Portsmouth City NHS
Teaching Primary Care Trust

Inquiry Report

Report of an Independent Inquiry Panel into the care of [redacted]

CONFIDENTIAL

Portsmouth City Primary Care Trust

Inquiry Report

Inquiry Into the Treatment and Care of [redacted]

1. Introduction

On 21st September 2004, [redacted], a 27 year old resident of Portsmouth was arrested on the suspicion of the murder of a female, his mother. [redacted] was known to the Portsmouth City Primary Care Trust's mental health services and at the time of his arrest had been receiving treatment on an out patient basis. This incident was reported to the Hampshire and Isle of Wight Strategic Health Authority on 22nd September 2004.

National Health Service guidance set out within HSG 94 (27) requires that an independent investigation be established to look into such events. This guidance is currently under review.

2. The Inquiry Panel

It was agreed between the Strategic Health Authority and the Portsmouth Primary Care Trust that the Trust would establish an independent panel to review the case.

The Inquiry Panel Members:-

Steve Barnes (Chair), Executive Project Manager, Portsmouth City PCT, on secondment from the Royal College of Nursing.
Richard Hibbert, Non Executive Board Member, Portsmouth City PCT.
Stewart Jamieson, Consultant Psychiatrist and Medical Director, Portsmouth City PCT.

Gemma Hobby, Secretary to the Associate Director for Mental Health provided administration and secretarial support. The panel are particularly grateful for her assistance.

None of the panel members had had previous knowledge of [redacted] or his family.

3. Terms of Reference

It was agreed that the Inquiry Panel would examine the following:

1) The quality and scope of the patient's health care, social care and risk assessments.

2) The suitability of his treatment, care and supervision in the context of:

- His actual and assessed health and social care needs
- The actual and assessed risk of potential harm to self or others
- Any previous psychiatric history, including alcohol and drug misuse
- Any previous forensic history
- Appropriateness of decisions made by the practitioners involved

3) The extent to which his care complied with statutory obligations, the Mental Health Act Code of Practice, local operational policies and relevant guidance from the Department of Health including Care Programme Approach.

4) The extent to which his prescribed treatment and care plans were adequate, documented, agreed with the patient, carried out, monitored and complied with.

5) The adequacy of the collaboration and communication between all parties involved with the patient.

The Inquiry Panel was clear that it was not within its remit to investigate any of the matters that would form part of any criminal investigation or prosecution. The panel neither requested nor received any information relating to the events of the 21st September 2004, the date of the alleged murder.

4. Methodology

The Inquiry Panel met on five occasions; the 30th November 2004, the 9th January 2005, the 25th January 2005, the 8th February 2005, and the 22nd February 2005.

In advance of the Inquiry Panel's initial meeting, copies of [redacted] clinical notes, together with notes from the Care Co-ordinator and Duty Team on the ACMS computer system were obtained. Further evidence was sought as the inquiry progressed.

The following witnesses attended the inquiry, the Inquiry Panel is particularly grateful for their attendance and the candour with which they gave evidence.

Dr. Elizabeth Caesar, Consultant Psychiatrist, Portsmouth City PCT.
Jill Hart Benson, Duty Team member, Portsmouth City PCT.
Dr Benjamin Dasyam, Psychiatrist, Portsmouth City PCT.
Julie Lyne, Team Leader, Community Mental Health Team, Portsmouth City PCT.
Dr Tutte, GP, Somerstown Health Centre.
Dr. Anna Mlynik, Consultant Psychiatrist, Portsmouth City PCT.
Dr. Charles Munene, Locum Consultant Psychiatrist, Portsmouth City PCT.
Janice Romer, Associate Director, Adult Mental Health Services, Portsmouth City PCT.

[redacted].
Dianne Palmer, Staff Nurse, Depot Clinic, Portsmouth City PCT.
Ann Reynor, Staff Nurse, Depot Clinic, Portsmouth City PCT.

In their invitation to attend the inquiry, witnesses were offered the opportunity to bring a friend or trade union representative. Portsmouth City PCT staff were also reminded that they could access Core Care, which is a counselling and support service contracted in as part of the Occupational Health Service. Clinical staff were offered access to the clinical notes.

Information was also received by the Inquiry Panel from the police and probation service.

Notes of the main areas of inquiry with each witness and their responses are separately available.

The Inquiry Panel sought to interview [redacted] The Panel was initially advised by letter dated 21st December 2004 from Dr. Manzar Kamal, Locum Consultant Forensic Psychiatrist at Ravenswood House, where [redacted] was being treated, that his view and the view of the multidisciplinary team was that [redacted] was *"currently very unwell*" and *"would not be able to make any sense of the inquiry proceedings".* A full copy of this letter is available.

The Inquiry Panel subsequently received a letter dated 1st February 2005 from Ashworths Solicitors, the relevant extract is set out here:

"We forwarded your letter to our client's leading counsel and he advises that we should ask you not to make any contact with our client re your inquiry until after his trial.

Any attempt to discuss details with him may have a detrimental affect on his mental state.

Counsel also advises that any enquiry of our client could become disclosable in the matter of his trial and that is another reason for his request that you do not contact our client directly."

A full copy of this letter is available.

In view of these representations the Inquiry Panel agreed that little purpose would be gained by making further attempts to interview [redacted]

[redacted] brother was also invited, through his solicitor, to attend. The panel was informed by [redacted], his sister that he would not be attending. Whilst the Inquiry Panel felt that his evidence would have been of assistance, the panel took the view that this was not a significant deficiency as it had received particularly helpful evidence from [redacted] on behalf of the family.

The Inquiry Panel would have wished to have been able to interview Helen Le Peuple who was [redacted] Care Coordinator until, approximately, July 2003, when Helen left employment with Portsmouth City PCT. The panel were given to understand that she is now in New Zealand. The panel believe that Helen Le Peuple's first hand evidence would have been particularly helpful in understanding [redacted] in the context of his family, the risks he may have posed and the decisions that were taken in relation to his care management.

5. Background

[redacted] was born in Birmingham but the circumstances of his birth and early development are unclear. His biological father, [redacted], is aged approximately 62 and he is cared for in a nursing home in London due to sustaining a severe brain injury whilst in the Navy when [redacted] was 16 months old. [redacted] mother, [redacted], was aged approximately 52 at the time of her death. [redacted] has an older sister, [redacted], who is aged 31 and a half brother, [redacted], who is aged 20. His mother suffered with alcoholism and his sister [redacted] has been under the care of the local mental health service for a number of years. There is no evidence of other family history of psychiatric illness.

[redacted] has told people in the past that he had a reasonably happy childhood even though his parents separated when he was 4 years of age. He enjoyed school particularly physical education and did not experience bullying or attract serious disciplinary measures. On leaving school he declined to go to college and had short periods of employment in manual work but had been unemployed for the most part over the last 4 years. Although he had dated girls, [redacted] had no long-term serious relationships. In terms of past medical history [redacted] had suffered a head injury when he fell off his bike at the age of 8 years, he was not knocked out and following a check up in hospital, was released. He sustained a fractured leg at the age of 11 when he fell off his bike again. He has had no other serious physical illness.

When interviewed by staff, his mother had described [redacted] as a happy child who was well until the age of 15 when he seemed to "go off the rails". Since this time he had indulged in cannabis misuse and become involved in criminal behaviour. This included theft, shoplifting, burglary and assaults for which he had received custodial sentences as well as probation. There had also been arguments between [redacted] and his mother, which led to violent attacks by [redacted] against his mother.

It is clear that between the age of 15 and his first contact with the psychiatric services at the age of 24, [redacted] behaviour changed and in retrospect he was most likely suffering from a prodromal schizophrenia which became manifest around the time of his first referral to the psychiatric services by his GP in 1999.

Following his two admissions under the Mental Health Act in December 2001 and February 2002, [redacted] attracted a diagnosis of schizophrenia. He became more engaged with the psychiatric service and benefited from anti-psychotic medication and input from his Care Co-ordinator although some criminal activity persisted. [redacted] continued to live with his mother and brother in her council flat and received Income Support and Disability Living Allowance and although some tensions remained their relationship appeared to improve.

6. Commentary on evidence

When [redacted] was receiving mental health care from Portsmouth City PCT he was under the care of three Consultant Psychiatrists. Dr. Caesar was the Responsible Medical Officer (RMO) from September 2001 until October 2002, Dr Munene from October 2002 until August 2003 and Dr. Mlynik from September 2003.

Dr. Caesar told the Inquiry Panel that she first treated [redacted] in 2001. She treated him with anti psychotic medication and at that time he appeared to be compliant with taking it. Dr. Caesar was of the opinion that when [redacted] was unwell he was a *"big risk to himself";* she described him as impulsive and chaotic. Dr. Caesar told the panel that details given to her did not indicate any serious risk to [redacted] mother although she agreed that [redacted] mother's alcoholism made their relationship difficult. She did comment that it was not until [redacted] became unwell that he became physical.

When the issue of alternative accommodation for [redacted] was discussed, Dr. Caesar told the Inquiry Panel that when the Care Co-ordinator went to visit [redacted] and his mother, everything was fine so this wasn't seen as a risk. The best thing for him seemed to be that he should be at home.

Dr. Caesar was concerned at the time when she heard that [redacted] had been storing petrol cans but told the panel that she was unable to get forensic details about him. At the time this was *"very worrying",* but it appears that this was less of an issue as there was such an obvious change in him once he got better. It is interesting to note that [redacted] also commented on the marked difference in [redacted] when he was well.

Dr. Caesar did say in her evidence to the Inquiry Panel that "*I feel we should try harder to get information from the police".*

Dr. Munene was the RMO from October 2002 until August 2003. He told the Inquiry Panel that he had no recollection of [redacted]. From the notes he records only seeing him once (21st January 2003), because [redacted] was having side effects from his medication. Before that [redacted] was being seen by a staff grade Doctor in outpatients.

Dr. Munene was not aware that [redacted] posed any risk to his mother and was not aware of him having been discussed at team meetings. When asked about the normal processes for managing risk Dr. Munene indicated that normally the Care Co-ordinator would pass on any risk issues.

Dr. Mlnyk who was [redacted] RMO from September 2003 until [redacted] arrest in October 2004 did not see [redacted] herself. She does recall discussion about [redacted] at the team meeting on 2nd September 2004 where there were some messages of concern. Dr. Mlynik stated that she had reviewed the notes of Dr. Dasyam who was seeing [redacted] at that time and was the last doctor to see [redacted] and did not feel that there were any urgent concerns. The Inquiry Panel discussed the governance arrangements for Dr. Dasyam with Dr. Mlynik and was told that when she discussed [redacted] case with him in July, he felt that [redacted] was well.

Dr. Dasyam worked as a locum staff grade psychiatrist from 2003. He saw [redacted] on 3 occasions; 13th August 2003, 3rd March 2004, 21st July 2004. His notes for those three appointments suggest that [redacted] mental health was good. Occasionally [redacted] suffered oculogyric crises when he forgot to take his medication, but no psychotic or depressive features were reported nor was there any suggestion that [redacted] was likely to self harm. Although [redacted] was not asked specifically about his mother at the interview in July 2004, Dr. Dasyam recorded that he had no ideas of harming others.

In his evidence to the Inquiry Panel Dr. Dasyam said that he did not feel that there had been any sign of risk to [redacted] mother. He based this on his own observations and the Care Co-ordinator's last visit to her. It seemed that things were very positive.

When asked about how things could have been improved, Dr. Dasyam suggested that obtaining more information from the police might have helped, as the service really only had [redacted] side of the story. Dr. Dasyam also stated that it might have been better if [redacted] had continued to have a Care Co-ordinator after Helen Le Peuple left.

Dr. Tutte, [redacted] GP described how his first contact with [redacted] was in 2002, when he re registered with the Somerstown Health Centre. [redacted] had previously been registered there in 1999. He stated that he saw him on a few occasions in 2002 and he thought there were signs that [redacted] was psychotic at that time. The practice did not see much of [redacted] in 2003. When Dr Tutte saw him in 2004 he felt that [redacted] was the best that he'd seen him.

Dr. Tutte told the Inquiry Panel that he had no concerns about risk, there were no indications of risk and he was receiving positive reports from [redacted] psychiatrist. His view was that [redacted] was having adequate support from the adult mental health service, however he was not made aware of the fact that [redacted] had ceased to have a Care Co-ordinator in the summer of 2003.

Dr. Tutte was not aware of [redacted] full forensic history, but he did believe that [redacted] had been sent to prison for pushing his mother to the floor.

Dr. Tutte also told the Inquiry Panel that his partner, Dr. Minay saw A[redacted] mother in June 2004 and had advised her to go to Kingsway House as she had a drinking problem. There was also an incident in July 2004 when she fell over; Dr. Tutte believed that this could have been alcohol related.

[redacted], supported by her partner [redacted], gave evidence to the Inquiry Panel. She described [redacted] as quite a gentle person when he was well and had been their mother's carer for some years. [redacted], their younger brother also lived at home but was working. [redacted] had moved out from home two weeks before their mother's death because he wanted to live with his girlfriend. Although [redacted] did not live at home she visited daily to check on her mother and brother.

[redacted] told the Inquiry Panel "*mum used to attack us when she was drinking, there had been previous evidence of violence, once a recent argument got out of hand".* She did not think that [redacted] had been to prison for hitting their mother.

[redacted] described how [redacted] had been becoming unwell during the three months prior to their mother's death; *" he used to sit and laugh in his room. He gave his sickness benefit to other people… He told me that he didn't need his medication any more".* During this period [redacted] disappeared for a couple of days and took his tent, he returned home, as he did not have the tent pole.

According to [redacted], their mother went to Cavendish House a couple of times and explained that [redacted] wasn't well. [redacted] thought that she wanted someone to take notice and to check on [redacted]. The inquiry panel could not find any record of these visits. There is a record of a call to the Duty Team on 2nd August 2004, where [redacted] mother expressed concern about him and that he had

attended the funeral of a close friend. [redacted] also described how the death of [redacted] friend around that time had put him into a depression.

Jill Hart Benson from the Duty Team gave evidence to the Inquiry Panel about the phone call from [redacted] on 2nd August 2004. She had not met [redacted] herself but knew of him from previous contact she had had with other family members. She said that he was considered to be badly behaved and bad tempered, and had a dreadful relationship with his mother.

Jill Hart Benson recalled that the phone call was just a few minutes long. [redacted] mother was concerned about him and was annoyed because he wouldn't talk to her. She could not recall if she looked up any details on the ACMS computerised record system. She stated that she spoke to Anne Reynor from the Depot Clinic about this but she had no particular concerns at the time. There was no indication of risk. The full note of that telephone call is reproduced here;

" [redacted] mother called in to Cavendish to express her concern re [redacted] In the last few days his mental state has deteriorated to the point that he ran out of his home and his mother reported him to the police as a missing person he later returned of his own accord but was not clear as to his movements. He attended the funeral of Martin Taylor a heroin addict who died and who was friend of his but his mother did not think this was a major contribution to his current problems He has reportedly been giving his tablets away. Information given to Anne Rayner who runs the depot clinic he attends. He had his last depot only a few (? days ago) *and his next one is due in 3 weeks. I advised [redacted] that [redacted] could ring duty if he needed support in the interim."*

Julie Lyne, Team Leader at Cavendish House gave evidence to the Inquiry Panel. She had been in post as a Team Leader from, approximately, the beginning of 2004. She had not had direct contact with [redacted] in that role but recalls meeting [redacted] some time previously when he was in Hospital.

Julie Lyne was notified that [redacted] had missed the depot injection that was due on 27th August 2004 and in view of this and the contact that his mother had made to the Duty Team by phone on 2nd August 2004, there was no immediate concern that this caused a risk or danger. [redacted] case was discussed at the team meeting on 2nd September 2004 and it was agreed that Sally Rumfitt together with Dr. Dasyam would follow this up. There is no record of any other action having been taken after this, prior to [redacted] death on 21st September 2004.

The Inquiry Panel discussed the process by which decisions to allocate or de-allocate Care Co-ordinators were made. Julie Lyne stated that at the time that Helen Le Peuple left in 2003, the practice would have been for there to have been a discussion with the responsible doctor to determine whether an individual needed a Care Co-ordinator, or whether they should go on a waiting list for one. The Inquiry Panel has examined the notes of the team meetings held at that time and can find no record of [redacted] ever having been discussed.

Julie Lyne felt, that with the benefit of hindsight, [redacted] should have had a Care Co-ordinator, however she expressed concerns that there were not enough Care Co-ordinators to go round and that there were concerns about people on the waiting list.

Di Palmer and **Ann Raynor** from the depot clinic gave evidence jointly to the Inquiry Panel. They described [redacted] as "*quite a nice smiley chap… he's always been the same quiet person but would speak to us and would never get impatient."* They did

not believe that [redacted] was a risk. They did not see him as particularly unwell nor did they have any concerns about his relationship with his mother. When he missed depot injections this was reported to either the Care Co-ordinator or the Team Leader, This happened in [redacted] case. Generally they were of the opinion that communication between themselves and the rest of the mental health team was good. The records in the clinical notes support this opinion.

Janice Romer gave evidence to the Inquiry Panel, She had been appointed as Associate Director for Mental health Services from August 2004, prior to that she had been a senior manager with the PCT's mental health service. She did not have any direct knowledge of [redacted].

Janice Romer told the Inquiry Panel that links between the PCT and the police are excellent although when she started her previous role in Adult Mental Health they had been poor. On reviewing the case, she felt that a multi agency meeting with the police might have helped the situation. The Multi-Agency Public Protection Arrangements (MAPPA) had more recently come into effect, but prior to this there was the facility of calling joint meetings where there was a serious risk to others.

The issue of resources was discussed. Janice Romer told the Inquiry Panel that although there always had been difficulties recruiting Care Co-ordinators, but the team involved with [redacted] care had been quite stable. The role of Care Co-ordinators is under review at the moment, and until that review had been completed it was difficult to assess whether there was a resource limitation.

Janice Romer also told the Inquiry Panel that she felt that the CPA policy should be followed better and that there was a problem sometimes with communication. The ACMS system had a flagging system for risk and this needed to be looked into.

With reference to risk training, Janice Romer stated that this was an issue. She was not sure if risk training was mandatory for staff working in adult mental health. Staff were given some risk training as part of the CPA training. Julia Carter-Meadows who now has responsibilities for training is proposing that in depth risk training is carried out for all staff and that this is followed up every two years.

7. Conclusions

From the evidence reviewed from [redacted] notes and the oral evidence of witnesses the Inquiry Panel were able to reach the following conclusions;

7(i). In general, the care received by [redacted] was of a satisfactory standard and complied with statutory obligations, local operational policies and the Care Programme Approach.

7(ii). [redacted] care was well documented and there was a consistent audit trail of his treatment and contact with the mental health services from September 1999 to September 2004.

7(iii). Healthcare professionals assessed the risk that [redacted] posed to himself, others and particularly his mother on repeated occasions, for example, questions around risk were regularly asked at out patient appointments. Although this risk and particularly risk to his mother was identified, this was not always comprehensive, nor was the full background to risk appreciated by all those involved. Risk and

particularly risk to his mother that had been identified was not always conveyed to all those involved with his care.

7(iv). There was not a consistent understanding by all healthcare professionals that the risks posed by [redacted] increased when he became unwell.

7(v). There was a failure to investigate fully [redacted] forensic history to develop a more comprehensive understanding of risk, as well as a lack of response to other risk indicators such as the storing of petrol cans in February 2002 and threats to the police. This should have prompted a multi agency meeting that could have significantly influenced the decision-making concerning risk management and enabled better communication with the police and probation services.

7(vi). If a multi agency RAMP meeting had been convened this would have influenced the decision-making concerning risk and enabled better communication with others such as the police.

7(vii). The family circumstances were not fully appreciated by healthcare professionals. Helen Le Peuple[redacted] Care Co-ordinator appears to have been the only person who had a full view of the main issues. After she left in mid 2003 nobody else appeared to have a complete picture of the circumstances

7(viii). There was no evidence of any discussion to de-allocate a Care Co-ordinator. The Inquiry Panel noted Helen Le Peuple's last ACMS entry that he *"may need a Care Co-ordinator".* At this time there appears to have been no analysis of risk and no alternative strategy considered for [redacted] management.
.
7(ix). The significant events relating to [redacted] mental health issues in 2004 leading up to [redacted] arrest in September were consistently and appropriately documented.

7(x). The Inquiry Panel noted the good communication between the Depot Clinic, the CMHT and the Duty Team.

7(xi). There were signals that [redacted] was becoming unwell in the summer of 2004, however these signals were not perceived to be of a degree that warranted urgent action. This was probably because the risk to his mother was neither understood nor communicated.

7(xii). Whilst the Inquiry Panel understands that the service pressures mean that not all mental health service users can be allocated a Care Co-ordinator, on balance of probabilities it is likely that if a Care Co-ordinator had been allocated after Helen Le Peuple left in 2003 [redacted] deteriorating condition would have been picked up. It is also, on balance of probabilities, likely that some intervention(s) would have occurred, thus reducing the likelihood of a serious incident.

7(xiii). The Inquiry Panel noted that whilst there was training for staff on risk assessment and risk management at that time, the training strategy was still being formulated. The lack of clear and consistent risk training for all mental health staff may have been a contributory factor in this case.

8. Recommendations

The Inquiry Panel has made the following recommendations;

8(i). For all mental health service clients with a forensic history, full facts should be obtained so that an accurate and enduring clarification of significant risk can be established.

8(ii). For all those clients with a forensic history of violence, a record of such risk and any contributory factors should be maintained. This record should be kept with the patient's documents and be readily available for all those accountable for the client's treatment and management**.**

8(iii). A formal recording of the team decision to de-allocate a Care Co-ordinator for all individuals should be made in the team meeting minutes and the CPA documentation completed.

8(iv). On de-allocation of a Care Co-ordinator, a formal record should be made in the CPA documentation of contingency arrangements and significant risk.

8(v). Issues of significant and potential risk at times of illness or relapse should be recorded as a caution in the ACMS/SWIFT computer records.

8(vi). The PCT must ensure that there is regular and appropriate risk training for all mental health professionals involved in the assessment or treatment of clients.

Annex 1

[redacted], Schedule of Events.

1998. 5 previous convictions noted relating to shoplifting/burglary/theft/ violence to mother.

1-9-99. [redacted] seen by GP. Dr Minay with depressive symptoms, no previous psychiatric history.

28-11-99. [redacted] attends GP. Dr Minay at Mother and GP's request.

6-12-99. Dr. Minay refers to Mental Health Team at Cavendish House; mother is "*frightened by his behaviour.. she tells me that* [redacted] *has pushed her and hit her but has never actually lashed out at his younger brother"*

Dec 01 approx. Serving 8 months in HMP Winchester. Due for release May/June 02

19-1-00[redacted] DNA appointment with Dr. Ostler, Consultant Psychiatrist.

28-9-01. Seen by Dr. E. Caesar, Consultant Psychiatrist, following presentation at St. James Hospital and an initial Duty Team assessment. He told Dr. Caesar that "*he had been in prison for hitting his mother".* He explained that *"now he was feeling angry with her again and had to remove himself from the situation as he feared he would hit her again and end up in prison".*
Contact was made HMP Winchester who *"said he was admitted to the Healthcare centre for two weeks. He was observed to be bizarre, voices, visual hallucinations,*

vacant expression, and refusal of medication. He was later located back in his own wing on request."

12-12-01. Admitted under section 2 of the Mental Health Act to Hove Priory Hospital as had been found at Beachy Head, appears to have walked in front of and spat at a police car. Section papers authorised by Dr. Lunt and Dr. Caesar.

13-12-01. From interviews With [redacted] and Sister (telephone interview) at the Hove Priory it appears that [redacted] had been evicted from mother's house. Sister describes a history of temper tantrums *"but not physically aggressive except towards mum who is an alcoholic".* Sister is *"sure that [redacted] uses cannabis quite regularly".*

14-12-01 Hove Priory assessment completed and sent to Solent Unit at St. James Hospital. Went AWOL from Hove just prior to discharge and was found on his way to mother's house when he spat at police. Police returned him to Solent Unit. No apparent risks recorded.

21-12-01. Reviewed on ward, notes refer to *"difficult relationship with mum – arguments concerning money"*

26-12-02 On home leave for p.m.

27-12-02. Seen on ward round. Mother agrees to have him home. Discharged from Section 2 by Dr. Caesar. On home leave.

11-1-02. Assessment and Support team (AST) contacted by GP, Dr. Simner. Sister had brought [redacted] to surgery *"worse for wear";* apparently [redacted] had not been taking the medication given to him when he left hospital. AST confirmed medication with GP for prescription. Ward also contacted by his sister who was advised to speak with Dr. Caesar.

16-1-02. Ward Round, CPA Review. Helen le Peuple to take over as Care Coordinator. Agreed to discharge. [redacted] Discharged from inpatient care.

17-1-02. Discharged to mother's address.

2-2-02. Admitted to Department of Psychiatry at Eastbourne General Hospital. Had been wandering at Beachy Head ? suicidal. Section 2 papers authorised by Dr. Mayhew and Dr. Naliyawala. Recorded as risk to self and risk to others.

7-2-02. [redacted]'s sister reports that he had been *"going out a lot, carrying a petrol can."*

8-2-02. Transferred to Solent Unit, St. James Hospital, Portsmouth.

9-2-02. Sister reports to ward that [redacted] had been buying petrol cans and hiding them at home so that he can *"blow up the police station."*

11-2-02. Seen by Dr. Adam, denies buying and hiding petrol cans

27-2-02. Dr. Adam interviews mother, no risk to mother or others reported at interview. Interview stopped as mother unable to give proper history because she was intoxicated.

4-3-02. Seen by Helen Le Peuple, Care Co-ordinator, (first visit). Mother also seen at home.

7-3-02. CPA held on Solent Unit with Dr. Caesar. Discharged from Solent to mother's address. Risk severity assessed as low.

19-3-02. Helen Le Peuple introduces [redacted] to Sports Interaction as he is *"interested in football and perhaps swimming."*

22-3-02. [redacted] and mother in contact with AST. [redacted] describes blurred vision; mother concerned and wants him admitted.

25-3-02. Reviewed by Dr. Adam at Cavendish House following concerns re medication side effects.

8-4-02. Reviewed by Dr. Adam.

17-4-02. [redacted] meets with Helen Le Peuple for CPA review. Risk issues; *has been violent towards his mum. Has been to Winchester Prison* 3 – 4 *times. Shoplifting, violence to mum, several weeks at a time."* ACMS note reports that, *he was quite well and getting on all right with his mother."*

14-6-02. Has been staying at a friend's home for a week and had presented at the Council as homeless. Helen Le Peuple enquires and [redacted] says that relationship with mother is fine.

1-7-02. Arrested for burglary.

12-7-02. Seen by Dr. Adam in outpatients. Seeing Helen Le Peuple every three months.

28-8-02. Helen Le Peuple tries to contact.

1-9-02. Charged with burglary.

18-9-02. Sees Dr. Adam in outpatients. No reference to burglary or criminal charges.

25-9-02. [redacted]'s solicitors write to Dr. Adam re sentencing for Burglary (Dr. Adam replies on 4-10-02).

7-10-02. [redacted] due to appear at Portsmouth Magistrates Court and is given 9 months probation (n.b. there would appear to be some confusion here about the exact dates).

12-11-02. Helen Le Peuple is still trying to contact [redacted]. An appointment is made for 26-11-02.

26-11-02. CPA review with Helen Le Peuple, risk issues;
"Violence toward mother, this has not happened since last year. Prison sentences times 5, normally theft but also violence against mum. No risk to himself."

3-12-02 CPA sent to GP.

14-1-03. Risk assessment completed by Helen Le Peuple. Assessment identifies low risks of suicide, deliberate self harm, risk to property and abuse by/to others but medium risk of violence to others (mum). Assessment also identifies *"physical harm to others – one year ago"*

21-1-03. Seen by Dr. Munene in outpatients. Helen Le Peuple had been expressing concerns that [redacted] had been having oculogyric crises.

12-2-03 & 26-2-03. Correspondence between Portsmouth Craft and Manufacturing Industries and Dr. Munene re supporting [redacted] to find employment.

3-3-03. DNA outpatient appointment.

8-5-03. CPA review: *"relationship with his mum has improved", "Risk issues – no suicidal thoughts, no violence for several months. Probation officer sees [redacted] monthly and has started some anger management with him".*

14-5-03. Outpatient appointment with Dr. Ahmed.

11-6-03. Dr. Ahmed writes to GP, Concerns about side effects of medication, *"he reports that he is otherwise fine, he feels fine in his mood and he sleeps well and eats well. He no longer hears any voices."*

24-6-03. Helen Le Peuple sends GP CPA review.

30-6-03. Helen le Peuple meets [redacted]: *"I informed [redacted] that I was leaving Cavendish in a few weeks and made sure that he knows how to seek help if needed. He attends the Depot clinic 3 weekly and has a Probation Officer for another month, Ben Keysell…. He also knows the AST and duty numbers and has used them before.*

[redacted] *still uses Sports Interaction weekly so may need a Care Co-ordinator. He is very well at the moment and attends OPAs."*

13-8-03. Attends outpatient appointment with Dr. Dasyam reported as still having oculogyric crises. *"No psychotic features, no depressive features, no ideas of self harm or suicide."*

29-8-03. Dr. Dasyam writes to GP following outpatient appointment on 13-8-03.

10-12-03. [redacted] DNA's outpatient appointment.

3-3-04. Outpatient appointment with Dr. Dasyam;
"On probation for assaulting police last year. Clare Justen is his probation officer, sees her once a week (probation for 12 months). …no ides of self harm or suicide, no psychotic features, no depressive features."

28-4-04. Dr. Dasyam writes to GP following outpatient appointment on 3-3-04.

20-7-04. [redacted] DNA's for depot injection.

21-7-04. Attends outpatient appointment with Dr. Dasyam;
"No perceptual disturbance, no paranoid ideas, no ideas of self harm/suicide, no idea of harming others. … discussed about coming off injections but a bit apprehensive, plan reduce frequency of depot..."

27-7-04. [redacted] DNAs for depot injection.

30-7-04 Receives depot injection

2-8-04. Mother calls duty team, stated that [redacted]'s mental state had deteriorated, he had left home and had been reported as missing, but subsequently he returned. He had also attended a funeral of a close friend of his. [redacted] advised that [redacted] could ring duty if he needed support.

6-8-04. [redacted] presents at Langstone Centre asking for food vouchers.

16-8 -04. Application for Disability Living Allowance completed.

27-8-04. [1]Message from Depot Clinic that [redacted] had DNA'd for his depot injection for the second time in 2 months, to be discussed at team meeting.

2-9-04. Discussed at team meeting.

21-9-04. [redacted] is arrested as suspect in homicide (his mother).

Annex 2

[redacted] – Forensic History

Note: this information was obtained by the inquiry panel from the police. Most of this information was not held in the clinical notes.

[redacted] had 21 convictions mainly for theft, drugs, burglary and various assaults. With regard to assaults against his mother police records show.

March 1999. Pushed mother around home, charged with assault and battery, not pursued.

August 2000. False imprisonment of mother. Punched her and threatened to stab her, Caused bruising and swelling to face and head. Arrested and charged with ABH. Convicted of battery, sentenced to 6 months probation, which was revoked after 2 months.

October 2001. Grabbed mother by throat. Punched and kicked her to the floor. Arrested but mother declined to proceed with prosecution.
Other significant incidents,

March 2003. Punched and kicked police woman.

January 2204. Assault on police officer, probation.