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Health & Social Care Consulting Ltd

Joint Safeguarding Adult Review and Independent Mental Health Homicide Investigation
Mrs A and Miss B

July 2019

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Niche Health and & Social Care Consulting Ltd is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

Andy Nash Limited is an independent health and social care consultancy specialising in:

- Complaints and investigations
- Statutory mental health homicide inquiries
- Service reviews
- Strategy development
- Consultancy support
- Audit
- Mental health
- Adult social care

The independent investigation team would like to offer their deepest sympathies to the family. It is our sincere wish that this report does not contribute further to their pain and distress.

We would also like to thank the family for their invaluable contribution to our investigation.

This report was commissioned by NHS England and Royal Borough of Greenwich Safeguarding Adults Board and cannot be used or published without their permission.

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1 Executive Summary

1.1 This Safeguarding Adults Review and Independent Mental Health Investigation (joint review) examines the circumstances surrounding the homicide of Mrs A in South London on 21 February 2016 and the care and treatment of Mrs A and Miss B by the NHS, local authority and other agencies. Mrs A was the mother of Miss B. There were initial discussions about whether an inquiry should be a Safeguarding Adults Review (SAR) or a Domestic Homicide Review. Subsequent discussions with NHS England concluded that the inquiry should be a joint SAR and Mental Health Homicide Investigation.

1.2 The joint review panel was chaired by Royal Borough of Greenwich Safeguarding Adult Board and NHS England. Andy Nash Ltd and Niche Health and Social Care consulting were commissioned to carry out the joint review. Andy Nash, Director (Andy Nash Ltd) and Dr Carol Rooney, Deputy Director (Niche) are the joint authors of the review. Expert clinical review was provided by Dr Susan Benbow (old age psychiatrist and family therapist) and Dr Huw Stone (consultant forensic psychiatrist).

1.3 The report was peer reviewed by Nick Moor, Partner, Niche, and quality assured by NHS England and Royal Borough of Greenwich (RBG). Legal review was carried out by Mills & Reeve LLP for NHS England, and legal review for Royal Borough of Greenwich was carried out by Lee Parkhill, Barrister.

1.4 The investigation comprised a comprehensive review of documents and series of interviews, with reference to the National Patient Safety Agency (NPSA) guidance and Safeguarding Adult Review report writing guidance. The terms of reference were agreed in February 2017 after family consultation, and are at Appendix A.

1.5 The family have requested that the victim be referred to as Mrs A throughout the report.

Homicide

1.6 On the 21 February 2016 Mrs A was found deceased at home by her other daughter Miss C. The attending ambulance crew noted marks on her neck, and it was later established that she had been strangled.

1.7 Miss B was subsequently arrested on suspicion of murder, and she was taken into custody, prior to being transferred to a mental health hospital. In June 2016 Miss B pleaded guilty and was convicted of the manslaughter of Mrs A and given a life sentence with a minimum 10 year term, and an order under Section 45A[1] of the Mental Health Act 1983 (updated 2007) under which she can be treated in a mental health

[1] *Power of higher courts to direct hospital admission. http://www.legislation.gov.uk/ukpga/1983/20/section/45A*

service, and transferred to prison if treatment in hospital is no longer necessary.

1.8 The independent investigation follows the NHS England Serious Incident Framework[2] (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights, the investigation of serious incidents in mental health services[3] and Safeguarding Adults Reviews, Section 44 of the Care Act (2014).[4]

1.9 The joint terms of reference for this investigation are given in full in Appendix A.

1.10 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

1.11 The underlying aim of an independent investigation is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.

1.12 Safeguarding Adults Reviews[5] seek to determine what the relevant agencies and individuals involved in a case might have done differently that could have prevented harm or death of a vulnerable adult. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.[6]

1.13 We would like to express our sincere condolences to the family of Mrs A.

Background

1.14 Both Mrs A and Miss B were receiving care from Oxleas NHS Foundation Trust (the 'Trust' hereafter) mental health services.

1.15 Mrs A was referred to older people's mental health services in June 2010 for memory problems and anxiety. She was seen by community teams, and in March 2011 was admitted informally to the Trust's older people's mental health unit. She was diagnosed as suffering from a psychotic

[2] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf*
[3] *Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*
[4] *Section 44, Care Act, 2014.*
[5] *Care Act 2014 c.23. PART Safeguarding adults at risk of abuse or neglect http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted*
[6] *Care and Support Statutory Guidance Section 14.168. 17 August 2017.*

disorder with delusions due to a known physiological condition (vascular dementia).

1.16 Mrs A was supported to live at home by her family, and continued to be seen regularly by a psychiatrist in outpatient clinics until prior to her death in February 2016.

1.17 Miss B has a lengthy history of mental health care and treatment dating back to her first psychiatric admission in 1981 aged 17, after taking an overdose of paracetamol. She had many admissions and remained under the care of Trust services, and was diagnosed as suffering from schizoaffective disorder.

1.18 In June 1995 Miss B stabbed her 9 year old child and was admitted to a secure hospital. Miss B was convicted of unlawful wounding in May 1996 and detained under Section 37/41 of the Mental Health Act.

1.19 A lengthy rehabilitation process ensued, with a structured reduction in mental health service supervision. However Miss B was recalled by the Home Office on 24 January 2003, under Section 37/41 MHA, following challenging behaviour in the residential placement and use of illicit drugs.

1.20 Miss B was conditionally discharged by a Tribunal in March 2004, and the conditions were to reside at a staffed group home, comply with medication, participate in therapeutic activities, have regular drug screening, accept counselling by the substance misuse service and comply with monitoring and follow up by her social supervisor/care coordinator and consultant psychiatrist. She moved into an independent flat in February 2004, and was referred to the Trust Locality Team at Woolwich Arsenal in the community, requesting that her care be taken over in the community. Miss B remained on enhanced CPA.

1.21 Miss B received an absolute discharge from the Section 37/41 in 2006, and was supported to live in the community, continuing to live independently. She was transferred in 2005 from the Complex Needs and Recovery service to the care of Greenwich Recovery Team. Miss B was on enhanced CPA until 2009 and received regular out-patient appointments and support from a third sector provider. Her diagnosis remained as schizoaffective disorder.

1.22 Miss B was transferred to standard CPA in August 2009, after a period of stability. Her risks were described as ‘suicide (low), non-compliance to prescribed medication (medium)’. From 2011 Miss B was later part of the Coordinated Operational Move to Primary-Plus Services project.

1.23 Miss B was prescribed risperidone 4 mg and fluoxetine 20 mg in the period before February 2016, and had been taking both of these for several years. The doses of risperidone were adjusted upwards and downwards at times, and occasionally night sedation was added for short periods. Miss B had fluctuating compliance with taking medication, and it was known that she would stop taking both her fluoxetine and risperidone

at times. She frequently complained that she did not really need medication, and great efforts were made to educate her about her illness and the ongoing requirement for medication.

1.24 The appearance of early warnings signs of relapse (staying indoors, paranoia, fearfulness, hearing abusive voices, sleep disturbance) were frequently associated with her not taking her medication. It was not always clear if this was a precipitating factor or a consequence, but it was known that there was a correlation. At times of crisis the Home Treatment Team (HTT) implemented a medication supervision plan, and then arranged for her medication to be supplied in 'blister' packs. Her most recent relapse before the homicide was in March 2015, and she had again not been taking her medication regularly.

1.25 In March 2015 Miss B was regarded as being in crisis, and was treated by the HTT for low mood, an increase in paranoia and suicidal thoughts. She was not sleeping and was afraid to go out, and admitted to not taking her medication regularly. She was noted to have recovered from this relapse by the end of April 2015. In June 2015 she was again feeling afraid and threatened by the external world and was not going out. Although this had improved when she saw Dr R later in June, she was irritable and described herself as 'very stressed' because her mother had fallen and she and her sister were spending time caring for her at her home. She was encouraged to try depot medication in this period but decided against it.

1.26 In July 2015 she started psychology sessions and no longer felt anxious or paranoid. She went on holiday to Monaco with her children in August 2015 which she said she enjoyed.

1.27 As a result of an adult mental health care service redesign in September 2015, Miss B was transferred to the step-down pathway of Intensive Case Management Psychosis (ICMP). She was not on CPA, and was 'placed' with a cohort of patients who were not seen as needing the regular input of a consultant psychiatrist.

1.28 Miss B saw a psychologist for CBT from July to October 2015, and was then offered a CBT group for people with voices and unusual experiences (called 'what is real'). Sessions with her care navigator finished on 13 October 2015, but she continued weekly contact with the third sector provider.

1.29 The psychologist sent an email in early February 2016 to the psychiatrist Dr N from the new team requesting a 'one off review'. Miss B was made aware the group started again on 11 March 2016 and that she would not be offered this group again if she did not attend.

1.30 The emailed request for a medication review sent in early February 2016 was received by Dr N, but prioritised as not urgent given the degree of change to caseloads and structures that took place at the time. Dr N had planned to discuss the request with the psychologist to get a sense of

what the issues were, this was not possible due to a combination of workload issues and that the psychologist worked across two teams so was not available on a day to day basis to discuss issues within either team.

1.31 Miss B did not see a psychiatrist from September 2015 until after the homicide, but continued to have medication prescribed by her GP. It is not clear whether she took this medication regularly or not.

1.32 We have included a direct quote from the family's response to this report here:

"Throughout this report I have seen many inconsistencies in the care of Mrs A and Miss B. I have read the report and am shocked and dismayed by the outcome. Considering the history of Mrs B and lack of intervention and risk management plans, it is questionable what the Oxleas health professions are doing to prevent incidences recurring and how much they are protecting vulnerable children and adults".

A family member who was a previous victim of an assault by Miss B has also raised the question of how victims are communicated with when the perpetrator is under the care of mental health services, in the case of appeal or release.

Conclusions

1.33 This was a complex investigation with a significant amount of documentary evidence to be reviewed and a wide range of staff interviewed. The care and treatment of two individuals has been reviewed, and we have tried to focus on the areas where their care and treatment overlapped.

1.34 As required in the safeguarding process we have made recommendations for wider systems learning.

1.35 The internal investigation by Oxleas has identified areas of learning, which we support and have expanded upon. We believe that although the Trust internal investigation did identify missed opportunities in the care provided to Miss B, it did not review the care of Mrs A in detail, and was not followed by an adequate or robust action plan.

1.36 We have heard from clinicians of the challenges presented by the service reconfiguration, and the resulting confusion about how patients were being managed.

1.37 There was a risk register where the assessment of risk was noted, and this was reviewed at senior level. However in our view the operational clinical risks were managed by clinicians.

1.38 Oxleas have provided information which shows how the redesign was planned, and what consultation took place with the CCG and service users and staff. We have heard how clinician's views were that the detail

of the reconfiguration was not adequately planned, leaving the risk to be managed by clinicians who were not familiar with patients who were newly assigned to their caseloads. The family have expressed their concern about how this could have occurred.

1.39 We have however seen a summary document and supporting evidence that demonstrates that the Trust Board were clearly aware of the planned changes, had opportunity to question senior operational managers about how risks were mitigated and managed, and received regular updates on progress.

1.40 We have reviewed the care provided to Mrs A and Miss B. We believe, given her history and the risks known, that it was more likely that Miss B would harm herself rather than someone else. However the family have expressed their concern that previous aggression to Mrs A was not communicated to them.

1.41 We do not consider that it was predictable that she would kill her mother at any stage, however in February 2016 she was not in receipt of the previous level of care, and risk to herself or others was not assessed. The family are of the view that the level of care should have been ongoing as she was still having psychotic episodes.

1.42 We have tried to avoid the bias of hindsight[7] in considering whether the degree of harm was avoidable.

1.43 We have considered the following points:

- Miss B had a diagnosis of schizoaffective disorder with a known lack of concordance and compliance with medication;
- The symptoms of her mental illness were known to include paranoia, irritability, abusive hallucinations and strong feelings of shame and guilt; and
- Mrs A was known to be very dependent and Miss B was known to spend long periods of time with her.

1.44 Actions taken which should have lessened the risk of harm and relapse include:

- Assessment of Miss B's risk to self or others;
- Communication between the Oxleas teams about the care of both women, and between Oxleas and Bridge; and
- Continuity of care for Miss B through the service reconfiguration.

1.45 Because of these issues, while we believe that the death of Mrs A was not preventable, however had any of these steps been taken, it is much more

[7] *Hindsight bias is the inclination, after an event has occurred, to see the event as having been predictable, despite there having been little or no objective basis for predicting it Roese, N. J.; Vohs, K. D. (2012). "Hindsight bias". Perspectives on Psychological Science. 7: 411–426. doi:10.1177/1745691612454303*

likely that Miss B would not have relapsed and presented as a risk to her mother. Risks were not known, understood or mitigated.

1.46 A family member has asked us to include that they disagree with our conclusions, and believe that the homicide of Mrs A was predictable and preventable.

1.47 The draft report was delayed by four months due to complexities of reviewing the care of two individuals, and the volume of documents to review.

Recommendations

1.48 This joint review has made 17 recommendations. These have been identified below as they occur in the narrative of the report, and are later grouped under the three headings of care and treatment, team, and organisational issues for ease of reference.

Recommendation 1
NHS Greenwich CCG should ensure that GPs are fully involved in information sharing with respect to information about individuals with long term mental health issues.

Recommendation 2
Royal Borough of Greenwich should assure itself that its statutory duties in respect of carers of people with mental health problems are being discharged.

Recommendation 3
Royal Borough of Greenwich should update its 2015 Carers Policy to cover mental health and children in transition.

Recommendation 4
Lewisham and Greenwich NHS Trust should provide assurance that where there is a question of vulnerability and capacity, a capacity assessment is always carried out and documented.

Recommendation 5
NHS Greenwich CCG must assure themselves that there are systems in primary care to monitor the treatment of patients under secondary mental health care.

Recommendation 6
Bridge should develop a quality monitoring process that provides assurance that risk assessments and wellbeing plans are completed accurately.

Recommendation 7
Oxleas NHS Foundation Trust should agree with Bridge what routine patient care information will be provided about patients under the care of secondary mental health services, and develop systems to ensure that the agreed information is received and processed in a timely way.

Recommendation 8
Oxleas NHS Foundation Trust must ensure that risk assessments are updated at the time of care or service transitions.

Recommendation 9
Oxleas NHS Foundation Trust Safeguarding policy should be amended to include consideration of whether the service user may present a risk to other vulnerable adults or children.

Recommendation 10
Oxleas NHS Foundation Trust should assure itself that race and ethnicity, gender and religious issues are routinely addressed in CPA needs assessment and care planning as per the Trust's policy.

Recommendation 11
Oxleas NHS Foundation Trust Board must provide assurance that the actions identified in the internal action plan have been completed.

Recommendation 12
Oxleas NHS Foundation Trust Board must ensure that action plans have an appropriate level of evidence based assurance before sign off.

Recommendation 13
Oxleas NHS Foundation Trust and NHS Greenwich CCG should agree standards for outcome focussed recommendations following a serious incident, and standards for the level of evidence required for assurance before action plans are closed.

Recommendation 14
Oxleas NHS Foundation Trust Board must ensure that any large service re-design has been assessed for impact and risk to quality of clinical care, and that detailed milestones are tracked on an appropriate risk register.

Recommendation 15
Oxleas NHS Foundation Trust and Local Authority should ensure that staff are aware of when they can, and must, share information about individuals whose care they are responsible for.

Recommendation 16
Where a major service change is proposed in mental health services, and the local authority is in a Section 75 arrangement with an NHS body, the redesign should be negotiated, led and implemented jointly by the local authority and NHS.

Recommendation 17
Where a major service re-design in mental health services is being proposed and implemented the Trust must ensure that it complies with the Regulations when considering a substantial development of the health service, and consults the Local Authority. This should be subject to regular scrutiny by relevant Local Authority council committees.

2 The Review Process

2.1 This section outlines the process undertaken by the Joint Safeguarding Adults Review and Independent Mental Health Investigation into the care and treatment of Miss B and Mrs A. The purpose of the joint review is to identify if there were any opportunities to intervene, which may have prevented the death of Mrs A, and also to identify if there are any lessons to be learned to improve practice.

2.2 The circumstances of the homicide met the requirements for an independent investigation into mental health homicides as outlined in the NHS England Serious Incident Framework (2015).[8] NHS England (London) (NHSE) along with Royal Borough of Greenwich Safeguarding Adult Board (RBG SAB) agreed to hold a joint independent review, as it was acknowledged that the objectives and process would be similar. The review will be referred to as the 'joint review'.

2.3 The independent investigation follows the NHS England Serious Incident Framework (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights, the investigation of serious incidents in mental health services, and the Care Act in conducting a Safeguarding Adults Review.[9]

2.4 The main purpose of an NHS England commissioned independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

2.5 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.

2.6 Safeguarding Adult Reviews seek to determine what the relevant agencies and individuals involved in a case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.[10]

2.7 The joint review panel was chaired by RBG SAB and NHS England. Andy Nash and Carol Rooney are the joint authors of the review. Expert clinical

[8] *https://www.england.nhs.uk/patientsafety/serious-incident/*
[9] *Section 44 Care Act, 2014.*
[10] *Section 14.168,Care and Support Statutory Guidance. August 2017*

review was provided by Dr Susan Benbow (old age psychiatrist and family therapist) and Dr Huw Stone (consultant forensic psychiatrist).

2.8 The report was peer reviewed by Nick Moor, Director, Niche, and quality assured by NHS England and RBG. Legal review was carried out by Mills & Reeve LLP for NHS England, and legal review for the RBG SAB was carried out by Lee Parkhill, Barrister.

2.9 The investigation comprised a comprehensive review of documents and series of interviews, with reference to the National Patient Safety Agency (NPSA) guidance and SAR report writing guidance. The terms of reference were agreed in February 2017 after family consultation, and are at Appendix A.

2.10 We would like to offer our deepest sympathies to the family of Mrs A and Miss B, and we thank them for their contributions to this report.

2.11 We are aware that the final report is lengthy, but this reflects the depth of the investigation across the care, treatment and safeguarding of two individuals.

Approach to the review

2.12 The process began formally in February 2017 with an initiation meeting which was jointly chaired by NHSE and RBG. The meeting involving the SAB, NHSE, Trust and other agencies who had the most contact with Miss B, and Mrs A prior to her death.

2.13 The daughter and grandchildren of Mrs A were contacted initially by RBG then NHSE, and later by report the authors. Miss B's youngest child did not engage with the review.

2.14 We made contact with family members at the start of the investigation, explained the purpose of the investigation and offered to meet with them to hear their perspectives. We met with Mrs A's other daughter Miss C, and two of Miss B's three children. We remained in contact throughout the investigation to ensure the family was updated on the progress of the investigation and had an opportunity to ask questions. A number of additions to the terms of reference were agreed at the request of the family. Family members requested to be interviewed separately as part of the investigation, and this was carried out.

2.15 The family are of the view that the input to both Mrs A and Miss B was not very frequent. We gave family members the opportunity to meet with us to talk through the findings of the report. We met them again with the independent chair of Greenwich Safeguarding Board, to hear their verbal feedback and take their written comments. We have included family comments as they have arisen in the narrative.

2.16 We have included a direct quote from one of Mrs A's grandchildren here:

"Throughout this report I have seen many inconsistencies in the care of Mrs A and Miss B. I have read the report and am shocked and dismayed by the outcome. Considering the history of Mrs B and lack of intervention and risk management plans, it is questionable what the Oxleas health professions are doing to prevent incidences recurring and how much they are protecting vulnerable children and adults".

A family member who was a previous victim of an assault by Miss B has also raised the question of how victims are communicated with when the perpetrator is under the care of mental health services, in the case of appeal or release.

2.17 We discussed the question of confidentiality in relation to the formal action taken by Greenwich Social Services when Miss B's children were young. The oldest two children expressed their views strongly that they believe these details should be left in, to ensure that there is maximum opportunity for learning for health and social services.

2.18 We do not have the view of her youngest child, hence references to their circumstances are minimal.

2.19 A full list of all documents referenced is at Appendix C.

2.20 The draft report was shared with the services who contributed information to the investigation. This provided an opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed to review and comment upon the content. Scott and Salmon[11] principles were adhered to.

2.21 The agencies participating in this review are:

- Oxleas NHS Foundation Trust
- Metropolitan Police Service
- Lewisham and Greenwich NHS Trust
- Adults and Older Peoples Services, Royal Borough of Greenwich
- Bridge Mental Health
- Plumstead Health Centre
- Plumbridge Medical Centre
- NHS Greenwich Clinical Commissioning Group

[11] *The Salmon Process' is used by a public Inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. https://uk.practicallaw.thomsonreuters.com/1-385-1407?transitionType=Default&contextData=(sc.Default)&firstPage=true&bhcp=1*

2.22 We have used information from Mrs A and Miss B's clinical records provided by Oxleas NHS Foundation Trust, Bridge, the GP practices where they were registered, social care records from RBG and other agencies as listed at 2.18. We have seen individual management reviews[12] (IMR) prepared by Oxleas, RBG, Bridge, Lewisham and Greenwich NHS Trust, both GP practices and the Metropolitan Police Service (MPS).

2.23 We have read the police case summary, and reviewed the police information with regards to the arrest of Miss B.

2.24 As part of our investigation we interviewed the following staff:

Oxleas NHS Foundation Trust

- Consultant psychiatrist, Greenwich West Recovery Team
- Social worker, Greenwich West Recovery Team
- Consultant psychiatrist, staff nurse and health care support worker, older peoples mental health
- Consultant psychiatrist, Greenwich West Intensive Case Management for Psychosis Team (ICMP)
- Consultant psychiatrist, Greenwich Crisis Resolution and Home Treatment Team
- Psychologist for COMPPaS Team
- Psychologist for recovery and community teams
- Consultant Forensic psychiatrist, Forensic service
- Forensic Social worker, Forensic service
- Associate Director, Adult Mental Health
- Associate Director, Older People's Mental Health
- Head of Mental Health Legislation and Safeguarding Adults
- Service Manager, Older People's Mental Health
- Executive Director of Nursing (internal report author)
- Consultant psychiatrist and Clinical Director, Adult Mental Health (internal report author)

[12] *An IMR used to analyse individual agency performance, and is requested by the review panel.*

- Consultant psychiatrist and Clinical Director, Informatics
- We also had a telephone call with the Chair of the Trust Board.

Other organisations staff

- Adult Safeguarding Manager, Lewisham and Greenwich NHS Trust
- Head of Safeguarding Adults, Royal Borough of Greenwich
- Bridge Mental Health Chief Executive Officer and Bridge staff
- Designated Nurse for Adult Safeguarding, NHS Greenwich CCG
- GP at Plumstead Health Centre
- Head of Safeguarding and Prevent, London Ambulance Service NHS Trust

2.25 Where these interviews were recorded they were transcribed and returned to the interviewees for corrections and signature to verify they were an accurate record of the interviews.

2.26 We wrote to Miss B at the start of the investigation, explained the purpose of the investigation and asked to meet her. Miss B did not give written consent for us to access her medical and other records, and the Caldicott[13] principles were followed. We met with Miss B in hospital, and offered her the opportunity to meet with us again to discuss the report prior to publication. Miss B declined to participate further in the investigation, but we have been able to discuss her care with her clinical team. The clinical team have shared the report with her and she indicated that she was happy with the investigation and the outcomes. She also confirmed that 'Miss B' was an acceptable identifier.

2.27 Agencies were asked to give chronological accounts of their contact with the perpetrator and victim prior to the homicide. Where there was no involvement or insignificant involvement, agencies advised accordingly. In line with the terms of reference, this report has reviewed the care, treatment and services provided by the NHS, the local authority and other relevant agencies from Mrs A and Miss B's first contact with services to the time of the offence.

2.28 All have responded with information indicating some level of involvement with the family and have completed an Individual Management Review (IMR).[14]

2.29 In March 2019 London Ambulance Service (LAS) drew our attention to the fact that they had not been asked to undertake an IMR. Their view was

[13] *The Caldicott Principles were developed in 1997 following a review of how patient information was handled across the NHS. https://www.igt.hscic.gov.uk/Caldicott2Principles.aspx*

[14] *An IMR is a report requested by an investigation or review, detailing the agency involvement with an individual.*

that as the Metropolitan Police Service (MPS) had provided us with information showing that LAS had attended both Miss B and Mrs A's home addresses they should have been asked to review their involvement. With hindsight we accept that we should have asked LAS to undertake an IMR. We asked LAS to provide us with any further information regarding their involvement. This is detailed in the relevant paragraphs in Section 4 and Section 5.

2.30 We asked the MPS if they were able to provide more information from their files and IMR but they informed us that they had no further information to add.

2.31 In June 2016 Miss B pleaded guilty and was convicted of the manslaughter of her mother Mrs A. She received a life sentence with a minimum 10 year term, and an order under Section 45A[15] of the Mental Health Act 1983 (updated 2007) under which she can be treated in a mental health service. She remains in a secure hospital.

Structure of the report

2.32 Section 3 sets out the details of the background, and care and treatment provided to Mrs A and Miss B. In preparation we developed a detailed chronology of Mrs A and Miss B's care, but this has not been included in this report to assist with confidentiality. Where questions and issues raised in the terms of reference are addressed these will be indicated throughout the report.

2.33 Section 4 examines the issues arising from the care and treatment provided to Mrs A and Section 5 examines the issues arising from the care and treatment provided to Miss B including comment and analysis, with regard to the terms of reference for the investigation.

2.34 Section 6 reviews the involvement of family in the investigation process.

2.35 Section 7 provides a review of the Oxleas NHS Foundation Trust (the 'Trust' or 'Oxleas' hereafter) internal investigation, and reports on any progress made in addressing the organisational and operational matters identified.

2.36 Section 8 sets out our overall analysis and recommendations, and comments on predictability and preventability.

Events of 21 February 2016

2.37 We have developed a chronology of events leading up to Mrs A's death from family accounts, and clinical and police information. Mrs A lived by herself and had been diagnosed with dementia. Her meals were provided by her family, and her family members all spent time with her, keeping her company and providing day to day support.

[15] *Power of higher courts to direct hospital admission.* http://www.legislation.gov.uk/ukpga/1983/20/section/45A

2.38 On the weekend of 19/21 February Miss B was asked by the family to look after Mrs A. Miss B did not usually stay overnight or cook for Mrs A, but she did spend long periods with her during the day. Miss B went to see her mother on the 19 February, then decided after she arrived that she may as well stay over. However she had not brought her own items of clothing and toiletries (or medication) to stay overnight.

2.39 She had some homework from a course which she had planned to do to keep busy over the weekend, and had forgotten that also.

2.40 Miss B described feeling more anxious on the second day, and spent the day plucking up the courage to go out for a walk. She stayed in and felt herself becoming unwell. Miss C had prepared food so Miss B did not need to go to any shops, she fed her mother but did not eat herself. She had left her phone charger at home so could not use her phone to distract herself. She described watching TV, hardly speaking to Mrs A, and could hear noisy neighbours.

2.41 She had left all her medication at home so took some of her mother's old risperidone[16] tablets, and she later admitted she had not been taking her own medication regularly before this. She was also feeling depressed over the breakup of a relationship which had been on and off for seven years.

2.42 On the morning of 21 February Miss B said she woke up feeling depressed, and only ate a banana. She gave Mrs A breakfast and then a banana for lunch. Mrs A had noticed that Miss B was upset so she suggested she lie down and offered her a cup of tea. Miss B said she didn't want one and was tearful. Mrs A put her arm around her.

2.43 Miss B has told psychiatrists since then that she felt her mother's movements being jerky, and when she looked at her, her face looked different, really old and witchlike, and she thought her mother had long bony claws like a witch.

2.44 Miss B later said she has always believed in supernatural evil and had thought for many years that there was some generational issue with witches in the family and had prayed it had not affected her own children. She had thought this about her mother for some time but had never attacked her and could not explain why she did on this occasion. She remembered thinking that her mother had to die to end the 'curse', and then put her hands around her mother's neck and squeezed, then also used a scarf to strangle her. She wrapped her in a blanket, and Mrs A was later found dead by Miss C.

2.45 Miss B said she felt too scared to phone an ambulance, her mobile phone battery was dead by then because she had no charger. She did not call her sister Miss C, because she believed that Mrs A's number was barred from calling that number because of frequent calls in the past. Miss B tried

[16] *Risperidone is an antipsychotic medication used to treat schizophrenia and other psychoses.* https://patient.info/medicine/risperidone-risperdal

calling one of her children from the landline, and eventually left when it was dark. When one of her children called back later that evening Miss B told them that she had killed Mrs A.

2.46 Miss B was arrested and later transferred to a secure hospital under the Mental Health Act.

3 The care and treatment of Mrs A and Miss B

Family background

3.1 Permission to access the Royal Borough of Greenwich (RBG) child and family services files for the purpose of this investigation was given by two of Miss B's children. The third sibling did not give consent. The Caldicott process was implemented by RBG and permission was granted. The two older children have read this report and given consent for the details of the local authority actions in relation to them to be provided, in the interests of system learning. We did not have contact or consent from Miss B's third child, hence there is no detail of their circumstances.

3.2 The family are of African background, and Mrs A worked in the NHS for many years. Miss B was born by normal delivery in Liverpool; she was the only black child in school and was reported to have been bullied and experienced racism. She has a brother in Africa that she has no contact with. Her biological father left the home shortly after her birth and Miss B had no recollection of him. During her early childhood her stepfather was present in the house, and she has a younger half-sister. Miss B has told professionals that her stepfather was violent with a history of mental illness, and greatly favoured her sister (Miss C), which caused tension in their relationship. Miss B was told at around aged six that he was not in fact her biological father. When Miss B was 10 years old Mrs A left this home leaving Miss C with her father, and moved to London. The family lived in the Lewisham/Greenwich area. Miss B reports an unhappy childhood and was described as nervous and shy.

3.3 Her stepfather and sister later moved to London, and at times Miss B lived with them. She stayed away from school aged 14 due to name calling, started to mix with a delinquent peer group and began truanting and engaging in antisocial behaviour. Miss B left school with seven GCE 'O' Levels after her father moved her to another school away from her current peers. She then went to study A Levels at a college of further education but failed to complete these due to onset of her illness. She worked for a local agency full time whilst the older two children were at school prior to the birth of her youngest child. She went on to take up a position in a GP surgery but after befriending colleagues, she divulged her condition and was consequently told she could not work there. She had made a visit to Africa with her mother when she was 17, and was introduced to her biological father and stayed with him. This was apparently a strained and unhappy visit as Miss B felt they were strangers. She became mentally ill for the first time after returning to England from this trip.

3.4 Mrs A was a retired midwife who took care of her grandchildren regularly. Miss B has three children, and Miss C has two children.

3.5 Miss B contacted Greenwich Social Services Department[17] in March 1985 asking to be housed because she was pregnant and saying her family were threatening to 'throw her out'. Her first child was born in September 1985, her second in November 1986. Miss B was in a relationship between 1981 and 1987 with the children's father who was an overseas student, although they did not always live together.

3.6 Miss B married in 1990, but separated in 1995 due to alleged domestic violence. She has a (third) child from this relationship, who was born in September 1991. Later in September 1991 Miss B attempted to strangle her eldest child (who was then aged 6). Following this incident the two children went to live permanently with Mrs A. There were formal limitations which prevented Miss B from having unsupervised contact with any of her children, to be in effect until December 1993. Miss B did however reconcile with her husband and lived with him between January 1994 and January 1995. At this time she had care of her youngest child, and weekend care of her older children.

3.7 Child protection case conferences were held by Greenwich Social Services in May 1987 after marks were found on the older child's face. The children were not placed on the Child Protection Register at that time. The second child protection case conference was held in October 1991 after an apparent attempt to strangle the older child. All three children were placed on the Child Protection Register, and removed in January 1992, after it was identified that Mrs A was the main carer for the older children, and the youngest child lived with their father.

3.8 In January 1995 Miss B and her husband separated again, and the two elder children spent considerable periods in Miss B's care. On 23 June 1995 Miss B stabbed her elder child (aged 9) with a knife in the presence of her youngest child (aged 4) and was admitted to a secure hospital. Miss B was convicted of unlawful wounding in May 1996 and detained under Section 37/41[18] of the Mental Health Act. Both older children were placed on the Child Protection Register in 1995.

3.9 A management review of the social services contact with the older child was carried out by the Royal Borough of Greenwich in October 1995. This review concluded that the potential risks to the older child were known, that formal procedures were not used early enough and were dispensed with too soon after the 1991 'strangulation' incident.

3.10 The older children remained with their grandmother. Mrs A at times looked after Miss C's two children also and was described by social services as being 'under strain' at this time.

3.11 The family case file was closed by social services in December 1999.

[17] *Now called Royal Borough of Greenwich.*
[18] *Powers of the Court to direct admission to hospital and restrict discharge. https://www.legislation.gov.uk/ukpga/1983/20/section/37, https://www.legislation.gov.uk/ukpga/1983/20/section/41*

3.12 When Miss B was discharged from hospital in 2000 the older children were living with Mrs A. They had contact visits with Miss B, supervised by social services. In 2000 Miss B's older children (then aged 15 and 14) were taken off the Child Protection Register. This appears to have been based on the belief that they were no longer at risk from Miss B, given her progress. It was agreed in 2000 that their aunt, Miss C, could provide supervision for the older children's contact with Miss B.

Mrs A - Physical and mental health history and treatment

3.13 From 1998 to 2006 the records show disabled 'Blue Badge' applications and general physical health consultations; for 'flu, orthopaedics, medication, blood tests, cholesterol, and minor surgery.

3.14 On 3 March 2006 Mrs A was assaulted on a bus. A man grabbed her by the neck and hit her head against the window after she asked him to move his legs so she could sit down. She was assisted by the bus driver, who detained the man. He also assaulted the bus driver. Police attended and arrested the perpetrator. Mrs A declined medical aid and was referred to the Victim Support Scheme. The perpetrator was subsequently interviewed by the police and charged.

3.15 On 17 and 21 March 2006 Mrs A attended casualty but the reasons for this and the outcome are not clear.

3.16 On Monday 19 June 2006 Mrs A attended her GP surgery about a burn injury she had sustained two weeks previously; she was given an appointment to have the wound dressed. Between June 2006 and June 2007 Mrs A had a range of consultations in respect of medication, diabetes and minor surgery.

3.17 In July 2007 at a patient review by her GP it was noted that Mrs A was still having problems with panic attacks, palpitations, fear of going out, poor sleep and headaches since the attack of March 2006. The review noted that Mrs A may need counselling which a victim support group could provide. It was noted that the perpetrator of the attack lived near her and that she might need to move. Between 2007 and 2008 Mrs A attended GP surgery for repeat prescriptions and medication reviews.

3.18 On 28 October 2008 at a GP patient review it was noted that Mrs A was still anxious about the assault in 2006; she was having nightmares, palpitations and was anxious. She kept reliving the attacker's voice saying, "I will kill you". She had not been taking her medication and was advised about this. It was reported that her daughter (not clear which) had rung the surgery because she worried about her mother not opening door for her when she went to visit. It was recorded that the daughter might have personal issues with Mrs A. It was left that the daughter would ring back if she had any worries.

3.19 Between October 2008 and May 2009 Mrs A had further various medication reviews, repeat prescriptions and tests.

3.20 On 8 February 2009 daughter Miss B contacted police as a neighbour of Mrs A had knocked a fence down. Mrs A was adamant that she didn't want police involvement as she was afraid of her neighbour. A referral was made to the police Safer Neighbourhood Team.

3.21 On 8 July 2009 the GP undertook a home visit, as a friend was concerned that when she visited Mrs A she did not open the door. Mrs A appeared well, alert, dressed to go out and was waiting for her daughter. She said she was feeling better and having fewer flashbacks from her attack.

3.22 On 13 August 2009 Greenwich social services took an anonymous call from someone concerned about Mrs A. The local authority contacted the GP surgery to confirm Mrs A's doctor's name.

3.23 On the 14 August 2009 this information was sent to the Emergency Intervention Team. A call was made to her daughter Miss C who said that her mother was a hoarder, forgetful and suffered from dementia. A home visit was arranged for the following week. On the same day the GP undertook a patient review. The GP contacted the daughter (not clear which one) who expressed concerns about her mother. The GP suggested that the daughter visit the surgery with her mother so that they could discuss any concerns.

3.24 From October 2009 until February 2010 Mrs A was subject to a number of patient reviews and tests by her GP.

3.25 On 17 May 2010 Mrs A saw her GP as she was having problems with paying part of her pension into savings with financial companies. She was not able to continue payments and the companies were threatening to withhold her money. Mrs A wanted a sick-note to give them. She was advised to seek appropriate legal and finance advice.

3.26 On 23 June 2010 police were involved in a neighbour dispute and a police 'welfare' visit was made, which is a visit to check on welfare after a concern has been raised. Discussions were had with Miss B who advised that her mother was probably paranoid and confused. Police records do not show whether a referral was made to social services but there is a record of a discussion with an 'in-house social worker'. The police also made a referral to the GP.

3.27 On 29 June 2010 Mrs A was seen by her GP and agreed to be referred to the Older People's Community Assessment and Intervention Team (CAIT)[19] in respect of her memory problems and anxiety.

3.28 On 4 July 2010 Mrs A called the police saying that the Safer Neighbourhood Team (SNT) had not visited her. An email was sent to the SNT.

[19] *The Oxleas NHS Foundation Trust Crisis and Intensive Treatment (CAIT) team provides an innovative service for older people living in Greenwich, who have complex mental health needs and require short term intensive support and treatment in their own homes*

3.29 On 27 July 2010, following a referral from the GP a clinical psychologist, accompanied by a Team Leader, from the Community Mental Health Team (CMHT) from Oxleas NHS Foundation Trust completed a core assessment of Mrs A, daughter Miss B was also present. Mrs A did not want any involvement with the CMHT.

3.30 On the 10 August 2010 Mrs A was discharged from the CAIT and referred for an outpatient appointment for 22 November. Between the end of July and 9 October 2010 Mrs A was given dietary advice and repeat prescriptions by her GP.

3.31 Between 7 and 15 October 2010 police were involved with Mrs A on several occasions about incidents regarding her neighbour, who was arrested. Mrs A was variously reported by the police to be vulnerable, scared and confused, suffering harmless delusions, her home in disarray, a repeat caller and suffering from 'mental health'. The police notes indicate that Mrs A needed more support and that her daughter (not clear which one) may not have fully appreciated her mother's deterioration in mental health. An assessment was recorded and sent to Social Services for intervention and the SNT asked to conduct follow up visits. A further referral was made by police and passed to the Emergency Intervention Team 'for info'.

3.32 On 29 October 2010 the Emergency Intervention Team contacted daughter Miss B to confirm that Mrs A would be attending her outpatient appointment in November. Miss B was advised to attend with her mother at her hospital visit.

3.33 Between 29 October 2010 and 25 February 2011 Mrs A was seen several times by her GP for patient review. The GP noted that Mrs A did not want her daughters involved in her care and had nominated a friend to be involved in her care and treatment.

3.34 At an outpatient appointment on 10 February 2011 Mrs A was allocated to the Older People's Community Mental Health Team and a care plan was agreed. It was noted at this meeting 'If there is any tangible evidence that her neighbour is victimising her this will need to be explored under the Safeguarding Adults Alert Framework'.

3.35 Between 15 February and 15 March 2011 the police were called several times and Mrs A expressed various concerns; a suitcase had been poisoned by her daughter who she was suspicious of, and her medication, shopping bag expensive plates and her keys had all gone missing.

3.36 Police noted that she was not making much sense, and that there were no signs of forced entry (and it was noted that her daughter had a key).

3.37 Police recorded that Mrs A felt unsafe in her house and was scared of her daughter but didn't know why, and she thought her daughters wanted her dead. The daughter's name was not recorded.

3.38 On Thursday 3 March 2011 the police visited Mrs A. Her house was found to be uninhabitable with rubbish everywhere and her clothing stained and dirty. This information was shared with social services (presumably Royal Borough of Greenwich).

3.39 On 14 March 2011 two social workers made telephone contact with Miss C as Mrs A was "deteriorating". Miss C reported that the situation with Mrs A was very difficult. She also reported that Mrs A was accusing people of stealing things, including accusing Miss B. It was noted that Miss B had paranoid schizophrenia and that the stress with Mrs A was having a detrimental effect on Miss B's mental health. It was, however also noted that Miss B was well at that time and was supporting her mother.

3.40 On the 15 March 2011 Mrs A was admitted informally to Oxleas House[20] following a CAIT assessment.

3.41 She was detained under Section 5(2)[21] of the Mental Health Act (MHA) after demanding to leave. She was assessed for detention under the MHA on 16 March, following staff reports that she was repeatedly asking to go home. She was assessed by the duty Approved Mental Health Act Professional (AMHP), the older peoples' psychiatrist and another Section 12 approved doctor. At this time it was thought that she may have vascular dementia. At interview she agreed to stay and it was noted that she appeared 'reasonably capacitated to consent' to informal admission. The working diagnosis was 'mild to moderate dementia complicated by delusions' and she was prescribed risperidone. This helped her agitation and delusions but she became over-sedated, so her risperidone was reduced to 1 mg twice daily.

3.42 A brain scan conducted on 24 March showed age related changes indicative of dementia. The diagnosis noted on the discharge letter of 24 May 2011 was F06.2: 'psychotic disorder with delusions due to known physiological condition'.[22] The 'known physical condition' was the organic brain changes. It appears that she was suffering from delusions, and this is what brought her into hospital. Her memory issues were seen as secondary to the delusions, impacting on her socially/environmentally rather than needing treatment in their own right.

3.43 Mrs A was very keen to spend time at home, and both daughters supported this. An initial visit was made with an occupational therapist (OT) in attendance to make an assessment of the environment at the beginning of April. She later spent two weekend nights at home.

3.44 There were concerns about how she would manage at home, and various care packages were discussed with her and her daughters. Mrs A was very keen to return to her home with minimal support, and it was noted that her daughters had concerns about how she would manage. Following

[20] *Oxleas House is an inpatient mental health facility. http://oxleas.nhs.uk/services/service/oxleas-house-greenwich-inpatie/*
[21] *Section 5: Application in respect of patient already in hospital. https://www.legislation.gov.uk/ukpga/1983/20/section/5*
[22] *International classification of diseases: ICD 10: F06.2 Psychotic disorder with delusions due to known physiological condition. http://www.icd10data.com/ICD10CM/Codes/F01-F99/F01-F09/F06-/F06.2*

some adaptations to her property to improve her safety and plan for discharge, Mrs A went home for an initial two weeks of leave on 16 May 2011. She was formally discharged on 24 May 2011. A depot injection of flupentixol[23] was prescribed, to try to ensure compliance with antipsychotic medication. Presumably, at this point she was put on Enhanced CPA but it is not clear from the notes.

3.45 At the outpatient appointment in June 2011 her diagnosis was given as F06.2 'organic delusional disorder'.

3.46 From 16 May to 18 July 2011 Mrs A received a home visit nearly every day from the CAIT Team. On some days Mrs A would not allow access to the team. Problems with medication compliance were noted and that Mrs A's daughters were helping with this. It was proposed that Mrs A be admitted to hospital to stabilise her medication but she was reluctant to be admitted. In June 2011 the consultant psychiatrist noted that he was now reluctant to prescribe the depot as Mrs A was 'slow and frail', and it was planned to reduce her medication to risperidone 1 mg.

3.47 On 24 June 2011 a social worker from CAIT met Mrs A at home with daughter Miss B and a care plan was formulated.

3.48 Following an assessment, social services commissioned the First Choice Agency to provide daily home visits. A Complex Needs Care Plan was agreed.

3.49 On 25 July 2011 Mrs A was discharged from the care of the CAIT.

3.50 A support worker from the Older Peoples Community Mental Health Team, (OPCMHT) was appointed to visit Mrs A regularly at home and she continued to have consultations with her GP. She continues to receive daily visits from the First Choice Agency for home care.

3.51 On Friday 26 August 2011 Mrs A was diagnosed at an Outpatients Clinic as having 'organic delusional disorder,[24] now in remission'.

3.52 Between August 2011 until October 2012 Mrs A continued to receive home visits from the OPCMHT worker and the agency, and see her GP for repeat prescriptions and consultations. There were occasions when First Choice Agency staff could not gain access and one occasion when she called the police following concerns about her neighbours shouting. She also had a podiatry review, a consultation about her diabetes and visits relating to financial assessments for her home care.

3.53 In September 2011 the consultant psychiatrist noted that Mrs A was doing very well psychologically, she was tolerating a small dose of risperidone, and appeared to be managing at home with the help of a small care package and the support of her two daughters. The diagnosis was

[23] *Flupentixol is a long acting injection of antipsychotic medication (depot injection). https://www.medicines.org.uk/emc/medicine/5397*

[24] *Psychotic symptoms secondary to a physical condition. Mental Health in Older People A Practice Primer https://www.england.nhs.uk/wp-content/uploads/2017/09/practice-primer.pdf*

'organic delusional disorder, now in remission F06.2'. In December 2011 she was again reported to be doing 'very well psychologically' and was 'quite stable', with no psychotic symptoms, and this continued at outpatients in 2012.

3.54 On 22 November 2012 daughter Miss C contacted the police saying Mrs A had dementia and had not been seen for several days. Police attended and forced entry and found Mrs A collapsed on the floor. London Ambulance Service attended, but Mrs A refused to go to hospital. There is no record of an assessment of her capacity to make this decision. The police secured the property and Mrs A was left in the care of her daughters. On 20 November Miss B spent two nights with Mrs A following a fall, which she did not require hospital admission for.

3.55 Between November 2012 and May 2013 Mrs A had regular home visits and provision of OT equipment and repeat prescriptions from her GP.

3.56 On 17 January 2013 the RBG contacted Miss B as they had a report from Mrs A's home care agency that Mrs A's property was cold and damp. Miss B said that this was not a problem and that the agency must have confused her mother with another client.

3.57 On 18 April the GP spoke to one of the daughters about a broken door at their mother's home, which was being left open ostensibly to avoid Mrs A locking herself in. The GP confirmed that there had been no change to Mrs A's overall health and recommended Telecare.[25]

3.58 From May 2013 care continued to be provided by the AO worker from the CMHT and the home care agency. Mrs A continued to attend outpatient appointments with her consultant psychiatrist. There were occasions when access to Mrs A's property could not be gained. At an outpatients appointment in June 2013 it was noted that during the previous week Mrs A had entered her neighbour's flat in a confused state, although nothing untoward had occurred. The consultant recorded that her daughter (Miss C) was concerned that 24 hour care may need to be considered, and it was agreed that the care coordinator would discuss this with Mrs A and the family.

3.59 On 10 July 2013 Mrs A called the police because she had no heating and could not heat her food up. When police attended Mrs A could not remember calling them and there was no problem with her gas supply.

3.60 On 26 July 2013 Miss C stated at a CPA Review meeting that that the neighbour whom Mrs A had problems with had assaulted her (Mrs A) in 2010. There is also a note to the effect that on 29 July the notes had been amended to reflect this. This was noted as being previously unknown to

[25] *Telecare is support and assistance provided at a distance using information and communication technology. It is the continuous, automatic and remote monitoring of users by means of sensors to enable them to continue living in their own home, while minimising risks such as a fall, gas and flood detection and relate to other real time emergencies and lifestyle changes over time. (definition by Telecare Services Association).*

the service, despite the fact that the service were aware of her complaints about the neighbour's conduct and harassment of her.

3.61 From August 2013 to January 2015 Mrs A continued to receive home visits, attend outpatients and see her GP for her diabetes and medicine management.

3.62 On 27 June 2014 Mrs A attended the GP surgery for a diabetic dietary review. It was noted that her daughter (although it is not clear which one) said she did not believe her mother had diabetes and therefore did not need diabetic medication. It was agreed that a blood test should be done. From July 2014 to October 2014 Mrs A had significant OT input in respect of OT assessment and provision of equipment. On the 27 June 2014 the GP paid a home visit to Mrs A. She was found to have pain and swelling from the jaw to the cheek on the left side of her face, tooth ache and a loose tooth. Her daughter was advised to make an appointment with a dentist as soon as possible. It is not known whether Mrs A subsequently attended a dentist.

3.63 On 21 November 2014 concerns were raised by the care agency about the number of times when they could not gain access to Mrs A. It was noted that Mrs A was either sleeping or out with her daughter.

3.64 On 22 January 2015 following lack of access daughter Miss C was informed and said that Mrs A was fine and did not need further visits. On 9 February 2015 the home care service was ended.

3.65 On Friday 20 March 2015 the GP noted that Mrs A was on CPA, was compliant with medication and was looked after by her daughters. Mrs A was informed that her GP was leaving the practice.

3.66 On 1 July 2015 a telephone falls assessment was undertaken by the Joint Emergency Team. Miss B (daughter) said that her mother had fallen three times in the last week and that the falls had not been witnessed. On 7 July Mrs A was referred to the Falls Team.

3.67 Mrs A did not attend a diabetic eye screening programme and her daughter was alerted. The family have clarified that the appointment letter was found after the appointment date. Mrs A's appointment letters were normally sent to Miss C, but this one was not.

3.68 On 10 July 2015 a safeguarding alert was raised when Mrs A was discharged by Miss C from Queen Elizabeth Hospital (QEH) in Greenwich. The alert was raised because Mrs A was discharged without her having the recommended blood tests, chest x-rays, assessment for care package and with a 'suspicious ECG'. The specific concern noted in the referral was 'neglect'. The family have told us that a similar situation had arisen two weeks previously and the hospital had discharged Mrs A, despite her being referred for risk assessment. Miss C says that she discharged Mrs A as she had an appointment with her consultant the following week. She was of the view that her current condition was

caused by her medication which, she says, was confirmed by the consultant. Miss C is of the view that a safeguarding alert should have been raised between QEH and RBG at the first incident. We have said that there was a failure in QEH taking four months to raise the safeguarding alert in the second incident.

3.69 On Thursday 16 July 2015 Mrs A was referred by the consultant psychiatrist for reallocation to the CMHT following her outpatient appointment. In the referral he noted that Mrs A had dementia, that the situation was unstable and there was 'carer stress'. The consultant also changed Mrs A's medication following falls and referred her for a CT brain scan and suggested increasing her care package.

3.70 On 21 July 2015 Mrs A attended the GP surgery to have a suture removed having sustained a deep cut to her finger. The GP told us that this cut was sustained when Mrs A fell at home. She fell several times as discussed above, and on this occasion tried to break her fall, cutting her finger in the process. The sutures were applied at Lewisham A&E on 10 July 2015. She did not attend the GP surgery for any follow up.

3.71 On 27 July Mrs A was allocated to a community psychiatric nurse (CPN) following a visit, which Miss B was present for. Home visits continued.

3.72 On the 10 August 2015 daughter Miss B was written to by the local authority offering her a carer's assessment. Miss B expressed her enjoyment of looking after Mrs A and another patient in the ward whilst Mrs A was an inpatient, assisting both of them throughout the day. She said she would like a carer's assessment as this would be beneficial for her if she applied for a trainee/ healthcare assistant position within a hospital setting as she enjoyed the work that they did. Miss C did not receive a carer's assessment letter.

3.73 No action was taken in respect of the safeguarding alert at the time. The referral was passed from QEH to the Joint Emergency Team on the 19 October. In response to this the GP was asked to visit which he did on 30 October. He had no concerns about Mrs A. Following this QEH were asked to conduct an internal investigation into the failure to act on a safeguarding alert and CQC were informed.

3.74 From 6 November 2015 onwards Mrs A had a number of routine medical consultations; she missed an outpatient appointment on 31 January. During this period it was confirmed by her daughter that she had no further falls following a change in her medication.

3.75 Mrs A's GP notes of January 2016 shows that she was on the following medication: diazepam 1 mg at night (1/2 of a 2 mg tablet); simvastatin 10 mg at night; amlodipine 5 mg in the morning; mirtazapine 15 mg at night; dispensed in a blister pack. Mirtazapine is an anti-depressant and diazepam an anxiolytic. Of note diazepam may be relevant to falls in older people; confusion and ataxia are potential side-effects are listed

(especially in the elderly). Her diabetes was diet controlled so she was not prescribed any medication for this.

3.76 Mrs A died on 21 February 2016.

Miss B - Physical health history and treatment

3.77 Miss B has a history of asthma, eczema and hypercholesterolemia.[26] These were treated by her GP, and she was prescribed simvastatin[27] for raised cholesterol, inhalers for asthma, and was seen regularly at the GP surgery asthma clinic. Miss B had suffered with eczema since 2011 and used regular emollient creams. This affected her fingers, hands feet and thighs and had worsened in July 2015, when she was referred to the dermatology department at QEH. Dermatitis was diagnosed and tested for and tinea pedis (athlete's foot) were carried out, and medication was prescribed.

3.78 She showed positive for trait thalassemia[28] although had no symptoms.

3.79 Miss B was diagnosed as having Type 2 diabetes and this was treated with medication. She attended the diabetic clinical and eye screening clinics. In 2014 she was offered a diabetic education programme (DESMOND)[29] which is an NHS training course for people with Type 2 diabetes that helps people to identify their own health risks and to set their own goals.

3.80 She was seen by the endocrinology department of QEH, Lewisham in July 2015, after presenting to her GP with palpitations and was diagnosed as having hyperthyroidism, probably due to Graves disease.[30] She was prescribed carbimazole[31] as long term treatment.

3.81 A diagnosis of rheumatoid arthritis was considered in July 2015, and she was seen in the rheumatology department of QEH, with back, hip and knee pain. Blood tests showed that she was severely Vitamin D deficient and she was taking high strength supplements. The consultant's opinion was that she did not have inflammatory arthritis, and suggested painkillers, gentle exercise and the vitamin supplements.

3.82 In July 2015 Miss B's GP made an urgent referral to QEH for suspected skin cancer and she was seen by the dermatology department in August 2015. Miss B complained of a lesion on her arm that she had for over 10

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[26] *High cholesterol. https://www.nhs.uk/conditions/high-cholesterol/causes/*
[27] *Simvastatin is a treatment for high cholesterol. https://www.nhs.uk/conditions/statins/*
[28] *Thalassaemia is the name for a group of inherited conditions that affect a substance in the blood called haemoglobin. People with the condition produce either no or too little haemoglobin, which is used by red blood cells to carry oxygen around the body. This can make them very anaemic (tired, short of breath and pale). http://www.nhs.uk/conditions/Thalassaemia/Pages/Introduction.aspx*
[29] *DESMOND is a UK NHS training course for people with type 2 diabetes that helps people to identify their own health risks and to set their own goals. http://www.desmond-project.org.uk/*
[30] *An overactive thyroid (hyperthyroidism) occurs when the thyroid gland produces too much of the thyroid hormones. In about three in every four cases, an overactive thyroid is caused by a condition called Graves' disease, an autoimmune condition, which means the immune system mistakenly attacks the body. http://www.nhs.uk/Conditions/Thyroid-over-active/Pages/Causes.aspx*
[31] *Carbimazole is one of a group of medicines called thionamides, which are a common treatment for an overactive thyroid. http://www.nhs.uk/Conditions/Thyroid-over-active/Pages/Treatment.aspx*

years, which had become itchy and more prominent in hot weather. A harmless growth called a dermatofibroma[32] was diagnosed, and no treatment was required.

3.83 In September 2015 she was diagnosed by QEH cardiology department as having rare ventricular ectopic heartbeats, which were regarded as a harmless symptom of her hyperthyroidism. In November 2015 Miss B called an ambulance, complaining of crushing chest pains. She continued to complain of palpitations, and investigations were carried out again in May 2016 and no heart problems were found. She was discharged by the cardiology department in November 2016, as her symptoms had improved.

3.84 She saw her GP in December 2015 complaining of difficulty sleeping, and in February 2016 for back pain. A GP referral for lower back pain was made for physiotherapy at QEH in February 2016.

Miss B - Mental health history and treatment

3.85 Miss B was 52 years old at the time of the homicide in February 2016.

3.86 She has a diagnosis of schizoaffective disorder (ICD10:F25.9).[33]

3.87 She has had numerous inpatient admissions over the span of her illness, and her relapses have been characterised by withdrawal, neglecting herself and paranoid and suicidal ideas.

3.88 Miss B had been known to mental health services since 1981 aged 17, after taking an overdose of paracetamol and was treated with chlorpromazine.[34] She was admitted again aged 19, after taking a further overdose. Her third admission was in 1984, aged 20, to Greenwich District Hospital. She had become increasingly withdrawn, isolating herself in her room and starving herself. At this time she was diagnosed with paranoid psychosis, with an underlying 'vulnerable personality'. She responded well to depot medication (fluphenazine).[35]

3.89 Her next admission was in September 1985 after the birth of her older child. She became mute and withdrawn, and was admitted to a psychiatric ward directly after delivery. She described herself as depressed, paranoid and hearing voices. She was discharged but admitted in October 1985 after she became withdrawn again. She was treated with trifluoperazine[36] and amitriptyline.[37]

3.90 Miss B was admitted to Greenwich District Hospital in July 1986. She had recently discovered she was pregnant, which was unplanned. She

[32] *A dermatofibroma is a common overgrowth of the fibrous tissue situated in the deeper of the two main layers of the skin. https://www.evidence.nhs.uk/document?id=1578939&returnUrl=Search%3Fps%3D20%26q%3DDye%2BLaser%26s%3DDate&q=Dye+Laser*

[33] *Schizoaffective disorder unspecified: ICD-10 Diagnosis Code F25.9. http://icdlist.com/icd-10/F25.9*

[34] *Chlorpromazine is a phenothiazine antipsychotic medicine. https://patient.info/medicine/chlorpromazine*

[35] *Fluphenazine is an injectable phenothiazine antipsychotic medicine.https://www.evidence.nhs.uk/search?q=fluphenazine*

[36] *Trifluoperazine is a phenothiazine antipsychotic medicine. https://bnf.nice.org.uk/drug/trifluoperazine.html*

[37] *Amitriptyline is an antidepressant. https://www.nhs.uk/conditions/antidepressants/*

withdrew to bed again and was detained under Section 2 MHA. She remained an inpatient for 12 days, but she was not prescribed medication because of her pregnancy. Her older child was considered at risk and was taken into care.

3.91 Her second child was born in November 1986. In 1987 Miss B had three admissions to Greenwich District Hospital, the second of which was under Section 4 MHA. On this occasion she was neglecting herself and requested that the baby be taken into care. She was noted to have a knife in her bed, and was mute and psychotic, reporting an auditory hallucination of a voice saying 'awful things about her'. She was treated with depot medication (flupenthixol)[38] and her children were fostered. A case conference in May 1987 noted that she had previously smacked and scratched her older child, which was not at the time thought to be serious enough to warrant placing her on the 'child at risk register'.

3.92 Miss B was admitted informally to Greenwich District Hospital in June 1988, after being non-compliant with medication. Two months prior to admission her mother (Mrs A) noticed bruising and scratches on the face of her older child. Miss B was again mute and neglecting herself, and her children were taken into voluntary care while she was in hospital. She again responded well to flupenthixol depot medication, and was given 40 mg monthly as an outpatient after discharge.

3.93 In May 1989 she had a further admission to Greenwich District Hospital under Section 2 MHA after she had again neglected herself and taken to her bed. A case conference was called with a view to making a decision to granting custody of her children to Mrs A, but this step was not taken.

3.94 Through the remainder of 1989 and 1990 Miss B was treated in the community, accepting depot medication. She was working as a clerical assistant in Woolwich during this time. She stopped taking medication in December 1990, and her youngest child was born in September 1991.

3.95 Miss B was admitted again in October 1991 in a mute state and after treatment with flupenthixol she began to communicate but remained psychotic. At this time she said that she heard derogatory voices coming from her children, and wanted to kill her two children and be put away for it. She also alleged that her husband had been violent to her. In October 1991 her children were placed on the Child Protection register by Greenwich social services under the category of physical abuse. She was diagnosed as suffering from paranoid schizophrenia and depression and her consultant psychiatrist at the time urged that she should not be allowed to look after her children, particularly since an assault on her older child had allegedly been carried out when she was regarded as mentally well.

3.96 After the October 1991 admission, Miss B was treated as an outpatient with regular depot medication, which was changed from flupenthixol to

[38] *Flupenthixol (now flupentixol) is an injectable phenothiazine antipsychotic medicine. https://patient.info/medicine/flupentixol-tablets-depixol-fluanxol*

clopixol[39] in December 1993 at her request. She was noncompliant at times with the antidepressant, but continued to accept the depot injection. She was placed on the 'supervision register'[40] in January 1995. This was a register introduced in 1994, where mental health services were expected to maintain a 'register' of people 'known to be at significant risk of committing serious violence or suicide or of serious self-neglect as a result of severe and enduring mental illness, people with a diagnosed personality disorder', and those liable to be at significant risk in 'some foreseeable circumstances which is felt might well arise in this particular case (e.g. ceasing to take medication, loss of a supportive relationship or loss of accommodation)'. Miss B appears to have separated from her husband around this time, and although she appeared low in mood and took to her bed for a few days, she appeared to respond well to the clopixol injection. She did not attend a routine outpatient appointment on 30 May 1995, and her consultant wrote to the community psychiatric nurse intending to send another appointment.

3.97 The assault on her older child occurred on 23 June 1995. Miss B apparently woke up feeling low in mood on 19 June, and cancelled a driving lesson she had booked. She felt tearful and phoned her community psychiatric nurse (CPN), who was on leave. Miss B told the interviewing psychiatrist (after the assault) that she forced herself to pick her youngest child up from nursery. Her mother Mrs A and her husband told the psychiatrist they felt she had deteriorated over the previous weekend. She did not return the children to Mrs A's house at the end of the weekend, and then cancelled their after school activities. As a result of their concerns, her husband went to her house but Miss B would not let him in. He called the police for assistance, and she opened the door to them and was persuaded to let her husband take the youngest child into his care. He asked the police to wait until Mrs A arrived to collect the children, but the police had left by the time she returned home. The community mental health team (CMHT) was requested by the family to visit her. The CMHT nurse manager tried to call on the Monday and Tuesday but got no reply. Her CPN went to Miss B's house on the Wednesday and could not gain access, and it appears Miss B had by then gone to stay with Mrs A, taking the children with her. The community nurse spoke to Miss B that evening and it was arranged that she would have her depot injection the following day. Miss B appeared much better that evening and was interacting well with the children.

3.98 The following day the older child was late getting ready, and wanted to stay at home rather than go to school late. Mrs A decided to take the younger girl to school, and felt sufficiently reassured to go on from there to a dressmaking class, leaving the older girl to stay home with Miss B. Miss B later said she had felt better the night before, but woke feeling panicky and frightened, and hearing TV performers making rude comments about her. Her child told her to have a cup of tea or go and lie

[39] *Clopixol is an injectable antipsychotic medication. https://bnf.nice.org.uk/medicinal-forms/zuclopenthixol-decanoate.html*
[40] *NHS Management Executive. Introduction of supervision registers for mentally ill people from 1 April 1994. Leeds: NHSME 1994. (HSG(94)5.*

down. Miss B recalled hearing voices calling her abusive names and saying she must die. She picked up a kitchen knife and tried to cut her wrists and stab herself in the stomach. She recalled asking her older child to help her kill herself and hearing voices telling her that she and the children should die. The older child snatched the knife and managed to call 999. Miss B recalled being by the stairs, stabbing the older child in the abdomen, and seeing blood on the child's hands. Subsequently she tried to strangle the child while still holding the knife, and was stopped by police after they broke down the door. Miss B was arrested and taken into custody.

3.99 Her mental health background was further explored after admission to the Bracton Clinic in September 1995 and it was noted that she had been 'frequently mildly aggressive' to her mother Mrs A. Early in the admission she had hit her mother while her mother was visiting in the ward area of the Bracton Clinic. There are no more details of this incident in the records.

3.100 Miss B was assessed while on remand in prison, and said she heard voices calling her names, she thought everyone in the prison knew about her and hated her. She continued to feel she should die but did not have active suicidal intent, and she also said she had not believed she had a mental illness before, but now because of what had happened she thought there must be something wrong with her.

3.101 Miss B was admitted to a psychiatric intensive care unit while awaiting a bed at the Bracton Clinic, and was admitted to Bracton in September 1995 on Section 48 MHA. She was initially physically aggressive, had a low tolerance to frustration and caused damage to property. On one occasion she attacked staff. Her mood varied from highly agitated and sexually disinhibited to profound depression, for which she was treated with medication and ECT. She was prescribed flupenthixol 100 mg fortnightly, and this was reduced to 80 mg after she was regarded as apathetic and lacking in motivation. On the reduced dose Miss B quickly became hypomanic, and was flirtatious and disinhibited.

3.102 In March 1996 she began a sexual relationship with another patient, and alleged that her husband tried to force her to have sexual relations in the grounds. After this incident she became profoundly depressed again, refusing to eat or drink and becoming suspicious of others. With increased antidepressants her mood stabilised, and a meeting was held with her husband and Mrs A, who had expressed concerns about her safety in relation to sexual relationships with other patients. Miss B was convicted of unlawful wounding in May 1996 and detained under Section 37/41 of the Mental Health Act.[41]

3.103 In February 1997 there was an improvement in her mental health, and she identified early warning signs of deterioration as self-isolation,

[41] *Powers of courts to order hospital admission or guardianship, and restriction on discharge. https://www.legislation.gov.uk/ukpga/1983/20/section/37*

deterioration in self-care and increased paranoia. In March 1997 a fire was started by another patient, and Miss B was distressed by the evacuation. She approached staff saying she felt suicidal, and her observations were increased. When she was informed that a member of staff would stay outside her door she became abusive and agitated and required physical restraint. A member of staff sustained a broken finger. When interviewed Miss B said she was feeling frustrated and angry at still being an inpatient and was not suicidal. She denied causing any harm to the staff member. She was interviewed by police and attended court in April 1997 but this was not proceeded with.

3.104 Miss B left the unit without authorisation on 3 May 1997: she went out for her half hour walk in the grounds and did not return. Her husband brought her back about 24 hours later. She alleged that she went to see her youngest child, and that her husband forced her to stay and have sex with him. He denied she had been in his company overnight. Her ground leave was stopped for a brief period.

3.105 She was observed on one occasion getting into her husband's car in the hospital grounds, in breach of her leave guidelines, although she did return on time.

3.106 In October 1997 a mental health review tribunal (MHRT)[42] decided that she should not be discharged from her section, and she became frustrated and despondent. About a week after this she absconded from ground leave with another patient. They both contacted their families, but Miss B did not contact the children or engage in any unsafe behaviour. They returned to the Bracton Centre of their own accord within 48 hours. It had been planned to request that the Home Office grant her unescorted leave in the community, however this was not done as a consequence of this unauthorised absence. Miss B became frustrated and volatile through November and December 1997, and was involved in an altercation with another patient and hit a nurse. In her subsequent interview with her consultant psychiatrist she smashed a cup on the table. Miss B agreed to an increase in her lithium[43] and gradually settled. Unescorted leave into the community was agreed by the Home Office and commenced in March 1998. Plans to move to the Barefoot Lodge[44] were delayed while a risk assessment report was prepared by the Bracton with regard to risks to her children. The opinion was given that Miss B would not present a risk to her children unless they were actually in her care or she had unsupervised access to them.

3.107 Miss B was transferred to Barefoot Lodge in July 1998. She was reported to be unhappy with the ward environment, and absconded in August 1998, being missing for an hour. She went to her mother's house but was

[42] *Mental Health Review Tribunals are responsible handling applications for the discharge of patients detained in psychiatric hospitals. Now called First Tier Tribunal. https://www.gov.uk/courts-tribunals/first-tier-tribunal-mental-health*

[43] *Lithium carbonate is a mood stabilising medication. In the UK, lithium carbonate (often referred to as just lithium) is the medication most commonly used to treat bipolar disorder. https://www.nhs.uk/conditions/bipolar-disorder/treatment/#lithium-carbonate.*

[44] *Barefoot Lodge is an inpatient community integration unit providing care for 15 people with mental health needs aged 18 to 65 from the borough of Greenwich who need intensive rehabilitation. http://oxleas.nhs.uk/services/service/barefoot-lodge/*

not allowed in, and was brought back to Barefoot Lodge by her sister. Her care plans were changed so that she was not allowed to go to either her mother or her husband's house.

3.108 A Mental Health Review Tribunal was planned for April 1999. She had not shown evidence of psychotic symptoms since November 1998, although it was reported she became low in mood in November 1998 but this responded well to paroxetine[45] 20 mg. Previous problems with compliance with medication had resolved, and blood testing for lithium showed that she was taking it regularly as her serum lithium were at therapeutic levels. No further 'absent without leave' (AWOL) episodes were noted, engaging in off ward therapeutic activities but not keen on these as she didn't feel she had a peer group at Barefoot. Over the following month she expressed frustration with these limits, and was unhappy at being at Barefoot. She was however regarded as mentally well with no hallucinations or delusions.

3.109 In October 1998 she again left the ward without leave. It transpired that there should have been a new application for leave made when she was transferred to Barefoot Lodge, and when this was discovered on 1 October, leave had to be suspended while it was sorted out. Miss B was angry and frustrated and refused her lithium for the next few days. She left without permission on 5 October 1998 although she went to attend her college course. She was angry on return, said she did not need to take lithium and should be allowed to look after her children because she was their mother.

3.110 Supervised contact with her children was now about every three weeks. There was some concern that as the children get older they may be able to meet her without supervision. Miss B was noted to be very critical of Mrs A, and this caused problems between Mrs A and the children. Family therapy sessions took place with Miss B, the older children and Mrs A.

3.111 Individual psychology sessions were provided over 10 months in 1998 to explore Miss B's offence. Miss B was reported to have fluctuating insight into this, at times able to acknowledge that her children may be frightened of her. At times she has shown evidence of regret and remorse, and at other times very angry and blaming everyone else for what happened. The psychologist's opinion was that her anger was a defence against accepting what had happened. At this time she was treated with clopixol 200 mg monthly, lithium 1200 mg and paroxetine 20 mg daily. The MHRT report by her Responsible Medical Officer[46] (RMO) in April 1999 noted that concerns still remained about her insight into her illness and the level of seriousness of the assault. Nevertheless it was recommended that plans to move her into the community should be progressed, but with oversight from the forensic services and in cooperation with social services.

[45] *Paroxetine is a type of antidepressant known as an SSRI (selective serotonin reuptake inhibitor). https://beta.nhs.uk/medicines/paroxetine/*

[46] *Now referred to as approved clinician – RC*

3.112 The social circumstances report written by Greenwich Social Services in November 1998 for the MHRT consulted Mrs A as Miss B's nearest relative. It was suggested that Mrs A was vulnerable in terms of being able to protect the children, and to influence from Miss B, but that this was being monitored closely by social services. The social worker who prepared the report stated he thought it would be premature for Miss B to be conditionally discharged at that time, but that plans to move her to the community slowly should progress.

3.113 Miss B moved to Bennett Park, which was a women-only hostel provided by Greenwich council, with support provided by a mental health charity (Bridge 86).[47] She was transferred in November 1999 for a period of trial leave, and was conditionally discharged by the MHRT in February 2000.

3.114 She remained at Bennett Park, but did not engage well, was not always compliant with taking medication and did not attend planned therapeutic activities. She began using crack cocaine in 2001, and was spending all her money on this and getting into debt. She was referred to substance misuse services for support. She was given written warnings by Bridge 86 in April 2000, August 2000 and September 2001 about her behaviour, which included making noise at night and having unauthorised visitors.

3.115 In April 2002, she was not engaging, using crack cocaine, and buying, selling and borrowing to get drugs. Police had been called to deal with a man whom Miss B kept letting in, so police had refused to attend after further complaints. This individual was banned from Bennett Park, and lived in a 24 hour hostel from which Miss B was banned. A letter of complaint was written to the Trust by Bennett Park, and Miss B was assessed but not felt to be detainable. She was served with an eviction notice on 16 April requesting that she leave by 6 May 2002, although this was later postponed to allow for accommodation to be sourced.

3.116 A professionals meeting was held, and discussion around admitting her to the Tarn Psychiatric Intensive Care unit (PICU) for detoxification ensued. Miss B was seen by substance misuse services, and initially agreed to a voluntary residential detoxification placement in April 2002, but changed her mind. At this time Miss B was insisting she would only move to a flat of her own, and wanted to have the children to live with her. Her social supervisor considered that she should be recalled to hospital under Section 37/41, and requested an assessment by the Bracton forensic service. This assessment supported the admission for detoxification and rehabilitation. She was found to be mildly hypomanic, but unrealistic in her aims and easily frustrated, however there were no concerns about an increase in her risk to others, but her crack cocaine use was noted, and she was engaging in other risky behaviours.

3.117 There was disagreement among professionals about whether she should be formally recalled, although the Home Office advised that she should be

[47] *Bridge 86 is now called 'Bridge' and is a charity providing mental health and wellbeing services in London. http://www.bridgesupport.org/*

recalled. She was not recalled, and agreed to attend the Tarn voluntarily, to detoxify from crack cocaine. She was not accepted as an informal admission because the Tarn is a locked unit. She was however admitted to an open ward on 13 June 2002 but threw a chair at her consultant and threatened to kill him. She was detained in the Tarn on Section 3 MHA on 20 June 2002. Miss B was very angry and appealed immediately. A MHRT in August 2002 for the Section 3 MHA did not discharge her. Her depot medication was changed to risperidone which initially caused a deterioration in her mental state, but this stabilised. She was also prescribed carbamazepine and paroxetine. Her motivation was poor and she spent days in bed, she maintained regular contact with a substance misuse worker but her engagement was ambivalent and she was described as 'insightless' regarding the need to stop using crack cocaine. She maintained regular supervised contact with her children.

3.118 Miss B was recalled by the Home Office on 24 January 2003, under Section 37/41 MHA. The Home office ordered that the Section 3 was incompatible with this and should be rescinded. An automatic referral to the MHRT was made as a condition of recall. In February 2003, the social supervisor wrote a report for MHRT which stated that the views of Mrs A as nearest relative were that Miss B should not be discharged from hospital at this time. She also noted to the MHRT and Mrs A that Miss B's eldest child would become her nearest relative under the MHA when she turned 18. Mrs A was shocked by this and there was a discussion about delegating this to Mrs A, but there is no evidence that this was done. The social supervisor noted she had also informed Greenwich social services of this fact.

3.119 Miss B was readmitted to Barefoot Lodge for a period of rehabilitation on 27 May 2003. In the nursing report for the MHRT in October 2003 Miss B was noted to be cooperative with medication, engaging in a therapeutic timetable of activities, and random drug screens were negative. Her consultant psychiatrist described her as reluctantly complying with medication, and it was recommended that she not be discharged, with a view to leave being introduced gradually. Unescorted leave was granted by the Home Office in August 2003.

3.120 Miss B was conditionally discharged by a MHRT in March 2004, and the conditions were to reside at a staffed group home, comply with medication, participate in therapeutic activities, have regular drug screening, accept counselling by the substance misuse service and comply with monitoring and follow up by her social supervisor/care coordinator and consultant psychiatrist. She moved into an independent flat in February 2004, and was referred to the Trust Locality Team at Woolwich Arsenal in the community, requesting that her care be taken over in the community. Miss B remained on enhanced CPA.

3.121 In December 2004 she wrote a suicide note and took an overdose. She was supported in the community and recovered. Bridge 86 continued to provide floating support. In March 2005 she was accepted by the Oxleas

Arsenal Locality Team, and allocated a care coordinator. This is the point at which she was discharged from the care of the forensic service.

3.122 As part of her conditional discharge arrangements, the consultant's report to the Home Office in June 2005 noted that she was stable, taking medication, was attending a positive parenting course and complying with weekly care coordinator and monthly consultant meetings. Her older children (by now 18 and 19) were noted to be spending time at her accommodation. In September 2005 she told professionals that her older children were staying with her permanently. At this time she was prescribed risperidone 2 mg twice a day, carbamazepine 200 mg[48] twice a day and paroxetine 30 mg once daily. She was transferred in 2005 from the Complex Needs and Recovery service to the care of Greenwich Recovery Team. Miss B was on enhanced CPA until 2009 and received regular out-patient appointments and support from Bridge 86. Her diagnosis remained as schizoaffective disorder (ICD10:F25).

3.123 In October 2005 her social supervisor reported that she was complying with medication, random drug screens were negative, and there were no indications of risk to herself or others. She was being supported by Bridge 86 with no problems. No risk to self or others were noted, and she had recovered well from the overdose in December 2004. A MHRT was planned for December 2005.

3.124 In June 2006 the consultant's report to the Home Office stated that Miss B was accepting support from Bridge 86, seeing her care coordinator regularly and had negative urine drug screen tests. She had begun to take half the dose of risperidone, and was advised to take the full dose prescribed. There was no change in mood or mental state, and no evidence of risk to self or others. At this time she said that she was seeing her children regularly, and they stay over sometimes, but they do not appear to have been living with her.

3.125 The social circumstances report prepared by her care coordinator noted that she was in contact with her mother and sister. Her older children still lived with their grandmother. Family relationships could be strained at times, but were generally reported to be positive. He recommended that she still receive enhanced support as the risk of a deterioration in her mental state remained. The consultant's report to the MHRT in September 2006 noted her diagnosis was restated as schizoaffective disorder (ICD10 F25.9). She was noted to be compliant, and it was stated that he would not oppose her absolute discharge from Section 37/41 MHA. Miss B received an absolute discharge from the Section 37/41 in 2006.

3.126 She drank bleach in December 2006, after feeling low in mood. She reported this was partly due to feelings evoked by the season. She had been referred to a clinical psychologist for ongoing problems with low self-

[48] *Carbamazepine is prescribed as part of the treatment for bipolar disorder, because it can modify some types of pain, and control some mood disorders. https://patient.info/medicine/carbamazepine-for-epilepsy-carbagen-tegretol*

esteem and difficulties dealing with stress, and remained on the waiting list for psychology until December 2008.

3.127 Miss B took an overdose of her prescribed medication in February 2008, she had not attended her last CPA meeting, and had not been taking her full dose of prescribed medication. It was reported that she had been experiencing problems with her family; an altercation with one of her children (not clear which one) was referred to. Miss B said she had hit her younger child on the shoulder, who then put a chair between them and left the flat. Miss B said she had felt like an inadequate mother. She was initially referred to the HTT on 2 February but discharged on 24 February 2008.

3.128 In June 2008 Miss B stated she had stopped taking her paroxetine medication because the colour of the tablets had changed and she thought there was 'something going on'. She described feeling flat with disturbed sleep and appetite but no suicidal plans. Her two grown up children were staying with her and were noted to be supportive. It was planned to refer her back to the home treatment team if her mental state did not stabilise. She resumed taking the paroxetine, and by August 2008 was more stable, she reported her older children were visiting her at weekends which she found less stressful than when they were living with her. She was still hearing abusive voices occasionally, but felt more motivated, and her risks were assessed as low.

3.129 Psychology sessions started in December 2008. In March 2009 she said she had returned from a holiday in Portugal in January feeling low in mood, she had stopped taking carbamazepine and was not taking risperidone and paroxetine regularly. Increased visits by her care coordinator were agreed.

3.130 In May 2009 Miss B was referred by her psychologist for Cognitive Behavioural Therapy (CBT), after the 11 psychology sessions had been completed. It was agreed she would be offered 10 sessions of CBT, focussing on these issues: being able to think more positively and find ways to cope with negative thoughts / feelings as they arise, feeling more confident and improving her self-esteem, dealing with social anxiety, improving her relationships with her children.

3.131 She was transferred to standard CPA in August 2009, after a period of stability. Her risks were described as 'suicide (low), non-compliance to prescribed medication (medium)'. There was no record of risk to others being assessed. She said she stopped taking her antipsychotics more than two months previously and felt more alert. She believed her paranoia was remarkably less although at times she feels people on the street spit as she walks past them or use abusive language. She did not want to be on any other antipsychotic.

3.132 The consultant tried to educate her about her illness, its course and her need for medication but she was not keen, and it was noted that 'however her paranoia is not affecting her activities'. The antidepressant fluoxetine

was continued, and support from Bridge 86 and her care coordinator was to continue, with a further outpatient's appointment in three months' time. In October 2009 the psychologist offering CBT treatment reported that [Miss B] maintained regular attendance, engaged well in sessions, worked hard and made significant progress. She was able to start and maintain attendance at First Step Trust.[49] Her mood lifted and she began to look into other work options and has recently attended her first job interview. She has been working on addressing some of the difficulties in her relationships with her older children, although these remain fraught at times. Most problematic for [Miss B] is her ongoing social anxiety, which manifests in many types of social and work situations. At times she also feels paranoid and hears derogatory voices, although she copes well with these and they are fairly infrequent. However, she feels that her social anxiety continues to hold her back, therefore I have offered her a place in the CBT group for social anxiety.

3.133 She had stopped her antipsychotic medication several months earlier, but restarted risperidone after one of her older children told her they thought she was becoming manic. She was referred for a 12 week course in social anxiety starting in October 2009.

3.134 At an outpatient appointment in December 2009 Miss B stated her 23 year old had been living with her, and had brought up past issues and argued with her which she found stressful. She had stopped taking fluoxetine but continued to take risperidone, and asserted that she knew which medication to take. She was noted to be somewhat low in mood and at risk of relapse, and an outpatient appointment was arranged for a months' time. Miss B missed the next appointment and was seen in March 2010. She was again taking medication erratically and was low in mood. She described having feelings of hopelessness and worthlessness, and that she might be better off dead but no active suicidal ideation or intent. She also mentioned that she still felt as if she interpreted conversations amongst strangers or things that she might overhear as referring to her (negatively), but not to the extent in the past when she would have clear ideas of reference from, TV, newspapers and radio etc. Compliance with medication was discussed and it was suggested that she should continue with the risperidone 4 mg at night and fluoxetine 20 mg, above but could try slightly less (2-3 mg) risperidone at night to see how it affects her the next day if 4 mg is too much, as she was complaining of drowsiness in the mornings.

3.135 In April 2010 she was referred to the Crisis Response Team[50], as she did not attend outpatients, and when the consultant called her she said she was too paranoid to leave the house. She was seen by Greenwich Rapid Response Team from 21 to 29 April 2010.

[49] *First Step Trust is a national charity with projects in Woolwich and Bexley, providing training and employment opportunities for people with mental health problems, drug and alcohol misuse and/or other disadvantages. http://firststeptrust.org.uk/*

[50] *Crisis Teams are a multidisciplinary team of professionals and support workers who provide short term help to people who are in a mental health crisis.*

3.136 The summary in May 2010 of her attendance at the CBT social anxiety group was that she had made progress in the group, but would benefit from a period of follow-up to support her in consolidating and applying the CBT skills learned in her daily life. A series of individual follow-up appointments over a six month period were offered. Her initial goals for the follow-up period were: to build use of thought questioning diaries into her daily routine, to combat low mood and anxiety, to explore options for undertaking a period of study in an area that interests her, possibly with support from a Greenwich College counsellor to build confidence, to gradually widen social network by engaging in social events as these arise. The first follow-up was booked for 14 May 2010 and will proceed after this on a monthly basis.

3.137 Miss B continued to attend outpatient appointments and in July 2010 her medication compliance was described as erratic, her mood was subjectively anxious, objectively overall euthymic, intermittently anxious. Her affect was reactive. She showed no formal thought disorder. Some paranoid/persecutory thoughts about other people but had good insight into this and they did not have the flavour of psychotic delusions. No thought interference, no passivity phenomena and no abnormalities of perception. She was encouraged to take medication regularly, attend psychology session and for review in two months.

3.138 At the September 2010 outpatient appointment it was noted that Miss B had requested to be discharged from psychology in August, and had called the rapid response service sounding agitated, and said she had fallen out with her (19 year old) son. She was accompanied by her Bridge 86 worker, and said that difficult family dynamics still weigh heavily on her mind and she reported poor sleep recently. In addition she was still paranoid and admitted to experiencing auditory hallucinations of a derogatory nature. These voices were not commanding but she finds them distressing at times.

3.139 It was noted that unfortunately [Miss B] was ‘not compliant with medication and it appears that she takes variable doses of her risperidone whenever she likes. She still gets anxiety symptoms from time to time, with mood swings and irritability. She denied alcohol or illicit drug use and though she discussed suicidal thoughts she denied intent. She was encouraged to take her medication regularly, and to be seen again in two months; the crisis plan and relapse indicators were reiterated’. In November 2010 she was reported to be taking medication regularly, with risks assessed as to self: self-harm low, suicide low, neglect low; to others: violence low, aggression low; from others: low. Her support worker reported that she thought she was doing well, but tended to become low in mood towards the end of the year. She was encouraged to continue with her structured activities, and for her Bridge 86 worker to increase contact.

3.140 In April 2011 Miss B presented as irritable and suspicious at her outpatient appointment. She was suspicious of her Bridge 86 worker and would not let the consultant address this. She described anger towards

her ex-husband and had thoughts of doing damage to his shop, but had no plans to carry this out. She described constant guilt feelings about the assault on her oldest child 16 years earlier, but that she has a good relationship with them now. She denied any current thoughts of harming them. She denied delusional thinking or passivity phenomena. She expressed ideas of reference regarding people spitting on purpose in front of her. Paranoid ideation which appeared to be unshakeable regarding derogatory comments she can hear from people in the streets, but she denied any active suicidal or homicidal thoughts. She was assessed as not psychotic, but at moderate risk of relapse, with risk of harm to self or others as low. A referral to MIND for anger management was made, and she was encouraged to take medication regularly. At the next appointment she was much brighter in mood and her mental state was more stable, but still taking medication erratically.

3.141 In December 2011 she was reported to say she cooks and does shopping for her elderly mother who lives alone and had recently been discharged from Oxleas House with a diagnosis of dementia. Miss B was enrolled in an anger management course due to start at Easter, and she had taken an agency job waitressing, over a weekend, though finished early as she found crowds difficult. Her risks to self and others were noted to be low, and she had no concerns about her Bridge 86 worker.

3.142 From 2011 Miss B was under the care of the Greenwich Recovery Team and later was part of the Coordinated Operational Move to Primary-Plus Services (COMPPaS) project. The aim of the COMPPaS project was to support the care of patients to primary care offering a ‘primary care plus’ service to existing and new service users through the supported development of effective and safe self-management skills.

3.143 It was noted at an outpatient appointment in June 2012 that Miss B shops and cooks for her elderly mother, and that her mother had recently been an inpatient in Oxleas House with a diagnosis of dementia. At this time Miss B was prescribed risperidone 5 mg and fluoxetine 20 mg. She said she was taking her prescribed medication regularly. She presented as irritable, believing that people were racially abusing her and was becoming angry. Her sleep was poor but she denied any indicators of relapse. She was persuaded to take an increased dose of risperidone.

3.144 Her Bridge 86 worker contacted mental health services asking for a joint visit in June 2012. Miss B’s oldest child had called to say that police were called to Miss B’s flat and she had been verbally aggressive and thrown a glass at them. Her oldest child took her to A&E but she would not wait to be seen. She had apparently worked for three days as a volunteer at the Olympic stadium but had not felt well so left. She reported eating and drinking normally but was suspicious of people. She did not want to go to hospital but agreed to an appointment with a psychiatrist. She said she did not feel like harming herself or others.

3.145 At her next outpatient appointment in September 2012 she was no longer preoccupied with people racially abusing her. She said she had taken the

extra 5 mg risperidone for two weeks and it had helped. She was sleeping poorly however and spending a lot of time in bed. She did agree to increase her dose of fluoxetine to 40 mg.

3.146 In March 2013 Dr R took over as her community consultant psychiatrist, and remained her psychiatrist until the service changes in September 2015. Miss B did not attend her outpatient appointment in early June 2013, and Dr R spoke to her by phone. Miss B reported feeling really 'down', and had an increase in paranoia and felt unable to leave the house. She reported some suicidal thoughts and imagery but said she would not act on them. The 25 June 2013 was noted to be her mum's (Mrs A's) birthday so she was spending the evening with her.

3.147 Miss B was referred to the Greenwich Home Treatment Team (HTT) in June 2013 and remained under their care until July 2013. She had become socially withdrawn and paranoid, with thought disorder and hearing derogatory voices. She had not been taking her medication regularly and had suicidal ideas. An urgent home visit was arranged and she was seen by Dr R, and her support worker from Bridge.

3.148 Miss B was found to have command hallucinations to kill herself and had contemplated hanging herself, with a detailed plan. She had not left the house for over two weeks, and was hearing voices that seem to come from either side of her flat. She also had command hallucinations to kill herself, and had had some suspicions that her medication had been tampered with but was taking it. Miss B was keen to avoid a hospital admission but agreed to a referral to the HTT.

3.149 She responded well to extra support and it was agreed that she would be provided with 'blister packs' of medication to help her to take the right tablets at the right time. She saw Dr R in July 2013 after discharge from HTT, and reported she was completely recovered and had started to think about future goals. She was thinking of starting a business using the massage skills she had learned, or starting a business with her current boyfriend. The next outpatient appointment was planned for two months' time. She did not attend the next appointments in September 2013 or November 2013. The next appointment was planned for three months' time. Miss B did not attend the outpatient appointment in September 2013, and an email was sent to her Bridge worker to see if she had any concerns. It was planned to book a routine visit if all was well, or arrange a home visit if there were problems.

3.150 An appointment was arranged for 26 September 2013, Miss B apologised for missing the earlier appointment, saying she had been physically unwell and very tired, and complained of daytime sedation. It was agreed to reduce her risperidone from 4 mg to 3 mg daily, and her GP was faxed to request this change. She had attended the 'personalisation' event and was very interested in pursuing this, and Dr R arranged for her to talk it through with a team social worker. Miss B was also looking forward to starting driving lessons; there had been previous correspondence with the DVLA, and Dr R had given details of her condition and current treatment.

It was noted however that she would be fit to drive in January 2014. She was also noted to be ready to access employment advice, and an appointment was made for October 2013.

3.151 Contact was made by the employment team in October 2013, and Miss B was interested in a food hygiene or business course, with a view to developing a food catering business. Miss B was seen by the employment team in October and November although was physically unwell and unable to meet. She was also contacted by the team social worker to plan input to her personalisation application.

3.152 Miss B did not attend the outpatient appointment in November 2013, and was telephoned. She apologised profusely for missing the appointment, she had been getting over a cold and was feeling physically unwell. She reported to Dr R that she had reduced the risperidone as planned and was feeling mentally fine. She was planning to contact the social worker about personalisation plans and the employment team in the New Year. At this time she was prescribed fluoxetine 20 mg and risperidone 3 mg, metformin 500 mg and simvastatin 20 mg. A further outpatient appointment was planned for three months' time.

3.153 At the next outpatient appointment in February 2014, Dr R noted a discussion about keeping well strategies, relapse prevention and risk management/safety planning. She had started at the Greenwich recovery college, and Dr R asked the care navigation team to help her with her personalisation application. Dr R noted that she had made a complete recovery from her depressive relapse in June 2013.

3.154 She was still being seen weekly by Bridge at this stage. In 2015 and early 2016 Miss B was provided with 'flexible community support' which allowed for more flexibility in approach than the previous 'floating support' of four hours per week.

3.155 Miss B expressed an interest in attending a CBT/psychology group for people with difficulty managing anxiety, called 'creating calm' and she was seen by the facilitators for an assessment in March 2014.

3.156 At outpatients appointment in May 2014 Miss B was again noted to be well and 'immaculately groomed'. She was attending the 'creating calm' group, working with the team OT. In June 2014 feedback to Dr R from the 'creating calm' group was sent to Dr R; [Miss B] attended four of the six sessions, she engaged well and reported that she found the programme helpful, in particular being in a group setting with others, the CBT model, and learning techniques such as relaxation strategies. Outcome measures completed before and after the group were unchanged, although Miss B did report feeling the group had been beneficial and she had learnt new skills. The measures were: GAD-7: [51] score 13 (indicating

[51] *GAD-7 (General Anxiety Disorder-7) Measures severity of anxietyhttps://www.mdcalc.com/gad-7-general-anxiety-disorder-7*

moderate anxiety) and WEMBWS[52]: score 39 (which is less than the national average of 51 for self-rated wellbeing).

3.157 The team OT called Miss B to discuss attending a local volunteer centre and would be in touch to support her if she wished to pursue this.

3.158 On 14 June 2014 Miss B took an overdose of risperidone tablets. She called the HTT to report this, and said she had taken them because she was low in mood. She was advised by the HTT to attend A&E, but she said she could not go alone. She called the HTT back later that evening and said she was with her mother and sister, she felt better and did not need A&E. She did agree to an urgent appointment with Dr R. She was seen at home by Dr R and her Bridge worker, she was getting extra daily support from Bridge so did not feel she needed HTT input.

3.159 Miss B had recovered by early July, and was keen to discuss having more structure to her week. At this time she was noted by Dr R to be paranoid towards others, but reacting with avoidance. It was also noted that she 'cooks and does shopping for her elderly mother who lives alone. Mother has a diagnosis of dementia'. At the team zoning meeting she was moved from amber to green in the risk assessment structure, that her relapse was now contained and she was back in remission.

3.160 After this it was agreed that she should have input from a 'care navigator'[53] and the OT from the recovery team. Weekly input was provided to assist her to plan and structure her time, alongside input from Bridge.

3.161 An urgent home visit was carried out by Dr R and the OT in September 2014, after she was reported by the care navigator to be low in mood and paranoid. She was found to be upset by a family issue over the weekend, and was now feeling very paranoid. Miss B was found to be pessimistic and 'cagey' and had not been taking medication regularly. Input from HTT was agreed, and daily contacts and supervision with medication were carried out. There was no apparent increase in the risk of harm to herself or others. She co-operated with supervision of her medication, although did express the belief that she did not need it, and was also suspicious that the risperidone tablets had changed colour, due to different suppliers.

3.162 At the HTT management meeting on 26 September, discharge was discussed, although a long term issue with medication compliance was noted and it was suggested that the recovery team consider a medication supervision package of care. The recovery team agreed to maintain a higher level of support by the care navigator, at least until she moved flat, which was planned in October 2014. Weekly care navigation input was

[52] *Warwick-Edinburgh Mental Wellbeing Scalhttps://warwick.ac.uk/fac/med/research/platform/wemwbs/*
[53] *Care navigation is a liaison role, introduced by Oxleas to: To prevent unnecessary acute hospital admissions, Direct patients to the appropriate care, Act as a liaison between acute hospital departments and community services, Make appropriate and timely referrals to community services, Ensure seamless care is continued for patients already having treatment.*

provided alongside input from Bridge, supporting her with the practicalities of moving flat.

3.163 Although periods of low mood were noted, Miss B went on a family weekend away to France in December 2014 which she said went well. Her Bridge worker changed in early 2015 and she did not initially engage with her. She was also noted to be unhappy with her new flat because it was smaller and there was more street noise and some noisy neighbours. By March 2015 she was feeling unable to not leave her flat and feeling unsafe, and a further crisis assessment by Dr R was requested.

3.164 Dr R saw Miss B at home on 3 March 2015. Although she said she had no current suicidal thoughts, her mood was low, she was sleeping poorly and was neglecting her environment, and for example her bed was covered in piles of clothes. She had thoughts that people in the street were talking about her, and was disturbed by her neighbour playing loud music. She had not been taking all her medication, which was seen as forgetting rather than intentional avoidance; these were provided in weekly 'dossette' boxes by her GP. At this time she was prescribed risperidone 4 mg, fluoxetine 20 mg, metformin 500 mg and simvastatin 20 mg, and she had missed one morning dose and one evening dose in the previous two weeks.

3.165 The plans agreed were that in the short term the recovery team would call her daily and the care navigator would see her weekly, and Miss B would try to clear her bedroom, and a prescription for zopiclone was given for her to take for a week. The medium term plan was for the recovery team and Bridge to help her to improve her environment, possibly helping her to purchase storage and explore noise reduction strategies. In the long term she was encouraged to contact her housing officer at Lewisham and Greenwich to enquire about registering for a mutual exchange if she remains unhappy in her flat.

3.166 She was referred to HTT but refused to let them in the following day. She did however call the HTT to let them know she was feeling better and was working with the recovery team. She was zoned as amber at the recovery team meeting, and was reported to still feel confused and afraid of going out. The care navigator maintained either face to face or telephone contact every few days until the outpatient appointment.

3.167 At a follow up outpatient appointment two weeks later Miss B was seen by Dr R and noted to be much calmer and presenting as smartly dressed. Dr R reflected back to Miss B that although her psychotic illness responds well to medication, she can go downhill quickly if she misses even a few doses. She was encouraged to consider changing to depot medication and given information to read, and an opportunity to meet the team pharmacist to learn more. Her mental state was more settled and she was able to reassure herself that the voices she hears from the car park outside her flat are strangers and are not talking about her. A further outpatient appointment was made for two weeks, to finalise decisions about medication.

3.168 Miss B did not attend either of these appointments although she did still meet her care navigator, OT and Bridge worker, and attended the recovery college. She eventually spoke to the pharmacist after many attempts at the end of April 2015. She met Dr R at the end of April and she appeared mentally well. She was still reluctant to agree to a depot, although this was recommended to her for relapse prevention and so that she could have sustained periods of being well. There was no risk to herself or others noted.

3.169 Miss B did not attend her next outpatient appointment but phoned Dr R to say she had decided not to change to a depot. Around this time she was diagnosed with overactive thyroid and was referred by her GP for further blood tests and possible treatment.

3.170 A case discussion in May 2015 noted that she had asked to stop seeing Bridge and declined the depot. Barriers to discharge were noted as 'frequent relapses, disengages quickly when gets EWS [early warning signs]', but it was also stated she had 'good recovery potential'. A discussion about her request to stop seeing her Bridge worker noted that Miss B seemed suspicious and paranoid about her, and it was questioned whether she was relapsing. She refused to allow recovery team staff to speak to Bridge about this.

3.171 It was decided to request a psychology opinion. She had already been referred to the 'creating calm' group (CBT for worry). A psychologist was available to the COMPPaS team, and she was seen by a psychologist and her care navigator on 12 June 2015. At this time she was hearing voices that were abusive and derogatory, felt anxious and that something bad was going to happen, had stopped going out and was not sleeping. It was decided that this was not the right time for psychology input but to re-engage when she was more settled.

3.172 At an outpatient appointment with Dr R in June it was noted Miss B was very tired, was only sleeping for a couple of hours every night and was paranoid and irritable. Her main concern was that she was "very stressed", her elderly mother had a recent fall and Miss B and her sister Miss C were taking it in turns to stay with her. She said her mother would not move her bed downstairs and they were constantly worried she would fall again. She was given information about the falls team.

3.173 She had stopped taking zopiclone and refused any other night sedation because she "did not want to be experimented on" or "forced to be injected like they did before". She was persuaded to see Dr R again a week later, and agree to try taking some 'kalms'[54] she had bought. No risk to herself or others were noted, although she was described as 'mildly irritable'. A further appointment was given for a weeks' time, which she cancelled via her care navigator. In this period the care navigator continued to see her or speak to her several times a week.

[54] *'Kalms' are a commercially available 'herbal remedy that is used to promote sleep'. https://www.kalmsrange.com/kalms-range/kalms-night/*

3.174 At the team meeting she was graded as amber, and a joint meeting with psychology to explore family work was suggested. The overall strategy was: ‘care navigator to continue social inclusion work, further joint sessions with psychology and explore possibility of having one or two family meetings with her children. Longer term she will need to go to the psychosis pathway’.

3.175 The psychologist contacted her to suggest this and she agreed to ask her children if they could attend a meeting. She was seen by the psychologist in July 2015, and reported continuing to wake feeling fearful, with lots of anxiety. She said she had been stressed and panicky at the previous meeting in June an afraid to leave her home. She reported currently feeling active and not so anxious and her neighbour was no longer noisy. She reported writing in her diary and practising mindfulness mediation had helped, and CBT skills she had learned before were reinforced. Miss B went on holiday to France with two of her children in August 2015, which she reported she enjoyed.

3.176 Her last outpatient appointment was with Dr R on 17 September 2015, with the team OT. Miss B reported that her mother’s health had improved slightly and she and her sister were providing lots of support at present, and she described her mother as “a bit stubborn”. Her mother had declined offers of additional help from social services etc, and Miss B was provided with information about carer resources. It was noted that Miss B was well groomed but appeared downcast though had minimal voices and paranoia. She was informed about planned changes to services, and that she would come under the new ‘Psychosis West’ team (Intensive Case Management Psychosis or ICMP), under Dr N. A discussion took place about what progress she would need to make to be discharged from secondary mental health care - this would be a 12 month period of stability without relapses. Dr R reiterated that she considered that depot medication could be helpful as she quickly forgets to take tablets when she develops symptoms of relapse. Miss B was continuing with support from Bridge and it was suggested that given the upcoming changes it may be useful to have input from another worker, which the OT agreed to arrange, and weekly phone calls form the care navigator over the next three weeks were agreed.

3.177 On 24 September the care navigator called her and noted she appeared low in mood, afraid to go out, and was confused about the changes to services and said she had been discharged at her last outpatient appointment. She asked to see a female doctor in the future, and she was encouraged to ask this when she sees the new psychiatrist. Miss B said she was not able to go out at present, felt confused and felt the outside world was hostile although she had food and medication at home. On 25 September the care navigator spoke to her again, and Miss B felt slightly better though had some difficult days, she said she had been to the GP who prescribed diazepam but said it was addictive so could only be short term. She refused the offer of seeing a psychiatrist. After a team discussion on 25 September it was noted by Dr R that Miss B had

stopped going out but was able to speak to the care navigator by phone. The plan recorded was 'book OPA[55] asap in redesign'.

3.178 As a result of an adult mental health care service redesign in September 2015, Miss B was transferred to the step-down pathway of ICMP, in which Dr N was a consultant psychiatrist. She was not on CPA, and was 'placed' with a cohort of patients who were not seen as needing the regular input of a consultant psychiatrist.

3.179 Miss B received seven sessions of CBT from the psychologist from July to October 2015, and was then offered a CBT group for people with voices and unusual experiences (called 'what is real'). Sessions with the care navigator finished on 13 October 2015, but she continued weekly contact with Bridge.

3.180 Miss B did not attend the first two 'what is real' sessions, and she called the psychologist in early February 2016 to apologise but said she had been keeping well without appointments and felt proud that she had not needed any support from mental health services over the last few months. She requested a medication review as she wanted her dose reduced, although she admitted she was not taking medication every night. The psychologist sent an email in early February 2016 to the psychiatrist Dr N from the new team requesting a 'one off review'. She was made aware the group started again on 11 March 2016 and that she would not be offered this group again if she does not attend.

3.181 The emailed request for a medication review sent in early February 2016 was received by Dr N, but prioritised as not urgent given the degree of change to caseloads and structures that took place at the time. Dr N had planned to discuss the request with the psychologist to get a sense of what the issues were, this was not possible due to a combination of workload issues and that the psychologist worked across two teams so was not available on a day to day basis to discuss issues within either team.

3.182 Miss B did not see a psychiatrist from September 2015 until after the homicide, but continued to have medication prescribed by her GP.

Miss B - History of violence

3.183 In 1985 it was noted that Miss B's oldest child had bruising on their leg, a lip injury and facial lacerations. Miss B admitted to hitting the child. There is a reference to violence towards her mother (Mrs A) around this time but there are no details in the clinical record.

3.184 In May 1987 Miss B was found to have smacked and scratched her oldest child, this was reported to social services as a child protection incident, although the children were not placed on the child protection register.

[55] *OPA: outpatient appointment*

3.185 In October 1987 Miss B is noted to have been violent towards her mother (with no detail) and scratched her oldest child's face.

3.186 In 1988 the oldest child was observed to have marks on their face, thought to have been caused by Miss B. Smacking the children was reported to social services, but the situation was felt to be contained.

3.187 A serious assault on her oldest child (aged 6) took place in September 1991, about three weeks after the birth of her youngest child. It was reported that Miss B had attempted to strangle the oldest child in the bath, but a clear picture of who was present and what exactly happened has never emerged. The family (Miss C) reported this to police and social services four days later. Hospital examination showed the child had bloodshot eyes, with an oedematous neck four days later, consistent with an attempted strangulation.

3.188 Her children were subsequently placed on the child protection register. Mrs A was deemed to be the main carer and the older children lived with her from this point, and they were taken off the child protection register in January 1992.

3.189 In June 1995 Miss B stabbed her eldest child (aged 9) with a knife in the presence of her youngest child (aged 4) and was admitted to a secure hospital. Miss B was convicted of unlawful wounding in May 1996 and detained under Section 37/41 of the Mental Health Act.

3.190 In 1995 whilst an inpatient Miss B hit her mother because she was 'smiling and happy'. In September 1996 Miss B hit out at a doctor and nurse who were trying to take her blood.

3.191 In March 1997 Miss B assaulted a staff member during a restraint which resulted in a broken finger. This was investigated by police, although charges were later dropped.

3.192 In mid-December 1987 she hit a nurse, and broke kitchen windows, and when the consultant psychiatrist discussed this with her she broke a cup on the table.

3.193 In February 1998 a report was provided by a senior registrar from the Bracton, regarding the potential future risk Miss B may pose to her children. It is noted that Mrs A had told this doctor that Miss B had frequently been mildly assaultive to her, for example she has hit, shoved and pushed her, without any injuries. This report did not regard her as a current risk to her children unless they were in her care. It was assumed that Greenwich social services would ensure that she did not have unsupervised access to her children. Care of the children was seen to be dependent on the ability of Mrs A and Miss B's ex-husband to maintain their safety in protecting them from Miss B.

3.194 In June 2002 Miss B threw a chair at a consultant psychiatrist during an assessment for detention under the MHA, though no charges were made.

3.195 In February 2008 Miss B reported a dispute with her youngest and eldest child (who would have been 23) during which she hit them on the shoulder.

3.196 In July 2012 her oldest child reported to Bridge that police were called to Miss B's flat, Miss B was verbally aggressive and threw a glass at police. She was apparently taken to A&E by the oldest child but did not wait to be seen. The call from the family was in fact made to the London Ambulance Service (LAS) who asked police to attend because of the behaviour of the patient. Officers attended and the remarks on the police record notes: *"Having a bad episode, has just thrown a glass at officers and the LAS are trying to speak to her now"*. With no criminal offences apparent, the family in attendance and the patient apparently safeguarded, the role of the officers attending appeared to be to assist the LAS in treating their patient and to stand by to prevent a breach of the peace.

3.197 The record is closed noting that the patient was, *'escorted to hospital, with the family in attendance'* which infers that this was by the LAS, but does not clarify this further.

3.198 On 21 February 2016 the homicide of Mrs A occurred.

Oxleas Adult Mental Health Service reconfiguration September 2015

3.199 The Trust had planned a reconfiguration of adult mental health services, to take effect at the end of September 2015.

3.200 In April 2014 the Trust Board was briefed about plans to make 'cash releasing efficiencies' across the Trust. Part of the rationale for the adult community mental health service redesign was a focus on cash releasing efficiencies, to develop a service fit for purpose and to deliver further savings in 2014/15 and future years. Various work streams were put in place to model the services based on best practice and it was expected that substantial savings would be made. The redesign was intended to maintain current levels of activity and extend capacity through closer working with primary care, other services, such as district nursing, and the voluntary sector. It was expected to deliver this, while releasing £1.2m towards cash releasing efficiencies in adult mental health services.

3.201 A paper entitled 'Proposed redesign of community mental health services'[56] was presented at the Trust Board of Directors meeting in May 2015. The 'drivers for change' were listed as:

'*As part of more cost effective care and because it is what patients and families say they want, we are looking to build more effective partnerships with the third sector so that patients can receive support from local voluntary organisations, under the clinical governance umbrella of Oxleas.*

[56] *Oxleas proposed redesign of community mental health services, May 2015*

The national policy imperatives to address the increased mortality rates of people with mental illnesses and the drive towards greater integration (eg, the national pioneer initiative, 2013), has led to the trust having a greater focus on addressing people's mental and physical health issues.

In addition, we constantly review whether we are making the best use of our mental health beds and that our crisis pathways and their interface with mental health community services are robust and efficient'.

3.202 A new operational policy was to take effect from October 2015 for all Locality Adult Mental Health services. The redesign was to be delivered in three phases:

Phase 1 (consultation and preparation)	
November 2014 – January 2015	Consult with GPs and other stakeholders
January 2015 – March 2015	Finalise the model
By end of May 2015	Consult with our staff
Phase 2 (transition)	
May – June 2015	Train staff in new ways of working
	Develop a new set of KPIs with our commissioners
September 2015	Implementation complete
Phase 3: review in April 2016	

3.203 The new Adult Mental Health service operational policy[57] states:

'The service model is a locality based pathway of care which offers a range of services comprised of Primary Care Plus (PCP) which is the direct link between primary and secondary care services and focuses on tele-triage, providing direct advice and support to GPs and directing service users to the pathway that will specifically meet their needs.

The Anxiety, Depression, Affective disorders, Personality disorders and Trauma (ADAPT) Pathway provides focused, therapeutic interventions to adults residing within the respective Boroughs who require care and treatment for anxiety, depression, affective disorders, personality disorders and trauma.

[57] *Oxleas Operational Policy Locality Adult Mental Health Service, October 2015.*

Intensive Case Management for Psychosis (ICMP) provides care and treatment for service users who are diagnosed a schizophrenia or bipolar disorder.

The service aims to be flexible, accessible and available outside of standard working hours, including from 7.00 to 8.00 pm for GP access. The Pathways of care aim to offer individuals choice and involvement regarding their treatment, actively encouraging their participation in the planning and implementation of their care'.

3.204 Miss B was identified as appropriate for the ICMP pathway, and was allocated to the Greenwich West ICMP, under the care of Dr N. She was not on CPA, therefore was allocated to the team as a whole, rather than to be seen in an outpatient clinic.

3.205 The ICMP had two functions:

1. Intensive Case Management (ICM) involving a multi-disciplinary team approach under CPA arrangements (i.e. "step up").

2. A "step down" function: This phase of care is focused on developing self-management skills, recovery planning and social inclusion. It results in a Well Being Plan which supports future transfer back to Primary Care.

3.206 The internal review panel established that although great attention and consideration had been given to which new team each service user would go to, the pressures of maintaining existing services whilst preparing for the changeover and the lack of detailed guidance or explicit provision of time to undertake such work, meant that there was limited handover between clinicians, and the new caseload sizes were perceived to be very large. It was anticipated that the step-down pathway would be most similar to the COMPPaS care provided to [Miss B] but the rationale for this was not documented.

3.207 The internal review also noted: 'a*s a result of not understanding where [Miss B] was in the system some false reassurances / misinterpretations were made. The previous consultant had prioritised [Miss B] for an early outpatient appointment with her new consultant because she was on the amber zone and had been a little anxious. The psychologist had provided an additional two weeks support post transfer to [Miss B] to mitigate any anxieties relating to the redesign'*.

3.208 The reconfiguration occurred at the same time as the roll out of the new Oxleas RiO clinical information system Trust-wide. This meant that the teams had less informatics infrastructure to enable them to book appointments to move patients to their new teams and give assurance of continuity of care in a timely and reliable manner. They were unable to make the new appointments needed as the new RiO system was blocked for 6 weeks while new clinics were set up.

3.209 The internal report notes that the project group had considered delaying the go-live date, which had been pushed back because additional time was required to set up the clinics on RiO, but the decision was made to proceed in September 2015 because of the alignment of implementation plans including those of estates and workforce. Informatics team members worked additional hours to support the RiO set-up.

3.210 RiO caseloads were set up in shadow form ready for the live RiO clinics, anticipated to be available in October 2015 and excel spreadsheets were used in the interim. The internal investigation panel heard that clinicians were seen referring to paper lists '*which did not instil a level of confidence for either clinicians or other agencies during this period exacerbating the impact of the change*'.

3.211 Miss B had a referral open with Greenwich Recovery Central from 26 November 2011 to 3 November 2015, it was then transferred on the 3 November 2015 to Greenwich West ICMP.

3.212 Miss B was allocated on the 3 November 2015 to Dr N. There were no booked appointments during that period. She had a booked appointment on 23 October 2015 with the psychologist and then not another booked appointment until 22 January 2016.

3.213 It was clarified by the Trust RiO support team that when an outcome was completed for the appointment in September 2016, there would have been a 'pop up' asking if a follow up appointment should be booked. If the response was 'yes' the diary screen would have appeared, to allow this to be done. It is not possible to identify what outcome was provided in this instance.

3.214 During the transition phase of the redesign it was intended that this system would ensure that patients with urgent needs were seen. Miss B was not regarded as in urgent need of an appointment, although her consultant Dr R had expected she would be seen 'as soon as possible,' after the redesign. There was no system of handover in place from the clinicians in the old service to the allocated clinical team in the new services.

4 Care of Mrs A - Arising issues, comment and analysis

4.1 We address each element of the terms of reference in separate sections, supporting our analysis with evidence as appropriate. We have included the relevant sections of the terms of reference for ease of reading.

Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies to both Mrs A and Miss B with specific attention to interagency working and safeguarding in relation to Miss B.

4.2 Mrs A was provided with services from her GP, Oxleas NHS Foundation Trust, the Royal Borough of Greenwich Social Services and the First Choice Home Care Agency.

4.3 She also had several contacts with the Metropolitan Police Service and one contact with the Queen Elizabeth Hospital.

GP Surgery

4.4 Mrs A had significant contact with her local GP surgery going back a number of years. She mainly saw the same GP, Dr I. She also saw Drs Y, Y, S and U. She presented with a number of physical health problems – urinary infections, 'flu, orthopaedics, various blood tests, diabetes and for minor surgery.

4.5 Following the assault on a bus in 2006 she also consulted her GP about panic attacks, palpitations, fear of going out, poor sleep and headaches. She also on one occasion consulted her doctor about financial problems.

4.6 The GP referred Mrs A to the Older People's Community Assessment and Intervention Team in respect of memory problems and anxiety.

4.7 The GP undertook regular patient reviews including medication reviews. Prior to the homicide Mrs A was being prescribed diazepam, amlodipine, mirtazapine and simvastatin.

4.8 Mrs A was having regular outpatient's appointments with the consultant psychiatrist from the Older People's Community Mental Health Team. The consultant sent regular written updates to the GP.

4.9 The notes often refer to "the daughter" and it is not clear to which daughter this refers. Sometimes the notes are more specific referring to Miss B and Miss C.

Comment and analysis - GP care

4.10 The GP, Dr I, was diligent in his care of Mrs A. He saw her regularly and he knew her well. However, he operated in isolation from rest of the care

system and was not given the opportunity of either sharing information or participating in care planning (see care planning section).

4.11 Some potentially significant information was held by the GP and not shared. In October 2008 Dr I noted that "the daughter (not clear which one) may have personal issues with [Mrs A]". On 25 February 2011 Dr I noted that Mrs A was "still worried that her daughters want her dead and that is why they have been taking away her medications".

4.12 On 15 February Dr I noted that 'As patient did not want her daughters to be involved in her case, has elected her friend (name) at (address) to be involved in her care/treatment. Friend has agreed'.

4.13 We can find no further record of this or of [Mrs A]'s friend being involved in any discussions about [Mrs A]'s care with any agency.

4.14 There are two incidents (apart from falls) where Mrs A was seen by her GP for physical injuries.

4.15 On 21 July 2015 she attended the surgery and was seen by Dr U who noted that '*following a Cellulitis and absess (sic) of finger unspecified, sustained a deep cut to right middle finger distal phalanx, was sutured but the finger looks discoloured, removal of suture of skin, all stitches removed on the left index finger, site appeard (sic) dry and intact, nil dressing needed and no follow up required'*. The GP told us that this cut was sustained when Mrs A fell at home. She fell several times as discussed, and on this occasion tried to break her fall, cutting her finger in the process. The sutures were applied at Lewisham A&E on 10 July 2015. She did not attend the GP surgery for any follow up.

4.16 On 7 December Dr I notes state *'Home visit, pain and swelling on the left side of the face, notice 2/7, slight tooth ache, loose tooth, only eat soft food, swelling of the face from the jaw to the cheek? Dental abscess, advised daughter make appt (sic) with dentist as soon as possible'.*

4.17 The GP had no information as to whether Mrs A attended a dentist or what the outcome was.

4.18 It would be easy with hindsight to attach more significance to the above issues than is warranted and given that Mrs A had a diagnosis of 'organic delusional disorder' this might be even more speculative. However, these incidents should have been discussed with the CMHT. Even so, given that Mrs A was on CPA we would expect there to be regular inter-agency sharing of information.

4.19 However it is clear from our analysis, that the GP was not given the opportunity of sharing information, which only he had, in a forum such as a CPA meeting with other professionals involved in the care of Mrs A. If he had been, then this information could have been assessed and its importance weighed up alongside the other information available and an informed inter-agency decision made as to its significance or otherwise.

4.20 In the Older Adults service GPs are not routinely invited to CPA meetings. There are several letters to the GP from Dr U updating on Mrs A's care, and informing him of her CPA status.

Recommendation 1:
NHS Greenwich CCG should ensure that GPs are fully involved in information sharing with respect to information about individuals with long term mental health issues.

Metropolitan Police Service

4.21 Miss B and Mrs A were both known to the Metropolitan Police Service (MPS). Miss B from the assault on her oldest child in 1995 and Mrs A from 2010 onwards due to her deteriorating mental health.

4.22 Mrs A came to the notice of the MPS ten times between February 2010 and December 2010. According to the MPS Individual Management Review (IMR) these interactions indicated that Miss B was the carer for Mrs A and that Mrs A was vulnerable due to her age and mental health deterioration. On 23 June 2010 Mrs A stated that Miss B visited her more than Miss C.

4.23 During all contacts with the MPS Miss B gave her surname as her maiden name rather than her previous married name, which meant that the MPS did not identify her as having been convicted of the assault on her oldest child.

4.24 The incidents were variously neighbour disputes, paranoid behaviour and that she was confused and scared. It was noted that Mrs A's house was in disarray.

4.25 According to the police IMR on one occasion (9 October 2010) Mrs A asked for Miss B to be returned home and that police felt that Miss B may not fully comprehend the extent of her mother's mental deterioration.

4.26 During this period the police made two referrals to Adult Social Care (ASC) [Confirmed on ASC file 29 October 2010 fax from Safer Neighbourhood Team to Royal Borough of Greenwich Emergency Duty Team. Home Visit by the Emergency Duty Team (EDT) 4 November, 29 December EDT visit following contact from police].

4.27 During the period 16 February 2011 to 19 February 2011 Mrs A made a number of calls to the MPS. During this time she identified Miss C as her carer.

4.28 Between 26 February 2011 and 14 March 2011 Mrs A made a number of calls to the MPS alleging that items had been stolen from her, knives and forks left outside her front door, that her medication had been stolen and that Miss B had left her locked in the house. Police took no action.

4.29 On 15 March 2011 Mrs A contacted the police saying she was scared of staying in her house and that she was scared of her daughter (not named) but was unable to say why this was. No action was taken.

4.30 On 22 November 2012 police were called by Miss C because her mother had not been seen since the previous evening. Police attended and forced entry to find Mrs A collapsed but conscious. She was left in the care of the London Ambulance Service (LAS) and both daughters were present.

4.31 On 10 July 2013 Mrs A contacted the police saying she had no heating and could not warm her food. When police visited the next day Mrs A was found safe and well and the gas working properly. It was noted that Mrs A's daughter (unnamed) visited daily to cook and clean.

4.32 There was one further contact with the MPS on 13 March 2015 when Mrs A made a silent emergency call and was shocked when rang back to be told that she had dialled 999.

Comment and analysis - MPS involvement

4.33 The MPS had significant contact with Mrs A over a number of years. Two referrals were made to Adult Social Care.

4.34 On most occasions the police response was appropriate and proportionate. However, there were three occasions as described in the MPS IMR when the response was not as it should have been.

4.35 On one occasion Mrs A was flagged as "mental health" and "repeat caller" and no action was taken. The MPS view on this is that following the implementation of the Care Act 2014 information would have been shared with ASC and mental health services.

4.36 On another occasion Mrs A contacted police six times over a period of three days (9,13,14 March 2011). Police were not dispatched and Mrs A was not identified as vulnerable and attempts were not made to locate her daughter. (See Safeguarding Section).

4.37 When Mrs A contacted the MPS saying she was scared of her daughter, despite the call being logged as a "concern for safety". The call was considered for a welfare visit but the matter was closed.

4.38 The concerns and problems with Mrs A's neighbours were real. Indeed, one neighbour was arrested and Miss C reported later in July 2013 that her mother had been assaulted by the neighbour on one occasion.

4.39 The MPS reactions to Mrs A's calls for help were influenced by the fact that she had apparently two supportive neighbours and two caring daughters. They did not identify Miss B as having a forensic history as she used a different name from the one she was detained under the Mental Health Act for the assault on her oldest child. The MPS have said 'If the offence had been uncovered, consideration could have been given

to sharing the details with ASC for consideration in any future care needs or carer assessment'.

4.40 The MPS have said that any shortcomings in their approach to dealing with Mrs A would have been addressed by recent policy implementation of the Multi-Agency Safeguarding Hub (MASH) and the Vulnerability Framework Assessment and other developments. We concur with this but are of the view that MPS should have been more assertive in making referrals to ASC given her acknowledged vulnerability.

4.41 However, it should be acknowledged that the MPS last substantial contact with Mrs A was in July 2013; two and a half years prior to her death. However, as with primary care, the historical information the police had could have been shared had inter-agency information sharing processes been in place.

4.42 We would like to commend the MPS for the quality and thoroughness of their IMR.

London Ambulance Service

4.43 London Ambulance Service (LAS) were called by the police to attend Mrs A's address on 22 November 2012. Miss C had called the police because Mrs A had not been seen for several days and there were concerns for her safety. Mrs A had fallen but had no injuries, she refused to go to hospital and was left in the care of her daughters.

4.44 LAS sent a 'welfare/vulnerable adult at risk report' to Royal Borough of Greenwich (RBG) raising concern about her environment and requesting that she be reassessed by the council for living aids. This was intended as a report of a welfare concern, which gave details of environmental hazards and falls risk in her bedroom, and suggested that a review of her living aids was carried out. At this time LAS crew were encouraged to report any welfare concerns they encountered, on a paper form entitled 'welfare/vulnerable adult at risk' form. Under the current 2017 policy, the electronic incident recording includes separate pathways for logging welfare or safeguarding concerns. This is included in safeguarding training, and there are clear systems for reporting concerns to local authorities, or in the case of hoarding, London Fire Brigade.

Comment and analysis - LAS involvement

4.45 We consider the reporting of welfare concerns as well as formal safeguarding concerns to be an example of good practice.

4.46 The report of 22 November 2012 was processed by RBG on 23 November 2012, and did not meet the threshold for a safeguarding investigation. The information was conveyed to Mrs A's care coordinator by RBG, and a referral was made to telecare for a person alarm.

4.47 The concern report was closed by Royal Borough of Greenwich after feedback about actions taken was received, which can also be regarded as good practice.

Royal Borough of Greenwich

4.48 Royal Borough of Greenwich (RBG)'s older people's mental health services are provided jointly with Oxleas NHS Foundation Trust as part of the Older People's Community Mental Health Team – see the section on Oxleas involvement.

This section deals with local authority involvement outside of that structure and is therefore brief, see also 4.46 above.

4.49 On 13 August 2009 an anonymous caller rang the local authority with concerns about Mrs A as she did not appear to be managing. This was passed to EDT for follow up. In 2009 Mrs A was provided with a range of aids by the local authority OT and provided with mobility advice.

4.50 In October/November 2010 the Early Intervention Team (EIT) received a fax from the police SNT expressing concerns about Mrs A. A unsuccessful home visit was undertaken and a follow up call made to Miss B to encourage her to attend an outpatient's appointment with her mother and explain to the consultant psychiatrist Dr U the difficulties her mother was experiencing.

4.51 On 29 December 2010 following a further police referral a home visit was undertaken and contact made with a psychologist and family. It was decided that a care package was not required and that Mrs A had a pending outpatient appointment.

4.52 On 3 March 2011 the police reported that a neighbour had alerted them that Mrs A's house was full of rubbish. This information was passed to the CMHT for follow up as Mrs A was allocated to them.

4.53 There is a Complex Needs Care Plan on file (undated but with service due to start on 30 September 2011) completed by a social worker from the CMHT. Mrs A was to be provided with personal care daily for 30 minutes to "prompt medication, prepare breakfast and help maintain a safe living environment". The emergency contact noted was Miss B.

4.54 We were told by the local authority:

'A complex need care plan or CPA should cover the complexity of the service user's needs. This is a holistic assessment of need covering both social care and clinical needs'.

4.55 There are then various records on file of the home care agency often not being able to gain access to Mrs A's house.

4.56 The OPCMHT referred Mrs A for an OT assessment and on 21 August 2014 an OT and Sensory Problem Focussed Review took place. Needs

were identified in respect of WC transfers, bathing and mobility. Miss C was noted as 'works f/time, visits 7/7: meals, hw, pc & shopping' and 'Daughter 2 (Miss B) can visit but intermittently'.

4.57 In July 2015 the Joint Emergency Team took a referral from A&E at Queen Elizabeth Hospital; 'Patient attended [emergency department] (ED) on the 1 July 2015 following a sustained fall at home….history obtained from daughter who advised that patient has approx. 2-3 falls …a week'. As a result of this Dr U asked the GP to stop the use of risperidone[58] which was contributing to Mrs A's falls. He noted that 'symptoms of organic delusional symptoms may re-emerge'.

4.58 Miss B was sent a letter on 10 August 2015 offering her a referral for a carers' assessment. This was sent from a Contact Officer at RBG. It is not clear why this was sent or whether it was followed up. Somebody in contact with either Mrs A or Miss B or both had assessed that a Carer's Assessment should be offered. It is unfortunate that we have no further information as to why this was.[59] This is discussed fully from Section 4.85 onwards.

Comment and analysis - RBG involvement

4.59 There is little evidence on the local authority file of a co-ordinated approach to the care being provided to Mrs A. Care co-ordination was the responsibility of the OPCMHT (Mrs A was on CPA from May 2012) but the local authority's input was in isolation from the work of the OPCMHT.

4.60 Throughout there are references to 'the daughter' but it is not clear to whom this refers. Occasionally there are references to Miss B or Miss C. It is not clear who was seen as the primary carer for Mrs A. The OT assessment of 2014 clearly identified Miss C as the primary carer but the local authority wrote to Miss B in 2015 offering her a carer's assessment. We asked the family and they told us that routine care was not provided by Miss B but references to the 'daughter' in files referring to daytime probably refer to Miss B as she could be available during the day because the rest of the family were at work or college.

4.61 It is not clear why Mrs A was not offered a social care assessment as identified in the local authority IMR:

'Whilst [Mrs A] only received domiciliary support for a short period of time, there is no evidence that a full community care assessment was ever conducted or offered to [Mrs A]. Whilst it would appear that the CMHT were the primary support team, an assessment should have been offered and may have identified evidence of carer strain'. We would concur with this.

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[59] *It is useful to note that the Care and Support Statutory Guidance published (August 2017) after the offer of a Carer's Assessment to Miss B. states that "Assessment of both the carer and the adult they care for must include consideration of the wellbeing of both people. Section 1 of the Care Act includes protection from abuse and neglect as part of the definition of wellbeing." Section 14.46*

4.62 The IMR also raises other important concerns, and we agree with the analysis and conclusions below:

'The most recent care plan was dated July 2011 and was not updated, despite services remaining in place until September 2014. There is no evidence of any reviews being conducted by RBG social care teams'.

4.63 We would also add that the plan as written is not 'a holistic assessment of need covering both social care and clinical needs'.

4.64 The IMR also notes:

'As no carers assessment was conducted, a further offer of a carer's assessment at the time of the safeguarding alert may have been advisable, as Miss B was also known to the CMHT'.

Oxleas NHS Foundation Trust

4.65 As Oxleas was the lead agency for providing and co-ordinating care for Mrs A we also address the following Terms of Reference in this section:

Review the effectiveness of care planning for Miss B and Mrs A including family involvement.

Review and assess compliance with local policies, national guidance and relevant statutory obligations.

4.66 Oxleas adult mental health services and older people's mental health services are jointly provided with the local authority. For adult mental health, the Local Authority's accountability is discharged through a Section 75 agreement.[60] Older people's mental health is not part of the Section 75 agreement, however it is a jointly provided service managed by the Trust.

4.67 Mrs A was under the care of the OPCMHT from October 2010. She also had interventions from the CAIT.

4.68 We have had sight of the OPCMHT's Operational Policy[61] which sets out the role and function of the team as follows:

'The service exists to provide specialist mental health services to older people with mental health needs in the boroughs of Greenwich, Bexley and Bromley through an integrated multidisciplinary approach. By providing specialist assessment and treatment and commissioning social support, the overarching principle of the service is to enable older people to live independently in the community for as long as possible'.p4

[60] *Section 75 partnership agreements, legally provided by the NHS Act 2006, allow budgets to be pooled between local health and social care organisations and authorities.*
[61] *Operational Policy Older Adults CMHT, Greenwich, Bexley, Bromley, March 2014.*

The team ensures that

'all health, social care needs and risks are assessed. That service users requiring a service are managed within the Care Programme Approach and an appropriate treatment/care plan and risk management plan agreed. The plan will include the views of the service user and relevant carers'.

4.69 The team is an inter-agency team with staff from Oxleas and the local authority though the policy is not explicit about the form that this takes.

4.70 The policy is in need of urgent updating. It does not take into account the implementation of the 2014 Care Act and references redundant policies e.g. the Mental Health National Service Framework.

4.71 Mrs A was subject to both enhanced and standard CPA. The Oxleas CPA Policy states:

'Oxleas NHS Foundation Trust and its three social services departments have been working towards integrated care planning, CPA and care management processes'.

Enhanced CPA:

'Individuals with a wide range of needs from a number of services, or who are at most risk, should receive a higher level of support. The system of co-ordination and support for this group only will be called CPA (Enhanced in RiO). The professional facilitating their care will be called a Care Co-coordinator'. (p10)

4.72 The policy describes what the service user can expect from CPA. (p13)

4.73 A comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks with use of interpreting and translation services where required:

- Support from a Care coordinator;
- Comprehensive formal written care plan: including risk and safety/contingency/crisis plan and in line with national best practice…;
- On-going review, formal multi-disciplinary, multi-agency review 6 monthly; and
- Carers identified and informed of rights to own assessment.

Standard CPA:

4.74 The policy goes on to describe the 'characteristics of those clients who do not meet criteria for CPA but still require services from secondary mental health':

- More straightforward needs; e.g. one axis of need being addressed by the Trust;
- One agency only involved;
- Service user able to easily access support and care needed either alone or with help of family, advocacy, or self-help agencies;
- Care likely to last the agreed 6-8 sessions or less;
- Risks are low;
- In stable housing, managing financially; and
- Employed and not experiencing work related stress.

4.75 The policy describes what the service user should expect when on standard care:

- A full assessment of need for clinical care and treatment, using self-assessment processes and tools where possible;
- A full risk assessment and risk management plan if risks have been identified;
- The care plan letter available through editable letters called “Oxleas standard care plan letter” which is uploaded to RiO using the document type “Care plan” and the naming convention “Care plan date/month/year”;
- On-going consideration of need for move to CPA if risk or circumstances change; and
- Carers identified and informed of rights of own assessment. Where the service users’ needs change and risk increases, a discussion at the MDT meeting will need to happen at the earliest opportunity to discuss whether the service user will require CPA.

4.76 The policy ‘acknowledge(s) the unique position and resource of the carer as someone who is looking after one individual as opposed to the professional who carries a caseload’ (p46).

Mrs A and the Care Programme Approach

4.77 Mrs A was on CPA from her discharge in May 2011 - we have to assume, as there is no formal record of the date Mrs A was put on CPA. The plan was that she be followed up by a support worker with regular outpatient’s appointments.

4.78 Up until 9 January 2014 the notes generally state that Mrs A was on Enhanced CPA; at this point the notes record Mrs A as being on Standard CPA. It is not clear in the notes how and why this decision was made. The notes are confusing in that it is not always easy to identify CPA meetings as notes of meetings, care plans and letters to the GP are embedded in the notes which also cover a range of other issues (e.g. home visits, telephone calls etc). The categories of Standard and Enhanced CPA were abolished in 2008 when the Department of Health published 'Refocussing the CPA', after which patients were either on CPA or not. The Trust policy reflects this, but it has not been changed in RiO, therefore RiO refers to all CPA care as enhanced. It is confusing that staff use the terms 'enhanced' and 'standard CPA'.

4.79 Following Mrs A's discharge from hospital CPA Reviews and Outpatients appointments occurred as listed below:

13 June 2011	Outpatient's appointment (CPA Level Standard)
25 November 2011	CPA Review (CPA Level Enhanced)
12 December 2011	CPA Review (CPA level not noted)
2 April 2012	CPA Review (CPA Level Enhanced)
26 July 2012	CPA Review (CPA level not noted)
19 November 2012	Outpatient's appointment (CPA Level Enhanced)
30 May 2013	Outpatient's Appointment (CPA Level Enhanced)
26 July 2013	CPA Review (CPA level not noted)
19 September 2013	CPA Review (CPA Level Enhanced)
9 January 2014	Outpatient appointment ("CPA Level")
24 April 2014	Outpatient appointment (CPA Level Standard)
28 August 2014	Outpatient appointment (CPA Level Standard)
29 January 2015	(CPA Level Standard)
11 February 2015	Outpatient appointment (CPA Level Standard)
16 July 2015	Outpatients Appointment (CPA level not noted)
10 September 2015	Outpatient appointment (CPA Level Standard)
7 January 2016	Outpatient appointment (CPA level not noted)

4.80 At each of these reviews/appointments Mrs A's Care Plan was reviewed. The essential components, with little variation, were as follows;

- Diagnosis of Organic Delusional Disorder;
- Medication review and changes to regime;
- Continue support by care-coordinator/AO worker; and

- Continue with plan.

4.81 Mrs A was for a period provided with a home carer from a local agency whose role was medication prompts. Sometimes the carer could not obtain access to Mrs A's home.

4.82 At various periods crises were identified of:

- The issues with Mrs A's neighbours;
- Mental state fluctuations;
- Diet;
- Finances (although the family are of the view that Mrs A's finances were always in order)
- Falls; and
- Carer stress.

4.83 The CPA policy (see above) makes a distinction between those who need Enhanced CPA and those who do not need CPA but need Standard Care. However, the notes often refer to 'CPA Level Standard'.

4.84 There is no formal CPA enhanced documentation on file as required by the CPA policy. Mrs A was on Enhanced CPA for nearly two and a half years. The documentation should include 'comprehensive formal written care plan: including risk and safety/contingency/crisis plan and in line with national best practice'.

4.85 The standard CPA reviews and outpatient's appointments are recorded in letters to Mrs A's GP as per the policy.

Risk Assessment and Management

4.86 The Trust has a Clinical Risk Assessment and Management Policy[62] which sets out what is expected of professional staff in assessing and managing risk. It sets out the model the Trust has adopted for this area of work.

4.87 'Structured clinical': this approach combines the use of an unstructured method of assessing risk with the use of actuarial approach to assess clearly defined risk factors, risk triggers and ameliorants of risk and makes use of:

- The clinical experience and knowledge of the service user;
- The service user's view; and

[62] *Clinical Risk Assessment and Management Policy for Mental Health and Learning Disabilities Services January 2016*

- The views of carers and other professionals. The structured clinical approach is the process which Oxleas NHS Foundation Trust staff should use'. (p7)

4.88 The policy is also clear that a full risk assessment and risk management plan should be developed for those on Standard CPA if risks have been identified.

4.89 Throughout the risk identified was a potential risk of self-neglect which was addressed by support from Mrs A's family and a care package. 'Family aware they can contact if necessary'. There is little evidence of a more systematic assessment of risk as required by the Trust policy.

Family Involvement and carers assessment issues

4.90 There is evidence of family involvement in most of the reviews/outpatients appointments. This often takes the form of references to 'her daughter' being present, so it is often unclear which daughter is being referred to though sometimes 'the daughter' is identified as Miss B or Miss C.

4.91 There is no evidence that discussions were held with either Miss B or Miss C about their rights to a Carers Assessment. There is a letter on the local authority file dated 10 August 2015 offering Miss B a carer's assessment but it is not clear why this was instigated at that point; four years after Mrs A was put on CPA. We were told that the responsibility for instigating a carer's assessment in this case would lie with the joint adult's mental health team but we can find no reference to this in the file. We have had sight of detailed information from the Trust about carers assessments offered in August 2015 and there is no recording of an assessment being offered to Miss B.

4.92 Carers Assessments are a local authority statutory responsibility.[63] The local authority's Carers Policy[64] states that:

'The Care Act entitles Carers to involvement in decisions around …adult's support and care, and requires Local Authorities to provide interventions to support and improve carers' wellbeing and prevent, reduce and delay needs. Carers are entitled to information and advice tailored to their specific needs, an assessment of their own needs for support, a support plan, and a personal budget where their needs are eligible'.

4.93 We have found no evidence that the above was considered in respect of Miss B or, indeed, in respect of other family members who were providing care for Mrs A.

4.94 We asked the local authority to comment on this and they told us that at the time the Trust undertook Carers' Assessments using their own Carers' Assessment form on RiO, which was not Care Act compliant. We were told that not many carers' assessments were being undertaken and, as a

[63] *Care Act 2014*
[64] *Royal Borough of Greenwich Adult's and Older People's Services Carers Policy 2015*

result of Oxleas deleting a Carer's post, the local authority developed a pathway for Carers of People with Mental Health Problems.[65] Oxleas have told us that the Local Authority Carer post that was deleted was an RBG post which was a strategic role, which did not carry out any carer's assessments.

4.95 In 2015 concerns about the provision of Carers Assessments by the Trust led to the issue being escalated to senior local authority commissioners with the objective of taking these concerns to the joint Section 75 meeting. We are unclear what the outcome of this was.

4.96 At the time of the Oxleas service re-design the RBG was developing its Carers Policy.[66] We were told that it was difficult to engage the Trust in the development of the policy because of the re-organisation.

4.97 We asked how the local authority assures itself about the quality of assessments and monitors uptake and we were told that this happens at the quarterly joint Section 75 meeting which involves senior directors from the Trust and the local authority.

4.98 We have had sight of minutes of the joint Section 75 meetings. Carer's assessments were discussed twice. Once in July 2013 where a substantive discussion took place but this was before the Care Act. Another substantive discussion took place in March 2015. This meeting noted: 'outcome of assessments should be monitored and progress reported back at a future meeting'.

4.99 We remain unclear how effective this mechanism is for the local authority to monitor the quality and uptake of Carers Assessments in the Trust, particularly given the changes introduced in the Care Act 2014 to assessment, eligibility, support planning, financial assessment and personal budgets for carers.[67]

4.100 We asked the Trust how it monitored the quality and uptake of Carers Assessments as a function under the Section 75 agreement.

4.101 We had sight of comprehensive spread-sheets dating from 2012 to current which set out in detail the number of carers assessments offered and accepted to those on enhanced and standard CPA. Targets are also set for the number of assessments to be offered and undertaken.

4.102 We also had sight of a report looking at the quality of carers' assessments dated 2014,[68] minutes of a meeting of the Trusts Professional Executive Committee[69] (where carers were a substantive agenda item) and the terms of reference for the Patient Experience Sub Group[70] which covers

[65] *Carers of Adults with Mental Health Problems: Pathway to Assessment and Support and to Carer's Personal Budgets 2015.*
[66] *ibid*
[67] *See DHSC Care Act Factsheet 8 April 2016.*
[68] *Trust wide Qualitative Review of Carers Assessment Audit October 2014*
[69] *Trust PEG minutes November 2017*
[70] *Patient Experience Sub-group of the Quality Committee Terms of Reference.*

carers. We also had confirmation that a named senior member of staff was responsible for implementing the carers' strategy.

4.103 The 2015 Carers Policy states:

'The following sections will be added following further consultation with Children's Services and Oxleas NHS Mental Health Trust:

- Carers of Children in Transition.
- Assessment of Mental Health Carers'.

4.104 As of the date of this report these sections have not been added.

4.105 We have found it difficult to assess the extent of level of care provided to Mrs A by Miss B. There are specific references to Mrs A or Miss B in the files but there are often references to 'the daughter' where it is unclear which daughter this relates to.

4.106 Miss C told us that she had main responsibility for Mrs A's care but she involved Miss B particularly in respect of daytime tasks when she was at work and on the rare occasions when she was away overnight. Both daughters were also involved when they had time. She also told us that she and Miss B held financial responsibilities with Mrs A's bank and that Miss B often dealt with this as a daytime activity.

4.107 Information from Miss B indicates that she regularly spent long periods at her mothers' during the day, sometimes for most of the day. She shopped and made snacks for her mother, and was concerned to keep her mother company during the day.

Recommendation 2
Royal Borough of Greenwich should assure itself that its statutory duties in respect of carers of people with mental health problems are being discharged.

Recommendation 3
Royal Borough of Greenwich should update its 2015 Carers Policy to cover mental health and children in transition.

Miss B's mental illness in relation to Mrs A's care

4.108 There are references to Miss B having a mental illness e.g. 'her daughter [Miss B] has a history of psychosis however this is currently stable and she is managing well with her medication' (July 2010); '[Miss B] who has paranoid schizophrenia' (March 2011).

4.109 In July 2015 it was noted 'unstable situation and carer stress', this does not seem to have been followed up and it is not clear who the carer referred to is.

4.110 There is a comment about [Miss B] having concerns about Mrs A being on certain medication as [Miss B] knows about side effects. The same overview mentions that 'Mrs A expressed some thoughts about daughters being cruel to her wanting her dead…..accusations seemed somewhat paranoid but not enough information about relationship with daughters'.

4.111 On 26 April 2011 it was noted that Miss C said at a ward round that any long term plan should not involve Miss B as there were doubts she could manage.

Mrs A's diagnosis

4.112 In our discussions with some staff and in the Trust internal review (p5) Mrs A is described as suffering from dementia. However, Dr U from the OPCMHT said that she was not suffering from dementia but, and this is clear in the care plans, she was diagnosed with an organic delusional disorder. It was further stated that they were considering discharging her to primary care because she was 'cognitively stable'. She was however placed in Payment by Results Cluster 20[71] which relates to 'Cognitive Impairment or Dementia Complicated (High Need)'.

4.113 'Organic delusional disorder' is categorised in ICD:10[72] as 'other mental disorders due to brain damage and dysfunction and to physical disease', which are described as 'miscellaneous conditions causally related to brain disorder due to primary cerebral disease, to systemic disease affecting the brain secondarily, to exogenous toxic substances or hormones, to endocrine disorders, or to other somatic illnesses'. This presupposes an 'underlying organic condition' which in Mrs A's case appears to be 'organic changes related to dementia'. Outpatient letters note a diagnosis of 'organic delusional disorder, in remission', and no formal diagnosis of dementia was ever made. The GP practice had not recorded Mrs A on their 'dementia register'[73] because of this.

4.114 The nuances of this diagnosis as recorded by clinicians does not appear to have had significant impact on Mrs A's care. While it could have given rise to confusion, her daughters were operating under the belief that she had a diagnosis of dementia. There does not appear to have been any dialogue or discussion to counter this belief, although it does suggest that professionals did not explain the nuances clearly.

Race and ethnicity

[71] *Payment by Results (PbR) is a system of paying NHS healthcare providers a standard national price or tariff for each patient seen or treated, taking into account the complexity of the patient's healthcare needs. http://content.digital.nhs.uk/PbR.*
[72] *http://www.icd10data.com/ICD10CM/Codes/F01-F99/F01-F09/F06-/F06.2.*
[73] *For each GP practice included in this data collection, NHS Digital receives a count of the number of patients with a dementia diagnosis in their clinical record, as defined by the QOF dementia business rules broken down by age and gender, as well as a count of the total number of registered patients at the GP practice. https://www.digital.nhs.uk/article/8412/Recorded-dementia-diagnoses.*

4.115 Little is said of Mrs A's ethnic origin apart from references to 'of African origin'. No consideration is given in assessment or care planning to whether she had any particular cultural needs.

4.116 This is discussed in Section 6 of this report.

Multi-disciplinary and Multi-agency coordination

4.117 Some of the letters to Mrs A's GP indicate that daughter(s), care coordinator, consultant and psychologist were present at some of the CPA or outpatients appointments. The OPCMHT is a joint NHS and Local Authority team but there is also a LA file, see above. There is no evidence of an approach which brought together information held by the CMHT, the local authority, the police, the home care agency and Mrs A's GP and family. It could be argued that the situation generally was relatively stable albeit with the occasional crisis, and the care plan was regularly reviewed. Mrs A received regular visits and the family were seen as being supportive and caring. Mrs A was also well known to the OPCMHT and her GP. On this basis there may have been little impetus to call a multi-agency care planning meeting.

4.118 However, the fundamental issue is the lack of discussion and information sharing with the Adult Mental Health Team at the same Trust. The team were aware that Miss B had a mental illness even if they were not aware of her forensic history and that she was providing an (unspecified) level of care for Mrs A. The Adult's team also did not think it necessary or possible to have a discussion with the OPCMHT because of concerns about confidentiality (see section on Care of Miss B). Senior managers at the Trust told us that is no impediment to staff sharing information between teams when necessary e.g. to assess risk.

4.119 We asked the OPCMHT staff why they did not seek to obtain information about Miss B's mental illness or her ability or suitability to provide care for Mrs A.

4.120 We were told that the family were very supportive and Mrs A was maintained at home with family support and a small care package. In their experience when Miss B felt unable to provide care for her mother she 'backed off'. The family have confirmed that when Miss B was unwell she retreated.

4.121 The OPCMHT also said that they saw Miss C as the 'active' carer for Mrs A, and it was Miss C who attended outpatient appointments and reviews.

4.122 At interview as part of this investigation, OPCMHT staff were uniformly of the view that had they been aware of the extent of Miss B's mental illness and her forensic history they would have re-assessed the situation.

4.123 The team were of the view that Miss B was not a carer in their perspective and that Mrs A was not vulnerable or suffering from dementia at the time of the incident. They saw her daughters as her 'protectors' and, in fact,

were proposing to discharge her to the care of her GP just prior to her death.

4.124 As noted above, from the family's perspective, they believed she was being treated for dementia, and that was why she was attending outpatient appointments.

Family views of the care and support provided to Mrs A

4.125 Comments from the family have tended to be about individual episodes. It is not clear from their perspective of how much they were involved in formal care planning. Care plan notes indicate 'daughter' (sometimes more specific) present at meetings.

4.126 The family have expressed their concern that previous aggression by Miss B to Mrs A was not communicated to them.

4.127 The family are of the view that the input to both Mrs A and Miss B was not very frequent. We gave family members the opportunity to meet with us to talk through the findings of the report. We have included family comments as they have arisen in the narrative.

4.128 We have included a direct quote from one of Mrs A's grandchildren here:

"*Throughout this report I have seen many inconsistencies in the care of Mrs A and Miss B. I have read the report and am shocked and dismayed by the outcome. Considering the history of Mrs B and lack of intervention and risk management plans, it is questionable what the Oxleas health professions are doing to prevent incidences recurring and how much they are protecting vulnerable children and adults*".

Comment and Analysis

4.129 The service in general provided to Mrs A by OPCMHT, was of a good standard. She was well known to them, had regular outpatient appointments, family were involved in her care planning and regular visits took place. However, we consider that the issues highlighted below meant that there was a lack of holistic risk assessment and management of Mrs A's home situation:

- There was a lack of multi-agency planning overall;

- Mrs A was on Enhanced CPA which was subsequently changed to Standard CPA (See CPA Section). It is not clear why this happened but we have to assume that it was because in general she was coping reasonably well with not many people involved and that the family was providing most of the care and support. Additionally, her care team did not regard her as vulnerable. However, this decision did not take into account the extent of her daughter's history of mental illness or any real understanding of how much care she might be providing to her mother;

- No carer's assessment was undertaken;
- It was still incumbent on the OPCMHT to seek information about Miss B from the adult mental health team (as they were aware that Miss B had a serious mental health problem) as much as it was incumbent on the adult's team to proactively provide it; and
- The Complex Needs Assessment of 2011 was not 'a holistic assessment of need covering both social care and clinical needs'.

Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies to both Mrs A and Miss B with specific attention to interagency working and safeguarding in relation to Mrs A. The investigation should specifically address the six principles of safeguarding in relation to empowerment, prevention, proportionality, protection, partnership and accountability.

Law and Guidance

4.130 Adult Safeguarding is a statutory responsibility under the Care Act 2014[74] for local authorities and their partner agencies. Guidance[75] to the Care Act defines Safeguarding as:

'protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances'.

4.131 The Care Act requires that each local authority must:

'make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect….. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect and if so, by whom…

set up a Safeguarding Adults Board (SAB)…

arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR)…

[74] *Care Act 2014, Sections 42-47 and 68*
[75] *Care and Support Statutory Guidance (updated August 2017), Section 14*

co-operate with each of its relevant partners in order to protect the adult. In their turn each relevant partner must also co-operate with the local authority'.

Principles of Safeguarding

4.132 The guidance sets out the six key principles[76] that should underpin all adult safeguarding work:

- Empowerment - people being supported and encouraged to make their own decisions and informed consent.
- Prevention - it is better to take action before harm occurs.
- Proportionality - the least intrusive response appropriate to the risk presented.
- Protection - support and representation for those in greatest need.
- Partnership - local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability - accountability and transparency in delivering safeguarding.

Safeguarding Adults Board (SAB)

4.133 Each local authority must set up a SAB. The main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area.

4.134 One of the core duties of a SAB[77] is to:

"arrange a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult".

4.135 The review should reflect the six core principles as described above.

4.136 The SAB has two other core duties:

To publish a strategic plan.[78]

To publish an annual report.[79]

Local Policies and Procedures

[76] *Ibid section 14.13*
[77] *Care Act 2014, section 44*
[78] *See Royal Greenwich Adult Safeguarding Board Strategic Plan and Action Plan 2017-2020*
[79] *See Royal Greenwich Safeguarding Adults Board Annual Report 2015 - 2016*

4.137 The RB has developed a local protocol[80] which describes in some detail how safeguarding policy is implemented in Greenwich.

4.138 The RBGis also a signatory to the London Multi-Agency Safeguarding Policy and Procedures[81] which "sets out an interpretation of the Care Act 2014, so that there is a consistent approach across London to adult safeguarding".

Safeguarding and the Care of Mrs A

Review whether local Safeguarding Adults policies and procedures were properly followed. The investigation should specifically address the six principles of safeguarding in relation to Miss B. The investigation should specifically address the six principles of safeguarding in relation to empowerment, prevention, proportionality, protection, partnership and accountability.

4.139 Greenwich Safeguarding Adults Board's 'Safeguarding Adult's Local Protocol'[82] describes the roles and responsibilities of local agencies in Greenwich in respect of safeguarding.

4.140 The protocol states that for people with severe and enduring mental health issues safeguarding enquiries should be led by the working age adults' team or the older adults' team (page 13).

4.141 Mrs A was under the care of Oxleas NHS Foundation Trust (joint NHS and local authority service) and as such would have been dealt with under the Trust's Safeguarding policy.[83] The version we have had sight of is dated June 2017 i.e. after the incident; however, version control indicates that the policy was only amended once between September 2012 and April 2016 and this was 'technical amendments and changes to contact details'. Oxleas have clarified that there were no changes to practice, therefore the policy did not require re-ratification.

4.142 The policy states that 'This document is supplementary to the local …SAB procedures. All staff are expected to be familiar with the procedures for their local authority area' (page 1).

Was Mrs A an 'an adult… experiencing, or…. at risk of, abuse or neglect'?

4.143 Mrs A was only referred for a safeguarding assessment on one occasion, in 2015, see below. The fundamental issue, therefore, is not whether procedures were followed (although we do address this in relation to the 2015 incident) but whether Mrs A should have been identified as 'an

[80] *Safeguarding Adults Local Protocol Royal Greenwich Safeguarding Adults Board, January 2016*
[81] *Pan-London Multi-Agency Safeguarding Policy and Procedures August 2106. London Association of Directors of Social Services, Metropolitan Police Service, NHS England and NHS and Local Authority Commissioners.*
[82] *ibid*
[83] *Oxleas NHS Foundation Trust, Safeguarding Adults Guidance 2016*

adult… experiencing, or…. at risk of, abuse or neglect' and therefore needing a safeguarding intervention.

4.144 These issues also need to be seen in the context of the issues identified above:

- The lack of multi-agency planning.
- Mrs A was on standard CPA.
- No carer's assessment was undertaken.
- There was a lack of information sharing between adults and older people's teams.
- There was no social care needs assessment.
- The lack of clarity about the actual level of care Miss B provided to Mrs A.
- Mrs A's care team identifying self-neglect as a risk.

4.145 Mrs A suffered from an organic delusional disorder and was 78 years old at the time of her death. She also had a number of physical conditions and was on a range of medications. On occasions she was paranoid and came to the attention of the police on a number of occasions.

4.146 These factors do not, in themselves, constitute a need for a safeguarding intervention. It would only be in the context of other factors giving rise to concerns about potential abuse or neglect that a safeguarding intervention would be required.

4.147 As we discuss above, the team caring for Mrs A did not see her as vulnerable or suffering from dementia at the time of the incident. They saw her daughters as her 'protectors' and, in fact, were proposing to discharge her just prior to her death.

4.148 The Trust's Safeguarding Policy contains a flow chart (page 30) detailing what actions are to be taken in Greenwich raising a safeguarding concern, this is divided into four processes:

- Raising a concern (48 hour time frame).
- Enquiry (5 day time frame).
- Case Conference and Safeguarding Plan (4 weeks' time frame).
- Review (which can be taken as part of a CPA Review).

4.149 It is helpful to look at what point concerns might have arisen and a safeguarding investigation instigated.

- Incidents with Mrs A's neighbours (psychological/physical)[84]

- Injuries - facial bruising and cut hand (physical abuse/neglect and acts of omission)

[84] *page 11/12 of Oxleas Adult's Safeguarding Policy refers to the different types of abuse.*

- The safeguarding alert in 2015 (acts of omission)

The Care Act says that safeguarding investigations should be carried out (section 42): 'This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there).
(a) has needs for care and support (whether or not the authority is meeting any of those needs);
(b) is experiencing, or is at risk of, abuse or neglect; and
(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it'.

Incidents with Mrs A's neighbours

4.150 Between 8 February 2009 and 15 October 2010 Mrs A was involved in a number of what were termed 'neighbour disputes' with a neighbour and the police attended on a number of occasions. The 'neighbour dispute' caused Mrs A some distress and she said that she feared her neighbour. The police response was variously to refer to the Safer Neighbourhood Team, social services, her GP and on one occasion have a discussion with an 'in-house social worker'. The dispute may have some basis in reality as the neighbour was eventually arrested. According to the case notes Miss C said in July 2013 that the neighbour had assaulted Mrs A. Her case notes were subsequently amended to reflect this and they also noted that Mrs A had concerns about their harassment of her. However, Miss C has told us that the neighbour who was arrested had, in fact, been protecting Mrs A from her drug and alcohol dependent neighbours. It was those neighbours who had attacked Mrs A but they had not been arrested.

4.151 During this period, (i.e. prior to the implementation of the 2014 Care Act) adult safeguarding was governed by 'No Secrets'[85] a Department of Health policy published under Section 7 of the Local Government Act. Section 7 guidance does not have the status of statute but local authorities are expected to comply with it.

4.152 No Secrets defined a vulnerable adult as someone 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'.

4.153 Abuse was defined as being physical, sexual, psychological, financial and neglect and acts of omission.

4.154 All agencies were expected to work together to prevent and investigate abuse and establish an inter-agency framework to oversee this.

[85] *No Secrets, Department of Health, 2000*

4.155 The policy set out the process for investigating and stated that one part of the process involved "decision making which may take place at a shared forum such as a case conference".

4.156 At the time of these incidents Mrs A was well known to the police and her GP as a vulnerable person. On one occasion police referred Mrs A to social services. She would have met the 'No Secrets' criteria as being a vulnerable person. Whether the neighbour disputes constituted "significant harm" is not clear.

4.157 No action was taken under the extant policy and it could be argued that given Mrs A's vulnerability and risk factors associated with the 'neighbour dispute' action could have been taken under the No Secrets framework; why it wasn't is not clear.

4.158 A later note from an outpatient's appointment, 10 February 2011, states 'If there is any tangible evidence that her neighbour is victimising her this will need to be explored under the Safeguarding Adult's Framework'. No action was taken and it is not clear why.

4.159 If action had been taken information could have been shared and a decision made as to whether Mrs A was at risk from her neighbours and appropriate action taken. What is less evident is whether any action taken under the extant policy would have revealed any concerns about Miss B caring for Mrs A. Given that when Mrs A was eventually admitted to Oxleas House in March 2011 no concerns about Miss B were identified in subsequent CPA meetings it is unlikely that any concerns would have been identified under the No Secrets framework.

Injuries

4.160 On 21 July 2015 Mrs A attended GP surgery to have a suture removed having sustained a deep cut to her finger. She had attended Lewisham A&E on 10 July 2015 for initial treatment for this cut, as described below, and a late safeguarding referral was sent in October 2015.

4.161 On the 7 December 2015 the GP paid a home visit to Mrs A. She was found to have pain and swelling from the jaw to the cheek on the left side of her face, tooth ache and a loose tooth. Her daughter was advised to make an appointment with a dentist as soon as possible.

Queen Elizabeth Hospital July 2015

4.162 On 29 October 2015 the Joint Emergency Team (JET)[86] were presented (by whom it is not clear) with a safeguarding referral dated 10 July 2015 from Queen Elizabeth Hospital in respect of Mrs A who had attended A&E.

[86] *The Joint Emergency team assesses people, aged 18 years and over, in their own home, A&E and the Acute Medical Unit (AMU) at the Queen Elizabeth Hospital, the team accepts referrals from all primary, community, acute and social services. The Joint Emergency Team (JET) is part of Greenwich Community Health Services, which is run by Oxleas NHS Foundation Trust, and Greenwich Council.*

4.163 The JET Safeguarding alert was as follows:

'The referral noted that 'Patient has dementia and very drowsy, not even complaining of pain. She has investigations and procedures to be done. But daughter declined. Clinical notes with an attached self-discharge form dated 11/07/2015 noted that daughter did not wait for repeats of bloods, chest x-rays or JET review (for package of care). It was also noted that patients ECG was suspicious but daughter reported her mother to have ECG concerns and signed a self-discharge form for her mother to be discharged from hospital'. T/C made to A and E to obtain further history regarding circumstances around the discharge and query the delayed safeguarding referral.

None of the medical staff were able to explain why and did not know Sister/Senior [M] who was present on the day the safeguarding referral was completed. JET admin checked on RiO database to see if there was further information regarding service user's discharge. No information was documented'.

4.164 This episode raises the question if Mrs A was a capacitous person (albeit) with dementia and able to make decisions for herself. Why was it necessary for her daughter to sign her "self"-discharge form? If Mrs A wasn't able to make decisions for herself then how was the decision to let her go made? There is no indication in the notes that Mrs A's mental capacity was considered as part of the decision making process.

4.165 Section 14.58 of the Care and Support Statutory Guidance[87] states that 'Mental capacity is frequently raised in relation to adult safeguarding. The requirement to apply the Mental Capacity Act in adult safeguarding enquiries challenges many professionals and requires utmost care, particularly where it appears an adult has capacity for making specific decisions that nevertheless places them at risk of being abused or neglected'.

There are some important issues arising from this incident; in particular the lack of safeguarding intervention for nearly three months and the action taken to address this both in terms of investigating the alert and investigating the cause of the delay.

4.166 Investigating the alert:

4.167 When JET received the referral on 29 October 2015 they arranged a home visit the following day. The type of abuse to be investigated was deemed to be 'neglect and acts of omission'. Under the personal details section of the safeguarding form the following is recorded:

'Relationships. Mother of [Miss B]. [Miss B] is responsible for finance for [Mrs A]. Grandmother of [older child] Grandmother of [younger child]'.

4.168 The 'Person Case Notes' state:

[87] *Care and Support Statutory Guidance, August 2017*

'*..made contact with CDU[88] to obtain further history regarding circumstances around the discharge and query the delayed safeguarding referral. However, none of the medical staff were able to explain why and did not know Sister/Senior [M] who was present on the day the safeguarding referral was completed*'.

4.169 A call was made to Miss C. *'I advised that JET received information from QEH that her mother was self-discharged without having any tests carried out. A stated that this was some time ago and could not understand the importance of this discussion and did not want to discuss further. She stated that she was not at her mother's home and agreed for me to visit her at home'.*

4.170 The investigating social workers notes describe the visit on 5 November 2015 as follows:

4.171 '[Mrs A] was visited at home on the 30 October 2015 and was informed of the safeguarding investigation. Although, she has a diagnosis of dementia, this did not affect her from engaging in conversation and although she could not remember the incident surrounding the allegation, [Mrs A's] view was that her daughter had no right to self-discharge her without her consent.

[Mrs A] reported that she lived alone and as I was concerned about her frailty and her managing the stairs, she allowed me to see whether she had sufficient foods inside her kitchen. I noted fruits, cereals and cooking ingredients. [Mrs A] explained that her children cook for her daily and stated that she was well cared for by them. She declined care package and demonstrated that she was able to walk up the stairs. We noted that she turned the light on before going up the stairs and held onto the stairs bannister as she climbed the stairs'.

4.172 The section of the notes 'Does the adult at risk appear to have the mental capacity to understand that a referral is being made?' is ticked as 'Yes'.

4.173 The notes continue 'She [Mrs A] feels there is no point in continuing with the investigation. However, consented for me to raise a safeguarding alert against the hospital (for lack of action)'.

4.174 It was agreed at a strategy discussion on 2 November 2015 between the JET Team manager and JET social worker that Mrs A's GP should be contacted and asked to visit. Dr S (GP) was contacted by phone on 2 November 2015 and on 4 November 2015 a fax was sent to him as follows:

'I note that this patient has a diagnosis of dementia and has no social care package in place and given her medical history, there may be a possibility that the patient may have on-going health risks.…please could you kindly visit the patient at …home.. and carry out a medical examination'.

[88] *CDU is the Clinical Decision Unit at Queen Elizabeth Hospital*

4.175 Dr S visited on 5 November 2015 and the safeguarding notes report that:

> 'Dr S carried out a medical check…..and reported there to be no medical concerns. He informed that [Mrs A] appeared to be well looked after. He reported to have seen the medical results when [Mrs A] was in hospital and recorded no concerns'.

4.176 A further strategy discussion was held on 6 November 2015:

> 'In light of the information gathered, there appears to be insufficient information to establish allegations of neglect by the daughter. However, the following action(s) should be taken:
>
> Raise a SVA trigger to alert professionals should similar incidences (e.g. daughter self-discharging her mother) occur'.

4.177 This was subsequently modified to 'ATM (Assistant Team Manager) advised that it will be suffice (sic) to raise a safeguarding part 1 as this will be noted on the system'.

Comment and analysis – Lewisham Hospital

4.178 In respect of the handling of the safeguarding alert, once it was received by the JET, we have the following comments.

4.179 Despite the time lapse the JET were diligent in their investigation and records are comprehensive and clear.

4.180 Policies and procedures were complied with in respect of investigating the safeguarding concern.

4.181 The investigation was concluded in a timely manner – eight days from notification to conclusion.

4.182 The main concern was that Mrs A was at some medical risk having been discharged early. The JET took steps to ensure that she had a medical check within seven days of the notification. The check confirmed that the GP had no medical concerns and he ensured that he accessed the test results from the hospital.

4.183 A home visit was conducted on the same day that the alert was received. The social worker who visited ensured that Mrs A understood the nature of the visit. She ensured that Mrs A had sufficient food; family involvement was noted and Mrs A, given her obvious frailty, was observed climbing the stairs. Mrs A was offered a care package which she declined.

4.184 Action was taken to ensure that if a similar occurrence were to happen this would be apparent on the system. A telephone discussion was held with Miss B which achieved little other than agreement to visit her mother. Given the concerns at the time of the discharge a more robust discussion might have revealed why Mrs A was discharged early.

4.185 The case notes identify Miss B as Mrs A's daughter but not Miss C, and the phrase 'the daughter' is used which makes it impossible to know who is being referred to. This is a common issue in both NHS and local authority notes.

Recommendation 4
Lewisham and Greenwich NHS Trust should provide assurance that where there is a question of vulnerability and capacity, a capacity assessment should always be carried out and documented.

Investigating the cause of the delay in referral

4.186 Following the delay in the JET receiving the safeguarding alert the JET formally wrote to a named individual at QEH as follows:

'Please see the attached safeguarding request…..Please submit your report within 28 days of this SVA request'.

'Lewisham and Greenwich NHS Trust is required to carry out an internal investigation on why the safeguarding information was provided to the …JET on 19 October 2015'.

4.187 A further note on the file states:

'A SVA request has been sent to QEH notifying them of the allegations and an allegation has been raised against them in relation to the delayed safeguarding referral sent to JET.

4.188 On 9 November 2015 the JET emailed the Care Quality Commission (CQC) at enquiries@cqc.org.uk as they are required to do when concerns about a provider in relation to safeguarding:

'The safeguarding alert is raised in relation to the hospital as they informed our department (JET) of the safeguarding alert in late October 2015'.

Comment and analysis

4.189 The JET acted appropriately and in a timely fashion in asking QEH to undertake an internal investigation into the causes of the delay. They also informed CQC of their concerns.

4.190 We can find no record of the internal investigation being conducted. We asked QEH and were told that at the time of the incident QEH had no safeguarding advisor. They informed us that they had no records of the referral or, indeed, any evidence that the internal investigation was implemented. We asked the local authority to comment and they told us that a request for a review would be 'flagged' on the system by the team requesting the review. Both told us that there was no overall governance arrangements for instigating and monitoring an investigation such as this.

QEH told us that any internal investigation would be dealt with by the Director of Nursing.

4.191 We found that the process at the time for instigating and monitoring the implementation of a request for an internal review by a provider to be muddled.

4.192 We have been assured by the RBG that a robust process is now in place. We have had sight of the 'Provider Concerns Procedures' which set out in some detail what should be done when concerns are raised about the performance of an individual provider. We are of the view that, if implemented, this policy should ensure that concerns are fully investigated with appropriate oversight.

4.193 We asked the CQC what action they took in response to the email from the JET on 9 November.

CQC provided us with their inspection plan for Queen Elizabeth Hospital[89] which confirms that the information about safeguarding concerns at the hospital in the email from JET were fed into the inspection as follows:

"A&E Safeguarding concerns – we have received several safeguarding concerns both from, and about, A&E".
"A patient's daughter signed her mother's discharge papers stating that there was not time to wait for blood tests. This was not reported as a safeguarding incident until three months later".

Safeguarding at Lewisham and Greenwich NHS Trust

4.194 Lewisham and Greenwich NHS Trust (LGT) told us that there had been safeguarding process problems at QEH at the time of the referral. There was no Safeguarding Advisor and QEH had been the subject of a CQC inspection[90] which had raised concerns about safeguarding at QEH.

4.195 As a result of this KPMG[91] were contracted to undertake an audit in August 2016[92] to review the processes for assessing safeguarding concerns for adult patients and obtaining appropriate authorisation when applying deprivation of liberty safeguards. The conclusion was that there was a significant assurance with little improvement potential. The conclusion was consistent with Management's expectation. A recommendation was made to continue auditing the adult safeguarding dashboard regularly to test that all referrals were included and there were no omissions in data'.[93]

4.196 CQC told us, and their inspection reports[94] confirm this:

[89] *Lewisham and Greenwich NHS Trust : Queen Elizabeth Hospital. Unannounced Responsive Inspection. Inspection Plan 7-8 June 2016.*
[90] *CQC Quality Report., Queen Elizabeth Hospital, November 2016.*
[91] *KPMG is a professional firm providing Audit, Tax and Advisory services. https://home.kpmg.com/uk/en/home.html*
[92] *KPMG September 2016, Safeguarding Adults, L & G Hospitals Trust.*
[93] *L & G Hospitals Trust Annual Safeguarding Report 2016 -2017*
[94] *ibid*

‘At the inspection of Queen Elizabeth Hospital in February 2014 we found that all staff in the emergency department (ED) had received training regarding the protection of both children and vulnerable adults and were able to tell us who the safeguarding lead for the trust was. At our inspection of the ED service at Queen Elizabeth Hospital in June 2016 we found that staff ‘were aware of their responsibilities to protect vulnerable adults and children and they understood safeguarding procedures and how to report concerns. However, there were varying levels of compliance with safeguarding training against the trust’s target of 85%’.

‘At the March 2017 inspection (report published in August 2017) of the Queen Elizabeth Hospital we found in the ED ‘There were appropriate systems and processes in place for safeguarding patients from abuse. Staff were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns’.

‘In the provider report for the March 2017 inspection (report published in August 2017) we found the Trust had an established adult and children & young people safeguarding committee which was chaired by a non-executive director. Meeting quarterly, the committee considered all elements of safeguarding both vulnerable children and adults. We also found the compliance with training had improved. The Trust was not rated ‘requires improvement for adult safeguarding’.

4.197 The Local Authority confirmed to us that as far as they were aware there were no concerns about safeguarding at QEH.

4.198 We were told by LGT that a number of further improvements to adult safeguarding had been put in place; improving the database, making the safeguarding referral form ‘personal’, introduction of three yearly safeguarding top up training, safeguarding as part of new staff’s induction and the development of a safeguarding page on the Trust’s intranet.

4.199 Neither the CQC nor the KPMG report identified policies, procedures, governance or management responsibility as issues of concern.

Other potential points at which a safeguarding alert could have been considered

- If information had been shared between teams at Oxleas which could have led to the Older People’s CMHT considering a safeguarding investigation.

- If the risk of self-neglect had been identified in risks assessments by the Older People’s CMHT.

- If Bridge had been aware of Miss B caring for Mrs A.

Summary of principles of safeguarding in relation to Mrs A

4.200 **Empowerment** (people being supported and encouraged to make their own decisions and informed consent). When the incident of July 2015 was eventually investigated in October 2015 the investigators took a personalised[95] approach. The investigator explained the safeguarding process to Mrs A was and also contacted Miss C to explain. Mrs A was encouraged to express her views.

Apart from this there is no record as far as we can ascertain of any attempts to engage Mrs A in any discussion about any risks she might be facing.

4.201 **Prevention** (it is better to take action before harm occurs). There were several missed opportunities to consider undertake a safeguarding investigation:

- The missed alert of July 2015.
- The "neighbour dispute" was effectively not given serious consideration as a safeguarding issue.
- The injuries to Mrs A.
- The identified risk of self-neglect.

4.202 **Proportionality** (the least intrusive response appropriate to the risk presented). Arguably, on the occasions that safeguarding could have at least been considered as an approach, the response was disproportionate in the sense that no action was taken. When a formal safeguarding alert was acted on in October 2015 the response was proportionate.

4.203 **Protection** (support and representation for those in greatest need). The team caring for Mrs A did not assess her as being in need of protection. Indeed, they viewed Mrs A's family as her protectors. They did, however, assess her as being at risk of self-neglect.

4.204 **Partnership** (local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse). During the period when Mrs A was experiencing neighbour disputes there was a lack of communication with the police. A neighbour on one occasion reported concerns about Mrs A. The GP noted that Mrs A had nominated a friend to be involved in her care and treatment as Mrs A did not want her daughters involved. There is no record of any discussions with Mrs A's friend. We are of the view that the failure of older adult mental health and adult mental health to share information is a lack of partnership working.

[95] *Personalisation is a social care approach described by the Department of Health as meaning that "every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings"*

4.205 **Accountability** (accountability and transparency in delivering safeguarding). We have no comment about whether the service delivered to Mrs A was accountable or transparent as no safeguarding interventions (apart from the late follow up in October 2015 of the discharge in July 2015) took place. The key safeguarding issue was whether Mrs A was safe being cared for by Miss B, and this was never really considered for either of them.

5 Care of Miss B - Arising issues, comment and analysis

Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies to both Mrs A and Miss B with specific attention to interagency working and safeguarding in relation to Miss B.

5.1 Miss B was provided with services from her GP, Queen Elizabeth Hospital, Oxleas NHS Foundation Trust, and Bridge Mental Health. Her involvement as an adult with RBG was confined to freedom travel passes only. RBG child and family services involvement is referred to in section 3.

GP Surgery

5.2 Miss B was seen at the GP practice for her physical health issues as described above from section 3.77 to 3.84. The medication for her mental health issues was prescribed by the GP, on the advice of her psychiatrist. Outpatient letters were routinely copied to the GP throughout Miss B's care by Oxleas.

5.3 Dr R's letters were copied to the GP, and any prescribing changes were communicated. There is evidence that these were acted upon, for instance when changes were made to the prescription, or it was requested that her medication be provided in blister packs and dossette[96] boxes to aid compliance.

5.4 A GP saw her in December 2015 for anxiety and sleep problems, and she attended in February 2016 with back pain. No mental health issues were noted.

5.5 The IMR written by the GP surgery notes that regular communication was required to monitor Miss B more closely, and the importance of regular review.

5.6 We concur with this view, particularly because the normal pattern was that the GP had been receiving regular update letters from Oxleas, for a patient who was known to have long term mental health issues.

5.7 The system appeared to work well when the Oxleas letters were received, that is they were acted upon and filed. There were no triggers to recognise when these letters ceased in September 2015, even though she had not been discharged. Miss B was seen by the GP in December 2015 and February 2016, which could have provided an opportunity for the GP to notice that there had not been any communication from Oxleas for some time.

5.8 The GP surgery had received four letters from Dr R between May and September 2015 providing updates on outpatient attendance. The last

[96] *Dosette type boxes are medication boxes that have separate compartments for days of the week and / or times of day such as morning, afternoon and evening, to help with self-administration.*

outpatient letter from Dr R indicated that Miss B would be transferred to the care of Dr N, in the 'Psychosis West' team, and it would have been reasonable to expect further letters in the usual two to three month cycle.

5.9 As with long term physical conditions that are under the care of specialists, we would expect to see a system of flagging and follow up for patients under the care of secondary mental health services.

Recommendation 5
NHS Greenwich CCG must assure themselves that there are systems in primary care to monitor the treatment of patients under secondary mental health care.

Metropolitan Police Service

5.10 Miss B was known to police because of her conviction for wounding in 1995, which was under her previous married surname. Interactions with Miss B in relation to Mrs A are described above, and in these later interactions Miss B was referred to by her maiden name as described above. It is noted that she did not present any concerns about her mental health.

5.11 The MPS have said 'if the offence had been uncovered, consideration could have been given to sharing the details with Adult Social Care for consideration in any future care needs or carer assessment'.

5.12 We have come across an incident in June 2012, described by a family member, which is not mentioned in the MPS IMR. It was reported that police were called to Miss B's flat to assist the London Ambulance Service after a disturbance at her flat. We enquired further and have been told that this did not show on the police systems because there was no identity in the text of the record to indicate that this referred to the subject or her family and therefore could have been an unrelated occupant of the address.

5.13 However their last contact with Mrs A was in July 2013. As discussed above, had Mrs A been identified as a 'vulnerable adult', this may have given rise to a multiagency approach to the care as a whole, and the relationship between Miss B and Mrs A may have had further examination.

5.14 We cannot see any obvious trigger in 2015 or 2016 that would suggest that the MPS should have been engaged in any safeguarding or police processes in relation to Miss B.

London Ambulance Service

5.15 LAS attended Miss B's home address in July 2012, after being called because of a disturbance. The LAS noted that it was reported to them that Miss B was becoming aggressive and '*not making sense'*. Following an

assessment by ambulance staff Miss B was conveyed to Queen Elizabeth Hospital.

5.16 Miss B called an ambulance in January 2013, and reported having lower chest pains. Following the ambulance staff assessment Miss B was conveyed to Queen Elizabeth Hospital.

5.17 There were no safeguarding concerns on either occasion.

Bridge Mental Health

5.18 Miss B was initially supported by Bridge in 2003, then called 'Bridge 86'. Bridge is a charitable organisation and provider of mental health and wellbeing services in partnership with other services such as mental health services. Bridge can provide a range of floating support services of varying levels of intensity, and they also provide a recovery college.

5.19 Miss B had been known to Bridge for over 10 years and received floating support. Bridge as a team were well engaged with the Oxleas mental health services, were routinely invited to CPA and MDT meetings, and communicated by phone or email when there was information or concerns that needed to be shared. In 2015 and early 2016 Miss B was provided with 'flexible community support' which allowed for more flexibility in approach than the previous 'floating support' of four hours per week. This was funded by the Royal Borough of Greenwich. Bridge provides training and supervision for all staff, and has on-call arrangements over 24 hours.

5.20 A 'universal mental health pathway risk assessment' document had been written on 29 September 2015. The form directs that all boxes that are ticked must be accompanied by an explanation. Historic risks must be given dates. There were no dates provided for the historic risks identified.

5.21 Risk factors rated 'high' were:

- Non-engagement with treatment/support service: When [Miss B] is unwell she does not engage in services;
- Non-compliance with medication: [Miss B] is known to not take her medication correctly during a relapse / or in the run up to one. [Miss B]'s relapse happens 3-6 months therefore she is very up and down;
- Issues with managing change; and
- Issues with trust/engagement with new services.

5.22 The interventions were around weekly face to face visits, increasing support as needed, ensuring the other services were kept informed such as GP, mental health services. As the Oxleas change was in progress it was also noted she needed support with transitions to the new Oxleas structure, and in getting to know a new Bridge worker.

5.23 Medium risks were:

- Aggressive or intimidating behaviour (including verbal abuse): [Miss B] is known to get verbally aggressive/assertive when she is feeling low on the verge of a relapse; and

- Other issues related to mental illness: depression.

5.24 Low risks were:

- Safeguarding concerns (whether victim or suspected abuser): were noted as previous history of a volatile relationship with her husband, many years earlier; and

- Physical aggression/violence (including DV and hate crimes): in a violent relationship with her children's father which ended years ago.

5.25 There was no history noted about risk to herself or self-neglect, or drug and alcohol use; which was inaccurate. The section on 'other issues related to mental illness' should have included her paranoia and hearing voices, which typically emerged early in her relapses. A mitigation plan was included in the document. We were informed that a 'recovery star' was completed for Miss B but we have not seen this.

5.26 Miss B sent an email to Bridge in June 2015 telling them she wished to be discharged, because she did not need them and did not want to be provided with services she did not need. This was raised with senior Bridge staff who advised that a meeting between Bridge and other professionals involved in her care, and Miss B, should be planned before any decisions were made. Miss B followed this up with a call in July 2015 demanding to be discharged from Bridge. She was seen at home in July 2015 by her worker and a senior Bridge staff member, and she agreed to review it in six months' time, after a discussion about the benefits she has gained from Bridge support. This appears to have been dealt with appropriately.

5.27 An email was sent to Bridge in late September 2015 by Miss B's Oxleas care navigator regarding service changes, advising that Miss B would no longer have a care coordinator, and would be seen in due course by a psychiatrist.

5.28 Miss B accessed support from Bridge to help with recent financial issues. She had an increase in her electricity bill in October 2015, which her Bridge worker helped her to resolve. In line with changes to benefit structures, she received an appointment for a health assessment to asses her for Employment and Support Allowance[97] (ESA). She verbalised some anxiety about this, and was supported to attend the assessment in January 2016, with the Bridge worker. The Bridge notes record that Miss B felt comfortable after the interview, although was keen to hear the

[97] *Employment and Support Allowance (ESA) https://www.gov.uk/employment-support-allowance/how-to-claim*

outcome. It was noted that she should hear within four weeks of January 2016. The outcome of this assessment is not known.

5.29 She was last seen by the Bridge worker on 2 February 2016. Miss B had slept badly and was tired on her arrival, and had some concerns about pains in her joints. It was agreed that they would not go out but would rearrange. No risk issues or concerns were noted. The notes made by the support worker in 2015 and 2016 are on a structured template, which requires the note maker to complete a proforma with an assessment of the person's presentation, environment, mental state and any risks noted. This appears to us to be a positive initiative, but the forms were occasionally completed in a confusing manner, e.g. it was indicated that the person's mental state was 'very good' and 'good' on the visit form.

5.30 The last contact with Miss B was on 18 February 2016, when Miss B called to cancel an appointment because she was planning to meet a friend for a meal, and she was noted to sound well and looking forward to the outing.

5.31 The IMR completed by Bridge describes a depth of historical knowledge about her conviction for assault on her oldest child in 1995, and subsequent pathway out of secure services since 2003. It was stated that the care plans and risk assessments were up to date, and that Bridge attended her last CPA meeting in October 2015. We question the accuracy of this, as Miss B did not have a CPA meeting in October 2015, nor is there evidence in Bridge or Oxleas records of a joint meeting. There was however a joint meeting in October 2014. However it is noted that Miss B had told Dr R that she did not want Bridge to attend her outpatient appointments routinely. Oxleas have clarified that there was no CPA meeting in October 2015.

5.32 The IMR also notes that Bridge were not aware of the extent of Miss B's involvement in the care of her mother, and had they known, it would have been incorporated into her support plans, exploring what level of support she was providing, and how she was coping. There are references in Bridge notes of Miss B saying she was going to see her mother, to help with her meals, but it was also noted that Miss B did not discuss her family openly and was not responsive to enquiry about them. The IMR notes a learning point from the homicide was that Bridge have identified and trained staff in motivational interviewing skills, to improve staff members' ability to elicit more information about what is going on for each person. There are plans to extend this training, and management supervision sessions will review how this training has impacted on their work with clients.

5.33 In our view Bridge senior managers and support staff knew Miss B well, and had contact with her over a number of years, with what was clearly a positive benefit to Miss B. Care was provided flexibly, with increased support tailored to Miss B's needs when she was not feeling well. Communication from Bridge to Oxleas was by phone and email and it was

evident that there was timely communication from Bridge staff to Oxleas when there were any concerns.

5.34 We did find that the risk assessment and support plan written in September 2015 had some inaccuracies and omissions, and we have made a recommendation about this. We consider this to be a quality issue and did not in our opinion have any bearing on the homicide committed by Miss B.

5.35 It was noted that Bridge were not routinely provided with copies of outpatient letters or CPA meeting notes, and this was felt to be an area that could be improved.

Recommendation 6
Bridge should develop a quality monitoring process that provides assurance that risk assessments and wellbeing plans are completed accurately.

Recommendation 7
Oxleas NHS Foundation Trust should agree with Bridge what routine patient care information will be provided about patients under the care of secondary mental health services, and develop systems to ensure that the agreed information is received and processed in a timely way.

Oxleas NHS Foundation Trust

5.36 As Oxleas was the lead agency for providing and co-ordinating care for Miss B we also address the following Terms of Reference in this section:

Review the effectiveness of care planning for Miss B.

Review and assess compliance with local policies, national guidance and relevant statutory obligations.

5.37 In this section we will review Miss B's care in 2014 to 2016 only, although we include some information about her care in 2017 to provide recent context.

5.38 Miss B had been formally diagnosed with schizoaffective disorder (ICD:F25.9) in February 2007, and this was her diagnosis at the time of the homicide. She had been on enhanced CPA until 2009, and then moved to standard CPA, which entailed seeing a psychiatrist in outpatients' and other interventions. The decision to transfer her to 'standard' CPA in 2009 was made after a sustained period of stability and engagement. At this time she was seeing a psychologist for individual CBT, attending training such as massage therapy and was supported by input from Bridge. On 'standard' CPA she did not however have the benefit of a care coordinator, who could have provided continuity of care

and coordination across teams and agencies, with co-ordinated management of risk and sharing of information.

5.39 She was prescribed risperidone 4 mg and fluoxetine 20 mg in the period before February 2016, and had been taking both of these for several years. The doses of risperidone were adjusted upwards and downwards at times, and occasionally night sedation was added for short periods. Miss B had fluctuating compliance with taking medication, and it was known that she would stop taking both her fluoxetine and risperidone at times. She frequently complained that she did not really need medication, and great efforts were made to educate her about her illness and the ongoing requirement for medication.

5.40 The appearance of early warnings signs of relapse (staying indoors, paranoia, fearfulness, hearing abusive voices, sleep disturbance) were frequently associated with her not taking her medication. It was not always clear if this was a precipitating factor or a consequence, but it was known that there was a correlation. At times of crisis the HTT implemented a medication supervision plan, and then arranged for her medication to be supplied in 'blister' packs. Her most recent relapse before the homicide was in March 2015, and she had again not been taking her medication regularly. Dr R tried to persuade her to accept a depot injection in May 2015, supplied her with information and arranged education sessions with the pharmacist. Miss B refused to change from tablets to depot medication. We agree that a depot injection would have been helpful in helping her medication compliance, but consider that Dr R made appropriate efforts to try to establish this. There were no grounds for compulsion using the MHA at that time. The argument against detaining is that she had similar episodes previously, including overdoses and had not needed to be detained. Also, she did seem to recover before the homicide. In favour, is the non-compliance with medication and HTT, which theoretically should at least trigger consideration of a MHA assessment. We did not see evidence of this having been discussed however.

5.41 The care plan on RiO had not been updated since 2008. There is reference to her developing a wellbeing plan in 2015, and there is a hand written undated copy within the records, which is recorded as having been uploaded on 14 September 2015. This plan was written by Miss B, and shows a degree of insight into her mental illness and what helps and what doesn't help:

Situations that can lead her to feeling distressed were 'voices, paranoia, being alone too much, being let down, feeling fearful'. What happens when she is distressed: 'suicidal thoughts and action, depression causes her to stop eating, take to her bed, take overdoses of medication, go mute'.

Positive things she can do when distressed: listen to gospel music, talk to somebody, and go out for a walk if possible, distraction.

Things which have not helped in the past: going to bed and staying there, taking overdoses, not taking medication.

Things she sometimes forgets that she might need reminding about: when really bad she does not shower, and forgets to take medication.

Her difficulties as she saw them now were: depression, anxiety, loneliness, feeling fearful and insecure. Support from healthcare professionals was: GP, psychiatrist, occupation therapy, psychology sessions, and support worker.

Things she would like professionals to do to help were: listen, understand, and help her to keep calm. Being admitted to hospital or not understanding were things that had been unhelpful in the past, and practical help in a crisis was; understanding, giving her time to be calm.

5.42 This wellbeing plan shows she had partial insight; the plan focusses on symptoms rather than acknowledging that she has a psychotic disorder for which medication is an essential treatment. It was later clarified that this was a Bridge wellbeing plan. The Oxleas 'Assessment and Care Planning including Care Programme Approach' policy dated March 2012 states that service users on standard care should have their care plan detailed in a letter and a structured template is provided (appendix 1 A of the policy). The letters prepared by Dr R after each outpatient appointment are completed in this format and sent to Miss B and her GP, which complies with the policy.

5.43 We question whether 'standard CPA' as described in the Trust policy was the appropriate level of care for Miss B. The criteria for 'standard' CPA within Oxleas policy are below:

- More straightforward needs; e.g. one axis of need being addressed by the Trust.
- One agency only involved.
- Service user able to easily access support and care needed either alone or with help of family, advocacy, or self-help agencies.
- Care likely to last the agreed 6-8 sessions or less.
- Risks are low.
- In stable housing, managing financially.
- Employed and not experiencing work related stress.

5.44 The Greenwich Recovery team had a project called COMPPaS (Coordinated Operational Move to Primary-Plus Services), which was aimed at patients with increased needs. This project was funded with a fulltime occupational therapist (OT) and a 'care navigator' and psychology input. Funding was provided over two years. The intention of the project

was to provide refreshers in life skills, CBT and provide family work. Another intention was to work closely with GPs, and eventually transfer to primary care. At interview Dr R told us she did not see Miss B being discharged to primary care in the next 12 months, and agreed that she was receiving an enhanced level of input.

5.45 Within Oxleas 'Assessment and Care Planning including Care Programme Approach' policy the criteria for CPA is as below:

1. Mental disorder (including personality disorder) with high degree of clinical complexity.
2. Current or potential risk(s), including:

- Suicide, self-harm, harm to others (including history of offending).
- Relapse history requiring urgent response.
- Self-neglect/non concordance with treatment plan.
- Vulnerable adult; adult/child protection

  e.g. exploitation, financial difficulties related to mental illness, dis-inhibition physical/emotional abuse, cognitive impairment, child protection issues.

5.46 We consider that Miss B met the criteria for CPA and allocation of a care coordinator. This would have enabled a coordinated approach to the various strands of her care, and provided a central point of communication. At the time of the service changes in September 2015, Miss B had weekly support from the care navigator, had input from the OT, and was being seen by a psychologist for a series of CBT sessions, attending the recovery college and having the support of a third sector organisation, Bridge. Following consultation on the draft report, Oxleas have confirmed that they recognise that due to her complex needs there is a clear argument that Miss B met the criteria for CPA and allocation of a care coordinator. The Trust's view is that the decision to do this would have been made by Dr N at the first appointment in the new team (had it happened).

5.47 While we have tried to avoid the use of hindsight bias[98] in this, it is clear that Miss B was offered a range of high quality therapeutic input on the COMPPaS programme. However it was acknowledged at interview that she was not typical of the intended patient group, in that she was not on a trajectory to be discharged to primary/GP care in the near future.

5.48 We consider that the COMPPaS project paradoxically masked her need for a higher level of input and the supportive infrastructure that a care coordinator could provide, and that she met the criteria for CPA. The

[98] *Hindsight bias is the inclination, after an event has occurred, to see the event as having been predictable, despite there having been little or no objective basis for predicting it. Roese, N. J.; Vohs, K. D. (2012). "Hindsight bias". Perspectives on Psychological Science. 7: 411–426. doi:10.1177/1745691612454303*

service redesign could have provided the opportunity for reassessment, but there is no evidence that patients' individual needs were taken into consideration in the allocation of clinical teams in the new services.

5.49 During her care at Oxleas Miss B was offered a wide range of psychological and psychosocial interventions. In 2014 and 2015 she was seeing psychology for CBT, an OT for life skills and a care navigator to help with social integration. She expressed an interest in attending a psychology group for people with difficulty managing anxiety, called 'creating calm' and she was seen by the facilitators for an assessment in March 2014. The group started in April 2014, and Miss B attended four of the six sessions. In September 2015 she was offered a place on a CBT group for people who hear voices.

5.50 The NICE guidance (CG 178) 'Psychosis and schizophrenia in adults: prevention and management' [99] (2009 and 2014) for subsequent acute episodes of psychosis or schizophrenia and referral in crisis states:

'Offer CBT to all people with psychosis or schizophrenia (delivered as described in recommendation 1.3.7.1). This can be started either during the acute phase or later, including in inpatient settings. [2009]

Offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user (delivered as described in recommendation 1.3.7.2). This can be started either during the acute phase or later, including in inpatient settings. [2009]'

5.51 We consider that Miss B was offered a wide range of psychological and therapeutic input over many years. The question of family work was raised with her many times, and her feelings towards her children in particular and her feelings of shame were a recurring theme. The most recent discussion about family work was in June 2015 when it was suggested that a family meeting with the psychologist may be helpful. Miss B had agreed to consider this and speak to her children, but did not follow up.

5.52 NICE Guidance (CG 178) Promoting recovery and possible future care states:

'GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually. The health check should be comprehensive, focusing on physical health problems that are common in people with psychosis and schizophrenia.

Offer clozapine to people with schizophrenia whose illness has not responded adequately to treatment despite the sequential use of

[99] *https://www.nice.org.uk/guidance/cg178/chapter/introduction*

adequate doses of at least 2 different antipsychotic drugs. At least 1 of the drugs should be a non-clozapine second-generation antipsychotic. [2009]

Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work. Consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment. [new 2014]'

5.53 Miss B's physical health was monitored by both Dr R and her GP and there is good evidence of this being carried out.

5.54 Miss B had input several times over many years with employment support workers, and she was assisted to attend a massage course and a business administration course. She attended Recovery College and was involved in activities such as meditation and tai chi, and she was involved in service user representation activities. She had spoken of wanting to start her own business and was supported to find out more about this.

5.55 Medication compliance was an ongoing issue. She was encouraged to change from oral medication to a depot in the summer of 2015, but eventually refused. She was not offered clozapine, and she remained on risperidone 4 mg despite it not achieving symptom resolution.

5.56 Dr R told us she was never sure whether Miss B's symptoms were breakthrough symptoms or due to non-compliance. Miss B would complain of over sedation, and it appears had voices telling her not to take medication.

5.57 Miss B was a life-long writer of diaries, and her diaries were made available to the Bracton service after the homicide. It is clear from her entries that Miss B was extremely suspicious of Dr R and the medication she was prescribing, but did not express this directly, which appears (from an informed hindsight view) to be because of her paranoia. In her diaries there was evidence of Miss B becoming increasingly depressed and paranoid, reflected in her diary entries from December 2015 and up to February 2016. In her diary entries in late January 2016 there is evidence that she was very low in mood, had suicidal thoughts and made reference to her believing that her mother should die. She did <u>not</u> disclose this to any of the professionals involved with her.

5.58 In summary, we believe Miss B met the Trust criteria for CPA prior to and at the point of the service changes in September 2015, and should have been provided with care coordination and associated care planning input

5.59 In her current care environment Miss B's diagnosis remains that of schizoaffective disorder, and she is treated with long acting depot medication and a mood stabiliser.

Review Miss B's risk assessments and risk management plans to ascertain if they adequately incorporated historic risks with specific

attention to the risk of Miss B harming her mother or others. To specifically address whether any safeguarding concerns were identified or should have been identified.

5.60 Miss B's Bracton consultant psychiatrist prepared a report regarding potential risk to her children and others in February 1998, at the request of legal representatives from Greenwich social services. The historical assaultive behaviour towards her older child was noted. The assault on 23 June 1995 is described, and on interviewing her the psychiatrist's opinion was that the motivation for the assault was influenced by both hallucinations and anger towards the child.

5.61 A serious assault on her oldest child took place in September 1991, about three weeks after the birth of her youngest child. She was brushing the child's hair and became frustrated that she would not sit still and made as if to strangle the child. The family did not report this until her sister reported it to social services. Miss C has informed us that she collected the two children at night with a cousin, and took them to A&E the next morning. It was at this point that she contacted social services. It was noted that four days after the assault the child's head and neck were still swollen. Miss B was admitted to hospital shortly after this, mute and uncommunicative, and it was judged likely that psychosis and anger had played a part in the assault.

5.62 The community team verbally reported an incident when Miss B was said to appear mentally well, when the family reported that she tried to drown her eldest child in the bath. The family did not report this at the time, and it was not documented in her community notes, but was thought to be around a year before the assault in 1991. In April 1987 there is mention of scratches on her older child's leg, in June 1987 a lip injury, in October 1987 an assault on her oldest child and that she was 'violent to Mrs A' and told her mother she wanted to kill herself and her older children. In June 1988 there were marks on her oldest child's face and Miss B was said to have smacked the children. In September 1990 Miss B told nursery staff that she was beating the children, but there was no sign of injury.

5.63 There are no reports of assaults on either of the other two children. Mrs A reported to the consultant psychiatrist that Miss B had frequently been mildly assaultive to her, had hit her, pushed her around and struggled with her, without any serious injuries occurring, and there is a report of an assault on Mrs A in October 1987, but with no details.

5.64 The view was given that an inability to cope with the needs of the children and acute mental illness had contributed to the serious assaults on her oldest child. The report states *"I cannot envisage a set of circumstances where it would be possible to consider her anything other than a continuing danger to any children in her care".* No risk to children was thought to be current unless they were in her care and the report is noted to "*assume that Greenwich Social Services will ensure she will not be having unsupervised access to her children".* The internal review

recommended that there be psychiatric input from Bracton in the children's reviews, and an agreement was drawn up detailing responsibilities, especially if Miss B were to be absent again.

5.65 There is no discussion of continuing risk to her mother, although the report notes that the safety of the children depends on the ability and commitment of Mrs A and Miss B's husband to protect them from Miss B.

5.66 A low tolerance of frustration was noted on her initial admission to Bracton, and she resorted to violence towards property and others when angry and frustrated. Miss B also showed a lack of tolerance of restrictions and guidelines, and was unrealistic about the future and lacked insight into her illness. Personality deterioration and poor impulse control were noted to be features of her psychotic illness. At that time (February 1998) Mrs A told the consultant psychiatrist that she would never again have Miss B in her house, and if she were to turn up she would not let her in.

5.67 At a children's case conference in April 1999 it was noted that the relationship between Mrs A and Miss B had deteriorated, and this had affected the children's relationship with their grandmother, to the extent that they hardly spoke to her. They were noted to be aware of an increase in Miss B's animosity towards Mrs A since the last children's case conference. Mrs A was noted to be "quite frail" and worried about finances and the social worker was trying to support her.

5.68 The last formal risk assessment in RiO was entered in 2010. Factors affecting risk were: refusal of services, discontinuation of medication and her mental state at the time.

5.69 At outpatient appointments in 2012 risk is not mentioned in the GP letters sent by a locum consultant psychiatrist.

5.70 At outpatient appointments with Dr R from 2013, an entry regarding risk is included in each outpatient letter to the GP. Her risks to self and others were noted as follows:

Date	To self	To others
March 2013 OPA letter to GP	Last noted in 2008, history of drinking bleach when unwell	1995 history of assault with knife on older child
June 2013 OPA letter to GP	Last noted in 2008, history of drinking bleach when unwell	1995 history of assault with knife on older child
June 2013 urgent home visit	Command hallucinations telling her to kill herself. Contemplated hanging herself, detailed plans, strong urges to kill herself	1995 history of assault with knife on older child

July 2013 HTT discharge letter	Suicide/self-harm/low	Risk to others: low
July 2013 OPA letter to GP	Suicidal thoughts now gone	1995 history of assault with knife on older child
December 2013 OPA letter to GP	Suicidal thoughts reduced at last outpatients	1995 history of assault with knife on older child
February 2014 OPA letter to GP	Suicidal thoughts reduced at last outpatients	1995 history of assault with knife on older child
May 2014 OPA letter to GP	Suicidal thoughts reduced at last outpatients	1995 history of assault with knife on older child
June 2014 HTT input: amber from green- relapsing	Overdose of risperidone 12/6/14	Previous risk to others when unwell, currently paranoid towards others, but reacting with avoidance
June 2014 OPA letter to GP	Overdose of risperidone 12/6/14	Previous risk to others when unwell, currently paranoid towards others, but reacting with avoidance
August 2014 OPA letter to GP	Overdose of risperidone 12/6/14	Previous serious risk to others when unwell over a decade ago
September 2014 urgent home visit – paranoid, not taking medication- red zone	Thoughts of hanging herself in spring this year- seen by HTT Last overdose in June this year- intensive input from COMPPaS team	Previous significant forensic risk, not been a risk to others for many years
September 2014 HTT management meeting	Suicidal thoughts but no intent or plan	Increasingly paranoid and thinks she's being watched, no evidence of increased risk to others
October 2014 discharged from HTT – red to amber	Suicidal thoughts but no intent or plan	Previous serious risk to others when unwell over a decade ago
November 2014 recovery team management meeting- amber	Suicidal thoughts but no intent or plan- feeling much better now	Previous serious risk to others when unwell over a decade ago
December 2014 - crisis home visit, relapse signs (moved to new flat)	Low- no current suicidal thoughts	Previous serious risk to others when unwell over a decade ago
December 2014 recovery team zoning meeting- green from amber	Low- no current suicidal thoughts	Previous serious risk to others when unwell over a decade ago

January 2015 - crisis home visit, relapse signs	Low- no current suicidal thoughts	Previous serious risk to others when unwell over a decade ago
March 2015 - crisis home visit, relapse signs, for HTT intervention – amber	Low- no current suicidal thoughts	Previous serious risk to others when unwell over a decade ago
March 2015- recovery team zoning meeting- amber, signs of relapse, discuss depot at next OPA	Low- no current suicidal thoughts	Previous serious risk to others when unwell over a decade ago
March 2015 OPA letter to GP, green from amber	Low- no current suicidal thoughts	Previous serious risk to others when unwell over a decade ago
June 2015 OPA letter to GP	Low- no current suicidal thoughts	Previous serious risk to others when unwell over a decade ago- currently mildly irritable
July 2015- recovery team zoning meeting- green from amber	Low- no current suicidal thoughts	Previous serious risk to others when unwell over a decade ago
September 2015 OPA letter to GP, discussed service changes	Low- no current suicidal thoughts	Previous serious risk to others when unwell over a decade ago- currently mildly irritable
September 2015 - COMPPaS case discussion – for OPA asap in the redesign	Not going out	Not noted

5.71 The internal report noted that these had started to develop a ‘copy and paste’ element to them, although they have changed over time.

5.72 In February 2014 a discussion at outpatients with Dr R noted the following:

- Relapse prevention issues: ‘reminding myself things will lift when I’m feeling down, not missing medication, and family taking me out’.
- Keeping well strategies: ‘doing things I enjoy, being active, having a positive attitude, letting go of anger, taking medication regularly’.
- Risk management/safety planning: ‘building bridges with my family, started attending church together, positivity and forgiveness, if I don’t attend appointments and withdraw it is a sign that I am not well’.

5.73 Dr R described at interview a very low threshold for 'zoning'[100] Miss B, and it is clear that throughout 2014 and 2015 Miss B was variously rated red, amber and green. A rating of red was in place in September 2014, after Miss B was found to be neglecting herself, not going out and was paranoid about noises and hearing derogatory voices. A period of intervention by the HTT followed.

5.74 Amber was in place in December 2014, around the time of her move to a new flat, and this resolved with extra support and regular medication. She was amber in June 2015, when she appeared low in mood, and was rated green at the end of July 2015 when her mood had stabilised. She was however rated amber in September 2015.

5.75 It is however clear that the risks of concern were about Miss B's risk of harming herself, and she was not regarded as a risk to others. She had taken an overdose of risperidone in April 2014.

5.76 The 'risk summary' section on RiO is intended to be used to log risk information. This had not been updated since September 2014, and should at least have included reference to the overdose.

5.77 Risk to others was mentioned in the summary of each appointment, noting that her last serious risk was 'over a decade ago'. There is no evidence that a definitive risk history was taken at any stage since 2013, and history was referred to in wide terms such as '10 previous admissions' and 'previous significant forensic risk, not been a risk to others for many years' when this was not completely accurate. Miss B had more than 10 admissions, and had presented with risk behaviours towards others since the assault in 1995 on her oldest child.

5.78 More detailed attention to risk history would have revealed that Miss B had a history of aggression towards her mother, albeit many years ago. We were told that the safeguarding policies in place assume that the potential vulnerable adult is the patient that the clinician is treating, rather than prompting any consideration that they may present as a safeguarding risk to someone else. However Oxleas Safeguarding Adults policy (April 2016) has a section which states that 'if the person allegedly causing the harm is also an adult at risk, arrange appropriate care and support'. There are also slides in Oxleas safeguarding adults e-learning that identify that an adult at risk may also be a perpetrator of abuse.

5.79 Accepting that what is known about Miss B's risk of aggression to her mother is from the 1990's, the Recovery team were aware that Miss B was spending time looking after her frail elderly mother, that her mother had been an inpatient in the old people's mental health service apparently with a diagnosis of dementia, and that at times Miss B and her sister had moved in to care for Mrs A after she had a fall. In June 2015 Miss B

[100] *Zoning is a way of assessing current need and level of input required: Oxleas Caseload Zoning Tool (undated)*

presented as particularly stressed because she was staying with her mother, and moved back to her own flat in July 2015.

5.80 We asked what the barriers were to having a professional discussion with the OPCMHT caring for Mrs A, to review possible carers' issues and discuss any possible risk issues, or need for support on either side. We were told that Miss B kept her family life very separate when she could, not involving her children or sister in her mental health care. This was seen as an extension of this approach, and confidentiality was cited as the reason for not approaching the OPCMHT.

5.81 We believe it would have been reasonable to have a professional discussion with Mrs A's treating consultant to discuss possible risks to either Miss B or Mrs A, and develop a joint approach, even if it was just for carer support.

5.82 According to the Royal College of Psychiatrists 'respect for medical confidentiality does not imply an absolute guarantee or promise to maintain secrecy at all times and in all situations, and this is recognised by the GMC (General Medical Council, 2009). There can be serious or tragic consequences for patients if relevant clinical information is not shared between agencies in a timely manner' page 9 of the Code of Ethics CR186.[101]

5.83 We considered the question of whether a patient with Miss B's history should have been under the care of a forensic service. She was discharged from the forensic service many years earlier, was no longer on a restriction order, and had not presented with risks to others for many years. We believe it is not unusual for patients with comparable histories to Miss B's to be treated in community mental health teams. Consultation and advice was available from the Bracton forensic service if required, and there are peer group and professional supervision meetings where case issues can be discussed.

5.84 The Oxleas internal investigation report identified that the Oxleas 'Clinical risk assessment and management policy for Mental Health and Learning Disabilities Services' April 2009 was not followed, in particular regarding the review of static and dynamic risks and the development of a formulation, as outlined in the policy:

'Risk formulation is an explanation of how risks arise for a particular service user in the context of conditions that are assumed to be risk factors for a hazardous outcome that is to be prevented (Department of Health, Best Practice in Managing Risk, 2007). The risk formulation should account for both protective factors and risk factors (Department of Health, Best Practice in Managing Risk, 2007). Essentially a risk formulation is a summary of all of the risk and protective factors identified

[101] *Royal College of Psychiatrists Code of Ethics* http://www.rcpsych.ac.uk/files/pdfversion/CR186.pdf

coupled with clinicians', service user's and carers' impressions of what that means and what can be done to minimise risk'.

5.85 In particular, it was known that the care team around Miss B was changing in September 2015, and we consider that this should have triggered a review of her risk profile.

Recommendation 8
Oxleas NHS Foundation Trust must ensure that risk assessments are updated at the time of care or service transitions.

To review Miss B's risk of relapsing with specific attention to compliance with medication and changes in her presentation in the weeks prior to the homicide.

5.86 In March 2015 Miss B was regarded as being in crisis, treated by the HTT for low mood, an increase in paranoia and suicidal thoughts. She was not sleeping and was afraid to go out, and admitted not taking her medication regularly. She was noted to have recovered from this relapse by the end of April 2015. In June 2015 she was again feeling afraid and threatened by the external world and was not going out. Although this had improved when she saw Dr R later in June, she was irritable and described herself as 'very stressed' because her mother had fallen and she and her sister were spending time caring for her at her home. She was encouraged to try depot medication in this period but decided against it.

5.87 In July 2015 she started psychology sessions and no longer felt anxious or paranoid. She went on holiday to Monaco with two of her children in August 2015 which she said she enjoyed.

5.88 In September 2015 Miss B was informed that the COMPPaS care team (care navigator, OT and psychology input) would no longer be available to her in the redesigned service, and she would be under the care of Dr N in the Greenwich ICMP team. The input from her Bridge worker would continue, but it was noted that she had been accessing her care navigator more than her Bridge worker. At the final outpatient appointment in September 2015 Miss B was noted to appear 'down cast' but reported that she was fine with minimal paranoia and voices, and her mother's health had improved slightly but she and her sister were still providing a lot of support. Her risk to herself was noted as 'low' and risk to others was noted as 'previous serious risk to others when unwell over a decade ago. Currently mildly irritable'.

5.89 At a meeting with the OT later that month Miss B was low in mood and anxious, and confused about the service charges, believing that she had been discharged. It was clarified that she had been discharged from the OT service but would be seeing a new consultant in the redesign.

5.90 She was last seen by Oxleas staff at an appointment with the psychologist in October 2015, and discussed her experiences of hearing derogatory

and abusive voices. Progress and coping skills that have helped her were discussed. She was telephoned by the psychologist in January 2016 to inform her of the start date of the CBT for psychosis group. She said that Christmas and New Year were 'ok, with ups and downs'. She missed the first two group meetings in January, and was telephoned by the psychologist to discuss this. Miss B called the psychologist in February 2016 to say she was keeping busy, and would like to see a consultant to review her medication. She said she felt proud that she was coping well without any appointments from staff, but would like to see a doctor to reduce her medication. She admitted that she does not take it regularly, but that when she does take it she feels groggy in the mornings. She was invited to start the group in March 2016. The psychologist emailed Dr N asking for a one off medication review.

5.91 Her Bridge worker saw her on 2 February 2016, and Miss B had not slept well so was too tired to go out, it was agreed they would rearrange. There were no obvious concerns. The last contact with Miss B was on 18 February 2016, when Miss B called to cancel an appointment because she was planning to meet a friend for a meal, and she was noted to sound well and looking forward to the outing.

5.92 There were no concerns expressed by Bridge during the first part of 2016. It is clear from the clinical records that Bridge workers knew Miss B well, were involved by Oxleas in her care to a reasonable extent and had good communication links with Oxleas, until the service redesign in September 2015. As discussed earlier, Miss B's role in relation to her mother was not known however.

5.93 In looking back over this period we acknowledge that Miss B historically presented with 'apparent competence' to professionals, although this was punctuated with frequent early warning signs of relapse. It was known that she was secretive about her symptoms and did not involve her family in conversations about her mental health care.

5.94 It is clear from reading her diaries, (which were not available to Oxleas until after the homicide) that her mood was very low at times from November 2015; she had split up with a long term partner, and expressed her guilt, shame and regret about her role as a mother. She wrote about spending longer periods with her mother, whom she said was 'more dependent and feeble'. In November 2015 she describes her mother's voice as 'always very loud' and she found this stressful.

5.95 Although she apparently enjoyed Christmas Day (2015) with the family, by Boxing Day she was berating herself for still being alive, and blaming herself for being 'used' by her partner. She described herself in January 2016 as 'depressed' and 'numb'.

5.96 It is unusual to have this level of insight into the internal world of someone who is experiencing the symptoms of a major psychotic disorder, and we have described them here to illustrate her mental state in the period of time before homicide.

5.97 There was a six month period between September and February 2016 when Miss B did not have access to the level of service that had previously been provided. The three-monthly outpatient appointments had served to monitor her mental health and crucially her medication compliance, and she had the ongoing input of other professionals in the COMPPaS team. Dr R had always responded immediately at times of crisis or increased need, which occurred regularly. In our view the risk of her relapsing had not diminished, although from recent history we consider that it was more likely that she would present as a risk to herself. It is clear from clinical interviews that took place after the homicide that Miss B was psychotic and very low in mood, and there was insufficient Oxleas input to pick this up and intervene.

Safeguarding and the Care of Miss B

Review whether local Safeguarding Adults policies and procedures were properly followed. The investigation should specifically address the six principles of safeguarding in relation to Miss B. The investigation should specifically address the six principles of safeguarding in relation to empowerment, prevention, proportionality, protection, partnership and accountability.

5.98 Greenwich Safeguarding Adults Board's 'Safeguarding Adult's Local Protocol' describes the roles and responsibilities of local agencies in Greenwich in respect of safeguarding.

5.99 The protocol states that for people with severe and enduring mental health issues safeguarding enquiries should be led by the working age adults' team or the older adults' team (page 13).

5.100 Miss B was under the care of Oxleas NHS Foundation Trust (joint NHS and local authority service) and as such would have been dealt with under the Trust's Safeguarding policy. The version we have had sight of is dated June 2017 i.e. after the incident; however, version control indicates that the policy was only amended once between September 2012 and April 2016 and this was 'technical amendments and changes to contact details'.

5.101 The policy states that 'This document is supplementary to the local …SAB procedures. All staff are expected to be familiar with the procedures for their local authority area' (page 1).

Was Miss B an 'an adult… experiencing, or…. at risk of, abuse or neglect'?

5.102 As outlined above, Miss B was receiving mental health care from the Trust, and community support from Bridge. These factors do not, in themselves, constitute a need for a safeguarding intervention. It would only be in the context of other factors giving rise to concerns about potential abuse or neglect that a safeguarding intervention would be required.

5.103 The lack of clarity about the actual level of care Miss B provided to Mrs A was discussed at paragraph 4.124 above. This should have been explored by both teams, and information shared, the safeguarding issue here is however in relation to Mrs A, not Miss B.

5.104 There was historical concern expressed by Bridge staff in relation to Miss B's adult children staying with her, and a concern that she may be vulnerable in her accommodation if her children were living with her but this was addressed as a care planning issue and did not become a concern to the extent of triggering a safeguarding notification.

5.105 There is no indication in her contacts with other agencies that she should have been regarded as a vulnerable adult.

5.106 The Oxleas 'Clinical risk assessment and management policy for Mental Health and Learning Disabilities Services' April 2009 mentions safeguarding adults, but focusses exclusively on considering whether your patient is at risk, and makes no mention of assessing whether your patient may be a risk to another vulnerable adult.

Recommendation 9

Oxleas NHS Foundation Trust Safeguarding policy should be amended to include consideration of whether the service user may present a risk to other vulnerable adults or children.

Principles of safeguarding

5.107 **Empowerment** (people being supported and encouraged to make their own decisions and informed consent).

5.108 There is no record as far as we can ascertain of any attempts to engage Miss B in any discussion about any risks she might be facing.

5.109 **Prevention** (it is better to take action before harm occurs).

5.110 There were no indications that Miss B was at risk from others, however we consider that the care and contact provided to her mother should have been considered as a safeguarding concern.

5.111 **Proportionality** (the least intrusive response appropriate to the risk presented).

5.112 There was considerable discussion in the Recovery Team about the question of Miss B's concordance with medication, and she was offered depot medication to help increase compliance. There were no indications however that this was required from a safeguarding perspective, and that she was vulnerable to influence.

5.113 **Protection** (support and representation for those in greatest need).

5.114 The team caring for Miss B did not assess her as in need of protection.

5.115 **Partnership** (local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse).

5.116 The partnership element we believe relates to the lack of sharing of information between the old people's mental health team and the adult services.

5.117 **Accountability** (accountability and transparency in delivering safeguarding). We have no comment about whether the service delivered to Miss B was accountable or transparent, as no safeguarding intervention took place in respect of Miss B.

6 Family involvement

Review the effectiveness of care planning for Mrs A and Miss B including family involvement.

6.1 It is clear that the OPCMHT saw Miss C as the primary carer for Mrs A, and she attended meetings and CPAs. There was no assessment of her wider family situation, as discussed earlier.

6.2 The OPCMHT knew of Miss B, she had told them that she took antipsychotic medication as discussed earlier, we would have expected both clinical teams to have made contact with each other to discuss the situation.

6.3 One of the key issues the family have asked us to look at is why were social services not more involved? Why did they not link information in Child and Family files to the current situation?

6.4 Our answer to this is based on our review of the Child and Family files and the information contained in Miss B's clinical records. The Child and Family services files were closed in 1999, and the children were taken off the Child Protection Register in 2000. Miss B was no longer seen as a risk to her children at this stage, because all visits were supervised and they did not live with her.

6.5 There were no recent indications, known to any service, that Miss B was a danger to any family members. The OPCMHT have asserted that there is no history of harm to Mrs A (found to be untrue), but it is not clear whether this was their view before or after the homicide.

6.6 In our view there was no known risk to Mrs A, but what services failed to do was assess the situation fully with regard to possible risks involving both Mrs A and Miss B.

Contact and support provided to family following the incident

6.7 The Trust made contact with family members after the homicide, and offered the opportunity to read the draft internal investigation report.

6.8 A Duty of Candour letter was shared with Mrs A's family on 24 March 2016, having confirmed that the family were amenable to contact.

6.9 Contact with Miss B's family liaison officer was made by the Patient Safety Team. The family liaison officer confirmed in March 2016 that Miss B's sister (next of kin for Mrs A) did not want to engage at that time and wanted to wait until the court case. He informed the panel that Miss B's son was willing to liaise with Oxleas regarding his mother's treatment.

6.10 Later the Panel Chair received an email from the Victim Support Homicide Caseworker who also advised that Miss C did not want to have any

contact with her or Oxleas at this time but would like to know when the inquiry was completed and would thereafter be happy to speak with us.

6.11 The Chair of the Panel arranged to meet with Miss B's youngest child in April 2016 which was later cancelled without further contact.

6.12 Members of the panel met with Miss C in July 2016. She has subsequently shared clarification information and following a reconvening of the panel in October 2016 it was agreed to add some additional information to the report.

6.13 We consider that contact with the family was made appropriately and offers of further support were made.

Race and cultural issues

6.14 *'Good health care cannot be delivered in a social and cultural vacuum. If this dictum is to apply anywhere, it belongs in the psychiatric services. The astonishing diversity of London's population means that if psychiatric services are to be effective, this is the one place that they must be more culturally sensitive'.*[102] *Halpern (2013).*

6.15 The family are of African heritage. Apart from this statement the family's heritage does not feature in needs assessments and care plans for either Mrs A or Miss B. Neither is it addressed in the Trust's internal investigation.

6.16 There is a wealth of research going back a number of years that addresses this issue.

6.17 Personalisation in health and social care also puts race and ethnicity as a key issue to be addressed.

According to NICE Guidance: 'Personalisation potentially offers people from black and minority ethnic groups the opportunity to arrange services that fit better with their ethnic, cultural, religious values and preferences'.[103]

6.18 NHS Choices provides a link to a CPA Factsheet, which states:

'Your age, disability, gender, sexual orientation, race and ethnicity and religious beliefs should be thought about as part of your assessment, care plan and review'.

6.19 The Trust's own CPA policy states:

'Assessments should take account of the needs of individuals in respect of age, disability, gender, sexual orientation, race and ethnicity and religious beliefs'. p16

[102] *Halpern, British Journal of Health Care Management, September 2013.*
[103] *National Institute for Clinical Excellence. Personalisation for People from Black and Minority Ethnic Groups. Better Health Briefing (number 34) (2014)*

‘Care plans should take account of the needs of individuals in respect of age, disability, gender, sexual orientation, race and ethnicity and religious beliefs’. p24

“Equality information should be sought including ethnicity, religion, disability”. Assessment Standards.

6.20 We asked why race and ethnicity were not addressed as part of needs assessment and care planning for Mrs A and were told it was not an issue.

6.21 We asked why ethnicity was not addressed as part of needs assessment for Miss B and were told that Miss B never raised race and ethnicity as an issue and that it was not an issue for the team. They had some concerns that their raising it might prove a barrier to meeting with Miss B.

6.22 We asked Bridge how race and ethnicity issues should be addressed and they told us they should be addressed as part of care planning. This was not the case in Miss B’s care plans however.

6.23 We asked why race and ethnicity were not addressed in the Trust’s internal review and the authors accepted that it should have been part of the review.

6.24 Miss B has since told psychiatrists that, at the time of the incident in February 2016, she felt her mother’s movements being jerky, and when she looked at her, her face looked different, really old and witchlike, and she thought her mother had long bony claws like a witch.

6.25 Miss B later said she has always believed in supernatural evil and had thought for many years that there was some generational issue with witches and had prayed it had not affected her own children. She had thought this about her mother for some time but had never attacked her and could not explain why she did on this occasion. She remembered thinking that her mother had to die to end the curse.

The internal review did not address this issue despite it being of potential cultural significance.

6.26 We asked the family about this and we were told that “maybe she was going to one of those new…churches, who knows…..I wasn’t aware of that she was going to any of these churches”. On one occasion Miss B was heard calling Mrs A “a witch”.

6.27 We are not suggesting, in this case at least, that the lack of attention to race and ethnicity issues in any way contributed to the outcome or indeed contributed to the quality of care for either Mrs A or Miss B. Indeed, the family when we interviewed them did not see this omission as a cause for concern.

6.28 However, what we are concerned about is that these issues were not addressed at all in assessment and care planning or the internal investigation, despite their importance in mental health practice.

6.29 Even if the conclusion was that Mrs A and Miss B had no particular needs relating to their ethnicity, or the internal investigation review concluded that race and ethnicity were not significant factors, they should still have been addressed. Significantly, neither were gender and religious beliefs addressed. These omissions can have serious implications for some service users.

6.30 Oxleas have clarified that equality and diversity has already been included in all terms of reference for comprehensive SI investigations, as this was a recommendation following the publication of Mr X[104] in 2017, and provided examples of anonymised reports accordingly.

Recommendation 10

Oxleas NHS Foundation Trust should assure itself that race and ethnicity, gender and religious issues are routinely addressed in CPA needs assessment and care planning as per the Trust's policy.

[104] *https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2017/08/Report-for-NHS-England.pdf*

7 Internal Oxleas investigation and action plan

7.1 The terms of reference for this element of the investigation require that we review:

Review the (Oxleas) Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.

7.2 The Trust conducted a 'Root Cause Analysis report', which was begun in March 2016 and completed in May 2016. The homicide occurred in February 2016 and according to the standards in the NHSE Serious Incident Framework, a serious incident investigation should be completed within 60 days.[105] The report was completed within this timescale.

7.3 This investigation was a level 2 comprehensive internal investigation as defined by the NHSE SiF, and according to Oxleas Incident Management Policy (v2.3), was a 'Level 5 Board Inquiry'. This level is explained as 'suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators where applicable'. The Trust met these standards in that the investigation panel was chaired by the Executive Director of Nursing, supported by a multidisciplinary panel comprising:

- Head of Psychological therapies, Adult Mental Health.
- Non-Executive Director.
- Public Governor.
- Patient Safety Officer.
- Associate Director of Nursing.
- Consultant psychiatrist and Associate Clinical Director, Adult Mental Health.

7.4 This panel shows a balance between clinical expertise and independent views which is good practice. We consider however that it would have been helpful to have had clinical input from an older peoples' mental health clinician.

7.5 The terms of reference for the internal investigation were as follows:

- 'The adequacy and appropriateness of the assessment care and treatment of [Mrs A and Miss B] by Oxleas NHS Foundation Trust, in the last year, and to consider, whether the incident could have been predicted and/or prevented. In particular, the Inquiry will consider:

[105] *NHSE England SiF (2015) p 8.*

- The quality of communication and liaison between Oxleas and outside agencies (including Bridge 86, a third sector “floating” support service) as well as communication within Oxleas NHS Foundation Trust (namely [Miss B and Mrs A’s] clinical teams, specifically in relation to the remit of Safeguarding Adults legislation and policy).

- The comprehensiveness of risk assessments, with a focus on the timeliness and quality of the risk assessments undertaken by [Miss B and Mrs A’s] clinical team and whether appropriate actions were taken to escalate and address any risks identified.

- The quality of [Miss B]’s care plan (including crisis plans identifying relapse triggers), and how they were documented, communicated and agreed with her.

- The robustness of arrangements for transfer of care to her new team following the reconfiguration of community mental health services.

- The matters raised by family members when the panel meet with them (*family later declined to meet with the panel*).

- In line with the new requirements, the inquiry will review the Duty of Candour notifications completed at the time of the incident.

In addition the panel will:

- Provide measurable and specific recommendations for any proposed actions and produce a final report for the Board of Directors.

- Share the findings from the inquiry with commissioners and others as appropriate’.

7.6 The report clearly described the methodology and processes for the investigation, and described in detail the techniques used, including root cause analysis, tabular timeline, interviews and documentation review.

7.7 Miss B’s full Trust clinical records were reviewed by the panel, but a chronology was developed dating from 2013, which appears reasonable. Mrs A’s Trust records from 2011 to 2016 were reviewed, and a chronology developed.

7.8 We consider that the internal investigation met the terms of reference outlined in relation to Miss B, but did not with reference to Mrs A, because the investigation did not review the care provided by the Trust to Mrs A. Mrs A’s clinical notes were reviewed and there was a report from her consultant psychiatrist. A chronology was compiled for Mrs A and reviewed by the investigation panel. It was referenced as appended to the report and this is documented on page 9 of the internal investigation report. There was no detailed analysis of her care and treatment however.

7.9 We asked the report authors about this, and they saw their review of the care of Mrs A as being through a safeguarding perspective, rather than an overview of her care and treatment.

Oxleas findings

7.10 There were four key internal findings:

Communication and safeguarding: lack of information sharing between the teams caring for Miss B and Mrs A, and to Bridge. Carers' assessments were not requested, although it was known that Miss B was spending long periods of time with Mrs A. It was noted that the Lewisham safeguarding issue was not followed through.

Risk assessments: risk assessments for Miss B from 2014 to September 2015 were not captured as a dynamic process and demonstrated minimal updating. Miss B's RiO risk assessment had not been updated since 2014. Risk plans should have been more explicit about actions to take if there were concerns about medication compliance (relevant to the request for a medical review in February 2016.

Care planning: while care plans were updated at outpatient appointments and communicated to the GP by letter, the RiO care plan had not been updated since 2008. Although update letters were sent to the GP after each review, the RiO CPA review forms were not completed.

Reconfiguration of adult community mental health services: the change in service design (discussed from 3.199 above) resulted in an outpatient's appointment not being arranged for Miss B. She was not seen by a psychiatrist after her last outpatient appointment in September 2015.

7.11 From these findings, three care delivery problems were identified and discussed.

1. [Miss B] was not followed up by the consultant psychiatrist in the new clinical team as anticipated by the consultant psychiatrist handing her over.

2. [Miss B] was recovering well but had a forensic history and the consultant psychiatrist was not systemically supported in reviewing forensic risks during the recovery period.

3. The risk assessment did not trigger a heightened awareness of risks associated with non-concordance with medication.

7.12 **Finding 1:** We regard this as a service delivery factor, rather than a care delivery factor. The service redesign did not take current clinical information into consideration, and the system was not designed to react to clinical communications. Dr R noted that there were early warning signs of relapse in late September 2015, and noted she appeared low in mood and she should have an outpatient appointment booked 'asap' (sic) in the new design. Within the RiO electronic system, there would have normally

been a prompt to arrange an outpatient appointment and this would have then been progressed through administration structures. This option was not available at the time of the service changes in September 2015, and the entry by Dr R was ‘closed’ on RiO without any further action.

7.13 There does not appear to be any doubt that if Miss B had remained in the structure of the existing Greenwich Recovery Team, she would have been seen in an outpatient clinic in due course, and probably within three months.

7.14 The recommendations to address this were:

- A review should be conducted to check that all patients have been followed up and have their next appointment in the reconfigured adult mental health teams.

- A review of caseload sizes for consultants within the new teams and the comprehensiveness of operational policies should be undertaken.

7.15 In our view these are focussed on addressing some of the unanticipated consequences of the redesign, and do not address the service delivery issue, which was that systems were not in place to ensure continuity of care for Miss B.

7.16 **Finding 2:** Availability of supervision for consultants and teams was identified as a concern for the consultant in assessing Miss B’s risks and recovery. This also seems to us a service delivery factor, in that consultation and supervision that the consultant would have found beneficial was not available.

7.17 The recommendations to address this were:

- Forensic supervision and input into forensic risk assessments should be available to adult mental health consultants where there are patients with a forensic history on their caseload.

- Cross directorate work to establish case-based discussions and guidelines for how decisions are made in respect of how patients moving through recovery adult mental health services receive support in risk management and other forms of assessment from forensic services.

7.18 This appears to us to be a finding that is tangential to the central issue. We were told that supervision from the forensic services would have been helpful. However Miss B had been well managed and contained in the COMPPaS service provided. The decision to move her to the ICMP without an outpatient appointments was a service issue and not a considered clinical decision, in our view. We do believe however that some structured consultation with a forensic service might have resulted in a revision of her needs, and identified that she required the structure of a care coordinator in an enhanced CPA care plan.

7.19 **Finding 3:** We agree that this is a care delivery issue, and that the risk assessment did not trigger a heightened concern around non-concordance with medication. This point is somewhat undermined by the service delivery issues which moved Miss B out of her previous service, however we agree that the risk assessments did not meet the requirements of the policy and lacked reflection on a formulation and of static and dynamic risks.

7.20 The recommendations to address this were:

- Focused clinical leadership to shape the expectations and culture of risk assessments so that all are clear of their responsibilities of who should be carrying these out, when and how they document decisions, thinking processes and reflections about dynamic and static risks.

- Explicitly state roles and responsibilities of doctors in relation to completing the HCR-20 for patients with a known history of violence and ensuring that there are joint sessions on case-based discussions and reflective practice to prompt reflection on one's own caseload.

7.21 We agree with these recommendations in principle, and note that these were then expanded in the action plan to be more focussed.

7.22 The Oxleas internal panel considered that there were no root causes in this incident. The panel were of the view that this incident could not have been predicted or prevented because of the manner in which [Miss B] had been interacting and presenting which was not showing signs or symptoms of relapse.

7.23 This appears to us to be an oversimplification. There was very little contact with Miss B after September 2015, and she had latterly only been interacting with Bridge staff, not Oxleas staff. We do not consider this to be an adequate assessment of her risk or presentation of possible relapse.

7.24 However, the NPSA guidance[106] identifies the root cause as the:

'earliest point at which action could have been taken to:
strengthen the support system for appropriate care to be delivered;
avert the cause of the incident or prevent its occurrence; and
significantly reduce its impact or recurrence'.

7.25 Using this as a guiding definition, we have to conclude that the root cause of Miss B's relapse were the service changes that led to Miss B being unmonitored, as her illness then went undetected. As discussed above, based on her history over at least the preceding ten years, the increased risk was most likely to be of harming herself, rather than others.

[106] *NPSA 'Root Cause Analysis (RCA) toolkit'*

7.26 However her circumstances had changed in that she felt more stressed by her mother's increasing frailty, and the system that would have picked this up had changed around her. However, we do consider this to be multifactorial, including Mrs A's vulnerability, lack of focus on Mrs A's safeguarding issues as well as Miss B's unmonitored care needs.

Analysis and discussion

7.27 The report does not effectively discuss or address the key issue of the impact of the Oxleas re-organisation on the individual care of Miss B, though it reports findings factually.

7.28 Effectively Miss B was not under the direct care of a psychiatrist for six months. She had been placed in a cohort of patients who were not being seen in outpatient clinics, but were expected to be seen by other members of the team. However in effect Miss B had no care plan and no psychiatric supervision of her medication. There is a recommendation that a review should be carried out to ensure patients followed up which implies that a number of users were affected; and after the homicide, local Service and Locality Managers were tasked with checking this. We have not been given sight of any report that followed, or information about whether there were other patients in a similar position. The current situation is that the ongoing monitoring of patients' appointments and iFox reports commenced after the homicide and continues as current practice. This has ensured that there are no patients in similar situations, and Oxleas have provided evidence of how this system works in practice.

7.29 The report also does not address the issue as to why Miss B was not on CPA given her history and most recent presentation. If she was on CPA she would have had a care co-ordinator. It appears latterly that Bridge were providing the only regular contact and the responsibility for risk fell to the new consultant, Dr N.

7.30 There was also a lack of clarity about whether Miss B was ready for discharge (she received services from a number of organisations). Dr R had discussed this with her, and highlighted a need for a twelve month period without relapses, before she could be considered for discharge to the care of her GP, and this had not been achieved.

7.31 The report did not in our view, address the issue of a lack of communication between OPCMHT and Adult teams in sufficient depth, or any safeguarding issues relating to Mrs A and Miss B.

7.32 The report notes that there was 'never any indication at all' that Mrs A was at risk of harm from her daughter Miss B, and Mrs A's consultant psychiatrist stated that there were 'no reported (to him) previous incidents of harm to her by Miss B during her lifetime'. It is however true that there is a history of Miss B having been aggressive to her mother, and this should have been checked as a fact, by the consultant psychiatrist, and by the internal report authors.

7.33 We accept that in the interactions that were seen by the OPCMHT consultant psychiatrist there were no issues of concern about Miss B regarding potential harm to Mrs A. However there is a history of Miss B assaulting Mrs A, and a legacy of her 'frequently pushing and shoving' Mrs A in her early life. While this information dates back a number of years, it is clearly in Miss B's history, and should have been used to reflect on her current risk assessment and Mrs A's vulnerability, by both the Adult and Older Person's teams.

7.34 The report did not consider whether issues of race and culture were pertinent as discussed in Section 6.

Progress the Trust has made in implementing the action plan

7.35 According to the Oxleas Incident Management Policy and Procedure[107] the management of incidents are overseen by the Patient Safety Lead in each Directorate who reports to the Patient Safety Group. The Chair of the Patient Safety Group is responsible for reporting to the Board. The Head of Patient Safety is responsible for oversight of policy application. The monitoring of these elements of the policy below is carried out annually by the Trust Internal Auditors as part of their annual internal audit programme:

- Incident reporting arrangements;
- Reporting to external agencies;
- Appropriateness of levels of investigations; and
- Concerns raised via whistle blowing are appropriately investigated.

7.36 The Head of Patient Safety is responsible for ensuring that:

- Lessons learnt from incidents (including medication errors) are shared appropriately; and
- Action plans are implemented.

7.37 This monitoring is to be provided through the provision of an Annual Patient Safety Report which will identify themes, lessons learning and record progress against action plans. There is a Trust wide Patient Safety Group and local Directorate Patient Safety Groups. The Trust wide Patient Safety Group is chaired by the Director of Nursing, and there is weekly meeting with the Head of Patient Safety to review all serious incidents. The Head of Patient Safety is responsible for 'supporting systems of learning from serious incidents in order to reduce the risk'.

7.38 The local Service Director is responsible for their Patient Safety Group, and for ensuring the investigations are carried out to expected standards and expected timescales. Both the Directorate Patient Safety Group and

[107] *Version 2.3 February 2017*

the Trust wide Patient Safety Group have 'ensured that lessons are learned from untoward incidents' as a key function.

7.39 The issues involved in managing a wholesale service change were not examined in any depth to draw out learning. Oxleas have clarified that the internal panel did not explore this in the investigation as individuals were well aware of the extent of planning and oversight. It is further stated that the executive directors were well sighted on the service changes and RiO changes planned. A Risk Register was kept which has been reviewed as part of this investigation. The mitigation plans were to ensure that 'robust governance arrangements and structures and appropriate staff are involved to implement the service model. Review of new service model - establish timescales and scope for external review'. And 'Ensuring patients are seen within CPA policy; delivery of new KPI to measure patients contact e.g. CPA patients are seen every 2 weeks'. These are all noted as completed on or before March 2017. Miss B was not on CPA.

7.40 We have seen evidence that the service changes and risk involved were discussed in various fora including the quarterly annual plan reviews of all service changes in both service directorates and IT.

7.41 The Director of Nursing reported that the action plan update was received from the Associate Director, and the Trust Board was updated at the end of 2016. Six monthly updates would be provided by the Associate Director, and through to the Trust Board until the action plan was completed. With regard to this action plan, there is a lack of detail in the evidence provided, which in our view should not have been accepted as evidence of completion.

7.42 In January 2016 the Board commissioned an external review by the Institute of Public Care at Oxford Brookes University, to conduct a review of performance management and evaluation across the Adult Mental Health Community Service in Oxleas NHS Foundation Trust.

7.43 A report was produced: 'Performance Evaluation Framework Report'[108] in September 2016. This report suggests four possible options for evaluating care and measuring whether treatment and performance outcomes are met. This is an evaluation of the outcome of the service changes, not of the processes involved. We have not found evidence of a review and reflection on the way that the service changes in September 2015 were managed, and Oxleas have clarified that this was discussed in the redesign oversight group and senior staff visits, which included Board visits by executive and non – executive directors.

7.44 **Recommendation 1: A review should be conducted to check that all patients have been followed up and have their next appointment in the reconfigured adult mental health teams**.

[108] *IPC Oxford Brookes report for Oxleas November 2016*

This was noted for immediate action which was then completed. A review of all clients on both CPA and non CPA was immediately undertaken to ensure that all clients have been seen and have a follow up appointment booked. New processes have been developed to allow teams to use iFox data (live) during meetings as well as part of supervision sessions.

We have seen some service reconfiguration workstream minutes and information which was to be transferred to RiO in November and December 2015. We have seen evidence of weekly locality implementation meetings led by the new locality management teams and service managers, involving all teams. The Programme Board, chaired by the deputy chief executive, met regularly to oversee the process.

We have seen a demonstration of the RiO and iFox systems, and seen the clinical dashboard. This shows a live display of indicators such as outpatient appointments due, people not seen in a specified time period. The display also shows the due dates of a range of clinical items such as care plans, risk assessments, carers' assessments and physical health checks. We have been informed by the Trust that work is ongoing to address caseload sizes includes incorporating into individual consultant job plans. There is also a productivity work stream monitoring demand and activity performance of individuals, and this will be subject to continuous quality improvement.

The iFox system is used in teams by team managers to check performance, and prioritise tasks, this information can then be used in team meetings and supervision. We have seen evidence of its use in team meetings in the Adult service. At January 2018 58% of patients in the Greenwich adult services who are not on CPA were seen within three months and this figure rises to 78% across the total of adult services.

The Trust has provided detailed information on the waiting times for patients in Greenwich ICMP in 2015 and 2016. This showed that 51.1% of patient had an appointment within 14 days, and 24.5% had an appointment within 31 days. Of those with no appointment in March or April, 45% had no qualifying appointment in May 2016. We consider that the Trust has demonstrated that there are systems in place to monitor the quality of care and ensure that there is sufficient information available to ensure that key issues are followed up in the future.

7.45 **Recommendation 2: A review of caseload sizes for consultants within the new teams and the comprehensiveness of operational policies should be undertaken.**

The completion date was July 2016, and it is noted that this has been completed. A consultant psychiatrist was tasked with reviewing caseloads sizes and producing a report, which we have not seen. The action plan update notes that the first phase of a review has been completed. Caseload sizes were found to be higher than anticipated. Further work is in process towards agreeing a number of measures to reduce and balance caseload sizes across teams. We have seen Adult Mental Health services redesign meeting minutes

for April 2016 where caseload sizes and patients without appointments were highlighted, and a number of actions were agreed to address this.

We consider that the Trust has demonstrated that this issue has better oversight, but not that the issues have been resolved.

7.46 **Recommendation 3: Forensic supervision and input into forensic risk assessments should be available to adult mental health consultants where there are patients with a forensic history on their caseload.**

The completion date was July 2016, and it is noted that this has been completed. Guidelines were to be developed for the quarterly meetings, and evidence was to be provided by minutes of reflective practice sessions.

The action plan also notes that the Directorate 'has been assured by medical colleagues of regular opportunities in reflective practice sessions for consultation and specific discussions around risk'.

The actions changed following the further reconfiguration in April 2017 - although reflective practice sessions can be accessed they did not develop into a formalised quarterly joint meeting with forensics which was not progressed after the borough reconfiguration and hence the guidelines were not developed.

At present the forensic directorate receives requests for risk assessments from in-patient wards and the community.

Forensic colleagues have also attended professionals meetings and individual cases have had joint working with the forensic community team.

There is also a forensic on call consultant who is available at all hours for discussion/advice.

Reflections from clinical directors is that discussing patients within quarterly reflective practice meetings are two fold, one there would not be robust documentation regarding the discussion and any action plan, secondly it would not be sufficiently timely and could cause a delay in accessing forensic supervision/support.

The South London Partnership (Oxleas, SLAM and SW London and St Georges Trusts) is at present trying to standardise the forensic risk assessment policy and is in the process of developing a standard referral format.

This action could be described as ongoing and under consideration.

7.47 **Recommendation 4: Cross directorate work to establish case-based discussions and guidelines for how decisions are made in respect of how patients moving through recovery adult mental health services**

receive support in risk management and other forms of assessment from forensic services.

The completion date was July 2016, and it is noted that this has been completed. Consultant reflective practice sessions should include a quarterly session with Forensic colleagues in order to discuss complex cases with a forensic history previously known to the Bracton or other Forensic services.

Guidelines were to be developed for the quarterly meetings. Minutes of reflective practice sessions would provide evidence. We have not been provided with any evidence of these, and the action plan update notes that 'Unfortunately the Forensic Team no longer dedicates time to attend our reflective practice meetings however referrals for opinions can be sent to forensic consultants for cases in which an opinion on risk is necessary or discussed individually with forensic colleagues. Inpatient colleagues routinely request forensic opinions for high risk cases'.

We were informed that the Forensic service has an on-call Forensic consultant at all times for advice if needed, and the Forensic service is available for consultation. Adult mental health consultants can discuss cases for reflective supervision with a forensic psychiatrist by joining the monthly peer review meetings that will give them access to several forensic consultants. Minutes are taken of the decisions reached at these meetings. Adult mental health psychiatrists are also welcome to discuss cases with a much wider forensic MDT (doctors, nurses and social workers) in the red flag meetings held monthly. These red flag meetings also generate minutes of discussions and agreements.

7.48 **Recommendation 5: Focused clinical leadership to shape the expectations and culture of risk assessments so that all are clear of their responsibilities of who should be carrying these out, when and how they document decisions, thinking processes and reflections about dynamic and static risks**.

This was noted for immediate action which was then completed. Consultant and Team Manager led multi-disciplinary zoning meetings are taking place in all localities. A review of Zoning has been undertaken by one of the directorate practice development nurses.

The zoning review has been completed. Multi-Disciplinary discussions happen three times per week with regular documentation of thinking processes, decision-making as well as details of risk plans.

We have seen the planned intervals for zoning meetings in each team, and examples of zoning meetings in Greenwich ICMP, ADAPT and Greenwich East locality team minutes. We consider that this action has been completed.

7.49 **Recommendation 6: Explicitly state roles and responsibilities of doctors in relation to completing the HCR-20 for patients with a known history of violence and ensuring that there are joint sessions**

on case-based discussions and reflective practice to prompt reflection on one's own caseload.

The immediate actions were to identify staff working in each locality who have had HCR20 training, which was completed in June 2016. In our opinion this is not good practice. Firstly, the HCR20 is only validated on a forensic population. If this were implemented, there is a risk that it may be used on other, less risky patients. Secondly, it is best undertaken by a team who are all trained rather than one individual. Lastly, the current evidence on the usefulness of the HCR20 suggests it is best used to rank patients in their risk with a team, not as an absolute measure of their risk to others. This would be a waste of resources which would not help risk assessment in General Adult teams.

'Each ICMP and ADAPT team per locality to identify one member of the team who will be trained in completing HCR20'. The training was to be completed by October 2016 (reflecting the fact that HCR20 training is a 5 day course, with no availability until September 2016). The update on this action is 'the list of consultants in the directorate who have not undertaken HCR20 is being compiled. We have prioritised senior clinicians going on HCR20 training. We have also been informed that there is now a forensic consultant who is a trainer, and the plan is now to access training in house'

We have seen information on all staff who have had risk assessment training up to December 2017, and a list of those who may have had HCR20 training in 2017, and this has been sorted into those trained before or after May 2016 (after includes staff recruited or moved post after May 2016 that did not then need new training).

The action was to train one person in each ICMP and ADAPT team, this is achieved for Bexley ICMP, Bromley East ADAPT, Greenwich East ADAPT and Greenwich West ICMP and ADAPT (important to note this was the team that worked with Miss B).

The teams where this was not achieved Bexley ADAPT, Bromley East ICMP, Bromley West ICMP and ADAPT and Greenwich East ICMP all have trained staff within the teams.

HCR20 is an MDT tool and in order for the training to be most useful it should be provided to teams. Access to the training was difficult as a new version of HCR20 was released in 2015 and there were no clinicians that could train to that version, and sending large numbers of staff on external training was financially prohibitive at around £500 per place. Training was therefore restricted to small numbers with a view to bringing back in-house training.

There is now a doctor in forensic services who can provide training and he has been asked to run seven workshops across the Boroughs ADAPT and ICMP in each Borough, inpatient and 1 'mop up' session, following the new directorate structure this is being costed to ensure each Borough can fund their share.

This is felt by the Trust to be proportionate to the level of referrals received.

A further element of this action was that: ‘All new referrals to the teams who have a history of violence will have a HCR20’ and that ‘all clients transitioning from forensic services to have a completed HCR20’. We believe this would be a far more useful recommendation.

In the time period May 2016 to December 2017 there were 19 referrals to Adult Mental Health teams from Forensic teams (across all three Boroughs). Of these 13 of the referrals were rejected and six were opened to Mental Health teams (four Bromley, one Greenwich and one Bexley). Of these six for a variety of clinical reasons a HCR20 would not have been appropriate in three cases, leaving three of which there was one HCR20 and two with no HCR20.

We consider that this demonstrates that the Trust is gathering the information, and that this is work in progress. Oxleas has clarified that the use of HCR20 was debated at the time of the report, as the adult mental health directorate were not certain that this would address the issue identified and would focus on service users with forensic histories in the teams. It has therefore already progressed for use in new referrals where there is a history of violence/forensic history or transitioning from a forensic service.

7.50 In our view the findings of the internal investigation are focussed on:

1. how information about planning care is used and managed; and

2. how teams who are caring for patients with a forensic history could be supported to assess risk appropriately, through training, case discussion and the opportunity for reflection.

7.51 Our view is that the Trust has shown that the current systems are more likely to ensure that service users in the adult mental health services have continuity of care. However we consider that the elements related to the availability of trained staff and Forensic expertise to ensure that service users with a history of violence are assessed appropriately have not been met.

7.52 The evidence for the implementation of the action plan has not been available to provide assurance. See Recommendation 11 and 12.

7.53 We have discussed the action plan with NHS Greenwich Clinical Commissioning Group (CCG). The CCG has a structured protocol for the management of serious incident reporting and ongoing actions. The CCG Patient Safety Manager attends the monthly Trust-wide Patient Safety Group meeting, going through action plans and reporting back to the CCG if there are any concerns. There is a mechanism for identifying issues that should be raised at the quarterly Clinical Quality Review Group (CQRG).

7.54 There is a CCG proforma to check the quality of serious incident reports as they are received, in preparation for the monthly CCG Serious Incident

Review panel meeting. The terms of reference include to monitor and improve the quality of care, oversee actions and ensure that effective processes have been put in place by providers to minimise the identified risk from re-occurring.

7.55 The homicide was reported as a serious incident and action plans have been reviewed by the CCG, and it was noted that the internal report did not consider the homicide to be preventable. The incident has been closed as concluded on the CCG system, but there is no structure to feedback on whether changes have been sustained. We consider that there is insufficient evidence to assure the CCG that this action plan has been completed.

Recommendation 11
Oxleas NHS Foundation Trust Board must provide assurance that the actions identified in the internal action plan have been completed.

Recommendation 12
Oxleas NHS Foundation Trust must ensure that action plans have an appropriate level of evidence based assurance before sign off.

Recommendation 13
Oxleas NHS Foundation Trust and NHS Greenwich CCG should agree standards for outcome focussed recommendations following a serious incident, and standards for the level of evidence required for assurance before action plans are closed.

Recommendation 14
Oxleas NHS Foundation Trust Board must ensure that any large service re-design has been assessed for impact and risk to quality of clinical care, and that detailed milestones are tracked on an appropriate risk register.

8 Overall analysis and recommendations

8.1 This was a complex investigation with a significant amount of documentary evidence to be reviewed and a wide range of staff interviewed. The care and treatment of two individuals has been reviewed, and we have tried to focus on the areas where their care and treatment overlapped.

8.2 As required in the safeguarding process we have made recommendations for wider systems learning.

8.3 The internal investigation by Oxleas has identified areas of learning, which we support and have expanded upon. We believe that although the Trust internal investigation did identify missed opportunities in the care provided to Miss B, it did not review the care of Mrs A in detail, and was not followed by an adequate or robust action plan.

8.4 We have heard from clinicians of the challenges presented by the service reconfiguration, and the resulting confusion about how patients were being managed.

8.5 There was a risk register where the assessment of risk was noted, and this was reviewed at senior level. However in our view the operational clinical risks were managed by clinicians.

8.6 Oxleas have provided information which shows how the redesign was planned, and what consultation took place with the CCG and service users and staff. We have heard how clinician's views were that the detail of the reconfiguration was not adequately planned, leaving the risk to be managed by clinicians who were not familiar with patients who were newly assigned to their caseloads.

8.7 We have however seen a summary document and supporting evidence that demonstrates that the Trust Board were clearly aware of the planned changes, had opportunity to question senior operational managers about how risks were mitigated and managed, and received regular updates on progress.

8.8 We have considered the issues across three levels:

- the care and treatment of the individuals;
- team approaches and responses; and
- organisational issues.

Care and treatment

Mrs A

8.9 Mrs A was initially identified as vulnerable through police contacts, and we consider this should have been acted upon more assertively at the time, by working collaboratively with Greenwich social services. We acknowledge that systems have changed considerably since the contact with her in 2013, and this kind of presentation would now be approached differently.

8.10 Safeguarding systems and structures have changed considerably in Lewisham and Greenwich NHS Trust, and we consider that notifications and investigations currently have robust support structures, and information is less likely to be lost in the way that occurred in this case.

8.11 There is confusion in the records about Mrs A's diagnosis and identification of subsequent care needs by professionals. She was diagnosed as suffering from an organic delusional disorder during her admission to an Oxleas mental health unit in 2011. Thereafter her psychosis is said to be in remission, but she remained on the outpatient caseload of the OPCMHT until her death in 2016. We heard that the team were considering discharging her, because she was 'cognitively intact'; yet the physical investigations done showed evidence of organic changes.

8.12 In outpatient letters and in communications with the family she was described as having dementia. Her family and her GP believed she had dementia. It may be that the OPCMHT did not consider that she required the input of a secondary mental health team, however in our view this premise was not based on a comprehensive assessment of her situation.

Miss B

8.13 Miss B had a long history of inpatient and community care by Oxleas. In 2015 she was provided with a care package that involved several agencies and an intense level of input such that we believe she should have been on CPA. We were told that although she was part of the COMPPaS project, she was not in fact seen as someone who would be transferring to primary care in the 12 months as expected, because she was not compliant and was subject to frequent relapses. The question of supervision from a Forensic service was raised, but in our view Miss B was appropriately placed in secondary mental health care, although clearly the team would have benefited from some reflective consultation with a Forensic service.

8.14 It has been noted that the Bridge workers knew her well and were the service which provided continuity after the service reconfiguration. Information regarding Miss B's care of her mother, and other risk assessment information was not however shared with Bridge, which meant they were working with incomplete information about Miss B's potential stressors.

8.15 We have analysed why these may have occurred below, using the 5 whys[109] root cause analysis technique.

Question	1st Why	2nd Why	3rd Why	4th Why	5th Why
Why was Mrs A not seen as a vulnerable adult?	Because the care team did not make a full assessment of her situation assertively - why?	They made the assumption that her daughters were protective factors and providing sufficient care for her – why?	Because carers assessments were not carried out and they were responding to Mrs A's assertion that she would be fine with her daughters looking after her - why?	Because they had not made enquiries about the family situation in any depth nor had they had assertive discussions with the family about potential carer stress and how it could be mitigated. And had not sought information from other services- why?	Because they had not made the appropriate assessment, there was no information to trigger a risk assessment.
Why was Miss B's risk to others not assessed?	Because the recovery team focussed on risk to herself and assumed any risk to others was historical, and thought it would be a breach of confidentiality if they spoke to the OPCMHT - why?	Risk to herself had been the focus for some years, and she was known to become low in mood when relapsing – why?	Relapses had been picked up quickly and managed intensively, but this level of care was not available after Sept 2015 – why?	The service reconfiguration did not allow for individual patients' care to be continued – why?	There was a lack of detailed planning that would have ensured that individual patient needs were assessed and addressed at the transition.

Recommendation 15
Oxleas NHS Foundation Trust and Local Authority should ensure that staff are aware of when they can, and must, share information about individuals whose care they are responsible for.

Team approaches and responses

8.16 In any assessment of her situation, the interests of Mrs A should have been paramount (as is the case with Miss B, discussed later). Mrs A was not the victim of a random homicide, but was killed by her own daughter, who was also known to the Trust. The OPCMHT had identified 'carer stress' (relating to Miss B) and a carers' assessment invitation was sent to Miss B but not followed up, in what was clearly a poorly coordinated approach. The OPCMHT were aware that Miss C provided most of the

[109] *The Five Whys is a technique to help to drill down into a particular issue through the various layers of cause to find the fundamental cause of the problem. Ammerman, M., The Root Cause Analysis Handbook: A Simplified Approach to Identifying, Correcting and Reporting Workplace Errors (Quality Resources, New York, 1998)*

practical support to Mrs A. They were however also aware that Miss B spent periods of time with her, and that she was in receipt of mental health services from Oxleas, including antipsychotic medication. We consider there was a lack of clinical assertiveness in working with Mrs A and with the family. It was acknowledged at interview that it would have been reasonable to share information with adult mental health services.

8.17 This would have allowed both teams to make a more thorough assessment of any potential risk presented by Miss B, and safeguarding concerns for Mrs A could have been raised if Miss B or the family did not participate. It may be that no increased risk would have been identified, but the assessment should have taken place. The risk was increased however because Miss B was not provided with consistent care after September 2015.

8.18 We do not accept the use of confidentiality as justification for not sharing information with the OPCMHT. Assertive assessment of Miss B's situation should have included risk assessment of the potential effects of her caring for her mother; on her and on her mother. We consider there was a lack of assertiveness in caring for Miss B in relation to her family situation, which was partly due to a lack of proper risk assessment. Risk assessment had been diluted to day to day observations, rather than a considered, structured view of her risk to herself or others. The service was aware that Miss B had been feeling stressed by her mother's presentation earlier in 2015. Consideration should have been given to a holistic approach to Miss B's care, which included any 'carer stress' she may have been experiencing.

8.19 Equally the family should have been made aware of the extent of Miss B's mental illness if she was caring for Mrs A. This overlap is the point at which there should have been consideration of safeguarding concerns for Mrs A by both teams. The family should have been told that there were potential risks if Miss B was caring for Mrs A and advised how these risks could be mitigated. We are of the view that both teams were not assertive enough in discussing potential risks associated with Miss B providing care even if she was not the main carer. Had the family not accepted this advice then this would have been sufficient grounds to trigger a safeguarding investigation. We have no reason to believe that the family would have not accepted and acted upon any advice; indeed one of their main concerns is that they were not advised about the extent of Miss B's mental illness.

8.20 We have tried to avoid the use of a hindsight bias in considering whether Miss B should have been regarded as at risk of harming Mrs A. Her current HCR20 regards her as an ongoing risk to a vulnerable family member, but this is of course influenced by the homicide. What is clear is that Miss B is at risk of harming herself and/or others if she feels uncontained, and if her mental illness is not appropriately treated.

8.21 Those caring for her in the service did not however make a considered decision to reduce the supervision and support available to her; although

she had been receiving a higher level of support in COMPPaS, this was drastically reduced after the service reconfiguration in September 2015. It appears that Miss B continued to take her medication erratically, and had variable contact with the psychologist and her Bridge worker. These presentations had been successfully managed by the previous level of service, but there was no organised structure to respond to any early warning signs or signs of distress or relapse after September 2015.

8.22 A potential 'safety net' could have been provided by her GP, whom she saw in December 2015 and February 2016, but who did not make enquiries about her mental health care.

Organisational issues

8.23 There was a reorganisation of adult mental health structures that was planned to take place in September 2015. We were told that it was initially thought that there should be a pilot test in the Bexley service, but there was a decision not to pilot. At the same time, the system of managing appointments through RiO was changed, which meant that there were six weeks where new appointments could not be made.

8.24 We heard that the new pathway for ICMP is now working well, and the informatics available in the RiO system are supporting the efficient management of key quality indicators.

8.25 We have seen evidence of assessment of the risk of carrying out this service change at an organisational level through inclusion in a risk register. We have seen evidence of the corporate governance structures that oversaw these changes, and Board oversight of the planning and outcomes.

8.26 We have seen evidence of stakeholder involvement in respect of the re-organisation. We have seen evidence that demonstrates consultation with CCGs, GPs and staff and service users, including formally at Healthwatch[110] meetings. The Trust Board were clearly aware of the potential for services to be affected by the scale of the change, and this was formally noted on the Trust Risk Register as 'a risk to the service that the significant change process will affect quality and performance of the service'. This was monitored regularly, however the Board was assured that systems were in place to ensure that no patients would be 'lost' to services.

8.27 At the March 2016 Risk Committee meeting the Risk item was reviewed and rated at moderate (8). This was agreed as a proportionate assessment of the risk:

'SMBID1: There is a risk to the service that the significant change process will affect quality and performance of the service:

[110] *Healthwatch are the independent national champion for people who use health and social care services. https://www.healthwatch.co.uk/*

Consequence = 4, likelihood = 2, risk rating = moderate (8)'.

8.28 It was noted that the re-design programme involved thousands of patients and as a percentage, the feedback was that few had a negative experience. The migration data was reviewed, and the Risk Committee was assured that patients have not been 'lost'. However at the Trust Board part II meeting in June 2016 the Board was updated on the initial findings of the internal investigation after Mrs A's homicide.

8.29 It was noted in an update about the investigation that Miss B had not been seen as would have been expected by her previous consultant in an outpatient clinic, and that her last appointment was in September 2015. The panel heard that this has been mitigated and since the beginning of April 2016 there has been a live report on the iFox information system showing details of patients that have not had a contact with a professional for 4 weeks and they are now actively followed up and monitored through a directorate governance arrangement overseen by the associate director.

8.30 We consider that there is evidence that the Trust made efforts to identify and manage the risk involved in the service reconfiguration, and that there were well-organised structures to plan and implement the changes at the organisational and service level. We have been informed that there are now local service risk registers in place to identify and manage team and operational risk, but these were not in place in 2015. We have not seen evidence of impact assessments carried out on an individual patient or team level.

8.31 The Oxleas Adult Mental Health Service is a joint service with Royal Borough of Greenwich arranged under a Section 75 agreement.[111]

8.32 We have asked the local authority:

- What formal involvement the local authority had in the service redesign?
- How the local authority assured itself that its statutory responsibilities were being discharged during and after this major re-design?
- If the re-design and implementation was subject to scrutiny by any of the Council's Committees including Health Scrutiny or similar?

8.33 We were told that the local authority were invited as participants to staff events which they attended and that these were mainly information events. The service re-design proposals were also discussed at the Mental Health Joint Commissioning Group, and also at the Section 75 meetings.

[111] *NHS Act 2006, section 75 - Arrangements between NHS bodies and local authorities.https://www.legislation.gov.uk/ukpga/2006/41/section/75*

8.34 We have had sight of the minutes[112] of the Mental Health Joint Commissioning Group where a number of concerns relating to the Oxleas service redesign were discussed including issues relating to the re-design itself, a lack of detail, a lack of information for stakeholders and concerns raised by local GPs. We have seen evidence of responses to GPs concerns which demonstrates that these were addressed. The redesign was presented at the Oxleas Council of Governor's meeting in March 2015.

8.35 Given the statutory partnership arrangement the local authority is in with the Trust we would have expected the local authority and the Trust to be jointly leading the re-design process. It appears to us that the local authority was in effect 'taking a back seat' in the service redesign process.

8.36 We asked how the local authority assured itself that its statutory responsibilities were being discharged during and after this major re-design? We were told that the quarterly Section 75 meeting was the main forum where the LA monitored its key statutory responsibilities.

8.37 We are of the view that the local authority should have taken a more pro-active role in ensuring its statutory responsibilities were met, and any risks to service users managed, during a period of such a major redesign rather than relying on a quarterly meeting.

8.38 We asked If the re-design and implementation was subject to scrutiny by any of the Council's Committees including Health Scrutiny or similar? Guidance from the Department of Health states:

'Health scrutiny has a legitimate role in proactively seeking information about the performance of local health services and institutions; in challenging the information provided to it by commissioners and providers of services for the health service and in testing this information by drawing on different sources of intelligence'.

8.39 We have been given no evidence that the Oxleas re-design was discussed by any committee of the Council. We would expect that a major re-design of health and social care services for people with mental health problems would have been subject to regular discussion at the relevant council committees.

[112] *2 November 2013, 20 March 2014, 24 April 2015*

Recommendation 16

Where a major service change is proposed in mental health services, and the local authority is in a Section 75 arrangement with an NHS body, the redesign should be negotiated, led and implemented jointly by the local authority and NHS.

Recommendation 17

Where a major service re-design in mental health services is being proposed and implemented the Trust must ensure that it complies with the Regulations when considering a substantial development of the health service, and consults the Local Authority. This should be subject to regular scrutiny by relevant Local Authority council committees.

8.40 We have asked NHS Greenwich CCG:

- Whether the CCG were consulted and involved in planning and in oversight? Was it planned as a Cost Improvement Plan in conjunction with the CCG?
- Was there a stakeholder engagement process that involved the CCG and/or partners e.g. Healthwatch?
- Were there risk mitigation plans shared with the CCG?
- Were any outcomes or evaluations discussed?

8.41 We have been informed that Greenwich CCG has undergone a significant change in personnel since 2014, which has had an impact upon the extent of information available. There is however, evidence of discussions at the joint mental health commissioning group with RBG, Clinical Quality Review Groups and attendance at workshops. The process was led by the Trust and some concerns about the model of care were raised at the time.

Predictability, preventability and root cause

8.42 We are asked to provide a view in such investigations on whether the incident that led to the death of Mrs A was predictable or preventable. We have stated above that we consider that the root cause of her relapse was the service change that led to Miss B being unmonitored, as her relapse then went undetected. As discussed above, based on her history over at least the preceding ten years, the increased risk was most likely to be of harming herself, rather than others.

8.43 In its document on risk, the Royal College of Psychiatrists[113] scoping group observed that:

'Risk management is a core function of all medical practitioners and some negative outcomes, including violence, can be avoided or reduced in frequency by sensible contingency planning. However, adverse outcomes cannot be eliminated. Accurate prediction is challenging for individual patients. While it might be possible to reduce risk in some settings, the risks posed by those with mental disorders are difficult to predict because of the multiplicity and complex interrelation between, factors underlying a person's behaviour'.

8.44 Predictability is 'the quality of being regarded as likely to happen, as behaviour or an event'.[114] An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.[115]

8.45 Prevention means to 'stop or hinder something from happening, especially by advance planning or action' and implies 'anticipatory counteraction'[116] therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

8.46 In considering these we have asked three key questions:

- Was it reasonable to have expected those caring for Miss B to have taken more proactive steps to manage any risks presented by her?
- Was it reasonable to have expected those caring for Mrs A to have taken more proactive steps to manage any risks presented to her?
- Did they take reasonable steps to manage these risks?

Was the death of Mrs A predictable?

8.47 We have reviewed the care provided to Miss B. We believe, given her history and the risks known, that it was more likely that Miss B would harm herself rather than someone else.

8.48 We do not consider that it was predictable that she would kill her mother at any stage, however in February 2016 she was not in receipt of the previous level of care, and risk to herself or others was not assessed.

Was the death of Mrs A preventable?

[113] *Rethinking risk to others in mental health services. Royal College of Psychiatrists CR 201.(2016)*
[114] *http://dictionary.reference.com/browse/predictability*
[115] *Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000)176: 116-120*
[116] *http://www.thefreedictionary.com/prevent*

8.49 We have tried to avoid the bias of hindsight[117] in considering whether the degree of harm was avoidable.

8.50 We have considered the following points:

- Miss B had a diagnosis of schizoaffective disorder with a known lack of concordance and compliance with medication;
- The symptoms of her mental illness were known to include paranoia, irritability, abusive hallucinations and strong feelings of shame and guilt; and
- Mrs A was known to be very dependent and Miss B was known to spend long periods of time with her.

8.48 Actions taken which might have lessened the risk of harm and relapse include:

- Assessment of Miss B's risk to self or others;
- Communication between the Oxleas teams about the care of both women, and between Oxleas and Bridge; and
- Continuity of care for Miss B through the service reconfiguration.

Because of these issues, while we believe that the death of Mrs A was not preventable, however had these steps been taken, it is much more likely that Miss B would not have relapsed and presented as a risk to her mother. Risks were not known, understood or mitigated.

A family member has asked us to include that they disagree with our conclusions, and believe that the homicide of Mrs A was predictable and preventable.

The draft report was delayed by four months due to the complexities of reviewing the care of two individuals and the volume of documents to review.

We offer 17 recommendations in total. These have been identified below as they occur in the narrative of the report, and are later grouped under the three headings of care and treatment, team, and organisational issues for ease of reference.

[117] *Hindsight bias is the inclination, after an event has occurred, to see the event as having been predictable, despite there having been little or no objective basis for predicting it Roese, N. J.; Vohs, K. D. (2012). "Hindsight bias". Perspectives on Psychological Science. 7: 411–426. doi:10.1177/1745691612454303*

RECOMMENDATIONS

Recommendation 1
NHS Greenwich CCG should ensure that GPs are fully involved in information sharing with respect to information about individuals with long term mental health issues.

Recommendation 2
Royal Borough of Greenwich should assure itself that its statutory duties in respect of carers of people with mental health problems are being discharged.

Recommendation 3
Royal Borough of Greenwich should update its 2015 Carers Policy to cover mental health and children in transition.

Recommendation 4
Lewisham and Greenwich NHS Trust should provide assurance that where there is a question of vulnerability and capacity, a capacity assessment is always carried out and documented.

Recommendation 5
NHS Greenwich CCG must assure themselves that there are systems in primary care to monitor the treatment of patients under secondary mental health care.

Recommendation 6
Bridge should develop a quality monitoring process that provides assurance that risk assessments and wellbeing plans are completed accurately.

Recommendation 7
Oxleas NHS Foundation Trust should agree with Bridge what routine patient care information will be provided about patients under the care of secondary mental health services, and develop systems to ensure that the agreed information is received and processed in a timely way.

Recommendation 8
Oxleas NHS Foundation Trust must ensure that risk assessments are updated at the time of care or service transitions.

Recommendation 9
Oxleas NHS Foundation Trust Safeguarding policy should be amended to include consideration of whether the service user may present a risk to other vulnerable adults or children.

Recommendation 10
Oxleas NHS Foundation Trust should assure itself that race and ethnicity, gender and religious issues are routinely addressed in CPA needs assessment and care planning as per the Trust's policy.

Recommendation 11
Oxleas NHS Foundation Trust Board must provide assurance that the actions identified in the internal action plan have been completed.

Recommendation 12
Oxleas NHS Foundation Trust Board must ensure that action plans have an appropriate level of evidence based assurance before sign off.

Recommendation 13
Oxleas NHS Foundation Trust and NHS Greenwich CCG should agree standards for outcome focussed recommendations following a serious incident, and standards for the level of evidence required for assurance before action plans are closed.

Recommendation 14
Oxleas NHS Foundation Trust Board must ensure that any large service re-design has been assessed for impact and risk to quality of clinical care, and that detailed milestones are tracked on an appropriate risk register.

Recommendation 15
Oxleas NHS Foundation Trust and Local Authority should ensure that staff are aware of when they can, and must, share information about individuals whose care they are responsible for.

Recommendation 16
Where a major service change is proposed in mental health services, and the local authority is in a Section 75 arrangement with an NHS body, the redesign should be negotiated, led and implemented jointly by the local authority and NHS.

Recommendation 17
Where a major service re-design in mental health services is being proposed and implemented the Trust must ensure that it complies with the Regulations when considering a substantial development of the health service, and consults the Local Authority. This should be subject to regular scrutiny by relevant Local Authority council committees.

Recommendations by theme

Care and treatment	
Recommendation 1	NHS Greenwich CCG should ensure that GPs are fully involved in information sharing with respect to information about individuals with long term mental health issues.
Recommendation 5	NHS Greenwich CCG must assure themselves that there are systems in primary care to monitor the treatment of patients under secondary mental health care.
Recommendation 6	Bridge should develop a quality monitoring process that provides assurance that risk assessments and wellbeing plans are completed accurately.
Recommendation 8	Oxleas NHS Foundation Trust must ensure that risk assessments are updated at the time of care or service transitions.
Recommendation 10	Oxleas NHS Foundation Trust should assure itself that race and ethnicity, gender and religious issues are routinely addressed in CPA needs assessment and care planning as per the Trust's policy.
Team	
Recommendation 4	Lewisham and Greenwich NHS Trust should provide assurance that where there is a question of vulnerability and capacity, a capacity assessment is always carried out and documented.
Recommendation 7	Oxleas NHS Foundation Trust should agree with Bridge what routine patient care information will be provided about patients under the care of secondary mental health services, and develop systems to ensure that the agreed information is received and processed in a timely way.
Recommendation 15	Oxleas NHS Foundation Trust and Local Authority should ensure that staff are aware of when they can, and must, share information about individuals whose care they are responsible for.
Organisation	
Recommendation 3	Royal Borough of Greenwich should update its 2015 Carers Policy to cover mental health and children in transition.
Recommendation 2	Royal Borough of Greenwich should assure itself that its statutory duties in respect of carers of people with mental health problems are being discharged
Recommendation 9	Oxleas NHS Foundation Trust Safeguarding policy should be amended to include consideration of whether the service user may present a risk to other vulnerable adults or children.
Recommendation 11	Oxleas NHS Foundation Trust and the Trust Board must provide assurance that the actions identified in the internal action plan have been completed.
Recommendation 12	Oxleas NHS Foundation Trust Board must ensure that action plans have an appropriate level of evidence based assurance before sign off.
Recommendation 13	Oxleas NHS Foundation Trust and NHS Greenwich CCG should agree standards for outcome focussed recommendations following a serious incident, and standards for the level of evidence required for assurance before action plans are closed.
Recommendation 16	Where a major service change is proposed in mental health services, and the local authority is in a Section 75 arrangement with an NHS body, the redesign should be negotiated, led and implemented jointly by the local authority and NHS.

Recommendation 17	Where a major service re-design in mental health services is being proposed and implemented the Trust must ensure that it complies with the Regulations when considering a substantial development of the health service, and consults the Local Authority. This should be subject to regular scrutiny by relevant Local Authority council committees.

Appendix A – Terms of reference

Final draft Terms of Reference for an Independent Investigation under HSG (94) 27 and Safeguarding Adults Review, under section 44 of the Care Act 2014.

Introduction

NHS England is commissioning an independent investigation into the NHS care and treatment of Miss B and Mrs A prior to the death of Mrs A, under the NHS England Serious Incident Framework (2015) as well as the duties under Article 2 "Right to Life" of the Human Rights Act. As a public organisation NHS England has a duty to ensure compliance with Article 2 "Right to Life" "the State must never arbitrarily take someone's life and must also safeguard the lives of those in its care. The state must carry out an effective investigation when an individual dies following the state's failure to protect the right to life, of the use of force by government officials"

The Royal Borough of Greenwich Safeguarding Adults Board (SAB) is undertaking a Safeguarding Adults Review (SAR) as required under section 44 of the Care Act 2014 SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

The NHS Serious Incidents Framework (2015) states that there should be……. early consideration for joint investigations if other agencies will be carrying out investigations into the same event(s)……. Wherever possible agencies involved should consider if it is possible to commission a single investigation.

NHSE and Greenwich SAB have agreed to commission a single investigation into the care and treatment and safeguarding of Mrs A and Miss B.

NHSE and Greenwich SAB will independently appoint an investigator but both investigators will be jointly accountable to NHSE and Greenwich Safeguarding Adults Board. Governance structures will be in place to enable this to happen.

Purpose of Investigation

To identify whether there were any gaps or deficiencies in the care and treatment of Mrs A and Miss B and the care, treatment and safeguarding of Mrs A and Miss B.

To identify whether the incident was predictable or preventable.

To identify areas of best practice, opportunities for learning across organisations and areas where improvements to local services and inter-agency working might be required which could help prevent similar incidents from occurring.

Specifically,

- Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.

- Review the progress that the Trust has made in implementing the action plan.

- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies to both Mrs A and Miss B with specific attention to interagency working and safeguarding in relation to Mrs A and Miss B.

- Review whether local Safeguarding Adults policies and procedures were properly followed. The investigation should specifically address the six principles of safeguarding in relation to Mrs A and Miss B – empowerment, prevention, proportionality, protection, partnership and accountability.

- Review Miss B's risk assessments and risk management plans to ascertain if they adequately incorporated historic risks with specific attention to the risk of R harming her mother or others. To specifically address whether any safeguarding concerns were identified or should have been identified.

- To review Miss B's risk of relapsing with specific attention to compliance with medication and changes in her presentation in the weeks prior to the homicide.

- Review the effectiveness of care planning for Mrs A and Miss B including family involvement.

- Review contact and support provided to family following the incident.

- Review and assess compliance with local policies, national guidance and relevant statutory obligations.

- Provide a written report to the Investigation Team and Greenwich Safeguarding Board and NHS England that includes measurable and sustainable recommendations.

- Assist NHS England and Greenwich Safeguarding Board in undertaking a post investigation evaluation.

Family Involvement

The investigation process will involve Mrs A and Miss B's family as fully as is considered appropriate, in liaison with the Metropolitan Police, Victim Support and other support organisations.

Clinical Input

The investigation process and final report should involve an independent psychiatrist in an advisory role.

Outputs

- A succinct, clear and relevant chronology of events for both Mrs A and Miss B leading up to the incident which should help to identify any problems in the delivery of care

- A clear and up to date description of the incident and any Court decision (e.g. sentence given or Mental Health Act disposals) so that the family and members of the public are aware of the outcome

- A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and the family

- Meetings with the family and Miss B to seek their involvement in influencing the terms of reference

- An Independent panel to involve police (including Family Liaison Officers) within the review process (this will be the SAR panel with additional membership)

- Monthly updates where required, to be shared with stakeholders including the family

- A concise and easy to follow presentation for the family

- At the end of the investigation share the report with the Trust and meet the family to explain the findings of the investigation

- A final presentation of the report to NHS England, Greenwich Safeguarding Adults Board, the Mental Health Trust Board and Greenwich CCG

- An assurance follow up and review, six months after the report has been published, to independently assure NHS England and Greenwich Safeguarding Adults Board that the report's recommendations have been fully implemented. The investigators should produce a short report for NHS England and the family and this may be made public

Timescale

The investigation process starts when the investigators receive all the clinical records and the investigation should be completed within six months thereafter.

The Safeguarding Adult Review commenced in August 2016 and is behind timescale due to agreeing arrangements between the Greenwich Safeguarding Adults Board and NHS England for a joint review.

Appendix B – Profile of services

Oxleas NHS Foundation Trust provides community and mental health services in Bromley Greenwich and Kent.

Bridge is a charitable organisation and provider of mental health and wellbeing services in London.

Lewisham and Greenwich NHS Trust is responsible for hospital services at Lewisham Hospital and Queen Elizabeth Hospital in Greenwich. The Trust also runs a range of NHS community services in Lewisham.

Royal Borough of Greenwich health and social care, provides health and social care services to the London Borough of Greenwich.

NHS Greenwich Clinical Commissioning Group (CCG) is responsible for commissioning most of the healthcare services for the people of Greenwich.

London Ambulance Service NHS Trust is responsible for operating ambulances and answering and responding to urgent and emergency medical situations within the London region of England. The service responds to 999 and 111 phone calls, providing triage and advice to enable an appropriate level of response.

Appendix C – Documents reviewed

- GP case notes for Mrs A and Miss B.
- Lewisham and Greenwich NHS Trust case notes for Mrs A.
- IMRs from Metropolitan Police, Bridge, Plumstead Health Centre, Plumbridge Medical Centre, Health and Adults Services, Royal Borough of Greenwich and Oxleas NHS Foundation Trust.
- Internal investigation report, Oxleas NHS Foundation Trust.

Oxleas NHS Foundation Trust documents

- Case notes for Mrs A and Miss B
- Safeguarding Adults Guidance April 2016
- Policy for assessment and Care Planning including Care Programme Approach (CPA) for all Oxleas Service users May 2012
- Clinical risk assessment and management policy for Mental Health and Learning Disabilities Services January 2016
- Oxleas NHS Foundation Trust Senior Management Structure April 2015
- Incident Management Policy and Procedure February 2017
- SAFE AND THERAPEUTIC OBSERVATION policy December 2016
- Operational Policy, Older Adults Community Mental Health Team, Greenwich / Bexley / Bromley, March 2014
- Operational Policy, Locality Adult Mental Health Service, incorporating: Primary Care Plus (PCP); Anxiety, Depression, Affective, Personality disorders & Trauma (ADAPT) and Intensive Case Management in Psychosis (ICMp)
- Caseload Zoning Tool undated
- Oxleas NHS Foundation Trust Performance Evaluation Framework Report, IPC Oxford Brookes, November 2016
- Procedure for missing/absconding patients or detained patients who are absent without leave November 2015
- Carers assessments spread-sheets 2012 to 2017
- Trust PEG Work-plan 2017/2018

- Trust Patient Experience Group Minutes 30/1/18
- Trust-wide Qualitative Review of Carers Assessment Audit October 2014
- Patient Experience Sub-Group of the Quality Committee - Terms of Reference
- iFox report 5 January 2018 – Percentage of patients not on CPA seen within 3 months
- Adult Mental Health and Older People Mental Health MHRD Programme Board Group meeting 19 April 2016
- East locality Zoning Meeting plans
- Greenwich East ADAPT Zoning Meeting Friday, 23 June 2017
- Greenwich East ADAPT Zoning Meeting Tuesday 05 December 2017
- Greenwich East Primary Care Plus Team (PCP) Team Minutes

  Wednesday, 16 August 2017
- Greenwich East ICMP Team Meeting Thursday 7 December 2017
- Greenwich East ICMP Team Meeting Thursday 26 January 2017
- HCR 20 training by locality January 2018
- Proposed redesign paper Greenwich CCG Feb 2015
- Proposal redesign letter Bromley CCG Feb 2015
- Proposal redesign paper Bexley CCG 2015
- Communication stakeholder plan
- Redesign leaflet for service users and carers
- Staff proposal (see slide 14 dates)
- Staff engagement event Q and As
- Email communications and stakeholder
- Healthwatch meeting minutes 1.10.14
- Agenda Healthwatch meeting 1.10.14
- Staff engagement venues and dates
- Oxleas council of governors meeting regarding redesign

- Partnership presentation for service users and carers
- Poster dates and venues open information sessions for service users and carers
- Risk register entries
- Redesign paper May 2015
- Copy of full risk history from open to close for AMH redesign
- Mrs A chronology
- Mrs A safeguarding JET chronology
- Chronological list of the information relating to this case that was discussed by the Board and the Board sub-committees dated 27 March 2018.
- Clinical Quality Review Group minutes (CQRG) 2/12/15, 6/1/16, 2/2/16, 6/4/16, 11/5/16, 1/6/16, 6/7/16, 3/8/16, 7/9/16, 5/10/16, 2/11/16, April 2017, June 2017, July 2017, August 2017, September 2017, October 2017.
- Risk committee minutes 15/9/15, 15/3/16.
- Annual plan presentations (adult mental health) October 2015, May 2016, July 2015, January 2016, July 2016.
- Anonymised serious incident report January 2018.

Lewisham and Greenwich NHS Trust documents

- Safeguarding Adults at Risk Policy and Procedure, September 2016
- Safeguarding Adults at Risk Alert Form, undated

NHS Greenwich CCG documents

- Serious Incident RCA Investigation Report Evaluation Tool
- SERIOUS INCIDENT (SI) NOTIFICATION PROCESS IN NHS GREENWICH CCG
- SERIOUS INCIDENT REVIEW PANEL Terms of Reference

Royal Borough of Greenwich documents

- Safeguarding Adults Local Protocol January 2016

- Procedures for safeguarding adult reviews and multiagency reviews December 2015
- Safeguarding Adults Board Joint Strategic Plan and Action Plan 2017-2020, March 2017
- Operational Structure chart, undated
- Royal Borough of Greenwich Adults and Older People's Services Carer's Policy 2015
- Royal Borough of Greenwich Health and Well Being Board minutes 2014 - 2016.
- Oxleas NHS Trust and Royal Borough of Greenwich Quarterly Joint Section 75 Meetings minutes 2014 – 2015.
- Minutes of the Mental Health Joint Commissioning Group - 2nd November 2013, 20 March 2014, 24 April 2015.

London Ambulance Service NHS Trust

- Policy for Consent to Examination or Treatment (OP031) 2012
- Policy for Consent to Examination or Treatment (OP031) 2016
- Safeguarding Adults in need of care and support Policy (TP019) 2012
- Safeguarding Adults in need of care and support Policy (TP019) 2017
- 2017 Safeguarding Report

Bridge Mental Health documents

- Adult Protection Policy October 2016
- Adult Protection Procedure October 2016
- Handling Client Complaints Procedure October 2016
- Harassment Policy October 2016
- Harassment Procedure October 2016
- Information Sharing Protocol October 2016
- Safeguarding – Recognising & responding to abuse or neglect of vulnerable adults October 2016
- Safeguarding Policy for Vulnerable Adults October 2016

Family submissions made in writing in February 2019