Shelia McInulty was suffering with a complex mental health condition which included repeated suicide attempts and was engaged in a program of rehabilitation towards a return to home.

In a performance review in July 2009 Mrs McInulty was identified as one of two patients who's care was over budget and the senior commissioning manager for NHS Barnet suggested that were they to be discharged early it would have a significant benefit on performance.

As part of the rehabilitation program Mrs McInulty was transferred to Mountview residential care home where Mrs McInulty progressed well.

On the 20th September 2010, Mrs McInulty was the subject of a funding assessment which was usual after 3 months. The funding assessment reached the decision that Mrs McInulty's needs were primarily social care needs.

There were failures at every level in the process in particular.

The two care workers present did not understand the process and believed that this was the start of a process.

The conclusion was not formed by the opinion of the psychiatrist who had recommended that an extended period of rehabilitation was required before Mrs McInulty could return to live at home at the review on the 15th of September 2010.

There were no support documents gathered

The decision tool document completed at the time on a computer was lost and the assessment was not repeated.

There was no panel meeting to verify the funding decision

Mrs McInulty was not told that the decision could be appealed.

The NHS Barnet senior commissioning manager was told that everyone was in agreement with the decision which was not correct and because of this did not request that the review be repeated which should have happened.

This represented a significant failure on the part of the individuals involved in this process and was the beginning of a chain of events that led to and directly caused Mrs McInulty's death.

Following the assessment and the mistaken belief held by the commissioning manager that there was an agreement that Mrs McInulty's need being primarily social care the decision was taken to transfer the funding for the care to the local authority from the health care trust.

A date was agreed with the local authority commissioning manager when funding would be transferred from NHS Barnet to the Local Authority of the19th November 2010.

There was ample evidence available from the clinical staff that to move Mrs McInulty from the residential care home was not in Mrs McInulty's interest and for her to move out may cause harm and interrupt the well thought out rehabilitation care package. In particular it was identified following a review on the 10th November by a psychiatrist that Mrs McInulty presented an on-going significant risk of further unpredictable overdose and that a continued gradual transition between the care home and her home may minimise such risk.

These concerns were conveyed to the Local Authority commissioning manager who made a fundamental mistake about whether the residential care home could be funded by the local authority and did not take steps that could easily have been taken, to correct that mistake.

Mrs McInulty was told that she would be leaving the residential care home with two days notice.

The NHS commissioning manager knew that there were clinical concerns about Mrs McInulty leaving the residential care home but this did not result in a softening of the NHS Barnet commissioning senior manager's position regarding the date that Mrs McInulty was to leave the residential care home or take an opportunity to explore the difficulty with the Local authority commissioning manager.

There was an opportunity at this point for the two commissioning managers to speak together to discuss the problem but this did not happen.

The residential care home were concerned when they learnt that Mrs McInulty who had refused a placement in an alternative residential care home was to be sent home and that her husband was working away from home and delayed the departure by a few days.

For the first two weeks Mrs McInulty did well but after this period was a downward path to her death on the 2nd of February from an overdose of her medication

There was a review planned for Mrs McInulty to be seen as an outpatient by the psychiatrist which was not attended as was an appointment to see her general practitioner.

There was a lost opportunity for Mrs McInulty to be assessed by her psychiatrist as her condition deteriorated but the need for this assessment was not recognised.

All of these factors are likely to more than minimally or trivially contributed to Mrs McInulty's death.

Mrs McInulty's death was directly caused by the interruption of the agreed rehabilitation program designed to allow Mrs McInulty to return home gradually and in this sense Mrs McInulty's death was contributed to by neglect.

It is not possible to be satisfied beyond reasonable doubt that Mrs McInulty intended to end her life when taking the medication and the possibility that this was a cry for help cannot be totally ruled out and although not probable remains a possibility.