central London. As described by his mother "he looked terrible, his eyes were blank and cold, he said "Mummy, now we play", tied her hands together and started to lead her upstairs in the house. Mother managed to push the panic alarm as she passed it and at that "D snapped out of his blankness and looked confused". Mother ran from the house, freed her hands and went straight to the GP who arranged a joint visit shortly afterwards with the Rapid Assessment Team. Dr C recorded in his notes the possibility of "schizophrenia and mood disturbance, some distorted thinking but no major symptoms". He also noted the calmness of D in the afternoon and the dissonance of that with the actions of the morning towards his mother.

This assessment led to D's eventual informal admission to Lloyd Still Ward, St Thomas' Hospital after some difficulty in finding a bed for him. Notes from the assessment suggest that he was flat, sometimes inappropriate in his responses, and malleable. It is suggested in the multi-disciplinary working notes at his admission that "emerging schizophrenia likely as vague, perplexed, inappropriate affect, bizarre behaviour and speech". Included in the immediate plan set out by the duty psychiatric Senior House Officer (SHO), was the potential use of Section 5(2) of the Mental Health Act to prevent him leaving hospital.

The duty psychiatric SHO, who carried out the Core Assessment on admission recorded in her Brief Summary section, possible diagnostic options of schizophrenia, bipolar affective disorder or drug induced psychosis.

On Lloyd Still Ward, D was under the care of Dr D, the consultant psychiatrist responsible for the Assessment and Treatment Team and the Community Team for the north of the borough. Dr D had responsibility for half of the beds on the ward. D was an unremarkable ward patient making little impression with any of those involved in his care.

No regular medication was prescribed during this time. The references in his multidisciplinary working notes describe him at different times as varying in his mood and presentation: being "perplexed and bizarre" in his thoughts, other entries suggest he was quiet and calm in his moods and behaviour. An entry on the 19th March says that he "expresses

ideas of reference", "still thinks that accidents are connected to him when he hears the sirens in the street. Mood is changeable at times, appears elated". There is no record of any in-depth discussions with any of D's extended family nor that his maternal grandmother was reported to have ''a history of paranoid psychosis''

While on Lloyd Still Ward, which was operating at an occupancy rate in the order of 140 to 160% during this period, it would appear that the member of staff who worked most closely with D was the SHO at the time, Dr R.

D went on weekend leave just over a fortnight after admission to attend a family gathering, he had been admitted on the 11th March with week-end leave effective from 26th March. While on home leave he wrote his mother a note and left the family home on the Saturday night/Sunday morning. Mother reported D's action to the ward on Sunday 28th March and asked Dr R whether she should contact the police but was advised this was not necessary.

D was formally discharged in his absence on Tuesday 30th March. He was not considered suitable for Care Programme Approach registration at Level 2 as he had not been subject to the Mental Health Act and he was not assessed as having a major mental illness at that time.

Dr R wrote in his Discharge Summary to the GP, dated 6th April 2003, the final diagnosis recorded was "unclear", there was also reference to D having "some obsessional ruminations", no medication was prescribed. An outpatient appointment was made for 15th April when he was seen by Dr R who considered him well and advised D to contact a psychiatrist in France if he needed to and also gave him his bleep number and contact details. At D's request in early May, Dr D wrote to the Head of Department of the Institute in Paris where D had returned to study, that D had been reviewed at the Scutari outpatient clinic and was considered to be "doing extremely well".

D returned to Paris briefly at this time, gave up his flat and returned to London.

7.5 Remainder of 1999 and until July 2000

D went to Russia with his grandmother for the summer. In November he wrote to St Thomas' Hospital asking for confirmation of previous treatment and support in his wish to transfer his studies from Paris to Goldsmith's London. Dr D responded positively to this request.

Throughout this time D had been living with his mother and was in daily contact with his grandmother. During this time D did not keep up with his studies; he appears to have had some fleeting relationships during this time; and indulged in some illicit drug usage.

During 2000 it seems that his relationship with mother became more strained, he appears to have become more self absorbed, preoccupied and, as reported later by his mother, "to talk aggressively to himself, he would slap his face and say 'stop it, stop it, stop it' then tell me 'It's not me talking, it's him talking'". His self care deteriorated, "his body would twitch, his face would grimace". His mother did not seek help or support for D or for herself during this period.

7.6 July 2000

For the purposes of clarity we have set this section out in numerical order.

7.6.1. On the 4th July D attempted to shoot himself in his bedroom with a shotgun that belonged to his mother. He missed and damaged the ceiling in his room. This incident was known about by his mother, but not reported to the professionals at the time, or during the assessment later in July.

7.6.2. On the 6th July D went to see his GP. He was seen by a partner Dr G who referred him by letter directly to Dr D at his university base. As well as his clinical responsibilities, Dr D also works in the university department where he has his office base. It would seem that this letter was not picked up for attention by Dr D's team as he was on leave at the time. Dr D only learned of the re-referral of D when he was contacted by Dr C on 17th July about another patient and D was mentioned in the phone conversation.

7.6.3. His mother reports that she followed up the referral with the GP surgery on the 12th July after there was no action following D's contact on the 6th July. She told the panel that she had left a phone message for Dr G. There is no record in the GP's notes of contact by mother.

7.6.4. Because of her increasing concern about D, mother visited Dr C on the morning of 17th July. Dr C spoke with Dr D that same day, initially in regard to another patient, and faxed an urgent referral together with Dr G's letter of 7th July to the Rapid Assessment Team for D to be assessed.

7.6.5. Acting on this information, the Rapid Assessment Team (RAT) arranged to see D that same afternoon. D attended the centre with his mother where they were seen together by Dr W and Community Psychiatric Nurse K (CPN). Prior to the assessment interview Dr W and CPN K obtained the following information:

a) The GP's letter of 7th July 2000 which referred to symptoms suggestive of a schizoaffective psychosis 1 year earlier. The GP stated that D had seen her "with symptoms of having unusual thoughts. He would not clarify these although he said that he was viewing people in a funny way and realised that this was unusual and not normal. He also said that he was interpreting things from the television in a different way and again believed that this was not normal" The Internal Inquiry records show that she reported that "the TV was trying to send him messages and as a result he had stopped watching it".

b) In his urgent referral to RAT on 17th July 2000 Dr C, having spoken to D's mother on that day, and having also spoken to Dr D, emphasized perceived very high risk of self harm, and spoke of D's perception that "external forces trying to harm him - sees threats everywhere."

During this assessment D was seen with his mother present throughout. The outcome of this assessment was faxed to Dr C later that afternoon with a follow-up letter dated 19th July, both from Dr W. Dr W also phoned the GP surgery the following day 18th July.

The recorded Treatment Options discussed with D and his mother were the possibility of informal hospital admission which D declined; "some form of talking therapy or counselling"; a future appointment with Dr D's team at St Thomas' and prescription of an antidepressant, Fluoxetine 20mg, brand name Prozac. The assessment outcome and subsequent treatment proposed was based on a view that D was depressed with suicidal ideation.

7.6.6. On the 24th July D's mother contacted the Assessment and Treatment Team as she had heard nothing and felt that D's behaviour was deteriorating. She spoke with the Team Leader, Ms N who contacted Dr W. He faxed the information through to her. Ms N phoned the Lambeth Early Onset Team (LEO) Services on 25th July who said that he was "not suitable for joint assessment", later confirmed in writing that he did not meet their referral criteria. LEO advised referral to mainstream community services. Ms N noted on the 25th July that the "referral has been prioritised, will be allocated in due course". Dr D asked that same day by a note to Ms N that "I won't be able to see him at the Clinic for several weeks, so please allocate if possible".

On the 24th July D watched the film Gladiator at the cinema. It emerged subsequently that D felt that this film spoke directly to him and told him that, "I needed to fight, materialise my demon in this world by killing someone I loved".

Early the following morning he went into his mother's room looking for cigarettes. He went downstairs, but returned shortly after when he lay on his mother's bed, then he started to stroke her and wanted to massage her neck, at which time he put some pressure on her larynx. His mother felt uneasy, got up, dressed and left the house taking the dog to the park.

When she returned to the house later that morning she was anxious to note that the alarm system appeared to have been tampered with and that D looked blank in the way that he had when she had been tied up previously. She left the house and went to her mother's flat, later she and D's grandmother returned to the house. D's mother reports that D was hostile towards her during the rest of the day; but he was warm and loving towards his grandmother.

As described by his mother "I knew that I couldn't stay, D was fidgeting all the time, standing up, walking around, sitting down, shaking his hands, slapping his face. I felt that D was going to hurt me, so I decided to leave the house for the night and stay at my mother's flat".

7.6.6. Late at night on the 25th/early hours of 26th July, D spread flammable liquids around his grandmother's bed and outside her bedroom door. He then set fire to these as she slept in the bed; she tried to get away from the flames, but they struggled in the doorway and on the stairs where D stabbed her repeatedly. A neighbour banged on the front door alerted by the smoke coming from the bedroom upstairs. D responded briefly, then ran from the house, later presenting himself to Kennington police station.

7.7 August 2000

D was transferred to a High Security Hospital from Prison where he had been on remand.

7.8 August 2000 to October 2001

In the course of the next year or so there was extensive consideration of the most suitable treatment setting for D before it was concluded that a Medium Secure setting was determined to be suitable.

7.9 October 2001

D was convicted of manslaughter and arson with intent to endanger life, and was made subject to a Hospital Order under Section 37/41 of the Mental Health Act 1983. At this time he was transferred from a High Security to a Medium Secure Unit.

8. CONSIDERATION AND ANALYSIS OF CRITICAL POINTS IN D'S CHRONOLOGY

8.1 Assessment and going into hospital

When D's mother went to her GP, Dr C, on the 4th March 1999, to register her concerns about D, the GP evidently took her concern seriously and noted that when D returned to London he "will need assessment by us and possibly RAT team on return". It does seem that the GP had understood D's mother's concern to be that D had not arrived in Paris, but in fact her concern was that he had not turned up in London when she expected to meet him. This does not seem to have had any material effect on the progress of events.

Subsequently, a week later on the 11th March, when his mother urged D to go to see the GP, D attacked her, tying her hands. On freeing herself, she went to the GP's surgery where she saw another doctor. This doctor spoke with Dr C who arranged to meet the Rapid Assessment Team at the family home that afternoon. Initially during this assessment visit, D's mother was not at home, but in her view when she arrived, it was her involvement that prompted hospital admission to be offered to D.

Whatever the accuracy of this perception, the swift response and assessment with its outcome of admission to an acute ward was a positive piece of work with the RAT and GP working effectively together. Dr C recorded in his notes the possibility of "schizophrenia and mood disturbance, some distorted thinking but no major symptoms". He also noted the calmness of D in the afternoon and the dissonance of that with the actions of the morning towards his mother.

8.2 In hospital

There was difficulty in obtaining a bed for D, but he was eventually admitted to Lloyd Still Ward, St Thomas' Hospital. The admitting doctor was the duty psychiatric SHO whose initial core assessment summarised possible diagnostic options of schizophrenia, bipolar affective disorder or drug-induced psychosis; she also proposed using Section 5(2) of the Mental Health Act should D seek to leave hospital.

The overriding impression given by those we have interviewed as a panel, is that D did not feature significantly in their work or consciousness while he was on the ward. For example, from his primary nurse: "I have somewhat searched my memory since being

asked to come today and I can't picture him and I don't remember him", or his consultant: "he didn't particularly come to the attention of any members of staff". This may be related to the very high occupancy level, reportedly 140 -160% at the time, as well as the picture presented of D as generally quiet and undemanding.

The person who appears to have worked most closely with D at this time was Dr R who was an SHO working to Dr D, consultant psychiatrist. Dr R reports that he spent a lot of time interviewing D but that he didn't think that D had a major mental illness. There is no record of who attended ward rounds, although Dr D recalls speaking with him in one. There are several references in the nursing notes to D's bizarre thoughts and ideas of reference, right up to going on leave, but little indication of any strong engagement with any of the clinical staff. While in hospital D was not receiving medication regularly, although on some nights when he was disturbed, he received oral droperidol, a major tranquillizer/anti-psychotic medication.

There is no record of any in-depth discussions with any of D's extended family. That his maternal grand-mother was reported to have "a history of paranoid psychosis" and his father "a history of manic depression" appears not to have featured significantly in the ward team's assessment and diagnostic process.

D's mother reports little engagement with D's clinicians and his father reports that when he tried to discuss his son's condition, care and treatment, he was refused the opportunity to talk about his son on the grounds of patient confidentiality. It is not known who rebuffed his father in this way. There is always a tension to be managed in balancing a patient's confidentiality and discussion with family members or close friends involved in the person's care and support. As described by D's father, the balance was not struck on this occasion suggesting an unsubtle appreciation of the various factors to be taken into account in respect of patient confidentiality, parental concern and vulnerability, and the gathering of relevant history and information. D's father had a contribution to make to the clinical team and had some knowledge about his son's mental health problems while in France and afterwards on his return to England. This opportunity was missed and maybe contributed to the unsatisfactory diagnosis made when D was discharged.

8.3 Leaving hospital and follow-up arrangements

D spent time away from the ward, and it is the case that he was discharged in his absence after he went on weekend leave, leaving the family home during the night whilst his mother was asleep. In a note he left, he said he was going away for two weeks and then would come back. Mother did seek advice from Dr R as to whether she should contact the police, but it was decided that this was not necessary. D

was discharged 2 days later in a ward round in his absence. The Care Programme Approach[1] (CPA) screening record shows that at this time D did not meet the minimum criteria for Level Two CPA. There is no indication in the notes that a systematic assessment of need or risk was either initiated or conducted during his time on the ward. He was placed on Level One CPA, which usually required only single professional contact either in outpatients by a doctor, or by a community nurse at home.

D was offered and kept an Outpatients appointment on 15th April with Dr R, the clinician most engaged with him whilst D was in hospital. As he told Dr R he was returning to France, D was not offered further outpatient appointments. The outpatient notes show no medication was prescribed. Dr R advised D to contact a psychiatrist in France if he needed to, and also gave him his bleep number and contact details.

After D's discharge, the panel was concerned to note the vagueness of the "Final Diagnosis" in the Discharge Summary, which was simply "Unclear". Apparently Dr R and Dr D discussed a suitable description of D's condition and considered the options of "obsessional ruminations" and "ruminative disorder". It is accepted that a definitive diagnosis, when the situation for a particular patient is unclear, is not desirable. However to state "Unclear" as a diagnosis did not offer guidance on care and treatment. In the panel's view this does not adequately take account of the history and symptoms that were at least suggestive of a more significant disturbance, as was recorded by the GP and the admitting SHO.

In the event D did return briefly to France, before going to Russia for the remainder of the summer. D then went back to the family home where he continued to live with his mother, in more or less daily contact with his grandmother.

Subsequently in November 1999 he contacted Dr D asking for confirmation of his previous treatment to help him transfer to Goldsmiths University from Paris. Dr D responded promptly to this request.

8.4 July 2000

At the time of D's second presentation to mental health services the Assessment and Treatment Team (A&T) had moved to St Thomas' Hospital. Their function remained as 'gate keepers to mental health services'. The panel heard that relationships and communication links operated well between A&T, RAT and the Care Management and Outreach Team. There had been some problems in relation to faxed referrals as the A&T did not have their own fax machine, relying on one

[1] Since April 2000 the CPA requirements are described as Standard and Enhanced not by Levels

elsewhere in the hospital. However, this did not seem to be a cause for concern as faxed referrals were generally followed through by a telephone call from the referrer.

Managers for both A&T and RAT informed the Panel that there had been "a lot of work on trying to (improve) communicate with GPs and other external agencies". It was stated that information had been sent out about the different 'set ups' as well as explaining the services when making telephone calls to GPs. There was comment "that because the teams felt as if they were always changing you could not really blame GPs if they got confused." There was a feeling expressed that regardless of this work some GPs would still refer directly to individual consultants. It was reported that the GP Practice, where D was registered was a prominent source of referral and would have understood the process well. In Dr C's written response to the panel's enquiries, he endorsed that the GP practice had an understanding of the referral process. It would seem from Dr C's response to the panel that the GP practice considered its working relationships to be clearer and stronger with the hospital based mental health professionals, than with the RAT

The panel heard conflicting views from Dr W and Ms K as to whose responsibility it was to collate additional information and follow through on referrals to other services. Both felt it was the other's responsibility to complete this. Mr A, Co-ordinator of RAT,

was clear that it was the responsibility of the nurse on duty to hand over cases and to follow through new information and disposal. There was an operational policy for RAT, but in the panel's view this did not detail operational responsibilities for handing over and following through episodes of work, and was not clearly understood by the rostered staff. Whilst files were left open for either further assessment or intervention, there was no evidence of any clear process as to how this was managed or monitored, much being reliant on verbal feedback at handovers.

8.5 History taking and Mental State Examination

History taking depended largely on speaking with D and his mother together, with no attempt to see them separately. The notes from the hospital admission in March 1999 were not available to Dr W and Ms K. They did however know of the incident when D had tied up his mother from the GP's letter of 7th July 2000 and the urgent referral to RAT on 17th July 2000. In the interview, D had complained of feeling "depressed" and admitted to having suicidal thoughts, but the main problems identified were "ideas of reference from TV''- he denied having "other persecutory delusions, confused thinking, forgetfulness, ambivalence and indecisiveness". There was no disturbance of appetite or sleep, and no diurnal variation of mood. D was not asked

about a change in sexual interest. There appears to have been no objective evidence of depressed mood. Ms K informed the Panel that she "didn't feel that he came across as being depressed", that "there was no clear indication that he was depressed" and that "there was no alteration of mood".

On questioning by the Panel, Dr W said that he knew that D had experienced "influencing of his thoughts" in the past, but he thought that the "ideas of reference" were not of delusional intensity when he saw him. Although he acknowledged the absence of disturbance of sleep, appetite etc, he thought that he was depressed. He said "I may agree that he had a delusional mood". On looking back at the presenting features, he said that they did not point to a diagnosis of schizoaffective disorder.

8.6 Diagnosis and Management Plan

Dr W's diagnosis of "depressive illness" appears to have been based largely on D and his mother's claim that he was depressed, and his admission of having suicidal ideation, there being little evidence of depressive features clinically. It appears however, that D was very troubled by symptoms, which were, at the very least, suggestive of a serious mental illness. Given the history, it would not have been possible to rule out a diagnosis of schizophrenia or schizoaffective disorder. The history of assault on D's mother does not appear to have been seen as a significant factor in assessing risk to others, with more emphasis being placed on D's risk to himself. In the event, Dr W's recommended treatment was with Fluoxetine, an antidepressant which would be likely to be helpful to a patient who was clinically depressed.

In his evidence to the Inquiry, Dr W said that, on looking back, he would not recommend the use of an anti psychotic drug in this case, because the presenting feature did not point to the diagnosis of schizo-affective illness and that he would not make such a recommendation "before we can get to the diagnosis of schizophrenia". However in his amendments for accuracy to the transcript of the panel interview, he indicated that he would now make such a recommendation.

As well as recommending the use of an antidepressant, in his "treatment options", Dr W responded to D's wish to have some "talking therapy or counselling", by listing this in the letter to the GP which was copied to Dr D for the A&T Team assessment at a date to be arranged. There was no plan for interim follow-up until this had happened, although it was made clear to D and his mother that they could contact the RAT if they had concerns, as indeed mother did on the next day. The homicide occurred before there was further professional contact with D.

During the week following the assessment on the Monday, Dr P discussed the use of an antidepressant as opposed to antipsychotic treatment, but accepted Dr W's assurance that the appropriate medication had been recommended. Dr W was considered a competent experienced member of that team whose views were respected. Such questioning of assessments and treatments was described to the panel as a function of the team, and this exchange would not have been exceptional.

The panel has seen no evidence of a file note of the assessment between D and his mother and no record was kept of this meeting other than an entry in the referral book that it had happened. However the panel have seen a record of the assessment in the referral to the A&T team and a fax letter to the GP about the outcome of the assessment.

8.7 Communication

At the time of the incident the health professionals were not informed that D was in custody or that an incident had taken place for more than 24 hours. A procedure has now been put into place between the two agencies where each is informed of any incident involving a service user prior to social services acting as an appropriate adult within the police investigation process.

9. FINDINGS AND RECOMMENDATIONS

9.1 March 1999 - Findings

The panel found that the response time in March 1999 was good when he was seen on the day of the referral.

The panel consider that the admission to hospital following the assessment in March 1999 was the right course of action. The panel acknowledge the pressure that Trust inpatient staff were facing in trying to maintain a good quality service when under such pressure as a 140-160% bed occupancy. This may well account for the fact that there is little evidence of any purposeful activity to investigate or understand this young man's mental health problems. This was reflected in the manner of his discharge and can be illustrated by:-

- No evidence that the ward staff took account of the history of D's maternal grandmother or father
- D's father apparently being rebuffed on a unduly narrow and restricted understanding of confidentiality issues
- Staff not being mindful of the contribution that D's carers had to make. D's father would have been able to provide information, ensuring that a much fuller history of his mental state was available
- No evidence that the CPA process was initiated while D was on the ward, and it would appear that this was a paper exercise after he failed to return from weekend leave
- No evidence that, when the ward staff were informed by mother that D had disappeared, attempts were made to establish where he was or the risk that he might have presented to himself or others
- The lack of detailed assessment work being completed during this inpatient stay, the only option open on discharge was for D to be placed on Level One CPA and a subsequent outpatient appointment being offered
- The final diagnosis submitted to D's GP of 'unclear' was unhelpful, unsatisfactory and gave no guidance to D's GP about his future care and treatment

That D was placed on the CPA at Level One and followed up by the outpatient appointment only, may reflect the reality of how inner city services cope with the pressures on their services and how they respond to people who present with early symptoms of psychosis. The CPA categorisation is not questioned by the panel on the information amassed by the clinical team at the time. However the absence of any

recorded preparation and planning prior to D's self discharge was inadequate.

It is unreasonable to expect inpatient units to work under such a sustained bombardment of pressure as experienced at that time. We know this is a matter of resources and is not entirely controllable by SLaM or PCT management, however this reinforces the need for strong clinical leadership and management systems in order to make clinical interventions and treatment purposeful.

Recommendation 1

The panel recommends that when admissions and discharges are arranged:

- *the purpose of the admission is clarified through assessment and planned engagement in the hospital setting for the clinical team*
- *the patient is informed of the purpose of their admission*
- *the contribution of carers is recognised and encouraged*
- *a carer's legitimate interest in their family member is recognised and also that their support needs are considered*
- *preparation for CPA on discharge, is commenced on admission*
- *clear guidance to GPs is incorporated in discharge information*
- *a proactive approach is taken for patients who fail to return from hospital leave*

9.2 July 2000, Assessment and clinical performance - Finding

Although the non urgent referral went astray, when it was eventually brought to Dr D's attention on his return from leave by the GP, the right action was taken promptly and D and his mother were seen the same day. The assessment was multi disciplinary and the doctor and nurse had read the referral letter from Dr G and the second referral fax from Dr C before the assessment was undertaken.

This assessment did not appear to take full account of the known history, the mental state assessment was not comprehensive and the conclusion reached did not appear to correlate with the presenting symptoms. The medication prescribed for a depressive condition in line with the assessment was unlikely, in the panel's view, to have had the desired effect.

No attempt was made to interview D on his own or his mother separately. The panel were surprised to hear that it was standard practice at that time not to interview service users and their carers separately.

The panel has concerns regarding the quality of the assessment and the subsequent outcome management plan in terms of medication management and follow up. It is difficult to see that the recommendation for "talking therapy", for which there was a waiting time following referral, of many months, was realistic in this circumstance.

The panel has considered whether the offence was predictable or preventable. We do not think that the homicide could have been predicted.

We have considered whether the offence was preventable and if it would have happened if D's assessment and management plan had been based on a diagnosis of a possible schizophrenic or psychotic condition, rather than a depressive illness.

The assessment team were not in possession of the information about D's attempt to shoot himself with a shotgun earlier in July. This is information that might well have raised the awareness of all the professionals involved to the level of risk that D posed to himself and potentially to others. It is possible that such information would have influenced both the assessment outcome and the management plan to contain the level of risk.

Had an assessment of possible schizophrenia or psychosis been made, it seems likely that the management plan might well have been different, for example hospitalisation or intensive community follow-up, or the use of anti psychotic medication.

We are not suggesting that the homicide was preventable. We are however of the view, that a different assessment and management plan might have reduced the risk of violent behaviour by D to himself or others.

Recommendation 2

The panel recommends that so far as it is possible, those engaged in an assessment: -

- *obtain and take into account full background information about the person's previous psychiatric history and social circumstances*

- *the assessment process must enable the individual concerned, members of their family and, as appropriate, informal carers the opportunity to be seen separately as standard practice*

Recommendation 3

On the evidence of the information available to the panel in this case we recommend: -

- *that SLaM review Dr W's clinical performance to ensure its quality in regard to assessment, diagnosis and treatment planning*
- *that Ms K's clinical performance is reviewed to ensure its quality in regard to assessment and treatment planning*

9.3 Service configuration and operational practice - Findings

In the view of the panel, in 1999 and in 2000, staff were expected to take on too many roles and responsibilities. This caused uncertainty in lines of accountability for staff and may not have been clearly understood by service users and referring agencies.

In cases where a GP directs a referral letter to a named consultant, there did not appear to be a reliable process for secretarial staff to check mail trays; or pigeon holes; bringing appropriate referral letters to the attention of either the SHO or specialist psychiatric registrar in the absence of the consultant.

Clinical and managerial supervision for non-medical staff in both the A&T and Case Management and Outreach Team were provided on a regular basis by various members of the teams they worked in. Supervision for doctors was provided by the sector senior clinician. It appears that agency nurses were not included as part of the appraisal system even though some staff were long term and worked within the team permanently.

The panel was concerned that record keeping in the RAT and the follow through of management plans seemed ad hoc. The need for formal record keeping and the processes of collating previous records and information is fundamental to the function of all teams, particularly to a disparate team such as RAT was at that time. The Friday review of the week's work meeting does not appear to have had a clear remit to further review, consider and agree treatment options and follow through plans.

This was compounded by the absence of any designated management function in the team and a degree of ambivalence on the role of the consultant psychiatrist in supervision of clinicians rostered onto the team.

Supervision arrangements for doctors in the RAT were incomplete because those with responsibility for clinical supervision were external to that team and therefore not fully appraised of their work and clients being considered. This meant that individuals' medical practice was insufficiently overseen and this aspect of their work not clearly appraised.

At the time of the assessment of D, neither the doctor or nurse saw D or his mother separately nor was it recognised as the normal process. The panel considered this poor practice as was also the lack of a documented report of the assessment undertaken.

The panel could not determine that the Friday work review meeting was documented and recorded regarding decisions relating to service users, or how these were arrived at. Our view is that this was an inadequate arrangement that created an unstructured review process.

The panel was aware that the Internal Inquiry report stated that there was a delay in the Trust being informed of the incident. It is understood that this has been rectified.

Recommendation 4

The panel recommends that systems and procedures are clearly laid out, accessible and understood by both clinicians, and those who will refer into the teams and work in partnership with them: -

- *that SlaM satisfies itself that the functions and contributions of the different clinical teams (different now to at the time of these incidents) is understood by the referral agencies*
- *that secure arrangements are in place to deal with referrals that may be addressed to individuals/teams are not directly responsible are identified and redirected without delay*
- *that in circumstances where clinical staff, of all disciplines, are working in more than one setting, their clinical supervision and accountability arrangements are clear and effective*
- *that when there is a long term agency staff member in post, a system must be developed for the clinical service lead managers to satisfy themselves as to the person's competency, and to ensure that these staff are included and encouraged to participate in professional development*

- *that all teams ensure that they have systems in place requiring written notes of any formal team assessments of individual service users, with recorded outcomes and purposeful management plans*
- *the impact of excessively high bed occupancy rates on patients and their care should be understood and included in future service planning and that when occupancy rates reach an agreed threshold over 100% there are processes put in place to deal with this*
- *that staff undertaking assessments, where both the service user and carer are present, provide the opportunity for a separate meeting to take place with each party*
- *that notes are made of all multi disciplinary review meetings which record the discussions and decisions made*
- *That SlaM compiles a checklist of all documents that should be secured following a Serious Untoward Incident. The panel suggests a sample checklist of:*
  Inpatient case notes
  Community case notes to include medical records
  Medical reports for coroner/court
  Relevant policies and procedures current at the time of the incident
  Coroner's report and judgement made at the time
  Staff statements made for the Trust and Police
  Incident forms
  Relevant diary, handover pages and notes of any discussions relating to the patient.

9.4 Concluding Comment

We have seen the Action Plan produced by SlaM and referred to in the Response section overleaf. The inquiry panel would wish to see a proactive programme of actions in relation to these recommendations, and in the continuing implementation of practice recommendations from the Internal Inquiry Report. The value of an independent inquiry is in identifying key issues with achievable recommendations that will promote improved practice and service delivery. The implementation of our recommendations will reflect the commitment of the Primary Care Trust and South London and Maudsley NHS Trust to continually improve the mental health services in Lambeth.

10. INTERNAL REPORT ACTION PLAN

As part of the terms of reference the panel also reviewed the Internal Inquiry report completed by the South London and Maudsley NHS Trust who carried out their internal review in a timely way. Our comments relating to the recommendations contained in that internal review are as follows.

Summary of Recommendations and Responses taken from the Internal Action Plan

10.1 Internal Inquiry Report Recommendation 1

Review supervision structure within the Rapid Assessment Teams including the frequency of reviews.

Response by SLaM
This will be taken forward as part of the supervision and appraisal work stream arising from integration.

Inquiry panel comment
This Recommendation and Response is endorsed by the inquiry panel

10.2 Internal Inquiry Report Recommendation 2

Review policy on interviewing patients with or without their relatives/friends/carers. There is a need for clear clinical guidance to indicate when separate interviews should be conducted.

Response by SLaM
This is part of the Risk Assessment policy.

Inquiry panel comment
The panel recommends that SlaM ensure that the Risk Assessment Policy highlights the importance of obtaining all relevant information relating to the assessment of a patient, and that where this has not occurred or is not possible the reasons are recorded in the assessment documentation.

Training provided in clinical assessment should address the importance of carer involvement and individual practice staffs responsibility to carers. Training, clinical supervision and team reviews should ensure that there is an opportunity for staff to discuss issues

relating to the engagement and information gathering from carers and friends both during assessment and continuing episodes of care.

10.3 Internal Inquiry Report Recommendation 3

Consideration to be given to the use of email as a mode of communication between the Trust and primary care agencies to speed up referrals and feedback following assessments. Confidentiality issues which may arise from this method of communication to be forwarded to the IM&T Strategy – Confidentiality Group.

Response by SLaM
The Trust email is inconsistent at the moment and is not probably the most effective communication tool with primary care. For the past referrals should be faxed to ensure a timely response.

Inquiry panel comment
The inquiry panel recommend that all faxed referrals should be followed up with a telephone call to ensure that they have been received by the correct person and to verify the action taken. We agree with the Response by SlaM that email is not a suitable vehicle for referrals.

10.4 Internal Inquiry Report Recommendation 4

Post system for mail to the Adamson Centre at St Thomas' to be reviewed.

Response by SLaM
An audit of the postal system will be carried out to assess the efficacy of the internal mail.

Inquiry panel comment
This Recommendation and Response is endorsed by the inquiry panel. We further recommend that a designated person is identified with clear responsibility for checking mail during leave periods.

10.5 Internal Inquiry Report Recommendation 5

Improve information given to patients and relatives/carers/friends with regard to crisis and contingency planning in relation to how to proceed in an emergency while awaiting assessment by teams.

Response by SLaM
The letters to patients will be reviewed and improved to ensure that they provide sufficient quality information. In this process however, it

will not be possible to supply information to carers and friends due to confidentiality issues.

Inquiry panel comment
The inquiry panel recognises the potential issues relating to confidentiality raised in SlaM's response. However, in practice staff should be encouraged to distinguish between withholding information or engagement from carers and friends where that is not justified and infringes the patient's proper right to confidentiality, and those circumstances where engagement is in the best interests of the patient and any carers or friends. This is an area of day to day potential tension which requires the production of guidance to staff, continuous training, and managerial and clinical support to staff in handling these inherent tensions.

10.6 Internal Inquiry Report Recommendation 6

Address communication with carers and relatives in medical and nursing training.

Response by SLaM
This is a nursing and medical issue and should be taken forward by the directors of these professions.

Inquiry panel comment
The inquiry panel recommend that this is included as part of the assessment process and that a carers assessment is always considered.

10.7 Internal Inquiry Report Recommendation 7

The Trust should be pro-active in inviting relatives to contribute in person, in writing or by telephone to Board Level Inquiries. Every effort should be made to check that the invitation has been received and to ascertain the relatives' intentions regarding the Inquiry.

Response by SLaM
This is an issue for the organisation of Board Level Inquiries.

Inquiry panel comment
This Recommendation is endorsed by the inquiry panel. These are stressful events for relatives and the organiser of any Internal Inquiry will need to be mindful of this and facilitate involvement and understanding for relatives.

10.8 Internal Inquiry Report Recommendation 8

Training in risk assessment techniques to be mandatory for all clinicians. Team Leaders to confirm that all staff involved in Rapid Assessment Team duties have undertaken risk assessment training.

Response by SLaM
365 people were trained as part of the rollout of the new risk assessment policy. Due to the turn over of staff it is impossible to retain 100% of team members, having formal training. However, team based solutions – such as induction shadowing will be implemented.

Inquiry panel comment
This Recommendation and Response is endorsed by the inquiry panel. We further recommend that all risk assessment training is monitored and updated every three years.

Glossary

Appropriate adult	Person defined as such in attendance at a police interview conducted under the Police and Criminal Evidence Act where the subject of the interview is a minor or not considered able to act for themselves by reason of mental illness or a learning disability
Bipolar affective disorder	A disorder characterised by two or more episodes in which the patient's mood and activity levels are significantly disturbed, this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (hypomania or mania) and on others of a lowering of mood and decreased energy (depression).
Valproate	An anticonvulsant drug primarily used in epilepsy, but also used in the treatment of affective disorders.
Care Programme Approach (CPA)	Introduced in April 1991 through the Department of Health Circular (HC (90) 23/LASSL (90)11) to offer guidance on a systematic and collaborative response in the assessment, planning and review of service users' health and social care needs
Discharge Summary	Prepared by the responsible clinical team and sent to the patient's GP on their discharge from hospital indicating future treatment requirements
Droperidol	An antipsychotic drug (also known as a major tranquilliser or neuroleptic) formerly used primarily in the treatment of psychosis, but now withdrawn.

Fluoxetine	An antidepressant drug, used primarily in the treatment of depressive disorder, commonly known as Prozac.
High Secure treatment setting	A special hospital which treats people with mental health disorders who require much greater levels of security and care and who pose an immediate risk to themselves and a serious risk to others and who are subject to detention under the Mental Health Act 1983.
Medium Secure treatment setting	A secure locked unit that treats people with a mental health disorder who could pose a serious risk to themselves or others and who are subject to detention under the Mental Health Act 1983.
Mental Health Act 1983 (MHA)	Legislation relating to powers of compulsion for people suffering from a mental illness as defined by the act
Osgood Schlatters	An inflammatory condition of the knee, which occurs in childhood, more often in males than females, and is treated, in part, by avoidance of sport and excessive exercise.
Schizoaffective Disorder	An episodic disorder in which both affective and schizophrenic symptoms are prominent but which do not justify a diagnosis of schizophrenic, depressive, or manic episodes.
Section 5(2) of MHA	Specific order allowing a patient to be formally detained while in hospital as an informal patient
Section 37	Treatment order under the MHA 1983, applied by the court
Section 41	Restriction order under the MHA 1983 applied by the court