# An independent investigation into the care and treatment of service users Mr A & Mr B

**March 2013**

A report for NHS London
Undertaken by
L Winchcombe and Associates

NHS London

## Acknowledgements

The members of the independent investigation panel in this case were asked to examine the care and treatment provided by the Mental Health Services of Central and North West London NHS Foundation Trust (CNWL) prior to the tragic death of a young man who was himself a patient.

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

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

## Condolences to the Family and Friends

The investigation panel would like to take this opportunity - at the outset of this report- to publicly offer their condolences to the families of the man who died. We were unable to meet his immediate family.

# Executive Summary

## Background to the incident

On 11th June 2010, Mr B a resident in bedsit accommodation in a shared house in Brent was attacked and stabbed. He died in hospital on 1st July 2010. A fellow resident, Mr A was arrested and subsequently found guilty of manslaughter on 14th March 2012 and committed to hospital under Sections 37/41 of the Mental Health Act 1983 (MHA).

Both men had been receiving Mental Health Services from Central and North West London NHS Foundation Trust (CNWL) and had been placed into the property under an agreement between the Trust and Atlantic Guest Houses (AGH), the owners of the property.

**Mr A**
Mr A had first come to the attention of Brent Mental Health Services in 2003. He had come to the UK from Sri Lanka in April 2002 and immediately made an application for Asylum in the UK. This application was refused in May 2002, Mr A subsequently appealed that decision which was refused in December 2002. At the end of January 2003 Mr A's appeal rights became exhausted.

An application for Leave To Remain in the UK was made in February 2003. In the course of the next four years until February 2007 there is a history of applications refused, appealed and further representations; it is understood that these representations remain outstanding to date.

Mr A spent two periods in prison at HMP Pentonville and HMP Wormwood Scrubs for assaults on strangers in 2006. In both prisons there was contact with Inreach Mental Health Services. He was transferred from Wormwood Scrubs to a low secure unit at Park Royal Hospital in October 2006. On his discharge in March 2007 he was placed in an AGH property with CNWL meeting the cost using Section 117 of the Mental Health Act 1983 (MHA) as he was a person with No Recourse to Public Funds and therefore unable to access any welfare benefits.

Mr A had three periods of hospital care: March 2003 until discharge in May 2004; October 2006 to March 2007; and December 2009 to February 2010. He has been diagnosed with paranoid schizophrenia.

**Mr B**
Mr B had been known to Brent services since 2005 but had a history of mental health problems dating back to episodes in hospital in the 1980s and in 1996. Mr B created noise nuisance to his neighbours when unwell and had been evicted from his Housing Association property before he was assessed and admitted to hospital in 2009. He was

placed in his first AGH property in March 2009. There was no consistent diagnosis of his mental state.

There is no indication from either man, from the professionals involved in their care, or from housekeeping staff at AGH that there was any friendship, tension or friction between the two men prior to the incident.

## Findings and Recommendations

The following section sets out the independent investigation panel's findings and recommendations. These have been identified from a detailed analysis of the evidence, both oral and written, that has been presented to the independent investigation panel. The recommendations have been completed for the purpose of learning lessons and for the Trust to put into progress any actions required to prevent a similar occurrence. It also sets out areas where the independent investigation panel have identified notable practice.

**Care Planning and Coordination of Support to both Men**

There are differences of detail for each man over the extended period of time they were involved with Mental Health Services. However, a common pattern for both men throughout their contact is that they were not supported in their community settings in line with a well set out and maintained care plan.

The inadequate transfer of care to the appropriate CMHT in 2004 in regard to Mr A detrimentally affected the communication of the discharge care plan to the community team and contributed to the poorly considered care that he received in the community.

If a CPA (Care Programme Approach) process had been applied according to Trust and national guidance then it is less likely that Mr A's support would have been ceased in such an uncoordinated way in 2008/2009. Risk assessments from his previous admission were not heeded and on discharge in 2007 he was allocated a female care coordinator despite his history of violence to women in the community and sexually inappropriate and intimidating behaviours towards women on both admissions.

Care planning in Mr B's case had similarities to Mr A. There is little indication of risk assessment or of CPA planning. It is acknowledged that Mr B was reluctant to engage so securing his compliance to engagement with a care plan would likely have been difficult to achieve.

There was a lack of clear guidance to care coordinators about assessing patients at home which applied to both men. It is positive that new guidance was issued in 2012 clarifying the importance of seeing the person in their home setting. However the

concerns generated in considering the care and treatment of both these men shows a pattern of disconnection between the individual's history, care planning, risk management and achieving continuity of treatment and engagement.

***Recommendation One***
***It is recommended that the Trust reviews how it ensures that the person's history is adequately incorporated in the assessment of risk and that risk management is part of the subsequent care plan. Relapse indicators must be clearly identified and monitored by the care coordinator in conjunction with the individual's consultant.***

***It is further recommended that the actions arising out of this review be included in the audit programme in such a way that the Trust Board are able to satisfy themselves that these requirements are reflected in actual clinical practice.***

***Recommendation Two***
***It is recommended that CNWL consider a process of regular peer review on a sample of cases chosen at random relating to:***

***a) The extent to which the individual's needs and the risks are incorporated into their care plans.***

***b) The delivery of the care plan, both immediately and over the 18 months after a care plan is put in place.***

**Effectiveness and Integration of Risk Assessments to both men**

At various times in their hospital care both these men were assessed in relation to risk. In relation to Mr A these accurately describe his history of inappropriate sexual behaviour, violence towards others, both in the ward setting, and in the community. They also indicate his regular denial of mental health problems and resistance to medication. It is not evident that this knowledge and the assessment of these risks was utilised in the arrangements put in place for his care and support.

A risk management document template was used but not adequately completed in either patient's care. The structure of the care plan document with its 10 categories may have contributed to minimal risk management documentation and planning in the CPA in these cases.

***Recommendation Three:***
***It is recommended that the Trust reinforce through training and supervision the critical importance in achieving effective care planning. This should include the integration of history, risk assessment and management in both the formulation and practice in***

***delivering the care plan with the patient. It is further recommended that the implementation of this recommendation be monitored by regular audit and reported to the Trust's Quality and Performance Committee.***

**Use of the Mental Health Act 1983**

There is no indication of consideration of a Community Treatment Order (CTO) (or prior to the introduction of CTOs, Supervised Discharge) for either man. This relates primarily to Mr A, and the investigation panel accepts that the impact of either of these instruments on the engagement of either man in care and treatment is likely to have been minimal. Nonetheless, the Responsible Clinician should document that they have included in their risk assessment consideration of the appropriateness or otherwise of the use of a CTO.

This inadequacy is recognised in the Trust's internal review. However the recommendation from the internal review is less clearly stated in the action plan's implementation which states an email was sent to CNWL consultants by the Medical Director asking them to consider CTOs. It is not clear if this has changed practice or how this is being monitored.

***Recommendation Four***
***It is recommended that the Trust audits the use of Community Treatment Orders and ensures that the results of this audit are made available to all Responsible Clinicians. It is further recommended that the implementation of this recommendation be monitored by regular audit and reported to the Trust's Quality and Performance Committee.***

There are further specific findings in relation to the application of the Mental Health Act in relation to both Mr A and to Mr B.

Mr A had been discharged from the community mental health service in 2005 and 2009 largely because he had chosen to disengage. In light of his risk profile a more robust response including possible use of the Mental Health Act should at least have been considered at these times.

In relation to Mr B the (then) Approved Social Worker obtained a Section 135 MHA warrant in mid December 2007 because of her concerns about Mr B and his probable psychotic state and potential violence. However there was then a gap of almost a month before the warrant was executed. This was over the Christmas period but this long gap is unexplained in the records. When this warrant was executed the subsequent Section 2 of the MHA order was rescinded by the consultant on the 9th January 2008 only two days later. There is no evidence that collateral information was obtained to give a more rounded picture of his mental state at that time.

**Diagnosis**

There were concerns about Mr B's diagnosis. Early in his engagement with Mental Health Services it was often repeated in his notes that he was diagnosed with paranoid schizophrenia during his 1996 admission to Park Royal Hospital. He was started on depot neuroleptic medication at that time. When he was discharged from hospital in November 2005 the Discharge Summary did not contain any diagnosis. In January 2008 he is described in his Discharge Summary as having a diagnosis of "Behavioural Changes due to cannabis use". In June 2010 his diagnosis is given as schizophrenia. It is the investigation panel's view that from the first of his admissions the evidence available strongly supported the diagnosis of schizophrenia.

The independent investigation panel believe that as Mr B was detained twice under the Mental Health Act, a more robust attempt should have been made to treat him on at least one of those occasions. Lack of clarity about his diagnosis probably played a part in this.

It is not the view of this independent investigation that Mr B's fluctuating diagnosis had a material effect on his treatment plan. He did not in the main receive medication while in the community and given his consistently stated reluctance to engage with Mental Health Services or take medication it is not evident that there is much more that the CMHT (Community Mental Health Team) could have done in this regard.

**Mental state awareness**

Mr A's main contact with services when in AGH accommodation was when he attended the local office to collect his cash payment made under Section 117 of the MHA as a person with no recourse to public funds.

Other than when he was in hospital care, assessment of his mental state was very limited outside of the psychiatrists' clinics. Contacts were all at the office with no assessment of Mr A at his AGH home setting. Meetings between Mr A and his care coordinator are documented but show little assessment of mental state and no substantial attempt to establish concordance with medication.

***Recommendation Five***
***It is recommended that adequate supervision of individual care coordinators is put in place and monitored on a regular basis to ensure that care coordinators are assessing the mental state and risk of their patients when seen in the community. Furthermore, that the Trust develops and implements a minimum frequency policy giving clear guidance on when a person's mental state should be recorded.***

**Medication**

Mr B consistently refused to comply with any medication regime while he was living in the community. His pattern was that he was able to sustain himself in the community while causing concern and nuisance to his neighbours which resulted in admission and housing difficulties. There was no apparent strategy devised by the team treating him other than to try to maintain low level contact and be responsive when his condition deteriorated.

In relation to Mr A there is a pattern over the years of his engagement that when in hospital and receiving depot medication (albeit reluctantly) his condition improved. However, given his continually stated opposition to this form of medication in particular, the community team was faced with the inevitable change to oral medication that would have required a different approach to monitoring concordance.

In the view of the independent investigation panel Mr A's history and established pattern of non-concordance with medication, or willingness to continue his engagement in community support was not adequately considered in the care plan on his various discharges.

***Recommendation Six***
***It is recommended that where patients have a pattern of non-concordance with medication that this is reflected in that patient's care plan and a contingency plan is agreed. It is further recommended that the implementation of this recommendation be monitored by regular audit and reported to the Trust's Quality and Performance Committee.***

**Clinical Record Keeping**

It is evident that information was not consistently conveyed from the different risk assessments into active care planning, and in the case of Mr B that historic information relating to previous engagement with Mental Health Services, possibly in the 1980s and in 1995/6 was not available.

The use of electronic records will have improved the availability of information but will not in itself resolve the issue of making use of available information to inform care and treatment for the individual and in risk assessing circumstances for staff working in the Mental Health Services.

The investigation panel do not make any specific recommendation in respect of this but use of information is a recurrent theme in relation to care planning and risk assessment where we have made recommendations.

**Support to students and trainees**

Education and training is identified as deficient by the Trust internal review, particularly as it relates to care planning and CPA. However the main focus of the internal review is on uptake of training.

***Recommendation Seven***
***It is recommended that the content of that training needs to be considered with a particular emphasis on the continuity of care planning process, risk assessment and management demonstrating improved training from that provided at the time of the incident in 2010.***

**Criminal Justice System and Inreach Mental Health Service**
**HMP Pentonville**

This independent investigation panel considers that there were opportunities to re-engage the CMHT prior to Mr A's release from prison in 2006.

While in the criminal justice system there was a lack of clarity about his support needs, possible release, transfer to the health service and the implications of his immigration status. His mental health needs and risks were not addressed in a timely fashion, hence he was released from Pentonville prison before community support was put in place.

***Recommendation Eight***
***It is recommended that the Inreach team at HMP Pentonville should ensure that systems are in place for the early referral of all remand prisoners who have a serious mental illness to their relevant CMHT in a timely fashion.***

**HMP Wormwood Scrubs**

Once contact had again been made with Mr A in August 2006 at HMP Wormwood Scrubs by the Mental Health Services, this was maintained and he was subsequently transferred to the low secure unit at Park Royal Hospital under Section 38 of the MHA on 11th October 2006. However, the relevant CMHT was not informed of this transfer during its planning or at the time and only became aware of it when they contacted the Inreach team the following week.

***Recommendation Nine***
***It is recommended that when transfers to local Mental Health Services are made, the local mental health team should always be informed and be party to the detailed transfer arrangements. CNWL as the responsible Trust for the Inreach service at Wormwood Scrubs should ensure this is achieved in regard to the offender services they provide. It is further recommended that the implementation of this***

***recommendation be monitored by regular audit and reported to the Trust's Quality and Performance Committee.***

***Recommendation Ten***
***It is recommended that Camden and Islington NHS Foundation Trust are sent a copy of this report as the responsible organisation for the Inreach mental health service at Pentonville Prison.***

**Housing and support**

This independent investigation panel have concerns about the housing arrangements on several levels:

- The support offered to both men in the setting by the Mental Health Service

- The level of mental health understanding and training of the AGH staff, and their apparent autonomy in relocating people placed in their accommodation by Brent Mental Health Services without prior discussion

- The lack of clarity in the Trust Agreement with AGH

- That this arrangement fell outside the Supporting People arrangements worked up by London Borough of Brent.

- The internal review made recommendations in regard to the AGH arrangement, and there have been improvements subsequently. However, in the view of the independent investigation panel it is not clear that these recommendations were based on a sufficient understanding of the then existent Agreement or the broader Supporting People context.

Both men were essentially placed in this accommodation without continuing contact from the CMHT in their homes. An opportunity to develop a more rounded understanding of their life and circumstances was missed which may have informed a better assessment of their respective mental health conditions. There was, and in the investigation panel's view, continues to be, a confusion about the use of this type of accommodation, and what the expected outcome for individual people should be. The properties were described variously in CNWL discussions and guidance with the panel as "temporary" or "Bed and Breakfast" or "partially supported" but in reality they were used – and may still be so – to provide long term housing for people who would most probably find obtaining any other accommodation very difficult to achieve. However, from the experience of the two men who are the subject of this independent investigation, (and from the review subsequent to the incident, the others in the property as well) it is clear that once placed they were regarded in practice as settled and no support in the accommodation was offered.

What is clear from the experience of these two men is that they received little in the way of active support or engagement, and there was an over reliance on an informal and unstructured system of support from unqualified domestic staff in AGH.

***Recommendation Eleven***
***It is recommended that where people are subject to CPA and placed in supported housing their care coordinator has an obligation to carry out home visits, suitably accompanied, dependent on individual risk assessment, on a regular basis. This frequency could be set with a minimum standard for the ratio of home or other location contacts, and be regularly audited as part of the clinical governance programme.***

***Recommendation Twelve***
***It is recommended that AGH is required as part of its Agreement, or as part of a wider Supporting People Agreement, to ensure that its staff are adequately trained to offer greater support to people in their accommodation. The Trust should consider in this arrangement whether AGH staff might access relevant training that they offer to staff in their services.***

Overall there have been improvements in the working arrangements between CNWL and AGH achieved at the local operational management level in Brent Mental Health Services. These have been largely focused on achieving the recommendations from the internal inquiry with its specific actions:

However, it is not apparent that these have been developed within a shared strategic framework with the London Borough of Brent (LBB) about the future development of supported housing as a main plank in achieving individual recovery for people with mental health problems.

The investigation panel are aware that the LBB is actively managing the Supporting People contract and there is clearly a strong argument for the AGH properties to be considered within the framework of a Recovery focussed Supporting People model of housing provision.

The following recommendation is made specifically in regard to AGH properties but this is an approach that should be applied to any other development of housing specifically for people receiving care and support of the mental health service:

***Recommendation Thirteen***
***It is recommended that the future usage of AGH is developed in concert with the LBB in its strategic development of Supporting People Housing, and is aimed at supporting***

***and sustaining people, many of whom are likely to have a continuing need of support and engagement, within Mental Health Services.***

**Mr A's Immigration status as a person with No Recourse to Public Funds**

With the refusal of asylum Mr A became a person with No Recourse to Public Funds. However, as he had been subject to the MHA he had acquired a right to support under Section 117 of the MHA. This is a not uncommon conflict that mental health and local authority services have to deal with where different legislation imposes differing requirements on them.

Unfortunately the panel were unable to discuss this situation with the UK Border Agency who did not consider that the Terms of Reference of this investigation were sufficient to enable them to provide information, and stated that they wished to protect the privacy of the individual. The investigation panel have taken the view that seeking Mr A's specific agreement to gaining information from the UKBA would probably be unhelpful to his mental health and unlikely to add significant further information and so did not seek to amend the Terms of Reference.

***Recommendation Fourteen***
***It is recommended that in any future independent investigations involving people who are known to be persons of No Recourse to Public Funds, or otherwise known to the UKBA, the Terms of Reference include obtaining information from and the cooperation of the UKBA.***

***Recommendation Fifteen***
***It is recommended that a copy of this report is sent to the UKBA and that the new commissioning body develops links with the UKBA which will establish better understanding of both health and UKBA processes.***

## Notable Practice

Throughout Mr A's periods in hospital care it is worthy of note that his nursing notes were informative and well kept.

There were periods when consultant cover was mainly by locums. It is noteworthy that when Mr B's consultant took up post she made a home visit in 2008 because of concerns expressed to her by other team members who had been involved in a previous assessment.

The Discharge Summaries and Mental Health Tribunal reports are considered to have been well structured and informative and of a generally good and frequently excellent quality.

## In Conclusion

The independent investigation panel considered whether the death of Mr B could have been predicted or prevented.

Although there was a low level of engagement with both men, and the investigation panel have raised questions in regard to risk assessment, there was no reason to believe that the attack on Mr B by Mr A was either predictable or preventable.

# 1. General Introduction

1.1 On 11th June 2010, Mr B, a resident in bedsit accommodation in a shared house in Brent was attacked and stabbed. He died from his injuries in hospital on 1st July 2010. A fellow resident, Mr A was arrested and subsequently found guilty of manslaughter on 14th March 2012 and committed to hospital under Sections 37/41 of the Mental Health Act 1983 (MHA).

1.2 Both individuals had been receiving Mental Health Services from Central and North West London NHS Foundation Trust (CNWL).

1.3 An internal review was completed by the Trust in July 2011 with their findings and recommendations presented to the Trust Board in August 2011. Subsequently an action plan intended to address the recommendations was presented to the CNWL Board in August 2011.

1.4 This Independent Mental Health Investigation was commissioned by NHS London on 9th January 2012 under the auspices of Health Service Guidance (94) 27. *The discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33 – 6 issued in June 2005.

1.5 The Independent Mental Health Investigation Panel is referred to as the investigation panel throughout this report although in order to clarify specific points, independent investigation panel may be used.

## 2. Purpose of the Investigation

2.1 The purpose of any independent investigation is to review the care and treatment, leading up to and including the victim's death, in order to establish the lessons to be learnt to minimise the risk of a similar incident re-occurring.

2.2 The role of this independent investigation is to gain a picture of what was known, or should have been known at the time, regarding both the victim and perpetrator by the relevant clinical professionals, and the organisational and policy context within which they were working.

2.3 Part of this process is to examine the robustness of the internal review and to establish whether the Trust has subsequently implemented changes resulting from the internal review's findings and recommendations. The purpose is also to raise outstanding issues for general discussion based on the findings identified by the independent investigation panel.

2.4 While recognising the potential value of hindsight in considering what might have been done differently, and in formulating possible service improvements, it is important to remember that those involved at the time were only able to act on the information they had available. The investigation panel have been careful not to misuse the benefits of hindsight and have sought to avoid this in formulating this report.

2.5 As an investigation panel we have tried to identify and draw out lessons that may be learned from examining the care of the perpetrator and the victim, and more generally with a detailed consideration of any complex clinical case.

2.6 The process is intended to be a positive one that examines systems and processes in place in Brent Mental Health Services within CNWL at the time of the incident, and by working with the Trust to enhance the care provided to their patients and to inform those commissioning and delivering the services. We can all learn from incidents to ensure that the services provided to people with a mental illness are comprehensive and coordinated in their delivery and safer for all concerned: patients, the general public and for staff working within them.

# 3. Terms of Reference

## Commissioner

3.1 This independent investigation is commissioned by NHS London in accordance with guidance published by the Department of Health in circular HSG 94 (27). *The discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33 – 6 issued in June 2005.

## Terms of Reference

3.2 The aim of the independent investigation is to evaluate the mental health care and treatment provided to Mr A and Mr B.

- A review of the Trust's internal investigation to assess the adequacy of its findings, recommendations and action plans:
- Reviewing the progress made by the Trust in implementing the action plan from the internal investigation:
- Involving the families of both patients as fully as is considered appropriate:
- A chronology of the events to assist in the identification of any care and service delivery problems leading to the incident:
- An examination of the Mental Health Services provided to both patients and a review of the relevant documents
- A review of the relationship between both patients whilst they were residents at the hostel
- The extent to which both patients care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies:
- The appropriateness and quality of assessments and care planning:
- Consider how the risk to others was managed and implemented:
- Consider other such matters as the public interest may require:
- Complete an independent investigation report for presentation to NHS London within 26 weeks of commencing the investigation and assist in the preparation of the report for publication.

## Approach

3.3 The independent investigation panel will conduct its work in private and will take as its starting point the Trust internal investigation supplemented as necessary by access to source documents and interviews with key staff as determined by the team.

3.4 The independent investigation panel will follow established good practice in the conduct of interviews, ensuring that the interviewees are offered the opportunity to be accompanied and given the opportunity to comment on the factual accuracy of the transcript of evidence.

3.5 If the independent investigation panel identify a serious cause for concern then this will immediately be notified to the Manager, Homicide Investigations, NHS London.

# 4. Panel Membership

4.1 The independent investigation has been undertaken by a panel of professionals independent of the services provided by Central and North West London NHS Foundation Trust and its preceding bodies.

The panel comprises of:

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| Panel Chair: | Nick Georgiou, formerly a Director of Social Services and a manager of NHS Mental Health Services |
| Panel Membership: | Dr Tim Bullock, Consultant Psychiatrist currently working in West London Mental Health NHS Trust. |
| Panel Membership: | Professor Jonathan Warren, Director of Nursing currently working in East London NHS Foundation Trust. |
| Panel Administrator: | Louise Chenery, LC Transcription Services |

# 5. Methodology

5.1 Following an initial assessment of the internal review into the incident the investigation panel identified the preliminary written documentation it required. As the investigation proceeded the investigation panel became aware of other relevant documentation and this was sought, largely from records within the Trust.

5.2 As each document was received it was indexed and paginated. A full list of the documentation considered by the investigation panel is appended. The internal review's findings and recommendations were reviewed in a systematic way and the process recorded in tabular form.

5.3 A basic history of the main events in relation to both men was produced, as was a chronology of the main events of clinical relevance. A narrative form of the chronologies was incorporated into the main report. As part of the internal review detailed chronologies were produced that this independent investigation has drawn on to develop the chronologies contained within the report.

## Trust Meeting

5.4 An initial meeting took place with senior managers of Central and North West London NHS Foundation Trust early on in the process in March 2012. This enabled the investigation panel to gain an initial understanding of the services provided by the Trust and their partners, and learn about the plans for future service developments. It also provided an opportunity for the investigation panel to hear about the actions taken at the time and subsequently in regard to this incident as well as allowing the investigation panel an opportunity to meet CNWL managers and discuss the investigation process.

5.5 Immediately following the meeting with senior Trust managers, staff who had been directly or indirectly involved in the care of both men were invited to an informal meeting with the investigation panel. This was to provide an opportunity for people to ask questions about the process and the purpose of the investigation. In addition those who might be called for interview could be reassured that rather than focusing on apportioning blame the process was involved in examining systems and processes with the aim of improving services and reducing the risk of a similar occurrence happening again.

5.6 Evidence was received from eleven individual witnesses during March, April and July 2012, some of whom provided a statement prior to their interview. Those identified for interview either had had direct contact with Mr A or Mr B or held managerial responsibility for some aspect of the services engaged with this case.

Additionally, representatives from the Police and London Borough of Brent managers responsible for Housing and Social Care were also seen, though not by the whole panel. There was also written correspondence with the UK Border Agency.

5.7 The Panel Chair met separately with, and on one occasion had an extended phone conversation with senior staff in the London Borough of Brent to understand better some policy issues relating to housing, commissioning and working with people with No Recourse to Public Funds, but these were not focused on the specific treatment of either man who are the subject of this independent investigation.

5.8 It was explained to witnesses that the report of the investigation would be submitted to the Strategic Health Authority (NHS London) and once formally accepted by them it would become a public document.

5.9 As part of the methodology for interviewing witnesses the investigation panel adopted Salmon compliant procedures, which included the following:

- Every witness of fact received a letter in advance of attending the investigation panel to give evidence informing him/her of the Terms of Reference and the procedure to be adopted by the investigation and the areas and matters to be covered with them.
- Witnesses were invited to bring with them a friend, member of their trade union or anyone else they wished to accompany them.
- A transcript of their evidence was sent to witnesses following their interview for them to sign to affirm that the evidence is true.
- Any points of potential criticism were put to witnesses, either orally when they first gave evidence, or in writing at a later time.
- Witnesses were given full opportunity to respond. All interviews were held in private.

5.10 Analysis of the evidence was undertaken using Root Cause Analysis methodology. The analysis is presented in the following way:

- Care Planning and Support
- In hospital
- In community settings
- At points of admission and discharge
- Risk assessment
- Mental State awareness
- Diagnosis
- Medication

- Use of the Mental Health Act 1983
- Clinical Record Keeping
- Clinical Supervision and leadership
- Criminal Justice system and Inreach mental health service
- Immigration status
- Housing arrangements

## Family Involvement

5.11 The investigation panel have not met with any members of the families of Mr A or Mr B. From the internal review we learned that Mr B's elderly aunt did not want to meet with them and we decided that it was not appropriate, in our view, to seek a meeting with her.

5.12 We did not meet with Mr A's family who, we understood at the beginning of the inquiry were in Sri Lanka. We became aware that there might still be one or more brother in the UK but decided that there would be little to gain from seeking such a meeting.

5.13 The Chair and Psychiatrist on the panel did meet with Mr A who is being treated in medium secure accommodation.

# 6. Central and North West London Trust Profile

6.1 Central and North West London NHS Foundation Trust is a large diverse health organisation that provides both physical and mental health care services to approximately one third of the population in London and the surrounding areas. The Trust became a Foundation Trust on 1st May 2007 and has its headquarters in Hampstead.

6.2 The catchment area spans a culturally diverse community which has over 100 first languages spoken and a population that is from the most affluent to the most deprived in the London area.

6.3 CNWL provides a wide range of services to treat people with a variety of health needs including physical long term conditions, adult and children mental health illness and learning disabilities. It covers the Boroughs of:

- Brent
- Kensington and Chelsea
- Westminster
- Harrow
- Hillingdon

## Local Services

6.4 Local services are provided to adults with a mental illness, both as inpatients and in the community by multi-disciplinary teams. Other services include sexual and reproductive health services that have walk-in centres in central London and Hillingdon.

## Specialist Services

6.5 A wide range of specialist services is also provided that includes Mental Health Services for children and adolescents and older people. The Trust has an Addictions service that provides for problem gambling, compulsive behaviour and problems with “club drugs”.

## National Services

6.6 A national inpatient, outpatient and day patient Eating Disorder Service is provided to adults with this illness. Other national services include an inpatient and community learning disability provision to clients requiring this service.

## Prison Inreach

6.7 The Trust provides a prison Inreach service to several prisons, in London and the South East in regard to mental health, addictions and primary care.

## Community Health Services

6.8 The Trust has recently taken on the responsibility for a range of general community services that includes adult and child physical health care in the Boroughs of Camden and Hillingdon.

6.9 In addition the Trust has taken over the Substance Misuse service component in the Borough of Hounslow which was previously provided by the Hounslow and Spelthorne Community and Mental Health NHS Trust.

# 7. Outline of Events in regard to Mr A

7.1 The following chronology of events has been compiled from case notes, oral, written and documentary evidence available to the panel in regard to Mr A and his care and treatment.

7.2 Engagement with services and specific episodes in their care are considered thematically in the Analysis section of this report.

## Mr A's history prior to engagement with Mental Health Services

7.3 Mr A was born in Sri Lanka in 1974. Prior to coming to the UK, Mr A received a good standard of education where he achieved A level passes and completed the first stage of an accountancy training course. It is understood that he travelled to the UK in April 2002 with his mother but she returned to Sri Lanka because of concerns about other members of her family there. Mr A is the youngest of four children with two older brothers living in the UK at the time and with whom he had contact at various points during his involvement with Mental Health Services, including living with one of his brothers for about a year. When two investigation panel members met Mr A, he reported that one of these brothers was in Manchester and the other had returned to Sri Lanka.

7.4 There is some uncertainty about Mr A's psychiatric history. The notes indicate that he was an unreliable informant and had no insight into his own mental health. Information from one of Mr A's brothers recorded in the notes indicates that he had not had any previous psychiatric contact before coming to the UK, and this seems to have been the dominant perception throughout Mr A's care and treatment records. However, information given by his father to a ward doctor in October 2006 states that Mr A received psychiatric care in Sri Lanka and in India in 1998. There is no record of further engagement or treatment until 2003 in the UK.

7.5 It is understood that Mr A came to the UK in April 2002 and immediately made an application for Asylum in the UK. This application was refused in May 2002, Mr A subsequently appealed that decision, which was refused in December 2002. At the end of January 2003 Mr A's appeal rights became exhausted.

7.6 An application for Leave To Remain in the UK was made in February 2003. In the course of the next four years until February 2007 there is a history of applications refused, appealed and further representations; it is understood that these representations remain outstanding to date.

## Engagement with Mental Health Services

**2003**

7.7 Mr A first came to the attention of psychiatric services in the UK in March 2003 when he was found attempting to break into a house through a window. At this time it is reported that he assaulted someone; either a woman in the street prior to attempting the break in or he assaulted someone in the process of attempting to break into the house. Mr A was apparently acting bizarrely, giggling, making strange noises and describing auditory hallucinations, was described as thought-disordered and had talked of wanting to kill his mother.

7.8 He was arrested and taken to a Police Station where he was assessed and transferred to the Park Royal Centre for Mental Health. On arrival he was dishevelled and uncommunicative, incontinent of urine on the floor, and he stared at staff and made strange noises. Mr A was restrained by ward staff and rapid tranquilisation was given. Mr A initially described hearing the voice of his brother's boss telling him that his brother was dead.

7.9 He was initially detained under Section 5.2 of the MHA because of the unpredictable nature of his behaviour. He stroked the doctors' hair and told them that they reminded him of his mother, he remained restless and overactive and did not sleep, he was over familiar with female patients.

7.10 Mr A described living with his two brothers who he alleged bullied him. He also stated that he wanted to kill his mother because she had returned to Sri Lanka. He described his father as having beaten him from when he was young.

7.11 On the 11th March Mr A was detained under Section 2 of the MHA. He remained restless and intrusive and continued to pace the ward. He also remained intimidating to female staff and expressed the view that one of the members of staff was his wife. He was treated with olanzapine (an antipsychotic).

7.12 On the 20th March 2003 he absconded from the ward. He was subsequently returned by the Police some two weeks later having been found trying to break into the house of an elderly woman in North London. He attempted to assault a Police Officer when they approached him.

7.13 In April 2003, Mr A was placed on Section 3 of the MHA shortly after his return to the ward, and was noted to be paranoid and thought the ward was full of immigration officials.

7.14 There are a number of reported incidents of him threatening and touching female staff and of throwing food and hot coffee at people. There were two CPA

Review meetings on the ward and these included consideration of Mr A's support and accommodation needs on discharge.

7.15 Although there was concern that Mr A was "still high" on 8th May his leave was increased to an hour twice daily, it is not known if this was escorted or unescorted leave. On the next day he absconded from the ward and was absent for 24 hours. When he returned he said he had been travelling on the bus. He continued in his attempts to touch female patients inappropriately.

7.16 On the 15th May Mr A was observed fighting outside the unit with an unknown person. He was returned to the ward by nursing staff and subsequently attacked a member of staff who attempted to address the issue of fighting with him.

7.17 The Police attended the ward and informed staff that Mr A had assaulted a taxi driver, broken his arm and caused damage to his car. Mr A was arrested and taken to a local Police Station but the Police Doctor assessed him as unfit to be questioned or kept in a cell overnight. (The forensic record shows that almost three years later in March 2006 he was convicted of common assault in relation to this assault and received three months imprisonment).

7.18 Shortly after the incident, another patient who witnessed these events, stated that Mr A believed that the taxi driver was from the immigration service and was coming for him. Mr A had broken the driver's arm by kicking him. In response to this his deport dosage (depixol) was increased to 60mgs and a place was sought for him on a secure ward.

7.19 It is recorded that Mr A assaulted staff on three occasions in May. During this period of just over two months on the admission ward to his transfer to the locked ward, Mr A showed a relentless pattern of aggression with a number of physical assaults on ward staff. There had been three serious assaults by Mr A in the three days leading up to this transfer, two on the 15th May and again on 18th May. He was also consistently sexually inappropriate with both staff and with other patients.

7.20 On the 20th May he was transferred to a locked ward due to his challenging, threatening and demanding behaviour. On this new ward he was described as being preoccupied with a female staff member and to be inappropriate in his behaviour, disinhibited and elated at times, and attempted to abscond from escorted leave on a number of occasions.

7.21 Over the next few weeks he continued to display incongruous affect and admitted to sometimes experiencing telepathy, especially with girls. Mr A also stated that he had said he wanted to kill his mother only so that he would not be deported. He did not believe that he needed to be in hospital or to take

medication. However, he was much less disturbed and aggressive and did not display the sexual disinhibition that characterised the earlier part of this admission. He continued to display incongruity of affect, a lack of insight and a tendency to minimise his past behaviour. He was unmotivated and engaged in little social interaction.

7.22 On 1st October 2003 at a Care Programme Approach meeting Mr A's persistent lack of willingness to stay in hospital or take medication was noted and his Section 3 of the MHA was renewed. At this time although he was under an order of the MHA he was on Standard CPA.

7.23 There was active consideration of Mr A moving in with his brother who had offered accommodation. However this was not pursued when the social worker became aware that the landlady of the house acted as a childminder and properly determined that such a setting would not have been appropriate with Mr A's history.

7.24 In November 2003 there was a consideration of his detention under the MHA by the Mental Health Review Tribunal, at which his detention under the MHA was renewed. There was also preparation of an application to the Complex Care Panel for funding of a Rehabilitation Unit/hostel placement on discharge.

7.25 During December 2003 and January 2004 there was introductory work with Mr A to achieve discharge to a rehabilitation hostel, this was eventually achieved at the beginning of February 2004 after a short delay to the planned date of the end of January because Mr A took unauthorised leave for a short period.

**2004**

7.26 On 20th January 2004, a CPA Review was carried out at the Rehabilitation Unit. Mr A's application for asylum had been refused in January 2003 when his appeal rights became exhausted, and as a result he was designated as a person with No Recourse to Public Funds. Subsequently an application to the CNWL Complex Care Panel was approved which enabled his placement in the Rehabilitation unit.

7.27 In February 2004 Mr A was transferred to the Rehabilitation Unit and was placed on Section 17 MHA leave until early March when the situation was to be reviewed. Arrangements were also put in place as part of the CPA to contact Mr A's solicitor about his immigration status and asylum application.

7.28 During the period March to May 2004 period Mr A was at the Rehabilitation Unit where Multi-disciplinary Process Notes were maintained. These show that there were no major concerns about his behaviour and he was regarded as mentally stable and compliant with medication.

7.29 At the beginning of March he was discharged from Section 3 of the MHA; an Assessment of Risk was completed a few days later; his social worker accompanied Mr A to an immigration appointment; housing options for Mr A were considered including the option of Mr A moving in with one of his brothers on leaving the Rehabilitation Unit, which is what eventually happened.

7.30 A Discharge Summary was prepared which included registration with a GP and referral to Brent Community Mental Health Service. Mr A was discharged from the Rehabilitation Unit on 11th May when he moved in with one of his brothers. This accommodation was not at the address where a previous discharge option in October 2003 had been judged inappropriate.

7.31 May to December 2004 was a period of minimal contact with Mr A, he remained living with his brother, was visited at this address by his care coordinator on 20th May and 5th August, and attended appointments, including a CPA transfer meeting between Community Mental Health Trusts (CMHTs) recorded in correspondence from the care coordinator to Mr A in October and November.

7.32 At this time there was some confusion in achieving his transfer between the North West and South CMHTs and identifying who was to be the responsible consultant, which affected the thoroughness of the contact with Mr A.

**2005**

7.33 In January 2005 Mr A's care was transferred to the North West Brent Sector CMHT and the consultant psychiatrist who remained responsible for his care until the incident in June 2010 first became involved. It is reported that Mr A did not attend a CPA Transfer meeting but he was seen by his care coordinator in early January who reported that Mr A told him that he had been busy with his accountancy course and so had not responded to requests to attend CPA meetings.

7.34 Nothing further is recorded until May 2005 when it appears that Mr A attended a CPA Review meeting at the Outpatient clinic. He was considered to be settled, did not feel mentally ill, and was not compliant with medication. He was asked to recommence risperidone with a plan to review in 4 months.

7.35 On 24th June 2005, Mr A contacted his care coordinator to state that he did not need the CMHT and that he was prepared to take a reduced dose of medication when feeling low. This was followed by, what is described in the notes as a group meeting including the consultant on 27th June when it was decided that Mr A's case would be closed and that the GP and Mr A informed of this decision.

The community team made no attempt to communicate with Mr A's brother, with whom he was living, once Mr A decided to disengage from care.

7.36 It seems that for the remainder of 2005 Mr A lived in hostel accommodation, possibly in Shepherd's Bush paid for by his family members.

7.37 There does not appear to have been further contact with Mr A during 2005.

**2006**

7.38 On the 3rd January 2006 Mr A was remanded to HMP Pentonville following an unprovoked incident when Mr A punched an unknown woman in the street. He was housed initially in the main part of the prison and moved to the healthcare wing on the 19th May 2006.

7.39 On the 30th May 2006 Mr A was seen by a Specialist Registrar and a Community Psychiatric Nurse (CPN) from the North London Forensic Service who prepared a psychiatric report. When Mr A was assessed he reported that he came to the UK after he was forced to assist the Tamil Tigers. At the time of the assessment he had been identified as known to Brent Mental Health Services with a diagnosis of schizophrenia.

7.40 Their assessment at the time was that "we could elicit no symptoms or signs of either a depressive or psychotic illness". However, the report also noted that "there is sufficient suspicion about his mental health and its possible relationship to offending behaviour that would warrant its monitoring in case his mental state were to deteriorate in the future."

7.41 It also noted that he was fit to attend court for sentencing and that Mr A's mental state was "neither of the nature or degree to warrant immediate transfer to hospital for further assessment or treatment." They recommended that he continue to be monitored by the Inreach team and be considered for follow up by the Brent CMHT once released.

7.42 In May 2006 the Inreach team wrote to the Brent consultant seeking further information.

7.43 Mr A attended court on the 12th June 2006 and there was a telephone discussion between the Inreach team and the CMHT social worker, which considered the possibility that Mr A would be deported on his release. The available notes indicate some confusion on whether he was to be released the next day or be deported back to Sri Lanka. He had previously been deemed unfit to plead, however, the report of the 30th May assessed him as fit to attend court for

sentencing. The care coordinator agreed a plan to have Mr A assessed by a psychiatrist and to facilitate a referral back to the CMHT.

7.44 In the event he was released from HMP Pentonville on the 13th June with no housing or mental health follow up

7.45 There was correspondence to the Rehabilitation Unit from a staff grade psychiatrist at the Inreach team at HMP Pentonville about Mr A's condition; this letter was conveyed onto the CMHT, but it arrived at the CMHT after Mr A had been released without a fixed address and with concerns that he was actively unwell and might deteriorate. No action was taken in respect of the possibility of deportation on his release from prison.

7.46 Mr A's next contact with Mental Health Services was in July 2006 when he was taken to HMP Wormwood Scrubs on another charge of common assault of a female victim. There is little information available but he was described as acting very bizarrely, being agitated, suspicious and guarded.

7.47 In early August 2006 the Brent CMHT learned that Mr A had been arrested for another assault and was being held at HMP Wormwood Scrubs. The CMHT contacted the prison Inreach team, subsequently visited him and discussion with the Inreach team was initiated.

7.48 In September 2006 **t**here was a dialogue with the prison Inreach team with a view to transfer Mr A to local services. At this time it was reported that he remained "nasty and lecherous" towards females and denied previous contact with Mental Health Services. At that time he was regarded as at medium risk of re-offending.

7.49 Mr A was transferred to a low secure Unit at Park Royal Hospital under Section 38 of the MHA from the prison on 11th October 2006. When he arrived on the unit he appeared quite unkempt and dishevelled. From the notes it does not seem that the CMHT were informed of this transfer by either the Inreach team or the receiving ward, and only became aware that the transfer had occurred when they contacted the prison Inreach team the following week.

7.50 When assessed by the Staff Grade Doctor, Mr A is described as labile in mood and affect, displaying pressure of speech, laughing inappropriately, displaying flight of ideas and poor concentration. He was intimidating to female staff, displayed an absconding behaviour pattern and was threatening, demanding and unpredictable. He was also noted to be perplexed and finding it difficult to cooperate with the interview.

7.51 His past admission was noted as was his medication by the junior doctor who commented that there had been a significant drop from depot to oral medication between the level he received when he was discharged from the Rehabilitation Unit and then subsequently when he was discharged from the hospital setting to community services.

7.52 Mr A was noted to be awaiting sentencing for an index offence of common assault. It was concluded that he was suffering from a relapse of psychotic illness secondary to non-compliance with his medication.

7.53 In mid October 2006 Mr A's sister and father visited him. They were interviewed by the Staff Grade Doctor and gave the history of Mr A's mental health before coming to the UK.

7.54 Mr A was given a test dose of clopixol and had to be restrained by ward staff when it was administered. He continued to request leave and showed no insight into his mental illness, continued to appear paranoid, displayed incongruous affect, was challenging to ward staff and denied any previous contact with Mental Health Services.

7.55 Mr A's father and sister attempted to visit him but he declined to see them on a number of occasions. When they had brought him food, he threw it away stating that it was spiked; he also occasionally refused to eat hospital food.

7.56 Mr A appeared at West London Magistrates Court on the 3rd November 2006 in relation to an altercation with a group of teenagers who wanted him to buy them alcohol, which he refused to do. The dispute continued when they all boarded a bus. Mr A described being bullied and shouted at. He acknowledged telling a girl in the group to shut up and to touching, but not hitting her. Mr A had previously pleaded guilty to this charge and he was due back to court in relation to it. At the court appearance he was described as restless, agitated, argumentative and abusive. He was returned to the hospital and detained under Section 38 of the MHA.

7.57 Over the next few weeks Mr A's behaviour became more settled and at the ward round on the 22nd November 2006 he was described as much improved.

7.58 On the 1st December 2006 Mr A was escorted to court, following the earlier court appearance on 3rd November, where he was reported to have been abusive to the magistrate. He was returned to hospital under Section 37 of the MHA.

7.59 After this, Mr A continued to improve. His behaviour became more appropriate and his personal hygiene improved. However, he spent a substantial part of his time in bed. At the ward round on the 6th December his dose of clopixol was

increased to 400 mg weekly. The plan was to consider authorising leave in about two weeks.

7.60 At the end of December it was agreed that Mr A could start taking 30 minutes escorted leave twice per day in the hospital grounds. His high risk of absconding was noted. He was subsequently described as stable in mental state, mood and behaviour with no psychotic symptoms. Thought disorder was no longer described in case note entries.

**2007**

7.61 On the 5th January 2007 Mr A went on leave with his father but ran away. He was returned by the Police the next day. He claimed that he had been travelling around on buses and had presented himself to Charing Cross Police Station as he had nowhere to go. His leave was subsequently suspended. His dose of clopixol was increased to 500 mg weekly. It was clear that he had very limited insight into his mental health and little understanding of the significance of failing to comply with his leave conditions.

7.62 There was a CPA Review meeting on the 12th January that included his community consultant and care coordinator where it was agreed that he would be transferred to an open ward. His unescorted leave was reinstated on the 15th of January. In late January 2007 a Hospital Managers Hearing upheld his continued detention under Section 37 of the MHA.

7.63 On the 21st February 2007 he was transferred to an open ward. At that time he was taking an hour of unescorted leave twice a day. On arrival on the ward he was described as calm and relaxed. His behaviour was subsequently unremarkable with no evidence of psychosis or sexual disinhibition. He tended to spend a lot of time in his room. However, his interactions with staff and other patients were appropriate when they occurred.

7.64 Confirmation of funding was awaited so that he could be moved to Bed and Breakfast accommodation. It was noted that he had a solicitor looking into his immigration status. Mr A did not appear to take a great deal of leave from the ward but returned without event from that he did take. Mr A's father was visiting at this time. Staff working with Mr A were aware of his immigration status, and there was occasional contact with his solicitor in this regard.

7.65 Mr A was entitled to support under Section 117 of the MHA and hence financial support, although as a person with No Recourse to Public Funding he was not eligible for financial support through the benefits system. By the 9th March arrangements were made for him to receive financial support because of his vulnerability and eligibility for Section 117 of the MHA support.

7.66 In March funding from the London Borough of Brent, administered through local arrangements with the Brent Mental Health Services by CNWL, was approved to meet his basic living and housing costs. Overnight leave was authorised to what has been described as a Bed and Breakfast bedsit within a property owned and managed by Atlantic Guest House (AGH) a private organisation which owned a number of properties in Brent.

7.67 In mid March his mental state was noted to be stable, and in late March he was reviewed in a ward round by his consultant and care coordinator. Mr A again stated that he wanted to take tablets, not the depot injection. There was concern that he would not comply with this and the initial plan on his discharge was to reduce the depot medication, and to review his mental state over the next few weeks. His depot was further decreased to weekly.

7.68 Ward staff liaised with the solicitor dealing with his Asylum Application. They were informed that his current application was lodged in 2003 and that the solicitors had sent the medical report to the Home Office that day. The solicitor could not predict how long it would take for a decision to be reached.

7.69 He was discharged from the ward and a social worker took over the task of being his care coordinator. Mr A's assigned care coordinator was a woman in the lead up to his discharge and she continued in that role when he moved back into a community setting. Both his assigned care coordinator and a student social worker were women,

7.70 On 3rd April Mr A's both women visited him together at home but he was not in.

7.71 Mr A was seen by the student social worker on the 18th April when he attended the depot clinic. Mr A wanted to cease depot medication and take only oral medication. He stated that he was unable to budget and requested an increase in his money, and because he did not have enough money he requested that he be put in a nursing home. He also requested a referral to a day centre, which was pursued.

7.72 During April, May and June 2007 immediately after his discharge back into the community, contact was mainly through the student social worker whom Mr A visited at a local CMHT office and through telephone calls.

7.73 Mr A was seen at an outpatients clinic in early May when the consultant recorded that his medication would be reviewed in four months, and that he would remain at the Bed and Breakfast. It was not recorded, and presumably was not known, that he had in fact moved to a different AGH property a few days previously, (see below).

7.74 Also during May he requested a move to the Kilburn area, and there is a letter from Brent Housing Services stating that because of his immigration status he is ineligible for housing from the council. Despite contact during May it only became known at the beginning of June that he had in fact moved to a different AGH property at the end of April. It is reported that Mr A said he deliberately did not tell the student social worker, and that he also denied his previous convictions. The student social worker described Mr A's reaction when she told him she was informing the Multi Agency Public Protection Arrangements forum (MAPPA) of his changed address as "punching one hand into the other".

7.75 When Mr A's move was discussed with AGH on 1st June, AGH staff reported that Mr A had become anxious when he witnessed equipment being stolen within the property and hence was moved to another. The student social worker requested that the services be informed prior to any future move.

7.76 In early June Mr A was assigned a new care coordinator. He had apparently told the student social worker when she was leaving the placement that he loved her.

7.77 During the period July to December 2007 there was regular contact with Mr A. He continued to seek to be taken off depot medication but this was maintained on a reduced dosage of clopixol, with which he appears to have complied. He is described as stable during these months.

7.78 During August 2007 Mr A was introduced to the day centre but he did not sustain this attendance. The care coordinator maintained good contact with Mr A to the end of the calendar year 2007 responding to many of the same issues documented since his first engagement with services in 2003. He was discharged from the day centre in December due to his non attendance.

**2008**

7.79 Throughout this year it would seem that intermittent contact was maintained with Mr A mainly through his visits to the office and outpatient appointments. A new male care coordinator appears to have been allocated in February but there is no reference to any CPA activity, or contact with AGH and only one entry from his care coordinator.

7.80 It would seem that, for the first half of the year, he was reluctantly compliant with depot medication, a request was made to the GP to commence Mr A on risperidone in August. At the time he was started on oral medication it is recorded that he had not been medicated for two months. At his outpatient appointment in December his personal hygiene was noted to be poor.

Throughout the year, Mr A reports his continuing difficulty in living on very little money as a person with No Recourse to Public Funding.

**2009**

7.81 During the period of January to November 2009 there was minimal contact with Mr A. It would seem that he was discharged to his GP in June. He was seen in outpatients by the SHO (Senior House Officer) in September when Mr A said he was compliant with medication, had changed his GP. He is reported as looking well kempt but with a strong body odour. A review in six months by a care coordinator was planned.

7.82 On 3rd December 2009, Mr A was re-referred to Mental Health Services apparently by the Police after the staff at the AGH property where Mr A was residing had expressed concerns about his behaviour when he was described as forgetful, aggressive and argumentative. Contact was made with the staff at AGH by the Crisis Resolution/Home Treatment Team. Over the next few days unsuccessful attempts were made to see Mr A but he was not at home when they visited.

7.83 Following assessment on 10th December 2009, Mr A was admitted under Section 2 of the MHA the same day.

7.84 His past history detailed at admission included the admission in Sri Lanka and his transfer from Wormwood Scrubs in 2006 but not his admission to hospital in 2003. Mr A described having one brother in the UK who lived in Manchester, other family members were said to be in Sri Lanka.

7.85 On the 14th of December he was seen by the SHO at a ward round and was described as still quite agitated. He claimed that he was brought to hospital because of a misunderstanding claiming that a female resident had come to his room at 2 am, requesting a cigarette lighter and he had offered her a drink. Mr A's personal hygiene was noted to be very poor. He was offered and refused risperidone.

7.86 Mr A was subsequently very agitated for the next week or so and wanted to leave the hospital. He approached the SHO demanding leave, when this was denied he became very angry and swearing at her aggressively. He subsequently attempted to apologise but would not acknowledge that his behaviour had been wrong and then told her that he loved her. There was also an occasion when he was very aggressive and abusive towards a member of nursing staff and told her that he was going to kill her. He questioned why she reported that he had grabbed her hand and not let go in a minor incident several days earlier. On another occasion he told a member of staff that if a female patient did not shut

up he would hit her, and maintained that staff had put this patient near to his room on purpose.

7.87 The next day he was described as displaying pressure of speech restlessness and sexual disinhibition. He said that he would only take a light medication and not on a daily basis. He was viewed as lacking capacity to consent and the consultant made a recommendation for Section 3 of the MHA which was completed on 6th January 2010. Over the next few days he was heard talking and shouting to himself in his bedroom.

**2010**

7.88 Mr A was in hospital until 8th February 2010. During this period it seems that he became more settled, attended occasional Art and Drama therapy sessions, and had periods of unescorted hospital leave.

7.89 On the 7th February a urine sample for drug testing was carried out because a member of the public stated that he had supplied illicit drugs to her son. The test was negative.

7.90 It was noted that he received £42 weekly which he collected from the office base every Friday. His uncle was said to be sorting his legal status with the Home Office. There were no current concerns to self care. He denied using alcohol although it was noted that on occasions he smelt of alcohol, he also denied illicit drug use.

7.91 The nursing notes show that a Discharge CPA was held on 8th February. On his discharge a Discharge Summary was completed and sent to his GP. Mr A was discharged back to AGH, which is described as "semi-supported" accommodation.

7.92 After his discharge, he was seen on the 12th February when he attended a local office and was seen by the care coordinator. This meeting at the local office is described as the seven day follow-up. The notes indicate a general update and contact with AGH by the care coordinator asking to be kept informed by AGH, however there is no information relating to any future meeting, medication monitoring or intention to carry out a home visit.

7.93 During March, April and May 2010 there was periodic contact with the care coordinator when Mr A attended the local office for his financial assistance and some discussion of his immigration status. There is minimal information available in the record about these occasional meetings.

7.94 A set of risk assessment forms were completed by the care coordinator on 15th April which demonstrate an awareness of his previous criminal convictions and history of intimidating behaviour.

7.95 There was no further contact with Mr A until Monday 14th June while he was held in custody charged with attempted murder following the incident on Friday 10th June.

# 8. Outline of Events in regard to Mr B

8.1 The following chronology of events has been compiled from case notes, oral, written and documentary evidence available to the panel in regard to Mr B and his care and treatment.

## Mr B's history prior to engagement with Mental Health Services

8.2 Mr B was born in North West London in 1955, and from about five years old he was brought up by his grandmother until her death when he was 14 years old. His parents had divorced with his mother moving to Australia.

8.3 After his grandmother's death he lived with his maternal aunt and uncle in the midlands until he was aged 16 when he went to live with his father. At the age of 17, he left home at his father's request.

8.4 Mr B left school aged 16 but later he attended a college in Newcastle and gained some O and A levels in his early 20s. Subsequently he moved to London and lived in squats for a number of years until he moved into a flat on the Chalk Hill estate in North London in 1990. Mr B last worked in 1986. There is no family history of mental health problems.

## Engagement with Mental Health Services

### 2005

8.5 It is stated in the application for a Section 135 of the MHA warrant dated 23rd September 2005 that Mr B was admitted to Shenley hospital in the 1980s. The provenance of this assertion is unclear. There is no contemporaneous record of this available now nor does there appear to have been during his engagement with services.

8.6 The electronic event history record (EPEX) record indicates that he was admitted to Park Royal Hospital in January 1996 from a "penal establishment". He was subsequently discharged in late February 1997 although he had taken leave from Christmas 1996, and was followed up in the community until September 1997. The EPEX record suggests that when he was discharged he was to receive depot medication but there is no evidence that he did. There was subsequently no contact with Mental Health Services until February 2005.

8.7 When assessed in October 2005 Mr B accounted for his 1996 admission by stating that he had been run down. Events of this admission are recorded on

EPEX but there is no paper record available, it was sought during his admission in 2005 but there is no indication that it was ever located.

8.8 The first contemporaneous record we have access to is the correspondence from the neighbourhood officer of Metropolitan Housing Trust to Mental Health Services on 7th January 2005 concerning complaints from several of Mr B's neighbours and requesting a visit for assessment. In that correspondence he is described as becoming more irrational and verbally abusing his neighbours and also making threats to them. On 17th January 2005 his GP also referred him in response to concerns raised by the Housing Trust.

8.9 He was interviewed by an Approved Social Worker on 2nd February 2005 when he was described as amenable, noted to be thought disordered but willing to accept help. It was not felt necessary to carry out a MHA assessment and it does not seem that there was further involvement until contact by the Housing Association in August 2005.

8.10 An e-mail from the neighbourhood housing officer to Mental Health Services in early August 2005 details concerns being raised in daily incident log sheets by one of Mr B's neighbours. Mr B's pattern of behaviour was perceived as harassment by this neighbour, with a detrimental effect on his young children. The incidents reported were described as shouting, screaming and banging at all hours of the day and shouting from the balcony in an abusive and aggressive manner, including threats to kill and threatening to kill himself. Mr B was also accused of shouting racial abuse. Other residents were in fear for their safety and described threats to kill occurring on a regular basis. He had flooded his flat causing water to come through the neighbour's ceiling on several occasions. Mr B had not attended an appointment requested by the neighbourhood housing officer.

8.11 Mr B had last been seen by his GP in August 2004. It seems that a mental health assessment was arranged for 9th September 2005 which he did not attend. A further assessment was arranged for the 19th September but Mr B refused to open his door.

8.12 Further concerns raised a couple of days later from his neighbour to the neighbourhood housing officer, described him as out of control; shouting ranting and making death threats to himself and unknown people in his flat. He was also smashing furniture. Mr B had previously verbally abused the neighbourhood housing officer when she had visited his flat to deliver the letter requesting a meeting.

8.13 Assessment for Section 2 of the MHA is documented on 7th October 2005. Access to his flat was gained employing S135 of the MHA. It is stated on the joint

assessment for Section 2 of the MHA, that he had been known to Mental Health Services with a diagnosis of paranoid schizophrenia. It was noted that he had not been taking any medication and that there was some evidence of paranoia and thought disorder. He was not willing to accept informal admission to a psychiatric hospital.

8.14 On admission on Section 2 of the MHA he denied all the behaviours alleged by his neighbours. He described feeling well, drinking rarely and using cannabis every two weeks. Mr B said that his next door neighbour complained of noise from his electric guitar two years previously and that water from his plumbing had leaked into the downstairs flat. His speech was described as rational and he was not displaying formal thought disorder. He was cheerful with no ideas of harm to himself or others. Mr B said that he had not worked for twenty years. His view was recorded as "if I work I want my wife, my children, a large house, otherwise I won't work. The work would have to provide these things for me". He was not considered to display any symptoms of psychosis nor did he think that he was mentally unwell.

8.15 When asked about his previous admission in 1996 he told the nurse that he would not tell her about it. Mr B was observed to be settled but engaged little with other patients. When reviewed by the consultant on the 10th October 2005 he was described as calm and appropriate and it was noted that he did not feel he should be in hospital. He was to continue to be given "as required" medication. Previous discharge summaries were to be found and his previous treatment regime established.

8.16 On the 11th October Mr B's aunt in the Midlands telephoned expressing concern that he would turn up at her house. She stated he had done this in the past and she was frightened of him, did not want any involvement with him and suggested that staff speak to his father.

8.17 Telephone contact with his aunt confirmed that she had been worried about him when he was first admitted. She had last seen him a year before. She stated that he can get very angry but had never been physically aggressive towards her. He had sent her obscene greetings cards in the past. She had visited him when he was last in hospital ten years previously and felt that he had improved after his discharge but then stopped taking his medication and had begun deteriorating about two to three years prior to this admission.

8.18 When reviewed by the consultant on the 12th October it is noted that he had been in the community for the last nine years without medication. He had been laughing and talking to himself whilst on the ward. However he was not felt to be a management problem, he had not been aggressive but had not wanted to take medication. He was given unescorted leave under Section 17 of the MHA.

8.19 On the 24th October he was assessed by the Crisis Response Team (CRT) who did not feel he was suitable to be followed up by them as they viewed him as not in crisis and with a history of dropping out of services. However, later records indicate that the CRT did see Mr B after his discharge. On the same day the consultant decided to discharge him from Section 2 of the MHA because he was seen as manageable except for talking to himself. It was intended that he would be observed for a further 7 to 10 days before he took overnight leave.

8.20 At a pre-discharge assessment on the 28th October Mr B said that he would accept follow-up by the CRT. However he had previously declined such follow-up and had resented the communication from the mental health team prior to his admission as he felt this was "authorities trying to impose on his life again." He denied extensive arguments with his neighbours and also denied threatening them. He accepted a follow-up but refused to take medication. No abnormal mental state symptoms were elicited and he was described as clear, coherent and spontaneous in his response to questions. There was an Assessment of Risk Form completed on his discharge but there is no indication that he received a care plan at the time of this discharge.

8.21 He was seen at home on the 29th October by the CRT who found him outside his flat speaking with a neighbour. The neighbour said that everything was well. Mr B refused further CRT follow up.

8.22 At his CPA meeting on the 2nd November 2005 the CRT reported no problems, despite only having seen him once when he declined any further follow-up by them. He was discharged to Standard CPA.

**2006**

8.23 The records indicate that Mr B did not keep his appointments reliably and Mr B and his GP were informed of the likelihood of closure with the CMHT if he did not attend future appointments. The CMHT discharged him in June and informed the GP of this decision.

**2007**

8.24 In November 2007 **t**he electronic records indicate that the CMHT were contacted because of concerns about Mr B's behaviour at home. The intention was for a joint visit with the housing association worker but in the event this home visit was cancelled because it was felt "not safe to visit without Police support, Mr B is dangerous and may be violent".

8.25 There is no record in the notes of whether a subsequent visit almost a fortnight later involved Police attendance, or of any action in the period from the 29th November to 11th December 2007.

8.26 The notes indicate that a pre MHA assessment unannounced home visit was made by a social worker on 11th December which described Mr B as "co-operative but irritable and agitated", denying problems with neighbours, or any need of mental health support. The record indicated that there were concerns and a need for follow-up.

**2008**

8.27 Police records indicate that a warrant for Police assistance was obtained on 14th December 2007, with a MHA assessment carried out at Mr B's home on 7th January 2008. Four Police Officers were in attendance because of the concerns of possible violent resistance although in the event he was compliant with the assessment process. He was admitted to hospital under Section 2 of the MHA.

8.28 During the course of the following week case notes indicate that he was calm and compliant. Mr B was made an informal patient on the 9th January, two days later, by agreement, he went on weekend leave but did not return. There was a subsequent discharge in his absence later that week.

8.29 The notes indicate that a home visit was carried out on 16th January 2008 by the female care coordination who had also acted as the Approved Social Worker the previous week. This was intended to be a visit where she was accompanied by another worker but the other person's transport failed so she visited alone. There is no record of what happened so it is possible that Mr B was not at home at the time. It is also recorded that he was assessed by the CRT but not considered appropriate for their service.

8.30 A Discharge Summary was sent to the GP, which gives his discharge date as 16th January and a diagnosis of "Behavioural Changes due to cannabis use". There was no immediate treatment plan and he was not on any prescribed medication.

8.31 In April 2008 Mr B's aunt phoned and spoke to a doctor expressing concern about his mental health and asked that he be monitored. A home visit was arranged for 30th April but Mr B did not permit access to his home.

8.32 During May to December 2008 the Housing Association were taking legal action to evict Mr B because of his growing rent arrears and noise nuisance.

8.33 During August there was a home visit by a mental health worker and a recently appointed consultant psychiatrist. There was concern about Mr B's mental state

and his resistance to engagement with Mental Health Services. Outpatient appointments were made for September and October which Mr B did not attend.

8.34 A Notice of Eviction was issued in November by the Housing Association.

8.35 Mr B made contact with the CMHT on the 12th December about the eviction notice and there was further contact with the Housing Association. The timescale of his eviction was explained to him. He felt the grounds for this were unfair.

8.36 A comprehensive Needs Assessment form was completed on 23rd December by a care coordinator, when it was noted that he continued to be reluctant to be involved with Mental Health Services. A Transfer CPA form was completed for transfer to the South Sector CMHT.

**2009**

8.37 Mr B was evicted on 21st January. There was contact with the CMHT and a plan including Bed and Breakfast accommodation was discussed with the CMHT as part of a support plan for him. Mr B is however reported as rejecting this because he was adamant that he did not have any mental health problems.

8.38 The CMHT was contacted by Mr B's aunt saying that he had turned up at her home with unrealistic expectations of the accommodation they could provide for him in the Midlands where she lived. The CMHT advised the aunt to contact her local social services and it is noted that "she sounded afraid of" Mr B. The care coordinator also spoke with Mr B. That same day the local social services where the aunt lived made contact, confirming that their Homeless Persons Unit would not offer Mr B accommodation. Brent Council Homeless Persons Unit made it clear that they would not offer accommodation as he had made himself intentionally homeless. As it was a weekend the care coordinator made arrangements with Brent Emergency Duty Team that if Mr B should return to place him in Bed and Breakfast (B&B) accommodation and that the CMHT would fund this.

8.39 During February and March 2009 there was contact with Mr B and it would seem that he returned to Brent in early February and was placed in B&B, and then on 11th March he was placed in an Atlantic Guest House (AGH) property funded through Housing Benefit.

8.40 This was the first AGH property that Mr B lived in. Approximately two weeks later he was moved to another AGH property as a result of conflict with another

person living there. The conflict appears to have been ascribed to the other resident.

8.41 During May to December 2009 Mr B continued to live in an AGH bedsit in one of their shared houses and was in approximately monthly contact with his care coordinator when he visited the local CMHT office. He was not on medication during this period.

8.42 A continuing theme during these months was Mr B's sense of grievance that he had not been allocated a council tenancy; he had strong views that everyone should be housed in their own property, and he did appear to have had an unrealistic and fixed view about his entitlement to housing. In the main he is described as settled during these months.

**2010**

8.43 On Monday 25th January Mr B went to the CMHT office to report that he had apparently spent the weekend at a local Police Station following an altercation with another resident in his AGH property. This caused Mr B to be rehoused by AGH into another of their properties that same week, where he resided until his death. This was also the property where Mr A lived.

8.44 It is not clear what actually happened, the care coordinator's notes are very basic, and other than a phone conversation with AGH no other actions were taken by the care coordinator.

8.45 There was no further contact with Mr B in person until 24th March. At this time Mr B reported further concerns about another person in the property who was also known to Brent Mental Health Services. This other person referred to is not thought to be Mr A who was also a resident in this property.

8.46 Mr B again attended the office on 26th March but did not see his care coordinator. He had been away visiting relatives and apparently when he returned to London, damage had been done to a door in the property. The Police had been involved and he said that he did not feel safe there and requested an immediate move. The community psychiatric nurse (CPN) to whom he reported these concerns referred him to AGH to resolve the issue.

8.47 The records indicate that there was also phone contact with Mr B's aunt on 25th March who, it appears, phoned the office to report her concern for her nephew, that she would prefer him not to visit as he was sometimes verbally aggressive.

8.48 The next contact was 26th April when Mr B attended the office, and again expressed his desire to move to other accommodation.

8.49 A CPA Review was carried out on the 1st June. The consultant, care coordinator and Mr B were all present at the CPA Review. He is described as mentally stable, issues about housing were identified. The documented contingency plan was for "Close monitoring and if need be prescribe medication…" and "Request assistance of the CRT if need be". It is recorded that "he appears relatively stable considering his diagnosis". A future CPA date was set for December 2010.

8.50 The Risk Management Plan completed at the same time did not identify Mr B as being vulnerable.

8.51 There was no further contact until 11th June 2010 when the care coordinator was alerted to the serious incident when Mr B was stabbed and had been admitted to hospital.

8.52 During June there was contact with the hospital where he was being treated for his injuries. There was an expectation that Mr B would be ready for discharge presently as towards the end of June he was described as improving.

8.53 When the care coordinator phoned the ward on 1st July 2010 she was informed that Mr B had suffered a cardiac arrest and had died.

# 9. Analysis of the Evidence - Mr A and Mr B

9.1 The independent investigation panel has gone to considerable lengths to describe as accurately as possible the narrative history and behaviour of both men in their contact with Brent Mental Health Services. Mr A was not a reliable informant, even when well. This is illustrated by his withholding of his psychiatric history before he came to the UK. This only became known in October 2006 when disclosed by his father, and did not appear to have been known to the internal review panel. However, in the case of both men, but particularly Mr A, repeated examples of non-disclosure or denial of key facts did not raise sufficient concern with clinicians. Neither man's own account of their condition could be relied upon to determine mental state, risk or concordance with treatment.

9.2 This Analysis is structured to focus on main themes in both the planning and delivery of services and on particular periods in the respective histories of both men. There are similarities in the care and treatment each man experienced so a number of the comments apply to both. The analysis of care planning contains several areas of consideration:

**Care Planning and Support**

- In hospital
- In community settings
- At points of admission and discharge
- Risk assessment
- Mental State awareness
- Diagnosis
- Medication

**Use of the Mental Health Act**
**Clinical Record Keeping**
**Clinical Supervision and leadership**
**Criminal Justice system and Inreach mental health service**
**Immigration status**
**Housing arrangements**

## Care Planning and Support

9.3 In considering what is an extended period of time there are differences of detail for each man in terms of their engagement with Mental Health Services. However, a common pattern for both is that they were not supported in the community in line with well set out and maintained care plans.

9.4 An early example of this is in relation to Mr A in March 2004 when at his discharge from the Rehabilitation Unit the actions identified in his risk assessment, CPA care plan and Discharge Summary were not carried through with the poor quality transfer to the North West Sector Team. An initial failure to follow CPA process led to a failure to implement a reasonably well formed care plan or take account of a good quality risk assessment by the community team.

9.5 If a CPA process had been applied according to Trust and National guidance then it is less likely that Mr A's support would have been ceased in such an uncoordinated way in 2008/2009.

9.6 In respect of Mr B there is reference to care coordination throughout the record of involvement from 2005. However, there is little documentation of risk assessment or of CPA planning. The newly in post consultant tried to have a care coordinator allocated in September 2008 but this was only achieved in December 2008. It is acknowledged that Mr B was reluctant to engage so securing his engagement with a care plan would likely have been difficult to achieve.

9.7 Communication by the care coordinator with the Police and AGH staff after the incidents Mr B described at his accommodation was insufficient to understand their significance, particularly so in the episode described by Mr B in January 2010. Hence his risks were less well understood than they could have been and opportunities for multi-agency coordination of his care were lost.

9.8 CNWL undertakes audits of compliance with the CPA process. However examination of the care and treatment of both these men shows a pattern of disconnection between the individual's history, clinical state, care planning, risk management and achieving continuity of treatment and engagement. The format of the audit presented to the independent investigation panel focuses on process and procedures and does not really address the issues of adequacy and appropriateness of risk assessment, management and care planning.

9.9 Illustrated below are a number of specific areas where practice did not deliver coherence across the range of considerations necessary to achieve comprehensive and effective care planning, treatment and support.

## Inpatient care – Mr A

9.10 The shortest of Mr A's periods in hospital was for approximately three months, and on all occasions ward staff had to contend with significant threats and actual assaults on them. He had periods in both open and secure ward settings and preparation for discharge on each occasion.

9.11 There was a pattern established over the years that when Mr A was admitted to hospital under a Section of the MHA he would present as disturbed, unkempt, aggressive and sexually disinhibited. He did not accept that he had a mental illness and was resistant to medication. However, in time, with medication his condition would improve and he would become more amenable and cooperative. However he was never fully insightful or transparent and reliable in his disclosure.

9.12 It is not evident that sufficient history was always taken into consideration in the assessment of Mr A's condition and treatment. For example, the independent investigation panel could find no trace of significant information in relation to Mr A, and to other family members that should have been incorporated in his records in 2006.

9.13 After the completion of the interviews the independent investigation panel were provided with a previously unlocated file with a reference to Mr A's brother being a CNWL patient who had "started experiencing mental health problems after an accident in July 2006 where his leg was amputated by a train when he fell off a platform".

9.14 This information was contained in a Social Circumstances Report prepared by a social worker in January 2007 after meeting with Mr A's father. It is evident that in 2005 and the second half of 2006 Mr A had significant contact with his father and other members of his family. It is surprising that this information about his brother does not appear to have been considered.

## Inpatient Care – Mr B

9.15 In respect of Mr B, his periods in hospital were relatively brief. There is little information about admissions in the 1980s and 1995, however both his 2005 admission and that in January 2008 followed the same pattern. Once in the hospital setting Mr B quickly became less abusive and threatening.

9.16 In October 2005, less than a week after his admission on Section 2 of the MHA, when he was reviewed by the consultant it is noted that he had been in the community for the last nine years without medication. He had been laughing and talking to himself whilst on the ward. However he was not considered to be a management problem, he had not been aggressive but had not wanted to take medication. Inadequate consultation occurred with the housing providers to support the decisions to pursue further inpatient assessment and treatment on either occasion.

9.17 At a pre-discharge assessment in late October Mr B said that he would accept follow-up by the CRT. However he had previously declined such follow-up and

had resented the communication from the mental health team prior to his admission as he felt this was "authorities trying to impose on his life again." He denied extensive arguments with his neighbours and also denied threatening them. He accepted follow-up but refused to take medication. No abnormal mental state symptoms were elicited and he was described as clear coherent and spontaneous in his response to questions. There was an Assessment of Risk Form completed on his discharge but there is no indication that he received a care plan at the time of this discharge.

## Community Care – Mr A

9.18 There were three periods when Mr A received community care, on his discharge in May 2004 to stay with his brother (it is not clear whether this brother was the person who was also in receipt of CNWL services); in March 2007 to the AGH property; and in February 2010 back to his address at the AGH property.

9.19 The transfer of Mr A's care from the Rehabilitation Unit to the North West Sector Community Team was not achieved in a timely fashion; this was envisaged to occur within four weeks but actually took over six months. The care plan at that transfer was very limited and did not demonstrate continuity with Mr A's care plan on discharge from the Rehabilitation Unit. Mr A's follow-up and discharge from the CMHT was not in keeping with national guidance or local policies for a man who had spent fourteen months in a hospital and rehabilitation, with a significant history of violence and sexual disinhibition associated with psychosis.

9.20 The inadequate transfer of Mr A's care to the appropriate CMHT detrimentally affected the communication of the discharge care plan to the community team and contributed to the poorly considered care that he received in the community during this period (2004/2005). In addition to the delay in transferring his case there is no evidence of any allocation process within the community team that was taking over responsibility.

9.21 On Mr A's discharge in March 2007 there was care coordination but this was provided by a female care coordinator and female student social worker despite previous risk assessments that had identified a risk of violence and of sexual approaches to women. Following the appointment of a new care coordinator later in 2007 there was consistent engagement for a period of time.

9.22 Mr A's engagement with psychiatric services was not maintained during 2008 and 2009 when contact was intermittent with no evidence of adherence to CPA reviews or risk assessments. There was intermittent contact when Mr A attended the office to receive his weekly allowance, and some attendance at outpatient clinics. However, the degree of monitoring of his mental state appears to have been limited. In addition there was insufficient rigour in

attempting to establish whether or not Mr A was compliant with his medication. It seems likely that he was poorly compliant or non-compliant with medication after stopping his depot in 2008 and certainly non-compliant from March 2009.

9.23 In February 2010, contact was maintained with Mr A on his discharge but it was partial and appears to have been at Mr A's instigation when he visited the office base to collect his allowance. This is discussed further below. The investigation panel were unable to meet with the care coordinator at that time (an agency worker) who had returned to his home country.

9.24 In the case of both men there was a lack of clear guidance to care coordinators about the need to see patients at home. It is positive that new guidance has been issued in 2012 by CNWL clarifying the importance of seeing the person in their home setting.

## Community Care – Mr B

9.25 With regard to Mr B, there is no doubt that he was resistant to engagement with Mental Health Services. There is some indication that he sought involvement when he felt under stress. This was essentially at times when he was under the threat of eviction.

9.26 There is evidence in the notes that attempts to engage with Mr B were made at different times in his engagement with the services but these did not secure any significant continuing contact.

## Effectiveness and integration of Risk Assessments with care and support

9.27 At various times in their hospital care both these men were risk assessed. Risk assessments accurately describe Mr A's history of inappropriate sexual behaviour, violence towards others, both in the ward setting and in the community. They also indicate his denial of mental health problems and poor concordance with medication. Previous supervision failures are apparent in later risk assessments.

9.28 Knowledge and assessment of these risks is not however evident in the care and support arrangements put in place. There are several illustrations of this spanning Mr B's engagement with service.

9.29 In March 2003 Mr A absconded from the ward for some two weeks before being returned to the ward by Police attempting to break into a house occupied by an elderly woman and attempting to assault a Police Officer when he was

approached. Again in early May 2003 although there was concern that Mr A was "still high" his leave was increased to an hour twice daily. On the next day he absconded from the ward and was absent for 24 hours. When he returned he said he had been travelling on the bus. At the time of his return to the ward Mr A was unkempt and malodorous. He expressed the view that ward staff were immigration officers. His behaviour was similar to that when first admitted. He was smiling inappropriately, irritable and aggressive and displayed threatening behaviour, telling a female member of staff that he would kill her. Later that same month he broke the arm of a taxi driver in the hospital grounds whom, it is reported, he had taken to be an immigration officer.

9.30 Mr A showed a continuing concern about the risk of deportation and the presence of immigration officials. The degree of this concern appears to have been held with a high level of intensity that was most evident when he was most disturbed. This might have been better identified as a significant indicator of risk, but the risk assessment forms completed at the time are limited and do not indicate how or if this was considered.

9.31 The Risk Indicator checklist dated 9th March 2004, and risk assessment on 11th May prepared prior to Mr A's discharge from the Rehabilitation Unit correctly identified Mr A as being at risk from others, of non-compliance with medication and as posing a risk of violence to staff, other patients, to the general public and to have been involved in incidents with the Police. His previous history and progress in the hospital wards is well detailed in the risk assessment, as is the link of his violent behaviour with his mental illness and that, as his mental state improved risk decreased. The risk assessment also reflects that his brothers did not see that he had a mental health problem, although they were expected to monitor him and he was living with at least one of them on discharge. The assessment also described very limited cannabis use but no history of alcohol or other drug misuse.

9.32 The completion of risk assessment documentation did not result in adequate planning to manage risk in 2005. A risk management document template exists within the Trust but none has been adequately completed at any point in either patient's care. The structure of the care plan document with its 10 categories, none of which relates to managing risk, seems to have led to minimal risk management documentation/planning in the CPA documentation. This could have been mitigated by good quality contingency or crisis plans. These were generally very limited.

9.33 In 2007 risk assessments from Mr A's previous admission are not heeded and on discharge he was allocated a female care coordinator and a female student at the same time despite his history of sexually inappropriate and intimidating behaviours towards women on both admissions. As with his previous cycle of

admission and subsequent follow-up in the community, difficulties quickly arose once his follow-up lessened.

## Mental State Awareness - Mr A

9.34 Mr A's main contact with services when in AGH accommodation was when he attended the London Road office to collect his cash payment made under Section 117 of the MHA as a person with No Recourse to Public Funds.

9.35 Other than when he was in hospital care, assessment of his mental state was very limited outside of the psychiatrists' clinics.. For example, in 2008 when he saw his care coordinator in August, twice in October and twice in December, an SHO and his consultant in mid December 2008. No psychotic symptoms were identified but he was malodorous which might have been identified as evidence of a deteriorating mental state. Most of his contact was around his finances and there is little indication of proactive work, either on occasions when he collected his money or in the rare CPA sessions that indicate that the team were adequately monitoring his mental state.

9.36 The Crisis Resolution/Home Treatment Team assessment of Mr A in December 2009 states that Mr A had been discharged from Mental Health Services in the summer, which presumably reflects ambiguity in the records, but had recently been relapsing in mental state. He was reported to be non-compliant with his medication and said to have recently been harassing a 16 year old female tenant in the room next to his.

9.37 At the MHA assessment on the 10th December, he did not want to engage with services and said that he would only speak to them if a solicitor and Police were present. The Police were contacted and attended. Mr A was aroused and angry about the visit, stating that this was continued harassment. He was guarded and extremely argumentative. He was unable to show any medication when he was challenged about taking it and maintained that he was not mentally ill and never had been. He would not accept admission to hospital voluntarily or visits to his home by mental health professionals.

9.38 Mr A is described as having become irritable and confrontational to the staff at AGH. He had been reported as wandering semi-naked and knocking on other resident's doors after midnight. He had asked a 16 year old female in the premises to join him for drinks in his room at night. When this was discussed at interview with AGH they were definite that the house Mr A was in was male only and they would not have a 16 year old female resident in the house. It is unclear what actually happened at this time and it may have been that there was a young woman in the house possibly visiting another resident but this is

speculation only. Mr A was reported to have been following a female member of staff around in the house, and AGH staff had often avoided him.

9.39 When in hospital a Mental Health Review Tribunal was held on the 22nd December 2009 which upheld his detention under Section 2 of the MHA. The report prepared for this Tribunal contained new information.

9.40 Mr A had stated that he was pestered by other residents at the house and had a disagreement with another resident upstairs and that the resident's friend had attempted to run him over with a car on Kilburn High Road the previous night. He also expressed the view that he felt that other people wished to harm him. It is not known if this actually happened, or the extent to which any possible delusional state was probed. Mr A also said that he had stopped taking his medication months previously as it did no good and made him sick. Subsequently in his Discharge Summary it is stated that he had been non-compliant from at least March 2009 based on prescriptions collected from his GP.

9.41 After his discharge in February 2010 to the incident in June 2010 there is little evidence of any detailed monitoring of Mr A's mental state, or of his circumstances at his home address.

9.42 Contacts are all at the CMHT office with no assessment of Mr A at his AGH home setting. Meetings between Mr A and his care coordinator are documented but show little assessment of mental state and no substantial attempt to establish concordance with medication. The investigation panel were unable to interview the care coordinator but it is not evident that he saw this as part of his role. Mr A's care coordinator focused on his concerns regarding his immigration status and did little to assess his mental state or establish compliance with treatment during his follow-up in the community. He was not seen at AGH, which would have provided an opportunity to gather additional information about his mental state.

## Mental State Awareness – Mr B

9.43 There were periods when Mr B showed clear symptoms of psychosis. For example in June 2006 when Mr B was seen by the (locum) consultant psychiatrist at an outpatient appointment. He had initially stated that he was doing very well but towards the end of the interview suddenly began to express delusional thoughts about having a girlfriend whom he had known since prior to his birth. There was no evidence of other paranoid ideation or hallucinations recorded. He maintained that he was getting on all right with his neighbours who were not complaining.

9.44 The plan was to review him in three months but in the event Mr B cancelled four appointments and he was not seen again until December 2007 by which time he was in a disturbed state.

## Diagnosis – Mr B

9.45 There were concerns about Mr B's diagnosis. Early in his engagement with Mental Health Services it is often repeated in his notes that he was diagnosed with paranoid schizophrenia during his 1996 admission. He was started on depot neuroleptic medication at that time. When he was discharged from hospital in November 2005 the Discharge Summary did not contain a diagnosis. Then in January 2008 he is described in his Discharge Summary as having a diagnosis of "Behavioural Changes due to cannabis use". In June 2010 his diagnosis is given as schizophrenia. It is the investigation panel's view that from the first of his admissions the evidence available strongly supported the diagnosis of schizophrenia.

9.46 There was a concern about his level of alcohol and/or drug abuse. Inconsistencies in his account of his substance misuse made it clear that he did not give a reliable account of this. It is the investigation panel's view that not particularly addressing this was a reasonably pragmatic approach to the management of this man since his engagement was insufficient to treat this problem.

9.47 Except at times of acute disturbance when he would be verbally abusive and threatening to others, neighbours especially and possibly with a racial tone to this abuse, he was able to consistently manifest minimal symptoms of psychosis.

9.48 The investigation panel believe that as Mr B was detained twice under the Mental Health Act, a more robust attempt should have been made to treat him on at least one of those occasions. Lack of clarity about his diagnosis probably played a part in this. However it is accepted that even a successful episode of inpatient treatment may not have had significant impact on his long term outcome.

## Medication – Mr B

9.49 Mr B consistently refused to comply with any medication regime while he was living in the community. His pattern was that he was able to sustain himself in the community while causing concern and nuisance to his neighbours which resulted in admission and housing difficulties. There was no apparent strategy devised by the team treating him other than to try to maintain low level contact and be responsive when his condition deteriorated.

## Medication – Mr A

9.50 The major concern here is in relation to Mr A where his poor concordance with medication was significant and appears to have had a consistent contributory effect on his deteriorating mental state.

9.51 The Trust's internal review suggests that after his last admission concordance with medication was established "as he had gone to his GP for a repeat prescription". It is not evidenced in the record that his care coordinator had established this and the investigation panel were unable to establish the source of this belief.

9.52 In the view of the independent investigation panel Mr A's history and established pattern of non-compliance with medication, or willingness to continue his engagement in community support was not adequately considered in the care plan on his various discharges.

9.53 There is a pattern over the years of his engagement that when in hospital and receiving depot medication (albeit reluctantly) his condition improved. However, given his continually stated opposition to this form of medication in particular, the community team was faced with the inevitable change to oral medication that might have prompted a different approach to monitoring concordance.

## Use of the Mental Health Act 1983

9.54 This focuses primarily on the absence of consideration of a Community Treatment Order (CTO), or prior to the introduction of CTOs, Supervised Discharge, for either man. The investigation panel agree that the impact of either of these instruments on the engagement of either man in care and treatment is likely to have been minimal. The decision of the Responsible Clinician not to use a CTO should be documented.

**Mr A**

9.55 Mr A had been discharged from the Community Mental Health Service in 2005 and 2009 largely because he had chosen to disengage. In light of his risk profile a more robust response including possible use of the Mental Health Act should at least have been considered at these times.

9.56 On discharge from hospital, the CPA Review meeting in February 2007 was attended by the care coordinator and the ward doctor. Mr A was regarded as consistently without insight into his mental illness or the need for medication in

the community. He was again asking for oral medication instead of depot, he was discouraged from stopping injections at this time but it was suggested they could be stopped in the future. Relapse indicators were suggested to be poor insight and knowledge which were however already present. He was discharged from Section 3 of the MHA and his depot was changed from weekly to two weekly. There is no indication that Supervised Discharge was considered for his discharge.

9.57 Similarly when he was discharged in February 2010 there is no indication in the discharge CPA that a CTO was considered although his pattern of non-compliance with medication was well known.

9.58 This inadequacy is recognised in the Trust's internal review. An email was sent to Responsible Clinicians asking them to consider the use of CTO's. This practice is likely to be increasingly scrutinised by the CQC (Care Quality Commission).

**Mr B**

9.59 There are also issues relating to the use of the MHA in respect of Mr B. The ASW obtained a Section 135 of the MHA warrant in mid December 2007 because of her concerns about Mr B and his probable psychotic state and potential violence. However there was then a gap of almost a month before the warrant was executed. This long gap is unexplained in the records.

9.60 It is also the case that the subsequent Section 2 of the MHA order was rescinded by the consultant on the 9th January 2008 only two days later. The assessment prior to rescinding his Section detailed Mr B's allegation that his neighbours made noise and he felt that neighbour had made allegations against him because he (the neighbour) was foreign and did not understand things. There is no evidence that collateral information from his neighbour, the housing officer or the man who was staying in his flat was obtained to give a more rounded picture of his mental state. The description at the time of Mr B's view on pre-birth experiences, the role of world war two and on mansions for everyone is insufficiently detailed to offer greater understanding now about the appropriateness of this decision.

9.61 In the event, Mr B agreed to stay in hospital informally. He was only on the ward for two more days before he went on leave on the 11th January 2008, did not return and he was discharged without follow-up being planned. He was assessed by the Crisis Resolution/Home Treatment Team on the ward, but he did not wish to be seen by them at home and they did not feel they had a role in his care.

## Clinical Record Keeping

9.62 The clinical records provide a great deal of detail about Mr A's behaviour over the years while he was in hospital care, They give an indication of his beliefs and actions when unwell and of the improvement achieved over time when Mr A was compliant with medication

9.63 On his first admission it is of note that throughout this period until his transfer to a locked ward the documentation of ward rounds and medical assessments is minimal and there is no documentation of medical assessment of his mental state after the first few days of his admission.

9.64 This is in contrast to the nursing notes which for all of Mr A's inpatient stays were of good quality and usefully descriptive of the man and his behaviours. Throughout the extended period as an inpatient the nursing records are succinct and informative. They convey a clear picture of his behaviour. This is however offset by a lack of documented 1 to 1 sessions detailing mental state information and reflecting the patient's wishes.

9.65 It is evident that information was not consistently conveyed from the different risk assessments into active care planning, and in the case of Mr B that historic information relating to previous engagement with Mental Health Services, possibly in the 1980s and in 1995/6 was not available.

9.66 The use of electronic records will have improved the availability of information but will not in itself resolve the issue of making use of available information to inform care and treatment for the individual and in risk assessing circumstances for staff working in the Mental Health Services.

9.67 Both electronic and paper records were used to record clinical information. The investigation panel learned that some staff made double entries but others do not. Hence it is only possible to get the complete picture of clinical activity by reconciling both records. This obviously poses a risk of staff having access to incomplete clinical information. The Trust's implementation of an electronic patient record will address this to some extent but raises issues of the access to complete historical information for some time post initial implementation.

9.68 This is of particular concern because of the number of care coordinators Mr A had during his period of follow-up in the community. In 2009 his contact with a care coordinator and follow-up falls away without any clearly documented intention for it to end. It is possible that the apparent change of mind by the SHO, who had the last contact with Mr A, during this period to follow up, rather than to discharge him, was the consequence of consultant oversight or supervision but there is no record of this.

## Support to Students and Trainees

9.69 Education and training is identified as deficient by the Trust internal review, particularly as it relates to care planning and CPA. However the main focus is on uptake of training. It may be that the content of that training needs to be considered with particular emphasis on continuity of process, risk assessment and management.

9.70 It is probable that the MAPPA referral for Mr A was not followed up because it was made by a social work student who left her placement shortly after completing the paperwork. However, the record indicates that the MAPPA paperwork was not fully completed. This along with the large number of ward rounds and ward assessments conducted by SHOs during Mr A's care without clear or apparent supervision suggests poorly supervised delegation to trainees and students.

9.71 The conduct of the care planning process and the quality of risk assessment indicates a need for improved training from the level that pertained at the time of this incident.

## Criminal Justice System and Inreach Mental Health Service

### HMP Pentonville – Mr A

9.72 Mental Health Services in HMP Pentonville were provided by two organisations. Barnet, Enfield and Haringey Mental Health NHS Trust provide specialist forensic assessments and Camden and Islington NHS Foundation Trust provided Mental Health Inreach Services.

9.73 Mr A was remanded into the custody of HMP Pentonville on the 3rd January 2006. While information from these services has been hard to collate, it would appear that Mr A was initially housed within the main part of the prison. However, after "a couple" of psychiatric assessments it was felt that he would benefit from a period of further assessment and treatment in the healthcare wing and he was subsequently moved to the healthcare wing on the 19th May 2006.

9.74 It is noteworthy that a psychiatric report prepared on the 30th May 2006 by a Specialist Registrar and a CPN from the North London Forensic Service noted that they had become aware of Mr A's previous psychiatric history with Brent Mental Health Services. Their assessment at the time was that "we could elicit no symptoms or signs of either a depressive or psychotic illness". However, the

report also noted that "there is sufficient suspicion about his mental health and its possible relationship to offending behaviour that would warrant its monitoring in case his mental state were to deteriorate in the future."

9.75 During his stay in Pentonville it was noted that Mr A had some incongruity of affect, negative withdrawal from association and a total lack of insight into the abnormality of his recent behaviour (this is not specified) and procedures were started for his transfer to hospital under the MHA. These were never completed. From the written records available it would appear that he was convicted to a short sentence leaving the Inreach team insufficient time to complete the process.

9.76 From the available notes it would appear that on the 12th June 2006 an Inreach worker from Pentonville Prison rang Mr A's care coordinator reporting that there had been some confusion on whether he will be released the next day or be deported back to Sri Lanka. He had previously been deemed unfit to plead, however, the report of the 30th May assessed him as fit to attend court for sentencing. The care coordinator agreed a plan to have Mr A assessed by a psychiatrist and to facilitate a referral back to the CMHT.

9.77 A psychiatrist from the mental health Inreach team subsequently wrote to the Rehabilitation Unit (from which he had been discharged two years previously) on the 21st June 2006 noting that he was released on the 13th June 2006 without the mental health team having adequate notice to arrange the planned assessment or any follow up.

9.78 The letter described Mr A as actively unwell and that he may deteriorate, that he has no fixed abode and is currently an illegal immigrant with no legal status in this country. It also notes that he might pose a threat to members of the public.

9.79 The locum consultant covering the Rehabilitation Unit received this letter on the 26th June 2006 and contacted the CMHT manager saying she was at a loss as to how to arrange to see him since his release, as he was homeless, and with no means of making contact. The CMHT manager responded on the 30th June 2006 and confirmed that his previous CPN had been withdrawn in June 2005. The records note that the Inreach worker had raised the issue earlier in the month just the day before the release had taken place, which apparently the Inreach team had been unaware of.

9.80 The locum consultant notes these unsatisfactory arrangements and agrees to take it up with the prison, in the meantime the care coordinator had agreed to try to ascertain Mr A's whereabouts.

9.81 From the records it would appear that the care coordinator contacted Mr A's previous GP who advised that he had been removed from the GP's list on the 12th May 2006 because he had moved address.

9.82 It is difficult to understand the circumstances that led to a vulnerable homeless man who had been in the healthcare wing of the prison for almost a month to be released with no follow up or even contact details. On the 30th May he was considered as not having a mental illness of the nature or severity to warrant transfer to hospital, yet it would appear that by the time of his release 12 days later they had started procedures for his transfer to hospital under the Mental Health Act.

9.83 The process of ensuring his transfer under the Mental Health Act had begun and his risk profile was evident. From the few available notes it would appear that the mental health Inreach team were aware of this possibility at least the day prior to his release and it is feasible that this was known prior to this. The Inreach team did contact the care coordinator the day prior to his release and did subsequently send a written referral (albeit to the wrong department) expressing concerns about Mr A's follow up.

9.84 It is acknowledged that his release was a surprise to the Inreach team but they were aware of the possibility of his release at least a day prior and he had been in the healthcare wing since the 19th May 2006 yet no contact seems to have been made with his previous CMHT to try to re-engage him prior to his release. It is certainly the case that it was only after 30th May that hospital transfer was considered.

9.85 This independent investigation panel considers that there were a number of opportunities to re-engage the CMHT prior to his release. The report to the courts on the 30th May 2006 makes reference to the need for follow up by the CMHT on release, and it would appear that between then and his release on the 13th June Mr A had further deteriorated and that transfer arrangements under the MHA were being considered.

9.86 While in the criminal justice system there was a lack of clarity about his support needs, possible release, transfer to the health service and the implications of his immigration status. His mental health needs and risks were not addressed in a timely fashion, hence he was released from Pentonville prison before community support was put in place.

## HMP Wormwood Scrubs Prison – Mr A

9.87 There are no further entries relating to this prison release or the proposed follow up by the locum consultant until the 7th August 2006 when it was noted that Mr

A was then in HMP Wormwood Scrubs following a further unprovoked assault of a girl on a bus.

9.88 Once contact had again been made with Mr A in August 2006 at HMP Wormwood Scrubs, this was maintained and he was subsequently transferred to the low secure unit at Park Royal Hospital under Section 38 of the MHA on 11 October 2006. It is known that the relevant CMHT was not informed of this transfer during its planning or at the time and only became aware of it when they contacted the Inreach team the following week.

## Mr A's Immigration status as a person with No Recourse to Public Funds

9.89 Mr A's legal status was complex. He had entered the UK illegally in April 2002, his application for asylum was refused, which he appealed against unsuccessfully. His appeal rights were described by the UK Border Agency (UKBA) as "exhausted" at the end of 2002.

9.90 A further appeal was lodged under Articles 3 and 8 of the European Convention on Human Rights early in 2003 which was refused, as was a subsequent appeal during 2004.

9.91 In 2005 an application for a High Court Review against the Adjudicator's decision was refused, and again in August 2005 all his appeal rights became exhausted. In March 2006 further representation on Human Rights grounds were submitted and to date these representations remain outstanding. Mr A is subject to control under the Immigration Act 1971 and as such is liable to deportation or administrative removal from the UK.

9.92 With this refusal of asylum he became a person with No Recourse to Public Funds. However, as he had been subject to the MHA he had acquired a right to support under Section 117 of the MHA. This is a not uncommon conflict that mental health and local authority services have to deal with where different legislation imposes differing requirements on them.

9.93 Mr A was assessed as to his vulnerability and destitution, and through this process his eligibility for minimal allowances was ascertained. The formal responsibility in this situation is with the local authority; however through a positive local arrangement with CNWL, Brent Mental Health Services made payments on behalf of the London Borough of Brent (LBB). One difference between how the LBB and CNWL carried this out was that had the LBB made the payments directly they would have provided Mr A with vouchers in place of cash whereas CNWL paid over cash to Mr A.

9.94 During this period while Mr A was subject to the Immigration Act 1971 and as such is liable to deportation or administrative removal, Mr A had been subject to periods of imprisonment, had been released onto the streets and was known to have entered the country illegally. The prison records do not indicate whether they, or any other part of the criminal justice system informed the UKBA of Mr A's imprisonment. If they did, it is remarkable that the UKBA took no apparent steps to engage with Mr A. On the other hand it would also be remarkable if the prison service had not informed the UKBA.

9.95 Unfortunately the investigation panel have not been able to discuss this situation with the UKBA who did not consider that the Terms of Reference of this investigation were sufficient to enable them to provide information, and stated that they wished to protect the privacy of the individual. The investigation panel have taken the view that seeking Mr A's specific agreement to gaining information from the UKBA would probably be unhelpful to his mental health and unlikely to add significant further information.

9.96 The investigation panel therefore did not pursue this issue further with the UKBA. However, there is a learning point here in respect to any future independent investigations involving people who are known to the UKBA to extend the Terms of Reference to include obtaining their information and cooperation.

9.97 It is the investigation panel's understanding from discussion with local staff in the London Borough of Brent that Mr A's situation was in no way exceptional, and that, anecdotally there are people who have waited 10 to 15 years for a resolution. However, since January 2012 they also report that there has been progress with a number of outstanding cases resolved with either deportation or granting leave to remain.

9.98 From reviewing Mr A's statements when in hospital and recorded in his case notes, it does seem that he was very anxious about the prospect of deportation. The apparent inactivity in respect of resolving his legal status would have caused concern to Mr A, as did the difficulty he experienced in managing on a small weekly financial allowance. While Mr A's immigration status obviously troubled him and added to the stress he exhibited when disturbed, it is not possible to form a view about the impact of this on Mr A's mental health, or indeed what the outcome might have been had his immigration status been resolved.

## Housing and Support - Mr A and Mr B

9.99 Mr A was found accommodation in a bedsit that was part of the range of such bedsit accommodation managed by Atlantic Guest Houses (AGH), a private

company, in March 2007. By this time he had been known to Mental Health Services on and off for four years, he had been subject to the MHA twice and had had periods in prison.

9.100 Shortly after his initial placement in an AGH property he was moved by AGH, with his agreement but without the awareness of his care coordinator, to the house he subsequently lived in until June 2011.

9.101 Mr B was found accommodation in an AGH bedsit in March 2009. Mr B had had two hospital episodes since 2005 in both of which difficulties with neighbours was known as a problem area - including a formal eviction by his housing association landlord in January 2009 - and on both occasions he had been subject to assessment and detention under the MHA.

9.102 Mr B moved into a second AGH property shortly after his initial placement. The records suggest that this first move was occasioned by the behaviour of another tenant in the shared house. There was further difficulty for Mr B when in January 2010 he reported that he spent a weekend in a local Police Station because he was fearful of staying where he was. The consequence of this was AGH moved Mr B, at his request, into another property where he was to remain until he was killed by Mr A, who lived in the same house.

9.103 In January when Mr B reported that he had spent the weekend sheltering at a local Police Station it is notable that AGH acted quickly to relocate him into another of their properties. It is also notable that although there was a phone conversation with Mr B's care coordinator when he went to her office on the Monday immediately after the weekend, and she at the time spoke with AGH, this appears to have been a single act of contact with no subsequent follow-up by either the care coordinator or AGH staff.

9.104 We have reviewed with the Police any information that they have about this self reported stay at Wembley Police Station in January 2010. The Police record is unclear, and it is indeed a line of inquiry they considered after the homicide. However, they did not find any evidence that supports the statement that Mr B stayed at the Police Station in either their records or in any mirror records that might be expected at the CMHT.

9.105 It seems quite possible that Mr B did go to the Police Station as he reported, and possibly on more than one occasion, but there is no provision for him to have stayed at the Police Station as he describes, and given that this is not recorded by the Police reinforces the improbability of this having happened as Mr B reported to his care coordinator at the time.

## The arrangement between CNWL and AGH

9.106 The nature of the relationship that CNWL had as an organisation with AGH is that it had a large number of people in their houses located across the borough. AGH has in the order of 50 properties and the investigation panel were told that CNWL had about 100 people placed there at any one time. The cost of these placements was largely met through housing benefit payments. CNWL set these arrangements in train for the individual, and it would seem that people with a range of mental health needs were accommodated in these properties.

9.107 The investigation panel's understanding from AGH is that they did not then and do not now offer a support service, or have staff with specific mental health expertise. The investigation panel were told that staff have an NVQ2 although it was unclear what the specific focus of the NVQ was in. It is understood that there are some five or six staff who work across the houses essentially engaged in house maintenance and cleaning work described as "just the occasional interaction with the people. If you see anything amiss, you have to report it". It is understood that these staff are not able to access any training from CNWL or the borough council, and that they do not themselves offer training but require people with an NVQ2 when they recruit.

9.108 It would seem from both the perspectives of CNWL and AGH that there was no formal process for communication between the agencies at the time of this incident in respect of the people placed by CNWL in these properties. There was some communication akin to the quotation above, and it is positive that in December 2009 staff from AGH raised an alert about their concerns for Mr A, who was described as "forgetful, aggressive and argumentative". It was as a consequence of this that he was subsequently admitted under Section 2 of the MHA.

9.109 The downside of the relationship was described when Mr A came out of hospital after this episode when the AGH manager expressed the view in his interview with the investigation panel that "he just didn't seem right and we kept on saying". There is no record that shows the nature of this report of concern to the care coordinator and it seems that the care coordinator communicated his contact details to AGH through Mr A and did not himself visit Mr A at his bedsit or respond to these expressions of concern from AGH.

9.110 The Chair of the investigation Panel has seen the photographs taken by the Police at the time of the incident and these show that the communal areas of the house were in a reasonable state of cleanliness and order, which reflects the information provided, that AGH have housekeeping staff. These photographs also show that the individual bedsits of the occupants of the house, including the

shed in the garden which was also equipped and used as bedsit accommodation, were untidy and did not appear to be clean.

9.111 This is clearly a difficult area and the single men who occupied the bedsits in the house will have set their own standards, as is their right. However, it does reflect the absence of input from care support staff who might have encouraged a greater level of cleanliness, perhaps as part of a self care programme. Mr B was the exception to this, and the photographs of his room show it to be well kept, clean, tidy and ordered.

9.112 Mr A and Mr B were not the only men in this property known to Brent Mental Health Services, and although it is outside our Terms of Reference to consider their care and support it is most likely that they received a similar level of support and engagement to Mr A and Mr B.

9.113 What is clear from the experience of these two men is that they received little in the way of active support or engagement, and there was an over reliance on an informal and unstructured system of support from unqualified domestic staff in AGH.

## Actions Subsequent to the Incident

9.114 A risk assessment was initiated by the Police after this incident which was carried out in conjunction with CNWL into this, and to a lesser extent the other AGH properties. In the three years prior to the incident, analysis showed that the Police received 30 calls to the address, mainly concerning low level acts of criminal damage, the most recent of which was in February 2010 and is referred to in Mr B's chronology.

9.115 There is no reference to this risk assessment exercise in the Trust's internal review either in regard to AGH properties and the support arrangements with the Trust, or, more particularly in regard to the specific address where Mr A and Mr B were living.

9.116 The investigation panel have seen evidence from CNWL that an immediate review of what was described as "As Assessment of Atlantic B&B's Fitness for Purpose" was carried out in June 2010, by two staff from CNWL. This involved visits to eight AGH properties with immediate assessment and actions in regard to the other residents of the property in which the incident occurred. This work describes the poor state of the actual property and the chaotic and risky circumstances in the individual rooms of residents of the property. Some residents were relocated and in reviewing their individual circumstances it is clear that they were living in very chaotic and unsuitable settings.

9.117 This illustrated the extent to which people, once placed in AGH, were left to fend for themselves with no supportive arrangements in place for these men in the property. The investigation panel cannot comment on the degree of care coordinator engagement there was with all the people in the properties at the time, but it does not appear that it was any greater than that received by Mr A or Mr B. It is probable that they did not have any visits to them at their addresses.

9.118 Further work was undertaken in the next few months to enable CNWL to get a better grip on the needs of people placed in the AGH properties and this resulted in detailed Assessments of Needs and Risks on some 50 people in the summer of 2011.

9.119 The investigation panel has also seen the continuation of that work by the production of "Guidelines for Managing Service Users in Bed and Breakfast Accommodation in Brent" in May 2012 by the Brent Recovery Team Operations Manager. These guidelines are a positive attempt to support care coordinators in the most effective use of this housing resource, in a geographic area of high demand and shortage of provision, and are to be commended. However, their actual relevance and operational effectiveness is dependent on the broader context within which this housing resource is managed, and its purpose which is discussed in the next Section.

## The nature of the Agreement with AGH and its Purpose

9.120 There can be no doubt that there was, and is, significant pressure on housing resources in Brent, and that access to these bedsits was a welcome addition to the resources available to the services, and to individual patients who might otherwise face homelessness. However the inadequacy of the contact and support by Mental Health Services to either of these men in their own homes through the housing arrangements in place at the time of this incident, and in the years beforehand, was identified in the internal review report with a specific recommendation relating to AGH.

9.121 The implementation of this recommendation is discussed in Section 10 in this report. But in the view of this independent investigation panel the recommendations of the internal review were based on an incomplete understanding of the nature of the contract with AGH and the London Borough of Brent, and the recommendations did not go far enough.

9.122 From discussions with senior staff in CNWL, the Brent Recovery Team Operations Manager, AGH management, and senior staff the London Borough of Brent with housing, and social care commissioning responsibilities what emerges is an absence of a clear understanding of the purpose of the AGH properties or of connectivity with the borough's Supporting People resources and strategy.

9.123 This is not a new situation and it is probable that the differing understandings contributed to the lack of engagement and support to either of these men in their bedsits in the AGH property.

9.124 The actual contract relating to the AGH properties is between the London Borough of Brent and Atlantic Properties Investments Ltd and dates from 2009. Neither the leases in respect of the properties nor the Agreement for the Supply of Services goes into any detail about the level of support that individuals placed in the properties can expect from AGH, or the involvement of CNWL. These documents are concerned with the bricks and mortar, with a small element of domestic support as the only reference to what actually happens within the properties.

9.125 In working practice, what appears to have happened is that the contract was developed by LBB working closely with Brent Mental Health Services in acquiring access to these properties as a significant component in meeting the housing needs of people with mental health problems in 2009. However, they were developed without the active involvement of LBB housing managers or as part of the Supported People programme. Access to the properties was through the local Brent CNWL service, and that has continued to be the pattern to the current day.

9.126 There was, and in the investigation panel's view, continues to be, a confusion about what the intended use, and outcome for individual people is. The properties are described variously in CNWL discussions and guidance as "temporary" or "Bed and Breakfast" or "partially supported" but in reality they were used – and may still be so – to provide long term housing for people who would most probably find obtaining any other accommodation very difficult to achieve. However, from the experience of the two men who are the subject of this independent investigation, (and from the review subsequent to the incident, the other men in the property as well) it is clear that once placed they were regarded in practice as settled and no support in the accommodation was offered.

9.127 There is evidence shown and discussed with the investigation panel by the local Brent Mental Health Team manager, and by AGH management, that arrangements have improved, and the new Guidance referred to above does provide the local mental health team with a clearer process and set of expectations. The investigation panel remain concerned however that the provision is setting a six week duration target for residents, and that it remains outside the Supporting People programme managed by the LBB who are commissioners of this service. Previous practice would suggest that this six week target is probably unrealistic.

9.128 It is reassuring that the investigation panel have heard from AGH that there has been an improvement in the degree and manner of their engagement with Mental Health Services in terms of both information sharing and the improved frequency of care coordinator contact and visits to people living in their accommodation. It is also understood that the administrative arrangements between the agencies has been improved.

9.129 Overall there have been improvements in the working arrangements between CNWL and AGH achieved at the local operational management level in Brent Mental Health Services. These have been largely focused on achieving the recommendations from the internal review with its specific actions:

- A formal agreement between AGH and CNWL should be agreed, covering information sharing responsibilities and feedback arrangements and shared with staff
- The agreement should describe the working relationship between AGH and operational services which outlines clearly the roles of each, how concerns are raised with services and timescales for the response, overseen by Team leaders
- An audit should be completed three months after the above is implemented to check visits being undertaken to those placed in AGH properties.

However, these have not been developed within a shared strategic framework with the LBB about the future development of supported housing as a main plank in achieving individual recovery for people with mental health problems.

9.130 We are aware that the LBB is actively managing the Supporting People contract and there is clearly a strong argument for the AGH properties to be considered within the framework of a Recovery focussed Supporting People model of housing provision.

# 10. Internal Review and its Recommendations

10.1 The Trust set up two Initial Management Reviews (IMR), one relating to each of the men involved, the victim and the perpetrator, immediately after the incident on the Friday 11th June and both were completed to time and are dated as completed on Monday 14th June.

10.2 Each of the IMRs was completed, using the CNWL electronic format, by a senior practitioner and contained relevant information about each man, the incident and summary information about their engagement with the Mental Health Service, key professional staff involved and recent contacts.

10.3 An internal panel of inquiry was established after Mr B's death on 2 July. Had Mr B's survived his injuries, as seemed likely in the weeks after the stabbing when he was reported to be recovering, the incident would have been investigated with a management review. However, with his death the seriousness of the incident was escalated and a Non Executive Director (NED) led Internal Review was established.

10.4 The internal review panel was composed of the NED, a Consultant Psychiatrist, the Associate Director of Operations and the Associate Director, Corporate Governance. They were supported by four staff from across other areas of CNWL and a major part of their work was to compile very detailed chronologies of both men. This support team were not directly involved in the interviews, analysis and report drafting by the internal review panel.

10.5 The internal review panel worked to a clear set of Terms of Reference which had been determined by the Trust Chief Executive and ratified by the CNWL Board of Directors. A number of members of staff involved in the care of Mr A and Mr B were interviewed by the internal review panel including the two consultants and care coordinators. Representatives from Atlantic Guest Houses were also interviewed. There was a telephone interview with the elderly aunt of Mr B, which was an appropriate course of action in line with her preferred way of being involved.

10.6 The final report of the internal review panel was not produced until July 2011, a year after it was commissioned, and it was presented to the private part of the CNWL Board in August 2011. The investigation panel understand that a draft was ready in March 2011, and circulated for factual accuracy by the people interviewed at that time, but there was then a considerable delay in taking the report to the Board. It would seem that the main reason for this delay was that when Mr A went to trial in April 2011 there was an indication from the Police

involved, that the judge wanted the internal review panel to take note of some specific comments he wished to make.

10.7 CNWL tried to get these comments but were unable to obtain them and indeed no such remarks were ever conveyed by the judge though it does appear that he expressed interest in eventually seeing the internal review report. This confusion about the judge's apparent intention to make comment caused delay in finalising the internal review report and submitting it to the CNWL Board. Subsequently, we understand that CNWL has received no further information from the trial or conveyed the internal review report to the judge.

10.8 The internal review panel report contains profiles of both men and analysis of the key issues identified by the internal review panel in relation to their care, a task facilitated by the very detailed chronologies that had been prepared as part of this internal review.

10.9 The basic structure was to identify key issues in relation to each man, in Mr A's case these were in relation to Care Planning; Risk Assessment; use of the Mental Health Act; the involvement of Junior Doctors; and his Asylum Seeking status. In relation to Mr B, these were Lack of a Clear Diagnosis and Care Planning. There was also an identification of General Issues that emerged in the review: Training and Induction; Records; Atlantic Guest House; Support to staff.

10.10 In carrying out this work the internal review panel used a Root Cause Analysis approach with a structured five point approach to each issue identified of:

1. Care and Service delivery Issues,
2. Contributory factors,
3. Root Causes,
4. Lessons Learned,
5. Recommendations.

The internal review panel also identified Notable Practice in relation to each man and in considering the general issues.

10.11 The work carried out using this methodology presented the issues identified and the further work needed to put in place lessons learned and recommendations relating to these lessons learned. However, it is at this point that this independent investigation panel feels that the internal review process lost its way and the content and actions needed from the internal review approach were seriously limited by a lack of clarity in respect of how recommendations were to be promulgated and implemented.

10.12 The internal review panel report was being drafted at a time when organisational changes were being made to service delivery into developing Service Lines, and it would seem that they took the view that their identification of some of the lessons learned and recommendations would be picked up in this process. This conflated issues of implementation and governance of some of the recommendations. As a result, whilst the organisational changes may well have delivered the specific change required by the internal review panel's recommendations, the assurance that this was the case was lost.

10.13 The effect of this was that the report went forward to the CNWL Board in August without an action plan or clear sense of direction how the recommendations were to be pursued, or clarity about where responsibility rested for their implementation and subsequent monitoring. It appears that although the CNWL Board received the internal review report in August 2011 no action plan was prepared until January 2012.

10.14 This independent investigation panel received a copy of an undated action plan in March 2012. The action plan does not contain detail on the proposed actions relating to all of the recommendations in the internal review panel report, and it seems that the lessons learned and recommendations in the report had been synthesised into seven recommendations, some with sub-sets. It has been difficult to reconcile this process with the actual actions that have taken place, and observations and lessons learned in the report that have been described to us as being addressed through other actions on the part of the Trust, notably incorporating the lessons learned in the development of Service Lines within the Brent Services.

10.15 We have found it very difficult to untangle this process but what is clear is that the process of producing the internal review report somehow became detached from the process of formulating an action plan to address the many lessons learned and specific recommendations generated by the work of that non executive director led panel.

10.16 It is also the case that the action plan, when it was generated, was prepared by the local Brent Service working from the internal review panel report and it seems that they prioritised and grouped the recommendations in line with their local appreciation of the internal review panel report and service requirements.

10.17 In the view of this independent investigation panel, the local Brent service manager charged with this responsibility did a commendable job seeking to draw from a process she had not been party to. While this is an important and entirely legitimate perspective to get a local drive for the implementation of the action plan, the fact of its detachment from the generation of the internal review panel report has meant that it is certainly very hard to reconcile an action plan

produced some five months after the Board report, or to have confidence that the specific issues generated in the internal review panel's process have been picked up. A further difficulty is that it is difficult to see how the implementation of the actions to put the recommendations into practice is monitored and evaluated.

10.18 It is regrettable that the internal review process that clearly had time and resources invested in it, and which did much to understand the treatment and care offered to both these men, at the very least had its impact diminished by the loss of focus in completing its work to time and with an owned and Board endorsed action plan to achieve the improvements identified in the report.

10.19 This independent investigation panel requested information about the application of the clinical governance process in respect of the internal review report. An account was given of the clinical governance structures; however, it is the view that clear evidence was not received of the extent of the oversight of the actions arising from this inquiry by responsible governance forums.

## Tabular review of Internal Review Panel Recommendations and Action Plan

| Recommendations | Action taken by CNWL | Timescale |
|---|---|---|
| **1)**<br>a. A formal agreement between AGH and CNWL should be agreed, covering information sharing responsibilities and feedback arrangements and shared with staff.<br>b. The agreement should describe the working relationship between AGH and operational services which outlines clearly the role of each, how concerns are raised with services and timescales for the response, overseen by team leaders. | In regard to a) and b) the action plan presented to the independent investigation panel in March 2012 states that:<br><br>B&B protocol has been redrafted and circulated by (local Operations Manager) to cover the issues highlighted (January 2012).<br><br>And in relation to c):<br>Audit practice re B&B service users (since circulation of new protocol) scheduled for April 2012. | January 2012<br><br>April 2012 |

| | | |
|---|---|---|
| c. An audit should be completed 3 months after the service is implemented to check visits being undertaken to those placed in AGH properties. | | |

**Independent Investigation Panel Comments**

We support these actions as positive reactions to the incident that appear to have contributed to improved working arrangements according to the reports of both the local service manager and the AGH manager who provided evidence. However, as is detailed in Section 9 the recommendations are insufficient as they are based on an inadequate understanding of the contractual arrangements pertaining to AGH, the nexus of the relationships between CNWL, LBB and AGH, and are not tied in with the development of the Supporting People strategy that is an integral part in securing accommodation for an effective Recovery programme.

| **Recommendations** | **Action taken by CNWL** | **Timescale** |
|---|---|---|
| **2)**<br>Support to staff following a serious incident. | Serious Incident Policy contains advice on supporting staff, which will be reinforced in revised policy.<br>Supporting staff Protocol being developed.<br>Reminders being given to service managers to ensure support to staff following serious incidents - ongoing. | <br><br><br><br>April 2012<br><br>April 2012 |

**Independent Investigation Panel Comment**

The independent investigation panel has seen evidence that this occurred at the time, in relation to staff involved in the incident, and that arrangements are in place to provide support in regard to any future incident should it be required

| **Recommendations** | **Action taken by CNWL** | **Timescale** |
|---|---|---|
| **3) and 7)**<br>Review of CPA operational policy. | Review of Recovery Team Operational Policy redraft has begun. Aim to complete by Operations Manager by April 2012. | April 2012 |

| |
|---|
| **Independent Investigation Panel Comment**<br>The independent investigation panel has seen evidence that this has happened and welcome the specific guidance on seeing people in their home setting.<br>There are significant additional concerns about the CPA operational policy that are set out in the body of this report, and suggest greater clarity in setting mimimum standards for the frequency of contact and for frequency in attending at the person's home. |

| Recommendations | Action taken by CNWL | Timescale |
|---|---|---|
| **4)**<br>To regularly audit CPA compliance | CPA compliance to be audited in April 2012 | April 2012 |
| **Independent Investigation Panel Comment**<br>The independent investigation panel has seen documentation in respect of this audit of practice on patients in B&B since the circulation of the new protocol referred to in recommendation 1c.<br>The audit shows good compliance with the CPA processes but does not look at the quality of the CPA risk assessments, need assessments or care plans or whether the identified actions within the care plans were appropriate or carried out well, which was not the case in this incident. | | |

| Recommendations | Action taken by CNWL | Timescale |
|---|---|---|
| **5)**<br>To inform RCs (of the need to consider the use of Community Treatment Orders [CTO] ). | Completed | November 2012 |
| **Independent Investigation Panel Comment**<br>This is assumed to relate to the need to assess patients for the use of a CTO where appropriate. The panel have seen an e-mail from the Service Director asking Consultants to do this but no evidence of whether this e-mail has changed behaviours. The CQC in their MHA oversight role have a responsibility to monitor practice in the use of the MHA by the Trust. | | |

| Recommendations | Action taken by CNWL | Timescale |
|---|---|---|
| **6)**<br>a) and b) Audit of risk event sheets and risk management plans<br><br>c) Review of Brent MAPPA arrangements | Audit of Risk Events sheets, Risk management plan to be audited in April 2012<br><br>No reference to this | April 2012 |
| **Independent Investigation Panel Comments**<br>The independent investigation panel have seen an audit of 30 patients across three teams. As was the case with this incident, compliance around risk assessment and management was found to be problematic. The investigation panel have seen no follow up action to confirm that actions have been taken to show how further improvements can be made. As recording of risk events is identified as an issue, further oversight is very important since there is always a possibility that the record of events being lost with the implementation of an Electronic Patient Record. | | |

# 11. Findings and Recommendations

11.1 The following section sets out the independent investigation panel's findings and recommendations. These have been identified from a detailed analysis of the evidence, both oral and written, that has been presented to the independent investigation panel. The recommendations have been completed for the purpose of learning lessons and for the Trust to put into progress any actions required to prevent a similar occurrence. It also sets out areas where the independent investigation panel have identified notable practice.

## Care Planning and Coordination of Support to both Men

11.2 There are differences of detail for each man over the extended period of time they were involved with Mental Health Services. However, a common pattern for both men throughout their contact is that they were not supported in their community settings in line with a well set out and maintained care plan.

11.3 The inadequate transfer of care to the appropriate CMHT in 2004 detrimentally affected the communication of the discharge care plan to the community team and contributed to the poorly considered care that he received in the community.

11.4 If a CPA process had been applied according to Trust and national guidance then it is less likely that Mr A's support would have been ceased in such an uncoordinated way in 2008/2009. Risk assessments from his previous admission were not heeded and on discharge in 2007 he was allocated a female care coordinator despite his history of violence to women in the community and sexually inappropriate and intimidating behaviours towards women on both admissions.

11.5 Care planning in Mr B's case had similarities to Mr A. There is little indication of risk assessment or of CPA planning. It is acknowledged that Mr B was reluctant to engage so securing his compliance to engagement with a care plan would likely have been difficult to achieve.

11.6 There was a lack of clear guidance to care coordinators about assessing patients at home which applied to both men. It is positive that new guidance was issued in 2012 clarifying the importance of seeing the person in their home setting. However the concerns generated in considering the care and treatment of both these men shows a pattern of disconnection between the individual's history, care planning, risk management and achieving continuity of treatment and engagement.

### *Recommendation One*

***It is recommended that the Trust reviews how it ensures that the person's history is adequately incorporated in the assessment of risk and that risk management is part of the subsequent care plan. Relapse indicators must be clearly identified and monitored by the care coordinator in conjunction with the individual's consultant.***

***It is further recommended that the actions arising out of this review be included in the audit programme in such a way that the Trust Board are able to satisfy themselves that these requirements are reflected in actual clinical practice.***

### *Recommendation Two*

***It is recommended that CNWL consider a process of regular peer review on a sample of cases chosen at random relating to:***

a. ***The extent to which the individual's needs and the risks are incorporated into their care plans.***

b. ***The delivery of the care plan, both immediately and over the 18 months after a care plan is put in place.***

## Effectiveness and Integration of Risk Assessments to both men

11.8 At various times in their hospital care both these men were assessed in relation to risk. In relation to Mr A these accurately describe his history of inappropriate sexual behaviour, violence towards others, both in the ward setting, and in the community. They also indicate his regular denial of mental health problems and resistance to medication. It is not evident that this knowledge and the assessment of these risks was utilised in the arrangements put in place for his care and support.

11.9 A risk management document template was used but not adequately completed in either patient's care. The structure of the care plan document with its 10 categories may have contributed to minimal risk management documentation and planning in the CPA in these cases.

### *Recommendation Three*

***It is recommended that the Trust reinforce through training and supervision the critical importance in achieving effective care planning. This should include the integration of history, risk assessment and management in both the formulation and practice in delivering the care plan with the patient. It is further recommended that the implementation of this recommendation be***

***monitored by regular audit and reported to the Trust's Quality and Performance Committee.***

## Use of the Mental Health Act

11.10 There is no indication of consideration of a Community Treatment Order (CTO) (or prior to the introduction of CTOs, Supervised Discharge) for either man. This relates primarily to Mr A, and the investigation panel accepts that the impact of either of these instruments on the engagement of either man in care and treatment would have been minimal. Nonetheless, the Responsible Clinician should document that they have included in their risk assessment consideration of the appropriateness or otherwise of the use of a CTO.

11.11 This inadequacy is recognised in the Trust's internal review. However the recommendation from the internal review is less clearly stated in the action plan's implementation which states an email was sent to CNWL consultants by the Medical Director asking them to consider CTOs. It is not clear if this has changed practice or how this is being monitored.

### *Recommendation Four*

***It is recommended that the Trust audits the use of Community Treatment Orders and ensures that the results of this audit are made available to all Responsible Clinicians. It is further recommended that the implementation of this recommendation be monitored by regular audit and reported to the Trust's Quality and Performance Committee.***

11.12 There are further specific findings in relation to the application of the Mental Health Act in relation to both Mr A and to Mr B.

11.13 Mr A had been discharged from the community mental health service in 2005 and 2009 largely because he had chosen to disengage. In light of his risk profile a more robust response including possible use of the Mental Health Act should at least have been considered at these times.

11.14 In relation to Mr B the (then) Approved Social Worker obtained a Section 135 MHA warrant in mid December 2007 because of her concerns about Mr B and his probable psychotic state and potential violence. However there was then a gap of almost a month before the warrant was executed. This was over the Christmas period but this long gap is unexplained in the records. When this warrant was executed the subsequent Section 2 of the MHA order was rescinded by the consultant on the 9th January 2008 only two days later. There is no evidence that collateral information was obtained to give a more rounded picture of his mental state at that time.

## Diagnosis

11.15 There were concerns about Mr B's diagnosis. Early in his engagement with Mental Health Services it was often repeated in his notes that he was diagnosed with paranoid schizophrenia during his 1996 admission to Park Royal Hospital. He was started on depot neuroleptic medication at that time. When he was discharged from hospital in November 2005 the Discharge Summary did not contain any diagnosis. In January 2008 he is described in his Discharge Summary as having a diagnosis of "Behavioural Changes due to cannabis use". In June 2010 his diagnosis is given as schizophrenia. It is the investigation panel's view that from the first of his admissions the evidence available strongly supported the diagnosis of schizophrenia.

11.16 The independent investigation panel believe that as Mr B was detained twice under the Mental Health Act, a more robust attempt should have been made to treat him on at least one of those occasions. Lack of clarity about his diagnosis probably played a part in this.

11.17 It is not the view of this independent investigation that Mr B's fluctuating diagnosis had a material effect on his treatment plan. He did not in the main receive medication while in the community and given his consistently stated reluctance to engage with Mental Health Services or take medication it is not evident that there is much more that the CMHT could have done in this regard.

## Mental state awareness

11.18 Mr A's main contact with services when in AGH accommodation was when he attended the local office to collect his cash payment made under Section 117 of the MHA as a person with no recourse to public funds.

11.19 Other than when he was in hospital care, assessment of his mental state was very limited outside of the psychiatrists' clinics. Contacts were all at the office with no assessment of Mr A at his AGH home setting. Meetings between Mr A and his care coordinator are documented but show little assessment of mental state and no substantial attempt to establish concordance with medication.

### *Recommendation Five*

***It is recommended that adequate supervision of individual care coordinators is put in place and monitored on a regular basis to ensure that care coordinators are assessing the mental state and risk of their patients when seen in the community. Furthermore, that the Trust develops and implements a minimum***

***frequency policy giving clear guidance on when a person's mental state should be recorded.***

## Medication

11.20 Mr B consistently refused to comply with any medication regime while he was living in the community. His pattern was that he was able to sustain himself in the community while causing concern and nuisance to his neighbours which resulted in admission and housing difficulties. There was no apparent strategy devised by the team treating him other than to try to maintain low level contact and be responsive when his condition deteriorated.

11.21 In relation to Mr A there is a pattern over the years of his engagement that when in hospital and receiving depot medication (albeit reluctantly) his condition improved. However, given his continually stated opposition to this form of medication in particular, the community team was faced with the inevitable change to oral medication that would have required a different approach to monitoring concordance.

11.22 In the view of the independent investigation panel Mr A's history and established pattern of non-concordance with medication, or willingness to continue his engagement in community support was not adequately considered in the Care Plan on his various discharges.

### *Recommendation Six*

***It is recommended that where patients have a pattern of non-concordance with medication that this is reflected in that patient's care plan and a contingency plan is agreed. It is further recommended that the implementation of this recommendation be monitored by regular audit and reported to the Trust's Quality and Performance Committee.***

## Clinical Record Keeping

11.23 It is evident that information was not consistently conveyed from the different risk assessments into active care planning, and in the case of Mr B that historic information relating to previous engagement with Mental Health Services, possibly in the 1980s and in 1995/6 was not available.

11.24 The use of electronic records will have improved the availability of information but will not in itself resolve the issue of making use of available information to inform care and treatment for the individual and in risk assessing circumstances for staff working in the Mental Health Services.

11.25 The investigation panel do not make any specific recommendation in respect of this but use of information is a recurrent theme in relation to care planning and risk assessment where we have made recommendations.

## Support to students and trainees

11.26 Education and training is identified as deficient by the Trust internal review, particularly as it relates to care planning and CPA. However the main focus of the internal review is on uptake of training.

### *Recommendation Seven*

***It is recommended that the content of that training needs to be considered with a particular emphasis on the continuity of care planning process, risk assessment and management demonstrating improved training from that provided at the time of the incident in 2010.***

## Criminal Justice system and Inreach Mental Health Service

**HMP Pentonville**

11.27 This independent investigation panel considers that there were opportunities to re-engage the CMHT prior to Mr A's release from prison in 2006.

11.28 While in the criminal justice system there was a lack of clarity about his support needs, possible release, transfer to the health service and the implications of his immigration status. His mental health needs and risks were not addressed in a timely fashion, hence he was released from Pentonville prison before community support was put in place.

### *Recommendation Eight*

***It is recommended that the Inreach team at HMP Pentonville should ensure that systems are in place for the early referral of all remand prisoners who have a serious mental illness to their relevant CMHT in a timely fashion.***

**HMP Wormwood Scrubs**

11.29 Once contact had again been made with Mr A in August 2006 at HMP Wormwood Scrubs by the Mental Health Services, this was maintained and he was subsequently transferred to the low secure unit at Park Royal Hospital under Section 38 of the MHA on 11th October 2006. However, the relevant CMHT was not informed of this transfer during its planning or at the time and only became aware of it when they contacted the Inreach team the following week.

### *Recommendation Nine*

***It is recommended that when transfers to local Mental Health Services are made, the local mental health team should always be informed and be party to the detailed transfer arrangements. CNWL as the responsible Trust for the Inreach service at Wormwood Scrubs should ensure this is achieved in regard to the offender services they provide. It is further recommended that the implementation of this recommendation be monitored by regular audit and reported to the Trust's Quality and Performance Committee.***

### *Recommendation Ten*

***It is recommended that Camden and Islington NHS Foundation Trust are sent a copy of this report as the responsible organisation for the Inreach mental health service at Pentonville Prison.***

## Housing and support

11.30 This independent investigation panel have concerns about the housing arrangements on several levels:

- The support offered to both men in the setting by the Mental Health Service
- The level of mental health understanding and training of the AGH staff, and their apparent autonomy in relocating people placed in their accommodation by Brent Mental Health Services without prior discussion
- The lack of clarity in the Trust Agreement with AGH
- That this arrangement fell outside the Supporting People arrangements worked up by London Borough of Brent.
- The internal review made recommendations in regard to the AGH arrangement, and there have been improvements subsequently. However, in the view of this independent investigation panel it is not clear that these recommendations were based on a sufficient understanding of the then existent Agreement or the broader Supporting People context.

11.31 Both men were essentially placed in this accommodation without continuing contact from the CMHT in their homes. An opportunity to develop a more rounded understanding of their life and circumstances was missed which may have informed a better assessment of their respective mental health conditions. There was, and in the investigation panel's view, continues to be, a confusion

about the use of this type of accommodation, and what the expected outcome for individual people should be. The properties were described variously in CNWL discussions and guidance with the panel as "temporary" or "Bed and Breakfast" or "partially supported" but in reality they were used – and may still be so – to provide long term housing for people who would most probably find obtaining any other accommodation very difficult to achieve. However, from the experience of the two men who are the subject of this independent investigation, (and from the review subsequent to the incident, the others in the property as well) it is clear that once placed they were regarded in practice as settled and no support in the accommodation was offered.

11.32 What is clear from the experience of these two men is that they received little in the way of active support or engagement, and there was an over reliance on an informal and unstructured system of support from unqualified domestic staff in AGH. We therefore make the following recommendation:

### *Recommendation Eleven*

***It is recommended that where people are subject to CPA and placed in supported housing their care coordinator has an obligation to carry out home visits, suitably accompanied, dependent on individual risk assessment, on a regular basis. This frequency could be set with a minimum standard for the ratio of home or other location contacts, and be regularly audited as part of the clinical governance programme.***

### *Recommendation Twelve*

***It is recommended that AGH is required as part of its Agreement, or as part of a wider Supporting People Agreement, to ensure that its staff are adequately trained to offer greater support to people in their accommodation. The Trust should consider in this arrangement whether AGH staff might access relevant training that they offer to staff in their services.***

11.33 Overall there have been improvements in the working arrangements between CNWL and AGH achieved at the local operational management level in Brent Mental Health Services. These have been largely focused on achieving the recommendations from the internal inquiry with its specific actions.

11.34 However, it is not apparent that these have been developed within a shared strategic framework with the LBB about the future development of supported housing as a main plank in achieving individual recovery for people with mental health problems.

11.35 The investigation panel are aware that the LBB is actively managing the Supporting People contract and there is clearly a strong argument for the AGH properties to be considered within the framework of a Recovery focussed Supporting People model of housing provision.

11.36 The following recommendation is made specifically in regard to AGH properties but this is an approach that should be applied to any other development of housing specifically for people receiving care and support of the mental health service:

### *Recommendation Thirteen*

***It is recommended that the future usage of AGH is developed in concert with the LBB in its strategic development of Supporting People Housing, and is aimed at supporting and sustaining people, many of whom are likely to have a continuing need of support and engagement, within Mental Health Services.***

## Mr A's Immigration status as a person with No Recourse to Public Funds

11.37 With the refusal of asylum Mr A became a person with No Recourse to Public Funds. However, as he had been subject to the MHA he had acquired a right to support under Section 117 of the MHA. This is a not uncommon conflict that mental health and local authority services have to deal with where different legislation imposes differing requirements on them.

11.38 Unfortunately the panel were unable to discuss this situation with the UK Border Agency who did not consider that the Terms of Reference of this investigation were sufficient to enable them to provide information, and stated that they wished to protect the privacy of the individual. The investigation panel have taken the view that seeking Mr A's specific agreement to gaining information from the UKBA would probably be unhelpful to his mental health and unlikely to add significant further information and so did not seek to amend the Terms of Reference.

### *Recommendation Fourteen*

***It is recommended that in any future independent investigations involving people who are known to be persons of No Recourse to Public Funds, or otherwise known to the UKBA, the Terms of Reference include obtaining information from and the cooperation of the UKBA.***

### *Recommendation Fifteen*

***It is recommended that a copy of this report is sent to the UKBA and that the new commissioning body develops links with the UKBA which will establish better understanding of both health and UKBA processes.***

## Notable Practice

11.39 Throughout Mr A's periods in hospital care it is worthy of note that his nursing notes were informative and well kept.

11.40 There were periods when consultant cover was mainly by locums. It is noteworthy that when Mr B's consultant took up post she made a home visit in 2008 because of concerns expressed to her by other team members who had been involved in a previous assessment.

11.41 The Discharge Summaries and Mental Health Tribunal reports are considered to have been well structured and informative and of a generally good and frequently excellent quality.

## In Conclusion

11.42 The independent investigation panel considered whether the death of Mr B could have been predicted and or prevented.

11.43 Although there was a low level of engagement with both men, and the investigation panel have raised questions in regard to risk assessment, there was no reason to believe that the attack on Mr B by Mr A was either predictable or preventable.

## Documentation Appendix One

A. Trust Internal Review

B. Clinical Records Part 1

C. Clinical Records Part 2

D. Clinical Records Part 3

E. Clinical Records Part 4

F Epex Records

G Governance Structures

H Observation and Engagement Policy – policy the same now and then

I Clinical Risk Assessment and Management Policy and Adult Services Clinical Risk Assessment and Management Procedure – policy the same now and then

J Executive Structure

K CPA Policy– policy the same now and then

L GP Records – Surgery 1

M GP Records – Surgery 2

N Serious Untoward Incident Policy

O Current Action Plan – Internal Investigation

P Transcript of (Care Coordinator), Internal Review interview

Q Police Transcripts in regard to their investigation of the crime

R Community Recovery Service Line Organisational Chart

S Atlantic Umbrella – Agreement for the Supply of Services

T Brent Mental Health Services Policy for Dual Diagnosis

U MAPPA Policy

V Dual Diagnosis Policy

W Draft Lease – Atlantic Guest House

X Organisational Learning Report 2010/11