Health and Social Care Advisory Service Report of the independent investigation into the care and treatment of Mr BM

A report for NHS London

February 2010

NHS
London

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1. Investigation Team Preface

1.1 The Independent Investigation into the care and treatment of Mr. BM was commissioned by Newham Primary Care Trust in accordance with *HSG (95)27*[1] as amended in June 2005. This investigation was asked to examine a set of circumstances associated with the death of Mr. Tom - Louis Easton on 15 September 2006. Mr. BM was subsequently arrested and he pleaded guilty on the basis of diminished responsibility as the perpetrator of this offence. He is currently a patient at Broadmoor Hospital.

1.2 Mr. BM received care and treatment for his mental health and substance misuse problems from the East London and the City Mental Health NHS Trust (ELCMHT). His accommodation at the time of the homicide was at a small supported hostel facility funded by the London Borough of Newham. It has been necessary to examine the treatment and care Mr BM received since December 2003 up to 15 September 2006 in order to fully understand all the circumstances surrounding the homicide.

1.3 The purpose of this Investigation is to learn any lessons that might help to prevent any further incidents of this nature, and to help the North East London Mental Health NHS Trust (now the East London NHS Foundation Trust [ELNHSFT]) and its partner agencies to improve their services and to share the lessons across the NHS.

1.4 Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They have all done so in accordance with expectations. We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's senior management who have granted access to facilities and individuals throughout this process. As a result, the Independent Investigation Panel has been able to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

2. Condolences to the Family of Mr. Tom - Louis Easton

2.1 The Independent Investigation Panel would like to extend their condolences to the family and friends of Mr Tom - Louis Easton, and in particular to Mrs Altaras, his mother and his step-father Mr Sinclair. The Panel sincerely hope that this Report will help to address any issues that have remained unresolved to-date.

3. Mr. Tom - Louis Easton

3.1 The Independent Investigation Panel would like to thank Mrs Dolores Altaras and Mr Peter Sinclair for their help in meeting the Independent Investigation Panel and talking about Tom - Louis Easton and his love of music. They have kindly added the following details about him and their sense of loss.

3.2 Tom – Louis Easton was 22 when he died as a result of stab wounds on 15 September 2006.

3.3 He was an only child but he left behind a long and painful list of suffering people: a girlfriend, three half sisters and one half brother, a father, grandparents and six uncles, twenty-five cousins and a staggering amount of friends, who are all still traumatised.

3.4 Tom - Louis Easton wanted to be a musician since the age of seven when he picked his first guitar. His passion for music carried him through his studies and he graduated from the School of Audio Engineering in 2005 determined to have his own production company and recording studio. His determination coupled with his ability to see the talent and potential in young people got him a job teaching young people music and recording technology at EC1 Music Project, a studio set up by The London Borough of Islington to help disadvantaged young people.

3.5 As a result of Tom - Louis Easton's murder, Mr Sinclair and Mrs Altaras and other family and friends have set up a charity called the Tom Easton Flavasum Trust (Registered Charity 1120245) to try and prevent similar tragedies like this happening again, and to raise awareness of the dangers of carrying knives. The Trust has been named after the music label Tom - Louis Easton created to record his first track.

4. Executive Summary

Incident Description and Consequences

4.1 Tom - Louis Easton was working in the EC1 Community Music Studio in East London when Mr BM visited the studio with a friend. After being there for some time he attacked Tom - Louis Easton with a knife and stabbed him several times causing his death. Mr BM left the studio and returned to his hostel where he had a confrontation with one of the care staff whom he assaulted. He was arrested the next day.

4.2 At the Court Case Mr BM pleaded guilty to manslaughter with diminished responsibility and was sentenced to an indefinite hospital order and was placed at Broadmoor Hospital where he still resides.

Background to the Independent Investigation

4.3 The Health and Social Care Advisory Service was commissioned by Newham Primary Care Trust and NHS London to conduct this Independent Investigation under the auspices of Department of Health Guidance EL (94)27, LASSL(94) 27, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

"*in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved"*.

4.4 This guidance was slightly amended the following year and the particular paragraphs in the guidance relating to 'when things go wrong' further amended in 2005.

4.5 The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimize the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

Terms of Reference

4.6 *"*The Independent Investigation Panel should undertake all the tasks listed below in order to produce a detailed report on the care and treatment Mr BM received and making recommendations to help ensure that any mistakes made will not be repeated in the future.

Stage 1

Following a review of clinical notes and other documentary evidence the Independent Investigation Panel will:

- 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;
- agree with the Primary Care Trust any areas (beyond those listed below) that require further consideration.

Stage 2

a) to examine the mental health care received by Mr BM in the context of his life history, taking into account any issues raised by cultural diversity which appear to be relevant in order to obtain a better understanding of:

- the extent to which Mr BM's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC (90) 23 and local operational policies;
- the extent to which Mr BM's prescribed care plans were effectively drawn up, delivered and complied with by Mr BM;
- the appropriateness and quality of any assessment, care assessment plan and supervision having regard to his past history to include:
    - diagnosis;
    - medication;
    - monitoring by health and social care staff;
    - staff responses to service user and carer concerns;

  - involvement of Mr BM and his family in the drawing up and appropriateness of his care plan;
  - range of treatments and interventions considered;
  - social care interventions;
  - reliability of case notes and other documentation.

- his assessed risk of potential harm to himself and others, by compiling a comprehensive chronology of the events leading up to the homicide. This should specifically include:
  - the risk of Mr BM harming himself or others;
  - the training of clinical staff in risk assessment;
  - the systems and procedures in place during the period of Mr BM's contact with services;

- the effectiveness of interagency working, including communication between the mental health services and other agencies, with particular reference to the sharing of information for the purpose of risk assessment and for appropriate accommodation and care.

b) review and assess compliance with local policies, national guidance and statutory obligations including (where relevant) the appropriateness of use of the Mental Health Act 1983 regarding admission, discharge and the granting of leave, and compliance with Human Rights legislation;

c) consider any other matters arising during the course of the External Investigation which are relevant to the occurrence of the incident or might prevent a re-occurrence;

d) use root cause analysis as appropriate for the purpose of enabling lessons to be learned;

e) ensure that any action plan and recommendations take full account of the progress that health and social care services have made since the completion of the Internal Investigation Report;

f) consider such other matters as the public interest may require;

g) in relation to the incident to involve:

- the victim's family as fully as is considered appropriate;
- the perpetrator's family as fully as is considered appropriate.

h) prepare an Independent Investigation Report for the Primary Care Trust;

i) work with the Primary Care Trust in the period between the delivery of the Investigation Report and its formal publication."

The Investigation Team

4.7 The Independent Investigation was undertaken by the following Panel of professionals who are independent of the healthcare services provided by the East London and the City Mental Health HNS Trust (Now East London Foundation NHS Trust) and the Newham Primary Care Trust:

Chair and Investigation Lead

Ian Allured — HASCAS Director of Adult Mental Health

Members of the Panel

Dr Susan O'Connor — Consultant Psychiatrist

Tina Coldham — HASCAS National User Development Consultant

Sharon Dennis	Former Director of Nursing, and Regional Co-Director at the Royal College of Nursing.
Charles Holloway	HASCAS Associate and Lay Member of the Panel

Independent Advice

Paul Grey	Independent Management Consultant and service user adviser on cultural and diversity issues
Ashley Irons	Capsticks (Solicitors)

Findings and Conclusions

4.8 The Independent Investigation Panel examined all the evidence and concluded that there were four main contributory factors leading to the homicide of Tom - Louis Easton at the EC1 Music Project on Friday 15 September 2006.

Contributory Factor 1: CMHT Workload, Staffing and having 75 Cases managed through the Duty System.

- Workload – the Independent Investigation Panel heard conflicting evidence about the workload of the CMHT working with Mr BM, but no conclusive evidence was obtained as the figures supplied did not analyse the complexity of the total caseload.

- Staffing and Duty - The North West Newham CMHT was the only one of the four CMHTs in Newham to adopt a Duty Caseload due to the pressure of work and the absence of three members of staff due to sickness and attending training courses. Mr BM was one of the cases held on Duty. This did

not affect his attendance at the depot clinic at the CMHT, but it did mean that unless he called at the CMHT he would be seen only once a month by a member of staff at the CMHT.

4.9 The Independent Investigation Panel considered that whilst the changes in staffing and being held on 'Duty' were far from ideal, Mr BM did appear to be more settled during this period. More probing by staff might have given the opportunity for detecting a worsening state but even then, symptoms may or may not have been elicited. Staff at Able Housing did see Mr BM regularly and had not noticed any deterioration in his mental health until the evening after the homicide. The Independent Investigation Panel considers that the actual outcome could not have been predicted.

Contributory Factor 2 : Internal Communications within the CMHT

4.10 The workload of the consultant psychiatrists required them to cover the inpatient wards and the CMHTs plus other duties leaving only two sessions a week for them to be part of the CMHT, (two sessions equating to one day). Less senior medical staff within the CMHTs undertook the medical reviews. Communication between the consultant psychiatrist and the social worker could have been better, but this was not seen as a direct causal factor. The Independent Investigation Panel considers that the lack of consultant oversight of Mr BM was less than ideal, but accepts that the Medical Director at the time did review, and then alter, the psychiatrists' work-plans to enable them to spend an extra half day with the CMHTs. Mr BM did take his depot regularly despite being a day or two late on occasions, but was reminded by his care staff at Able Housing to get his prescription and medication and attend the CMHT depot appointments.

Contributory Factor 3 : Length of Time without regular Anti-Psychotic Medication

4.11 Mr BM may have been suffering from a psychotic illness which was left untreated for several months whilst he was in the Youth Offenders Institution and for a further four months at the Newham Centre for Mental Health. It is possible that the

lack of assertive treatment and engagement with Mr BM at the start of his mental ill health may have set the pattern for his partial engagement with services, and his refusal to accept that he had a mental illness. The Independent Investigation Panel considered that whilst the lack of full engagement and the delay in prescribing anti-psychotic medication may have influenced the way in which Mr BM reacted to 'treatment' there was no evidence to suggest that it led to the homicide.

Contributory Factor 4 : Continued Use of Cannabis

4.12 The Independent Investigation Panel considered that his use of cannabis did make the probability of a relapse in his mental health more likely, and that this may well have played a part in the homicide, although his relapse was not noticed by anyone. He had appeared 'normal' at his supported accommodation until he attacked one of the staff in the evening after the homicide.

Other Factors

4.13 Some service issues were identified and discussed in the Report. These were:

- the prescribing arrangements
- the lack of understanding about the Safeguarding Children Policy
- the lack of a Carer's Assessment for Mr BM's mother.

Conclusion

4.14 The Independent Investigation Panel considers that the tragic homicide of Tom - Louis Easton by Mr BM could not have been predicted. The care and treatment of Mr BM could have been better, and several factors have been improved since September 2006 as a result of the Internal Investigation. The Independent Investigation Panel has recorded some other areas where improvement is required, and it is anticipated that the ELFT will similarly address these.

4.15 There was no single cause of the homicide other than the fact that Mr BM did have a serious mental illness for which he was being treated. He did regularly attend for his monthly depot injections, often after being reminded by the care staff where he lived. He was regularly seen at least once a month, and although a slight fluctuation in his mental state was observed he was generally found to be well with no psychotic ideas present. This 'formal' observation by staff of the North West Newham CMHT was confirmed by the information provided to the CMHT by his mother and the staff at Able Housing.

4.16 Mr BM's mental ill health was identified as the only causal factor, and this linked with the four contributory factors of the CMHT workload and staffing, internal communication within the CMHT, the length of time without regular anti-psychotic medication at the onset of mental ill health and Mr BM's continued use of cannabis combined to contribute to the homicide taking place.

Recommendations

The following recommendations are made in the Report:

Recommendation 1

The ELFT should undertake a joint strategic needs assessment of the population of each CMHT catchment area and link this to a review of the workload of each of the four CMHTs to determine the actual workload of each and then adjust the staffing to better reflect the known needs as indicated by the statistics and information gathered. The information should include population size, morbidity, weighted caseload analysis, turnover data, referrals and assessments.

Recommendation 2

The Operational Service Manager, Clinical Leader (Consultant) and the Associate Clinical Director should make sure that they regularly discuss the running of the CMHT and how it functions. Their discussion should include how risk is assessed and managed, how work is prioritised, the management of particularly complex cases and whether there are any issues which adversely affect the expected flow of communication between members of the multidisciplinary team. If such issues

cannot be resolved locally they should be 'escalated' to the Borough Director for resolution. There should also be a system to ensure that all cases are regularly reviewed.

Recommendation 3

The consultant psychiatrists should hold regular medical reviews and routinely see their patients at CPA meetings. If there are significant concerns about the patient's health or social care, then the consultant psychiatrist should ensure a full review is undertaken him/her or a senior deputy.

Recommendation 4

When patients are with a service for a period of three months or longer, the timely introduction of treatment and medication and the review of dosage and type of medication should be reviewed on a regular basis. This should also be discussed at CPA Meetings.

Recommendation 5

The carers of patients must be offered an assessment of their own needs and any help that they may require in order to fulfil their caring role. The East London Foundation Trust should undertake an audit of case records to determine whether Carers' Assessments are being offered and whether their identified needs are being met.

Recommendation 6

The East London Foundation Trust should audit the training on Safeguarding Children to ensure that all relevant community staff have received the training and any follow-up or updating training and that they are sure of their responsibilities under this legislation

Recommendation 7

Any systems of care and treatment for service users with severe and enduring mental ill health should be as simple as possible and encourage the individual to engage and cooperate with mental health services and *not* place unnecessary and cumbersome barriers in their path. The processes in place within the community should be regularly tested to ensure there are no disincentives to active engagement with the mental health services.

Recommendation 8

The East London Foundation Trust should take steps to identify the family of any person murdered or injured by a patient in the care of the Trust and to offer them any help and support they feel they would like. The Trust should also be open about the Internal Investigation and provide details of the findings and recommendations. Identification of any family of the victim and making contact with them should occur within one week of the incident.

Recommendation 9

The East London Foundation Trust should liaise with NHS London to ensure that discussions take place between the NHS in London and the Metropolitan and City Police Forces to ensure that in future the Memorandum is implemented effectively.

5. Incident Description and Consequences

5.1 Tom - Louis Easton was working in the EC1 Community Music Studio in East London when Mr BM visited the studio with a friend. After being there for some time he attacked Tom with a knife and stabbed him several times causing his death. Mr BM left the studio and returned to his hostel where he had a confrontation with one of the care staff whom he assaulted. He was arrested the next day.

5.2 At the Court Case Mr BM pleaded guilty to manslaughter with diminished responsibility and was sentenced to an indefinite hospital order and was placed at Broadmoor Hospital where he still resides.

6. Background and Context to the Investigation (Purpose of Report)

6.1 The Health and Social Care Advisory Service (HASCAS) was commissioned by Newham Primary Care Trust and NHS London to conduct this Independent Investigation under the auspices of Department of Health Guidance EL (94)27, LASSL(94) 27, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

"*in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved"*.

6.2 This Guidance was slightly amended the following year and the particular paragraphs in the Guidance relating to 'when things go wrong' further amended in 2005. Now the criteria for conducting such an investigation include: -

i) When a person who has been under the care, i.e.; has committed a homicide subject to a regular or enhanced Care Programme Approach, of specialist mental health services in the six months prior to the event;

ii) When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level;

iii) If the Strategic Health Authority determines that an investigation is required.

6.3 The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Mental Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

6.4 The role of the Independent Investigation Team is to gain a full picture of what was known, or should have been known at the time, by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Independent Investigation Team to form a view of what would have happened based on hindsight, and we have tried throughout this report to base our findings on the information available to relevant individuals and organisations at the time of the incident.

6.5 The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and the interests of the wider public.

6.6 It is important to note that this case has been fully investigated by a totally impartial and Independent Investigation Panel.

7. Terms of Reference

7.1 An Independent Investigation should demonstrate and promote good practice by being open and honest when addressing any shortfall in service provision to service users and carers. The national introduction of a Clinical Governance Framework (1999) of setting standards, sharing information and developing partnerships should already have encouraged a culture of openness. Services for service users and improved quality of care should flourish, thus moving away from the 'blame culture' historically prevalent in many NHS Trusts. The main outcome must be to increase public confidence and to promote professional competence.

7.2 Such an Independent Investigation should therefore establish the facts, provide an independent perspective on the events, extract areas for development to improve services and thus endeavour to prevent a similar event happening in the future. To enable this task to be carried out, the Independent Investigation Panel used the following Terms of Reference:

*"*The Independent Investigation Panel should undertake all the tasks listed below in order to produce a detailed report on the care and treatment Mr BM received and making recommendations to help ensure that any mistakes made will not be repeated in the future.

Stage 1

Following a review of clinical notes and other documentary evidence the Independent Investigation Panel will:

- 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;
- agree with the Primary Care Trust any areas (beyond those listed below) that require further consideration.

Stage 2

a) examine the mental health care received by Mr BM in the context of his life history, taking into account any issues raised by cultural diversity which appear to be relevant in order to obtain a better understanding of:

- the extent to which Mr BM's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC (90) 23 and local operational policies;
- the extent to which Mr BM's prescribed care plans were effectively drawn up, delivered and complied with by Mr BM;
- the appropriateness and quality of any assessment, care assessment plan and supervision having regard to his past history to include:
    - diagnosis;
    - medication;
    - monitoring by health and social care staff;
    - staff responses to service user and carer concerns;
    - involvement of Mr BM and his family in the drawing up and appropriateness of his care plan;
    - range of treatments and interventions considered;
    - social care interventions;
    - reliability of case notes and other documentation.

- his assessed risk of potential harm to himself and others by compiling a comprehensive chronology of the events leading up to the homicide. This should specifically include:
    - the risk of Mr BM harming himself or others;
    - the training of clinical staff in risk assessment;
    - the systems and procedures in place during the period of Mr BM's contact with services;

- the effectiveness of interagency working, including communication between the mental health services and other agencies, with particular

reference to the sharing of information for the purpose of risk assessment and for appropriate accommodation and care;

b) review and assess compliance with local policies, national guidance and statutory obligations including (where relevant) the appropriateness of use of the Mental Health Act 1983 regarding admission, discharge and the granting of leave, and compliance with Human Rights legislation;

c) consider any other matters arising during the course of the Independent Investigation which are relevant to the occurrence of the incident or might prevent a re-occurrence;

d) use root cause analysis as appropriate for the purpose of enabling lessons to be learned;

e) ensure that any action plan and recommendations take full account of the progress that health and social care services have made since the completion of the Internal Investigation Report;

f) consider such other matters as the public interest may require;

g) in relation to the incident to involve:

- the victim's family as fully as is considered appropriate;
- the perpetrator's family as fully as is considered appropriate.

h) prepare an Independent Investigation Report for the Primary Care Trust;

i) work with the Primary Care Trust in the period between the delivery of the Investigation Report and its formal publication.

8. The Investigation Investigation Team

8.1 The Independent Investigation was undertaken by the following Panel of professionals who are independent of the healthcare services provided by the East London and the City Mental Health HNS Trust (Now East London Foundation NHS Trust) and the Newham Primary Care Trust:

Chair and Investigation Lead

Ian Allured	HASCAS Director of Adult Mental Health

Members of the Panel

Dr Susan O'Connor	Consultant Psychiatrist
Tina Coldham	HASCAS National User Development Consultant
Sharon Dennis	Former Director of Nursing, and Regional Co-Director at the Royal College of Nursing.
Charles Holloway	HASCAS Associate and Lay Member of the Panel

Independent Advice

Paul Grey	Independent Management Consultant and service user adviser on cultural and diversity issues
Ashley Irons	Capsticks (Solicitors)

9. Investigation Methodology

9.1 Newham Primary Care Trust commissioned this Independent Investigation under the Terms of Reference set out in Section 5 of this Report. The Investigation was led by a Chair (who also acted as Project Manager) from HASCAS. A meeting to discuss the procedure to be followed was held between Newham Primary Care Trust and HASCAS on 09 May 2008.

9.2 In October 2008 HASCAS received written consent from Dr L, Medical Director and Caldicott Guardian of the ELFT permitting access to Mr BM's clinical records. The consent was granted because Mr BM was unwell and was not in a position to make an informed decision, so it was deemed that an Independent Investigation was in the public interest. The Associate Director of Governance couriered the medical records to the Investigation Lead in early November 2008. In addition an initial identification was made of the documentation required by the Independent Investigation Panel including the various relevant policies and procedures in force from 2002 to 2006. A careful analysis was made of these records to determine the skills and experience required by the Independent Investigation Panel. The Panel was then recruited, and at the first meeting of the Independent Investigation Panel a list of people to be interviewed was compiled.

9.3 All documentation received by the Independent Investigation Panel was indexed and paginated. A timeline of critical events was compiled and is contained within this Report at Appendix 1.

9.4 All witnesses were written to four weeks in advance of their interviews detailing the Terms of Reference of the Investigation, the areas that the Independent Investigation Team would be questioning them about, and the operational process and timescale of the work. All witnesses to the Investigation were invited to attend an informal meeting on 21 November 2008 to meet the Investigation Chair. During this meeting the process was explained and a question and answer session conducted.

9.5 Evidence was received orally from 16 individual witnesses over a period of four days during November 2008, January and February 2009. Table 1 lists the witnesses interviewed during the Investigation.

Table 1 : Witnesses Interviewed by Investigation Team

Date	Witness	Interviewers
27 November 2008	Dr A – Consultant Psychiatrist Mr P Sinclair and Mrs D Altaras Dr B – Consultant Psychiatrist Mr BQ – Manager of Hostel and Mr FO hostel worker Ms YE – former Ward Manager at ELCMHT	Mr Ian Allured Ms Tina Coldham Dr Susan O'Connor Sharon Dennis
28 November 2008	Mr AD– CPN Ms CS - Social Worker Mr KH– Locality Manager	Mr Ian Allured Dr Susan O'Connor Sharon Dennis
07 January 2009	Mr TL – CPN Dr Bo – Consultant Forensic Psychiatrist Ms MP - locum CPN Mr RD – Chief Executive ELCMHT Ms CB – Borough Director	Mr Ian Allured Ms Tina Coldham Dr Susan O'Connor Sharon Dennis Charles Holloway
02 February 2009	Mr SM – former CMHT Manager	Mr Ian Allured Sharon Dennis

9.6 All the interviews were recorded and a transcript prepared. The transcript was forwarded to each individual in order for it to be checked for accuracy and also for any additional information to be added to it. It is the amended versions that have been used as evidence in this Investigation. In addition to their panel interview, Mr Sinclair and Mrs Altaras were interviewed at their home by Mr Allured and Dr Johnstone, Chief Executive of HASCAS, in order to fully explain the Independent Investigation process and to answer any questions they might have. This interview was manually minuted by Dr Johnstone and approved as accurate and correct by Mr Sinclair and Mrs Altaras.

Root Cause Analysis

9.7 The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying causes that on detailed analysis are considered to have contributed to a critical incident occurring. This methodology is the process advocated by the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service.

9.8 The ethos of RCA is to provide a robust model that focuses on underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learned to prevent similar incidents happening in the same way again. It must, however, be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.

9.9 RCA is a four-stage process. This process is as follows:

1. **Data collection.** This is an essential stage, as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews.
2. **Causal Factor Charting.** This is the process whereby an Independent Investigation begins to process the data that has been collected. A timeline is produced and a sequence of events is established (please see Appendix 1). From this timeline causal and contributory factors can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This investigation utilised the Fish Bone. This is a process where nine specific areas are examined and the findings written on the diagram shaped like the skeleton of a fish. (The nine areas are listed on Page 48)
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

9.10 When conducting the Root Cause Analysis the Independent Investigation Panel avoided generalisations and sought to use findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

Salmon Compliant Procedures

9.11 The Independent Investigation Panel adopted Salmon compliant procedures during the course of their work. This process is set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:

(a) of the terms of reference and the procedure adopted by the Investigation; and

(b) of the areas and matters to be covered with them; and

(c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and

(d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and

(e) that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them with the exception of another Investigation witness; and

(f) that it is the witness who will be asked questions and who will be expected to answer; and

(g) that their evidence will be recorded and a copy sent to them afterwards to sign;

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

5. All sittings of the Investigation will be held in private.

6. The findings of the Investigation and any recommendations will be made public.

7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's Final Report.

8. Findings of fact will be made on the basis of evidence received by the Investigation.

9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

11. In addition witnesses to the Panel were offered the opportunity to read records relating to their involvement with Mr BM prior to their interview.

10. Information and Evidence Gathered (Documents)

10.1 The Independent Investigation Panel examined all the clinical files. These comprised the following files about the involvement of health and social care services with Mr BM from 2003 to 2005:

- Clinical Records from the Feltham Young Offenders Institute
- Clinical Records from the ELCMHT
- Primary Care Records
- Letter from Dr Bo to Dr B giving a Forensic Opinion of Mr BM dated 20 September 2004
- The Department of Health Policy Implementation Guide for Assertive Outreach Teams (30 March 2001)
- The Internal Panel Review report into the Incident
- Action Plan Update Report on progress in implementing the recommendations of the Mr BM Internal Review dated February 2007
- The London Borough of Islington Report entitled: Management review of action required following tragic incident at EC1 Music Project
- The Operational Policies for the East London and the City NHS Trust in force during Mr BM's period with the Trust regarding:
    - ð Assertive Outreach Services
    - ð Community Mental Health Teams
    - ð Dealing with Untoward Incidents
    - ð Early Intervention Service Newham Locality
- Caseload data for the Newham CMHTs from January 2005 to September 2006
- Email of 05 September 2006 regarding Vacancy Freeze and Bank Usage
- Savings Schedule Monitoring 2006/2007
- Letter from Dr D to Newham Council over Savings to be made dated 20 September 2006
- Minutes of the Trust Board Meeting (Part 2) for 22 February 2007

11. Profile of the Mental Health Services (Past and Present and Transition)

11.1 The East London Foundation NHS Trust has provided this short description of the Trust at the time of the homicide and as it is now.

Past

11.2 In 2006, the Newham Directorate was led by a Borough Director and Clinical Director. The services available were:

- The Newham Centre for Mental Health opened in 2002, where services provided include admission and intensive care beds. The Centre had experienced significant bed pressures up to June 2006 especially on Psychiatric Intensive Care Unit (PICU) beds;
- Newham PCT had provided additional funding to establish a fourth CMHT and services had been geographically aligned to named GP practices in line with this investment;
- The National Service Framework specialist teams were all newly in place;
- The Assertive Outreach Team which had been established for four years had expanded to meet the caseload requirements of the Department of Health;
- The Home Treatment/Crisis Service was in place. This service also offers Day Treatment as an alternative to Hospital admission and resources for this element of service come from Home Treatment Team funds. A Crisis House managed through third sector partnership but gate kept by the Home Treatment Team had also just been established;
- Early Intervention Services were very newly created and building up caseload.

In addition, the Borough had well regarded Rehabilitation and Recovery services that treated and provided support to service users in hospital, step down accommodation and independent settings. Much of the community accommodation was run through third sector partnerships and utilising available Supporting People funding.

Highly specialist mental health services were accessed locally (forensic/mother & baby) from units in the Trust outside the borough or specifically purchased from external providers.

In 2006, the then Medical Director of East London & the City Mental Health Trust led a review of community services across the Trust. Key aspects of this review are referenced at relevant points in this report. Issues identified included assuring the consistent quality of team assessment processes, time spent by senior psychiatrists in community teams, the effects on team functioning of poor recruitment and specifically the number of consultant vacancies in National Service Framework(NSF) teams.

Present

A follow-up to the Community Services Review has been undertaken by the Chief Executive (previously the Medical Director) and the new management arrangements established.

In this arrangement, the Borough Director and Clinical Director have appointed Associate Clinical Directors, each of whom is responsible for the management and performance of a clinical business unit. Some important details are:

- Clinical Leadership of CMHTs is vested in consultant psychiatrists who are supported by Operational Service Leads in ensuring robust practice and service delivery;

- Consultant time in each team has increased by 50% and there is highly competitive recruitment to consultant posts. Until recently there were no consultant vacancies in the Newham adult service; one vacancy arising from a high flyer being seconded and the second from a move back to Germany – both posts have been advertised;

- Other vacancies have been rigorously managed and monitored each month with a vacancy rates reduced to 6%; this is a strong performance by comparison with other London mental health trusts;

- Team assessment processes have been strengthened and are undertaken by senior experienced staff.

All the teams recently established in 2006 have matured and the Borough achieves high compliance with contract targets. Beds are managed within numbers and the acute admission wards all achieved the AIMs excellent standard.

The Trust now manages a specialist mental health out of hours Approved Mental Health Practitioner (AMHP) service for the Borough and has been an early adopter of opportunities under the Mental Health 2007 to nominate non-social work staff to become AMHPs.

The action plan arising from the Trust Inquiry into this homicide has been implemented as described elsewhere in this report.

Since 2006 there has been significant investment in psychological services to support the implementation of NICE guidelines and achievement of an 18 week waiting standard. In addition, the Borough was one of two national pilot sites for Improving Access to Psychological Therapies (IAPT) and is now expanding services with further investment under the second stage of IAPT. This has coincided with successfully bidding to establish a Single Point of Referral arrangement tendered this year by NHS Newham. In conjunction with NHS Newham and its provider services, the Trust has undertaken a review of psychological therapies that incorporates all these developments and critically envisages a strengthened series of partnerships with community organisations.

12. Chronology of Events

Mr BM's Early Life

12.1 The Independent Investigation Panel was unable to speak to Mr BM and his mother as neither responded to invitations to be involved. The social worker at Broadmoor Hospital, where Mr BM is currently being treated indicated that he did not wish to be interviewed or involved in the process. His mother was telephoned and written to but did not respond.

12.2 In view of the lack of contact with Mr BM and his mother the information on Mr BM's early life has had to be taken from the clinical records and various psychiatric reports. These included a letter from Dr SLJ, Consultant Forensic Psychiatrist to Dr L, Consultant Psychiatrist at the Newham Centre of Mental Health dated 27 May 2004, and also a report by Dr PN, SHO to Dr L prepared as a case summary for a presentation to the ward team.

12.3 'Mr BM was born and raised in the Newham area. He described his childhood as "living in the ghetto". His mother is Caucasian and his father is black. His father left home when Mr BM was a young child. His mother's boyfriend lived with the family until Mr BM was about 16 years of age. He attended mainstream schooling in Newham. He was suspended a few times for writing graffiti and skateboarding in school. Mr BM stated that he was somewhat of a loner in school and did not have many friends, in fact he identified only two.

12.4 He admitted that he had been bullied at primary school. He gave quite detailed information regarding his peer group relation difficulties at school and afterwards. He identified strongly with the character "Donnie Darko" from a film. It is a 2001 cult psychological thriller written and directed by Richard Kelly, which depicts the reality-bending adventure of the eponymous character as he seeks the meaning and significance of his troubling end-of-the-world visions. (It is worth noting that these reflections on his childhood were made after the head injury and illness and therefore may have been influenced by this.)

12.5 Despite his difficulties Mr BM completed seven GCSE's and then got a job working in a clothes shop in Oxford Street. He began studying music technology at Newham College and started to play in a band called The Mantis Clan in which he was the lead singer.

12.6 When Mr BM was 16 he sustained a head injury by being struck by a mechanical road sweeper while he was walking in the street. He had a skull fracture with a right frontal and left temporal lobe contusion under extradural haematoma which was treated conservatively. The notes describe that he was intubated and ventilated at the scene of the accident, and noted to have a Glasgow Coma Score (GCS) score of 8. He was transferred by helicopter to hospital and had a significant epileptic seizure during his recovery. Mr BM was started on Epilem but having suffered no further fits after several months he was no longer treated with anti-epileptic medication.

12.7 Mr BM had a complete sense of amnesia for the event and can only recall waking up in hospital several weeks after the incident. He made a slow recovery and struggled a little with speech and word finding. About 6 months after the accident he started getting aggressive, would lose his temper and punch the wall. He stopped going out and spent much of his time in his room.

12.8 On 31 May 2001 a neuropsychological report stated that Mr BM had a verbal IQ of 84 and a performance IQ of 119 using the WAIS-R test. His visual recognition memory was said to be in the very superior range. On 06 June 2001 Mr BM had a language assessment which said he had moderate receptive and expressive dysphasia.

12.9 Mr BM has one younger brother, but details of this child are minimal. He described his father, who had left home when he was a child, as being a selfish person who had never been emotionally available for him. His mother with whom he lived was in a relationship with another man until Mr BM was 16. He stated that he had hardly ever spoken to this man despite living with him.

12.10 In 1999 Mr BM received three cautions from the police for offences against property and one drug offence.

First Episode of Mental Health Problems

12.11 Following the head injury Mr BM lost the drive to do things as he had previously and was pleased to obtain work in a Stratford clothing store. **By 2003** he felt this was not sufficient and he again became involved with music. He worked with two music producers, one black and one white and found it very difficult to decide which one he should stay with to further his career. At this point he was also going to start a college degree in music and had to decide on a university for the foundation course.

12.12 Mr BM found making this decision very stressful and gave up his job in **July 2003**. At this time he stayed at home with his mother and smoked a lot of cannabis with his brother.

12.13 **In December 2003** Mr BM noticed that he was not thinking clearly. He decided to go to Edinburgh to visit a girl he had known at college. He did not check that she was going to be in Edinburgh and when he arrived he discovered that she had gone home for Christmas. He returned to London via Nottingham where he spent Christmas Eve. He was in a pub where a man threatened that he would have his legs broken if he did not have sex with him. He was scared and missed the train back to London.

12.14 **On 29 December 2003** Mr BM travelled back to London by train. Whilst on the journey Mr BM attacked a ticket collector on a train, stabbing him with a pen when he was challenged for not having a ticket. He ran off the train at St Pancras and assaulted two police constables, a British Transport Policeman and later his solicitor, again with a pen. He was remanded to HMYOI Feltham.

On Remand at Feltham Young Offenders Institute

12.15 **On 30 December 2003** Mr BM had an assessment and was found to have no suicidal ideation. On **02 January 2004** Mr BM assaulted another prisoner and attempted to assault staff. He was placed in the segregation unit. The next day he was agitated and irritable and appeared very suspicious. He appeared lethargic but would suddenly become very active and was seen to be laughing inappropriately. A bed was sought in the Health Care Centre but there was no bed available. Later that day he was admitted to the Health Care Centre – he admitted using cannabis every now and then.

12.16 **On 19 January 2004** Mr BM cooperated well with a psychology assessment. He was tending to seclude himself by staying in his cell and not participating in the association times. The medical staff at YOI Feltham considered referring Mr BM to the Newham Mental Health Centre and this was done on 23 January 2004.

12.17 **On 12 February 2004** Mr BM sent his family a letter detailing his wishes for his funeral and the distribution of his belongings. A week later he was considered fit to attend a court hearing. He appeared to be settling down as he was keen to attend the one to one Music Therapy session and started to attend groups and take part in Association, and he appeared to be more involved in the routine of Feltham.

12.18 **On 02 March 2004** Mr BM became very loud and noisy overnight singing at the top of his voice. The following day Dr W, Staff Grade Psychiatrist to Dr B saw Mr BM and prepared an assessment regarding his transfer to NCMH. Later that day Mr BM had a verbal altercation with another prisoner.

12.19 **On 18 March 2004** it was clear that the Newham Centre for Mental Health (NCMH) had not accepted Mr BM for admission and wanted to undertake another assessment. An Extra Contractual Referral was being mooted, which would mean a referral to another specialist unit for assessment.

12.20 The next day Mr BM, who was not taking his medication, refused to see Dr B who had visited to undertake a further assessment about the transfer to the NCMH. **On 22 March 2004** Dr McA completed a court report on Mr BM and concluded by saying he was suffering from a mental illness. The next day Dr B assessed Mr BM as requiring transfer to the PICU (Crystal Ward) at NCMH as soon as possible.

12.21 **On 24 March 2004** Mr BM attempted to stab another prisoner with a knife without provocation. The person attacked had minor lacerations on both forearms and the left shoulder. Mr BM was restrained but attacked a prison officer who received a superficial laceration to his right inner thigh. The prison staff felt Mr BM needed to be in hospital urgently. He was deemed unfit to return to court for another hearing and was placed in Cell 29 (used as a safe holding place with low stimulus).

12.22 **On 28 March 2004** Mr BM painted the window of his cell which hindered observation by staff. He ignored a request to clean the window and was restrained and placed back in Cell 29. Over the weekend Mr BM smeared toothpaste over the observation camera in Cell 29 so he could not be properly observed. He also attempted to assault staff during Association Time using a table.

12.23 **On 30 March 2004** Mr BM was still refusing medication. At the Multidisciplinary Team Meeting (MDT) it was felt that BM had no insight into his illness or the need for treatment. He was deemed to pose a high risk of violence.

12.24 The Prison rang Dr L (in charge of the PICU at NCMH) to see if there was news on when BM would be transferred there. A series of delays took place at NCMH:

- Dr L was off sick so no decision could be taken until the next week;
- Dr B was on leave from 02 April 2004 so again no decisions were able to be taken ;
- Nothing happened until 07 May 2004.

12.25 In the meantime Mr BM punched a prison officer and dismissed his solicitor as he did not trust him.

12.26 **On 07 May 2004** Dr L referred Mr BM for an assessment by the John Howard Unit (Medium Secure Unit). It appeared that the NCMH were unable to agree whether Mr BM required a PICU placement with them, or a placement in a more secure setting.

12.27 **On 19 May 2004** the West London Mental Health NHS Trust which provided some of the staff for the Feltham YOI made a formal complaint to ELCMHT about the delay in dealing with the referral of Mr BM to NCMH. On 24 May Dr SLJ (Consultant Forensic Psychiatrist from John Howard Unit) assessed Mr BM, but on 02 June Feltham Health Care Centre recorded that a decision from Dr SLJ was still awaited. The report had been written but was not signed. On 14 June Mr BM was placed under a Section 48/49 MHA. The following day he was transferred to the NCMH. It is important to note that this was almost six months since he was referred.

12.28 **From 02 June to 08 June** Mr BM was allowed to use an acoustic guitar in his cell. He refused to sign a ‘contract’ to accept this privilege so he was not allowed to use the guitar in his cell but could during Association time. Refusing to sign necessary paperwork is a recurring theme throughout this period and up to the homicide in September 2006.

Treatment and Care on Crystal Ward (PICU) (13 June 2004 until 06 September 2004)

12.29 On admission his medical notes stated that Mr BM had eczema, hay fever and asthma. The head injury was reported. It was thought that he possibly had paranoid schizophrenia/organic schizophrenia. He was placed on 2:1 observations.

12.30 **On 17 June 2004** Mr BM was said to appreciate that his thinking and planning ability had slowed down and that this added to his frustration. He graphically described it as being like “having all the right ingredients for making a cake, but the process of putting them together is just so slow, almost to a frustrating level.” He denied all paranoid feelings and all symptoms of mental illness. On 20 June the observation level was reduced to 1:1 as Mr BM was assessed as presenting a low risk of violence and aggression. The next day the observation was further reduced to every 15 minutes.

12.31 **On 22 June 2004** Mr BM was given a full needs assessment. It was noted that:

- his behaviour had been appropriate
- he preferred to rest a lot
- he kept himself to himself
- he was not complying with prescribed medication
- that when he leaves hospital he would like to live on his own despite having previously lived with his mother
- he said he had the skills for independent living
- he maintained contact with his circle of friends
- he did not believe that he had a mental health problem.

12.32 The next day (23 June) Mr BM became very engaged in the Talking Group and mentioned how boring he was finding the ward. He was also active in the Games Group with an Occupational Therapist (OT). Mr BM was seen by NS, a psychologist and participated in a good conversation about his experience, and said that he had less confidence since his accident and was more self-conscious. He said he was violent in the past as he felt he had something to prove but no longer felt this. He also denied having ever having had any symptoms of mental ill health.

12.33 Dr A stated that Mr BM had a diagnosis of Organic Mood Disorder with a background of head injury. The symptoms were:

- irritability,
- a low threshold for tolerance
- mood swings and poor impulse control
- Mr BM was said to exhibit both expressive and receptive messages/voices.

12.34 **On 24 June 2004** Mr BM was still refusing to take medication. He appeared in court and was made subject to a S37 Hospital Order. He refused to have his rights read to him, but agreed to this the next day. His level of observation was further reduced from 15 minute observation to general observation. It was noted that Mr BM refused to speak to his mother and brother on the phone.

12.35 At this time Mr BM's behaviour was described as unpredictable at times. Staff observed that Mr BM tried to "wind some patients up".

12.36 **On 30 June 2004** Mr BM spoke to another psychologist, MS. In talking about the incident on the train he admitted that he had had paranoia and it had all blown up when he was challenged by the ticket inspector. He said that he regretted the incident and that he had used Feltham for reflection. He grew up with a mixed race/dual heritage background and not having had a male role model he found life difficult. He was encouraged to write his own account of what had happened in the recent past and how it had influenced the present situation.

12.37 **At the beginning of July 2004** Mr BM became more difficult to manage. Some examples in the notes comment that between 02 and 19 July 2004 Mr BM had:

- asked for some money but refused to sign for it;
- refused to remove his hands from inside his trousers at lunchtime in the queue for dinner. It was noted that he appeared to want an immediate response to his requests and was thought to be pushing the boundaries on the ward;
- incisional marks on his left forearm. He shouted and refused to show or discuss these injuries. He said he had superior views and was too clever for society and therefore had his own rules. Eventually he said the self harm was impulsive and due to internalised anger. He agreed it would be useful to have an opportunity to ventilate his feelings daily. He was placed back on 15 minute observations;

- banged on the nursing office door and had shouted abuse at a staff nurse as he wanted something. He soon calmed down (it had been over a lost T shirt).

12.38 **On 20 July 2004** the nurses contacted a neurological nurse specialist for information about the possible effects of Mr BM's head injury following the accident with the road sweeper. The specialist nurse thought that Mr BM's behaviour might be affected if something suddenly happened out of the blue and unexpectedly, and he could find it difficult to adjust and react. Mr BM had an altercation with JA (another patient) and it was noted that he "is unpredictable and quick to anger."

12.39 **On 23 July 2004** Mr BM spent over two hours in the bathroom and was checked by staff. He was upset and mentioned to one of the staff that he would punch him if he ever challenged him over any of his actions again. The next day he entered the TV room and immediately changed the channel. A nurse asked if he could see that this action could be perceived as being rude. Mr BM became abusive and swearing "You don't tell me what to do!!" He repeatedly refused to go to his room for 30 minutes to reflect. Staff removed him to his room and told him he would have an hour to reflect. He was given Lorazepam (a mild tranquilliser) to calm him down. A comment was made in the notes stating that Mr BM was trying to dominate others with little sensitivity of their feelings.

12.40 At a CPA meeting **on 25 July 2004** his mother stated that she was pregnant and would not want Mr BM to live with her as it would be too risky with his temper. The Plan was for Mr BM to be admitted to an open ward for further assessment and to plan for the future including accommodation. His mother described how her son's behaviour had changed after his accident and resulting head injury. It was agreed that he should have regular psychology sessions.

12.41 Mr BM was annoyed that someone had been in his room and had allegedly taken a sweatband. A search of the ward was undertaken but no trace was found of the sweatband. A sharpened toothbrush was found inside the hood of a jacket in Mr BM's room, which he said he had brought from Feltham YOI. When confronted about the weapon he was hostile to staff but there was no actual overt aggression. He stayed in his room and did not want to interact with staff. It was agreed that he

should only be given one pencil at a time and only get given another when the first had been handed back.

12.42 **On 27 July 2004** BM refused to sign the form about MHA Rights under S37. He had a one to one OT session and it was agreed that these should be regular in order to help him prepare for independence and to discuss the situation on the ward. He was interested to hear more about a voluntary sector organisation called Working Well which helped people gain employment.

12.43 **On 29 July** 2004 Mr BM had a psychology session when he talked about the ward round and his need for a weapon. He felt he no longer needed it so he would not overreact. He wanted to have a job, different from the music, but he was worried about the effect of prison and mental ill health on his employment chances. In discussion about his mother's pregnancy he stated that "Mum knows what she's doing and if she wants me out of the parenting role this is fine." He did acknowledge that the sort of arrogance his behaviour demonstrated might make some people dislike him.

12.44 **During August 2004** Mr BM appeared to become angry easily and sought to cut himself off from other people in his life. Examples were that he:

- asked why he was not allowed to use the computers, when he would be discharged and he argued and disagreed with all explanations to such a degree that the discussion had to be terminated due to his aggressive attitude;
- discussed his sleeping patterns as he was staying up to 00.30 and was awake much of the night and then slept for most of the morning. He was given a leaflet about sleep. He went to bed at 00.30 as usual and stayed in the bathroom until 02.00;
- refused to speak to his mother when she rang the ward. She left a message to say she had had a baby boy and was on Oak Ward. Mr BM didn't want the message and said he didn't believe his mother would have called him;

- stated that he wanted to alter his sleep pattern and to be 'relentlessly' persuaded to get up at 09.00. He did not put this into practice in the next few days and was abusive when staff tried to wake him for meals;
- refused to speak to two friends, Rochelle and Lucy, who wanted to speak to him and to visit him on his birthday. Mr BM said he did not want them to visit or to listen to their message.

12.45 During this month the plan was to transfer Mr BM to Sapphire Ward from the PICU so that plans for his discharge could be arranged and put in place. It is noteworthy that throughout his detention in the YOI Mr BM had refused to take any antipsychotic medication, and had not had any during his time on the PICU. Despite this he did not appear to present with any positive psychotic symptoms although he did display difficulty in complying with rules and regulations on the ward.

12.46 Mr BM was transferred from the PICU to Sapphire Ward, an acute adult mental health ward, on 06 September 2004, where he was to remain under Section 37 of the MHA.

Treatment and Care on Sapphire Ward (From 06 September 2004 until 17 January 2005)

12.47 **At a CPA meeting on 25 October 2004** it was noted that Mr BM had started taking Haloperidol 5mg a day which had made him calmer. (This was prescribed after Mr BM had experienced a particularly difficult episode in his illness.) It was felt that his brain injury and cannabis may have contributed to the mental health problems. Mr BM felt the medication made him "feel strange" and to have "vivid dreams". He said that he was pleased he saw his best friend and his brother on the ward.

12.48 The Plan was to:

- make a referral to the OT for an assessment;
- investigate a placement for Mr BM in semi-supported accommodation;

- have 15 minutes escorted leave whilst remaining on S37.

12.49 It was noted that Dr Bo had recommended that Mr BM needs medication and could be 'quite dangerous' if he did not comply.

12.50 The forensic element in Mr BM's presentation was taken seriously and in November 2004 TL, a CPN with the community forensic service, saw Mr BM and discussed his history. He advised Mr BM that if he did not have medication he would not be allowed to leave hospital. He noted that Mr BM had tried to leave hospital and had kicked a female nurse when he was being restrained. Mr BM said that using cannabis made him more suspicious of people.

12.51 **On 14 December 2004** the Mental Health Commissioner seeking to find a suitable placement for Mr BM stated that she felt he needed "a placement where staff have an understanding of forensic issues or a very tight care plan." **On 23 December 2004** on returning from leave Mr BM had taken cannabis whilst at his mother's as his girlfriend had given him some. He explained his use of it saying that he had had to use it again to realise that he should refrain from doing so.

12.52 The plan was that Mr BM should have day leave to Deter Lodge on 04/01/2005 and overnight leave there on 10/01/2005, and he should be discharged there if this was mutually acceptable to Mr BM and the staff at Deter Lodge.

12.53 **On 17 January 2005** a CPA Discharge Meeting and a S117 care in the community meeting was held. The trial leave at Deter Lodge had gone well although Mr BM was positive to cannabis when tested on his return to the ward. The agreed plan for discharge to Deter Lodge was to be managed by CS (Social Worker) and TL. Mr BM was to:

- have Haldol Decanoate 50mg every 4 weeks. He had experienced side effects of restlessness and a tremor so he was also prescribed Kemedrine 5mg BD. Mr BM had been calm, pleasant and friendly unlike prior to the last Depot when he kicked a nurse in the face. Charges of battery prior to his S37 had been dropped
- be randomly tested for drugs at Deter Lodge

- be seen two weekly – four weekly for depot- four weekly by Carol Spencer
- be reviewed in four weeks with a further CPA in two months.

Early Warning Signs of Relapse

- Irritable
- Quick tempered
- Aggressiveness

12.54 It was agreed that there should be a low threshold for admission to hospital due to his high potential for violence. A MHA assessment should be undertaken should Mr BM not comply with medication or stop engaging with services.

In the Community (17 January 2005 until 16 September 2006)

12.55 Initially the placement went well. TL went to Deter Lodge and the proprietor felt that Mr BM had settled well. He had spent time visiting friends, going to the recording studio and looking for work. He would not agree to sign his contract of residence. The proprietor did not have a copy of Mr BM's care plan.

12.56 A month later **(21 February 2005)** Mr BM was reported to be staying out late. The staff at Deter Lodge were not happy with his progress. TL was unable to give Mr BM his depot because he had not got the prescription from the GP, taken it to the chemist to get medication, and then handed it to the staff for safekeeping. (The Internal Investigation Panel and this Independent Investigation Panel felt this was a cumbersome method to put in place for a young man who already found it difficult to comply with medication.)

12.57 **On 07 March** Mr BM called in to the CMHT NW offices as agreed on 21February 2005. He remained mentally stable and he was working as a volunteer from 07.30 to 02.30. Mr BM was not collecting his prescription despite many reminders from staff at Deter Lodge. Staff got his medication so he had his monthly depot. He denied refusing a drug urine test. He was reported by staff to be staying

out late and sleeping during the day. It was agreed at a CPA Meeting on 26 May 2005 that a support worker should help Mr BM to collect his monthly depot prescription. Staff at Deter Lodge were clear that he was breaking the rules and therefore they wanted to end his placement.

12.58 On **16 June 2005** Mr BM did not keep his depot appointment. **On 20 June 2005** Mr BM visited the CMHT NW but had failed to get his medication. He denied that he had ever had a mental illness and said that he never had symptoms in prison. He did not want to have medication.

12.59 **On 12 July 2005** Mr BM was accused of damaging property at Deter Lodge which he denied. Staff insisted that he should leave Deter Lodge on 28 July 2005. **On 18 July 2005** Mr BM felt worthless and again denied having any symptoms and ever having had a mental illness. TL used this session for some psycho-education. **On 03 August** Deter Lodge extended Mr BM's stay despite him having brought two girls home who stayed in his room overnight. He had repeatedly refused to tidy his room and was reported to have kept sneaking out of the fire door late at night.

12.60 **On 08 August 2005** Mr BM moved to Newham House. He refused to complete his Housing Benefit forms and **on 01 September 2005** did not attend his CPA Meeting. **On 05 September 2005** the Newham House staff thought BM was using cannabis in his room due to the smell.

12.61 Over the next three months, September, October and November of 2005 Mr BM had several problems and one or two successes as illustrated by him:

- having no food and staff ringing CS as he needed money. The request was agreed;
- being unable to budget. Mr BM stated that he hated being in the mental health system and would like to live independently;
- feeling that the future was "quite bleak". He denied cannabis use but refused a urine test. It was noted that he seemed to lack motivation to take his life in hand and that he needed more support from supported housing staff. Mr BM

stated that he had never had mental illness and did not believe that there were any harmful effects from using cannabis;

- refusing to pay his rent. He had lost his mobile phone. He stole a Freedom Pass from another resident's room after climbing a ladder and entering through the window;
- refusing to pay rent and thinking that he had no responsibility to find other accommodation;
- refusing to pay rent despite being £300 in arrears. He was given notice to leave Newham House by 10 December 2005. Notice was for not paying rent and not working with the staff as agreed.

12.62 The two successes were that Mr BM was reported to be working part time on a building site, and that **on 07 November 2005** he had attended an appointment with the Shaw Trust about gaining employment.

12.63 **On 05 December 2005** Mr BM forgot his depot as he was doing up a flat with a friend. He agreed to attend the next day and kept the appointment.

12.64 **On 08 December 2005** there was a CPA meeting. The letter from Dr T to Dr Q, Mr BM's GP stated that " Mr BM had been engaging with TL but needs prompting with his depot medication. He has little insight into his mental health problems and is very reluctant to engage in treatment. He is poorly motivated, has no structured activities during the week and despite TL prompting him on several occasions and discussing possible options Mr BM has shown minimal interest. TL has concerns that Mr BM has been using cannabis on a regular basis.......and has refused any urine screening."

12.65 As a direct result of the above difficulties with the tenancy at Newham House Mr BM was moved to Able Housing on 12 December 2005. On 30 January 2006 and 27 February 2006 Mr BM had kept his meetings for depot at the CMHT, although for the latter meeting he had had to be phoned to attend as he had forgotten the appointment. He appeared to be lethargic and slightly hostile and suspicious.

12.66 On **27 March 2006** Mr BM had to be phoned to be reminded to attend for his depot. Staff reported that he still refused to keep his room tidy and that he was still smoking cannabis. There had been no signs of psychosis. At the CPA Meeting three days later (**on 30 March 2006**) it was agreed that;

- Mr BM should remain in contact with the workers and carers at Able Supported Accommodation;
- he should be referred to his RMO/SCMO if he failed to continue medication;
- staff should liaise with his mother;
- he would have a medical in three months;
- TL (forensic CPN) would no longer be involved and AD (CPN) would take over.

12.67 The Crisis Planning section stated that a relapse could be indicated by:

- non compliance with medication;
- being over-argumentative;
- being very suspicious;
- having increased obsessive traits.

12.68 Mr BM stated that he would probably not engage if he lived on his own.

12.69 **On 24 April 2006** when Mr BM attended the CMHT for his depot he had not collected his prescription. Three days later Mr BM returned to the CMHT NW when the depot was available as staff from Able Housing had got it. Mr BM refused a urine test.

12.70 AD (CPN) took over the role of care coordinator from CS, which meant that Mr BM had lost the two consistent staff he had had regular contact with since his discharge from NCMH in January 2005 within just over three weeks. Able Housing had changed GP for Mr BM thinking that the new one was closer to where he was residing and would make it easier for him to collect his depot. Mr BM was annoyed by this and insisted that he returned to his usual GP.

12.71 **On 18 May 2006** Mr BM went to the CMHT NW a week before his depot was due, but returned on 25 May 2006 for his depot having been phoned in advance to ensure he would remember to come.

12.72 **On 21 June 2006** Mr BM went to the CMHT NW for his depot. He appeared paranoid and suspicious.

12.73 **On 19 July 2006** Mr BM attended the CMHT NW for the depot injection Mr BM appeared mentally stable, and was receptive and accommodating. The following month on **18 August 2006** Mr BM was phoned as he was two days late for his depot. The next one was due on 15/09/2006. Mr BM was upset that AD had written to say that he would not be his care coordinator anymore, but it was explained to him that this was due to a team reorganisation.

12.74 The next depot was due on 15 September 2006 but Mr BM did not attend. Unbeknown to the CMHT that afternoon Mr BM attended a community music recording studio in Old Street and stabbed the technician working there, Mr Tom - Louis Easton, using knives he had bought that morning. Mr BM was arrested at his Able Housing address the following day.

13. Timeline and Identification of the Critical Issues

Timeline

13.1 The independent Investigation Panel produced a Timeline in table format in order to plot significant data and identify the critical issues and their relationships with each other. (The Timeline is attached as Appendix 1.) This process represents the second stage of the RCA process and maps all of the emerging issues and concerns of the Investigation Team.

The Timeline and the chronology in the previous section of the report was examined by the Independent Investigation Panel and its contents considered alongside the Root Cause Analysis 'Fishbone'. The topic areas for analysis using this methodology are:

a) Team and Social Factors
b) Communication Factors
c) Task Factors
d) Education and Training Factors
e) Patient Factors
f) Organisational and Strategic Factors
g) Working Conditions Factors
h) Equipment and Resources Factors
i) Individual Factors (which stand alone and are not embraced by the other categories).

13.2 The interviews with the members of staff and managers were examined at length by the Panel and are the basis of the next section where the Fishbone Analysis is described in detail using the nine headings above.

14. Further Exploration and Root Causes

RCA Third Stage

14.1 This section of the Report will examine all of the evidence collected by the Independent Investigation Panel. This process will identify the following:

1. Areas of good practice
2. Areas of practice that fell short of both national and local policy expectation
3. Causal Factors

14.2 There are three types of factors to be identified in Independent Investigations into the care and treatment of people who have committed a homicide whilst under the care of mental health services or having been under their care in the preceding six months of the homicide. These are:

Key Causal Factors:

14.3 This term is used in this report to describe an issue or critical juncture that the Independent Investigation Panel has concluded ***had a direct causal bearing upon*** Mr BM and the homicide. When considering mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the care and treatment that a service user receives and any subsequent suicide, or a homicide perpetrated by them.

Contributory Factors:

14.4 This term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Panel to conclude that it made a direct contribution to the state of Mr BM's mental health and/or the failure to manage it effectively.

Service Issues:

14.5 Service issues is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of 25 June 2005, need to be drawn to the attention of the Trust in order for lessons to be identified and learned with a subsequent improvement to services made.

14.6 The headings in this section of the Report are taken from the Fishbone Analysis. The Independent Investigation Panel examined all the evidence from the clinical records and the interviews it conducted. The appropriate National Guidance, Policies and Operational Policies in the East London and the City Mental Health NHS Trust were also examined in order to identify any causal factors relevant to the homicide.

Team and Social Factors

Workload of the CMHT

14.7 During the interview process the Independent Investigation Panel heard conflicting evidence about the workload and available resources in the North West CMHT. It was stated that the CMHT NW working with Mr BM was one of the busiest in Newham and was less well resourced than the other three CMHTs. The Panel also heard that this was not the situation and that the team was not overstretched and did not suffer unduly from the effect of staff vacancies as some witnesses had reported.

14.8 The conflicting evidence gathered is examined in the next two sections of this Report. The workload of the CMHT will be considered here, and the effect of the staffing situation in the next section.

14.9 The four CMHTs had roughly the same staffing and covered similar sized populations based on GP practices but it is unclear whether they were of the same morbidity. The North West CMHT considered that it was hard pressed and did have a higher referral rate due to the nature of its population and the fact that it had a large National Probation Bail Hostel within its area. The Borough Director denied that this was the case and stated that the CMHT was in the middle of the four and did not have the highest caseload. She also stated that the Bail Hostel produced relatively few referrals but could have led to some additional assessments. TL also confirmed that the referrals were in single figures each year, and the figures showed less than 10 in three years. The caseload figures were not sufficiently detailed to determine the severity of each case and therefore the total workload.

14.10 The Independent Investigation Panel was informed that each CMHT comprised five social workers, five CPNs, psychologists, two doctors (staff grades), two associate specialists, an Occupational Therapist plus administrative staff. There were therefore about 19 staff including the administrative team. KH commented that whilst it was possible that the CMHT might have had a very high referral and assessment rate that did not necessarily mean all were allocated for active involvement by the team. The CMHT workload on a day-to-day basis was stated to be no greater than for any of the other three teams.

14.11 In order to clarify the position the Independent Investigation Panel requested the actual data on the work of the four CMHTs, and the data supplied supported the view that the CMHT was not as hard pressed and out of kilter with the other CMHTs as some of the staff had indicated. It must be mentioned that the data was not broken down to show the complexity of each case and was done purely on numbers and not content. A more detailed breakdown was not available.

14.12 SM, the manager of the North West Newham CMHT, told the Independent Investigation Panel that there was no population needs assessment made to identify the respective needs of the four populations covered by the four CMHTs, so they were all roughly the same size with the same staffing disciplines. He accepted that a CMHT manager would argue for more staff, but that it would have been prudent to

look at the respective needs of each population rather than standardising each team.

14.13 Staff commented that the North-West CMHT was right outside Stratford, almost on the High Street and as a result people were in the town centre and would often visit the CMHT office ‘off the street’. All sorts of people were said to have turned up seeking help, including some of the high immigrant population who had been advised that the CMHT could help them. It was suggested that the situation would be very different for the CMHT which was based in East Ham.

14.14 The Independent Investigation Panel appreciates that work has been done since September 2006 to improve the working arrangements within the CMHTs and by their staff, but the lack of information about the relative workload content of each CMHT should be addressed, rather than seeing all four as the same with similar populations.

Recommendation 1

The ELFT should undertake a joint strategic needs assessment of the population of each CMHT catchment area and link this to a review of the workload of each of the four CMHTs to determine the actual workload of each and then adjust the staffing to better reflect the known needs as indicated by the statistics and information gathered. The information should include population size, morbidity, weighted caseload analysis, turnover data, referrals and assessments.

Staff changes and vacancies

14.15 One of the clinicians (Dr B) told the Independent Investigation Panel that staff shortages had been an ongoing problem and that discussions with the manager about staff shortages, the level of locum staff and high staff turnover, especially with the locums had taken place.

14.16 The locality manager (KH) described the position regarding staff shortages in the CMHT. He confirmed that AD was a locum (covering for a member of staff who was on maternity leave), so that was one temporary vacancy being covered. The other temporary vacancy was MP, who was on sick leave following an operation, so this was a temporary absence of a member of staff. The third missing member of staff was undertaking the 60-day Approved Social Worker training. He commented that in the last two situations where staff were on sick leave or away on a training course the CMHT was not encouraged to fill the posts with a locum.

14.17 During the interviews the Independent Investigation Panel were informed by the Chief Executive of the ELFT that cost savings and a review of filling vacancies was not imposed until September 2006 and therefore bore no relevance to the reasons why Mr BM committed a homicide. The Investigation Panel was informed that in 2006/7 there was an agreed Trust-wide savings plan that was going to save £10.1 million overall. In addition, in late August 2006 NHS London announced that the health services in London were very short of money, there were major financial difficulties and Trusts had to make savings. The overall effect on Newham was that it had to contribute to an overall requirement for the ELFT to find savings of £4.8million.

14.18 The Chief Executive took up this post on 12 September 2006 having previously been Medical Director. Just prior to this the Trust had introduced a vacancy freeze so that any vacancies in the Trust could not be recruited to without the agreement of a Trust Board director. The Director of Nursing had to approve the recruitment of nursing posts, the medical director had to approve recruitment for medical posts and the Director of Human Resources had to approve all other recruitment.

14.19 It was clear from the interviews that in Newham this vacancy freeze had not been discussed with more senior managers (the Borough and Clinical Directors) by the Locality Manager to obtain their views. It was not realised that he could discuss the need with either the Director of Nursing or the Director of Human Resources for other posts. This explains his refusal to let SM, the CMHT manager, fill his vacancy when he was concerned about the staffing. This led directly to Mr BM losing AD as

his care coordinator and having MP instead until she became ill when AD returned. Mr BM was placed on the Duty List.

14.20 Whilst Mr BM did have several changes in the personnel working with him in 2006 which may have been unsettling for him, he was seen regularly and reminded to have his depot injections. Three members of staff were away due to illness or Approved Social Worker training and as result 75 patients were held by the duty system rather than having a named worker.

Relationships within the CMHT

14.21 Some witnesses mentioned that there were tensions within the North West Newham CMHT during the time that Mr BM was under their care. Dr A, a recently recruited psychiatrist from Italy became his RMO just as he was being discharged into the community in January 2005. Mr BM was to have TL, a forensic CPN, working with him and monitoring his depot injections, and CS, a social worker, as his care coordinator.

14.22 Dr A described how difficult she found it to acclimatise to the English mental health services. This was in part due to the fact that the North West Newham CMHT had been without a permanent consultant for nearly three years. There had been several locum appointments since the previous consultant had left. The team had learned to survive and operate without a consultant, and had developed procedures and customs without any consultant input as a locum consultant is expected to carry out the clinical duties and to get the job done.

14.23 As a result, the multidisciplinary team had grown used to working without a consultant who was taking an interest in the structure of the service and its strategic development. It was reported that when Dr A did take an interest in the way the team functioned and in its development she met passive resistance with staff saying ‘We don't do this’, ‘We don’t do that’, ‘We do it like this’, ‘We do it like that’. One specific example was that the team did not allocate referrals of patients in supported accommodation because it was deemed that they already had a support worker where they lived.

14.24 It took a bit of time for Dr A to establish a relationship with the team and she wanted to have an input into decision making at all levels: the clinical level, the policy level, the managerial level and at the structural level.

14.25 The consultant psychiatrist for the other team in the North West CMHT had been with the service for several years and was well liked and respected by the staff. It was mentioned by some witnesses that Dr A and CS had some difficulties in working together, but nothing major which could have affected the care and treatment of Mr BM or other patients.

14.26 Dr A discovered, whilst reading the Internal Investigation Report, that CS had not told her about her gut feeling that Mr BM was dangerous. This information had never been discussed in CPA meetings or at any other time. It was clear that there had been communication issues between CS and Dr A. From the Internal Report, and from the interviews with the same staff by the Independent Investigation Panel it was evident that CS did not feel comfortable with Mr BM.

14.27 CS explained that when she interviewed Mr BM she made sure she was sitting close to an open door as she had a gut feeling about him and felt ill at ease when with him. Dr A felt that if any member of the team was concerned about a client they should have called a professionals meeting to discuss the concerns that he was dangerous. There were no emails sent to Dr A explaining any concern about Mr BM.

14.28 No concerns were expressed at the CPA Meetings and there had been no discussions with other members of the team when Mr BM's accommodation placements were in danger of breaking down and he was at risk of being evicted. None of the evidence for these difficulties Mr BM was experiencing in the community was shared with the consultant psychiatrist. This meant that Dr A did not have all the available information at the CPA meeting when important decisions were made.

14.29 The Locality Manager (KH) was not aware of any difficulties within the CMHT as no issues had been brought to his attention. SM, the team manager confirmed to the Investigation Panel that the North West CMHT that had not had a manager for a long time prior to his appointment and that when Dr A joined the CMHT he was still fairly new in post and was trying to change the culture of the team. It appeared that

because it had got used to not having a manager the staff had been used to doing their own thing, and it proved a difficult team to manage.

14.30 The communication within the CMHT between the consultant psychiatrist and the social worker, and between the team and the team leader/manager, was not good and it was evident that discussions about clients were not held as often as perhaps they should have been and staff did not ensure that all those involved in the care and treatment of a client/patient were kept up to date about every issue.

Recommendation 2

The Operational Service Manager, Clinical Leader (Consultant) and the Associate Clinical Director should make sure that they regularly discuss the running of the CMHT and how it functions. Their discussion should include how risk is assessed and managed, how work is prioritised, the management of particularly complex cases and whether there are any issues which adversely affect the expected flow of communication between members of the multidisciplinary team. If such issues cannot be resolved locally they should be 'escalated' to the Borough Director for resolution. There should also be a system to ensure that all cases are regularly reviewed.

Role of Consultants – were they in or out of the team?

14.31 As Dr A explained to the Independent Investigation Panel the consultant psychiatrists were expected to lead both the ward team and the CMHT team to which they were attached. In addition they were also expected to visit the day hospital as well as having outpatient clinics. The then Medical Director also explained that the consultants were only spending two sessions a week with their CMHTs, which he felt was too little.

14.32 The Independent Investigation Panel was told that patients often only saw their consultant when they attended a Care Programme Approach meeting (every six months in most instances), as the other day to day contact was with the less senior medical staff. The then Medical Director explained that he was involved in two reviews of community services. The first reported in February 2006 and found that

the practice in Newham was much the same as elsewhere in the Trust, which was that the consultants were not spending as much time as the Trust felt necessary working with their CMHTs.

14.33 It was reported by some staff that Newham was different to the other two Directorates in the adult service, in that it had quite a number of non-consultant medical posts which was considered positive. It was noted that Newham had less training and senior training doctors (SPRs) than the other Directorates. The issue in Newham, together with the other Directorates, was that the consultants were spending an average of one to two half days directly with their CMHTs. The Review of Community Services made a number of recommendations including making it a requirement for consultants to spend three half days working with the community teams separate from any out-patient clinics.

14.34 This change was mentioned and welcomed by Dr A, although she would have preferred to have had the inpatient and outpatient role split between two psychiatrists, one for inpatients and the other to work in the community. The change in the work plan for the psychiatrists meant that as from 2006 they spent three sessions a week with the CMHT. This was still only 30 per cent of their time, and as the difficulties between Dr A and CS described in the last section demonstrate, face to face contact was limited, and issues were not necessarily raised at the CPA meetings when the consultant was present.

14.35 The Investigation Panel concluded that although the Community Review had increased the consultant presence within the CMHTs, they were still absent much of the time, and for a new psychiatrist this could have lessened the ability to really get to know the team, as there were other teams to be a part of as well. At least they were more visible to the team and had more time to provide leadership and advice.

14.36 The Panel concluded that Mr BM did not have a medical review for several months which was an issue as his mental state was not examined as often as one would expect. His medication was never altered and he had very few in depth medical reviews, and apart from his CPA Reviews these were not with the consultant psychiatrist. It was agreed by the Independent Investigation Panel that the medical reviews carried out by the staff grade doctors should sometimes, and always where

there are concerns about the client/patient, be performed by the consultant psychiatrist.

Recommendation 3

The consultant psychiatrists should hold regular medical reviews and routinely see their patients at CPA meetings. If there are significant concerns about the patient's health or social care, then the consultant psychiatrist should ensure a full review is undertaken him/her or a senior deputy.

Duty system – holding cases on duty

14.37 In the discussion of the staff vacancies and the workload of the North West CMHT it was mentioned that there was a short period during 2006 when there were 75 patients open to the CMHT being seen on a duty basis. This means that these patients did not have an allocated member of the CMHT assigned to their care, but had to turn up at the CMHT, or request a visit from the duty worker for the day.

14.38 The Independent investigation Panel considered that this was not best practice, as it formally builds in the lack of having a consistent and known contact within the CMHT for patients who are deemed to require a care coordinator by virtue of their CPA status. Mr BM was one of these patients.

14.39 It is noticeable that Mr BM had several staff changes during his last three months with the North West CMHT. As mentioned earlier TL the forensic CPN decided that he no longer needed to see Mr BM and this was confirmed at the CPA meeting on 30 March 2006. AD was to take over as CPN and CS would continue as care coordinator and social worker.

14.40 From the time that TL became the forensic CPN for Mr BM it was planned that he would withdraw once his position had stabilised and hand over the role to another CPN. The forensic CPN remained with Mr BM for longer than originally intended due to the initial difficulties with his accommodation placements

14.41 At the March 2006 CPA it was agreed that TL should withdraw but that he still needed a CPN in order to supervise the depot injections and to regularly monitor his mental state. At the same meeting CS stated that she felt two people from the same team working with him was not a good use of resources and that the care coordinator role and the CPN role could be performed by the same member of staff.

14.42 TL expressed concern at two people leaving at the same time and CS agreed that she was aware of this and that she would not withdraw straightaway and a CPN would be allocated for Mr BM. It was agreed that TL would meet the new CPN at the next depot appointment. This meeting took place and CS was also present. It was agreed that CS would continue until AD had got to know Mr BM and CS would not withdraw until AD was ready and Mr BM was used to the idea.

14.43 In the event CS decided that as Mr BM was settled at Able Housing and he had a job at the Greyhound Track she no longer needed to be his care coordinator. In her interview CS stated that she had to hand over her care coordination role because as the senior practitioner in the team she was deemed to have too many cases. This was linked to a change in the CMHT whereby a senior practitioner would work with one consultant and a clinical lead nurse would work with the other consultant. In order to effect this change CS had to reduce her caseload and was advised to hand Mr BM to AD for both CPN and Care Coordinator roles.

14.44 AD took over this role on 27 April 2006, within three weeks of the CPA meeting. CS considered the handover to AD appropriate because Mr BM had settled in his placement quite well and his mother was said to be quite comfortable with this as well.

14.45 With the decision to keep some cases ‘on duty’ Mr BM did not see AD as he had not been retained due to the decision not to have agency staff. In effect AD was back with the team relatively soon to cover for the absences of staff through sickness, maternity leave and undertaking Approved Social Worker Training. In the absence Mr BM saw MP until AD returned.

14.46 On 18 August 2006 Mr BM went to the CMHT for his depot and was upset to meet AD who had written to say he would not be his care coordinator anymore. It was explained that this was due to team reorganisation and AD had been moved to do other work but had been brought back. AD explained that Mr BM would be seen by whoever was on duty. He had his depot and it was noted in the medical file that the next depot was due on 15 September 2006.

14.47 During the period from March to September 2006 Mr BM had less input from the CMHT than previously (as AD acted as both CPN and Care Coordinator) and also a lack of consistent staff contact. He had settled at Able Housing and appeared to have a good relationship with the staff there. He continued to need reminding about his depot, but during the period he appeared to be settled. From his perspective it could have appeared that the people he had known best within the team had deserted him, hence his annoyance when AD said he would no longer be involved.

14.48 As will be discussed in the next section, the North West CMHT tended during the last few months of their involvement with Mr BM to use the Staff at Able Housing and Mr BM’s mother as their eyes and ears to monitor the situation. This was a lower level of involvement than at any time since Mr BM was first admitted to the Newham Centre for Mental Health on 15 June 2004.

Communication Factors

Communication between Dr A and the other members of the CMHT

14.49 Dr A described that due to the work arrangements and the overall workload she saw very little of her patients except at their Care Programme Approach (CPA) meetings. At other times the more junior medical staff saw the patients either at the CMHT or at outpatients. At the CPA Meeting on 30 March 2006 it appeared that Mr BM had settled well at Able Housing, and despite a few incidents he was mentally stable. Mr BM's mother reported that his attitude had changed since the last CPA meeting and he was more cheerful and assertive in trying to achieve what he wanted to do. TL described Mr BM's mental state as settled, although he did have some concerns about his continued cannabis use, and his relatively limited insight into his mental illness.

14.50 Dr A found Mr BM to be "alert, collaborative, with good rapport and eye contact throughout the whole interview. He reported that his mood had got better since the day he started working, even though he did still feel a bit low and somewhat down on occasions. In view of this the care plan was for:

- Mr BM to remain in contact with the workers and carers at Able Supported accommodation;
- To refer to RMO/SCMO if Mr BM fails to continue with his medication;
- To liaise with his mother.

The Crisis Planning section stated that a relapse could be indicated by Mr BM displaying the following traits:

- Non compliance with medication
- Being over-argumentative
- Being very suspicious
- Having increased obsessive traits.

14.51 Mr BM stated that he would probably not engage if he lived on his own. The plan was to continue with the Haloperidol Decanoate 50mgs every four weeks, and for him to remain on enhanced CPA. A medical review was planned for three months later and a CPA meeting in six months with Dr A.

14.52 Prior to this CPA meeting the communication between CS and Dr A had not been very clear. CS described in her interview with the Independent Investigation Panel that she felt uneasy about Mr BM because she always felt that there was something going on in his head. She found him to be always quite suspicious. She thought that he was somebody who could easily become very aggressive. It was difficult to rationalise anything with him because he would twist round anything that was said to him. This is contrary to how other members of the team felt with him.

14.53 Dr A had never been told this, and if she had known she might have handled Mr BM differently if CS had reported her gut feeling that he was dangerous and had explained that he had been having difficulties with his accommodation. Dr A may have made a different decision about the frequency of reviews or the level of medication had she been aware that the care coordinator considered Mr BM was potentially dangerous.

14.54 By March 2006 the assessment at the CPA meeting was that Mr BM was stable and that he appeared to be coping well in the community provided he had his medication regularly. He needed to be reminded to collect his medication and to take it to the CMHT, but he usually had it within a day or two of the due date. It was agreed that he should have a CPN to replace TL and that CS should continue to be his care coordinator.

Reliance on Able Housing and Ms C (BM's mother)

14.55 It is clear from the clinical records that CS relied heavily on Mr BM's mother to keep her informed about how Mr BM was. She also regularly liaised with the staff at Able Housing to discover whether there were any issues to be addressed concerning Mr BM.

14.56 CS stated that she had had a good relationship with Mr BM's mother and found her a good source of information on how he was coping. She tended to phone his mother if she had not been able to see Mr BM and was informed if he was well or if there were any concerns about him.

14.57 Mr BM had been told a great deal about Able Housing by CS and he accepted a place there without having visited. CS thought that Mr BM would get on better with male staff and that he would like the placement as it was close to his mother's home, as he liked to keep in contact with her. She was very positive about the placement as she felt certain that Mr BM would get on well with the manager. The regime at Able Housing was relaxed and had someone sleeping there overnight, but the care and support was not too obtrusive. Mr BM had explained that his goal was to eventually have his own accommodation and he did not want anywhere that was going to make too many demands on him. CS did not think that a more supported 24 hour placement would have been appropriate.

14.58 During the last six months of his contact with the North West Newham CMHT Mr BM had relatively little direct contact with staff apart from the monthly depot injection. The staff at Able Housing kept the CMHT aware of how Mr BM was, and when he was at the CMHT he appeared to be managing well. His presentation at the depot session was usually seen to be mentally stable (from the clinical record), although on 21 June 2006 he was described as being paranoid and suspicious by AD who gave him his depot injection. This could have been because the staff at Able Housing had changed his GP without his consent, thinking the surgery near them would have been more convenient for him than him having to travel to Leyton. Mr BM did not like this change and he returned to his longstanding GP. It is not clear whether this paranoia and suspicion was reported to the medical team members.

14.59 Mr BM was on enhanced CPA and some additional direct contact with the CMHT would have allowed staff to have more first-hand contact with him. It is unclear how well the CMHT staff working with Mr BM monthly from April 2006 actually knew him and whether he disclosed much of his mental state. More frequent contact may have facilitated this.

14.60 His mother and the staff at Able Housing considered him to be doing well, as had the CPA Meeting on 30 March 2006. On 19 July 2006 Mr BM went for his depot and was described as being "mentally stable, receptive and accommodating." The following month he was upset that AD had written to say that he would not be his care coordinator anymore. It was explained that this was necessary due to team reorganisation within the CMHT.

14.61 The level of help and support Mr BM received from the CMHT was halved since March 2006, and was delivered by different staff than the two he had had since his discharge from the Newham Centre for Mental Health. The relationship Mr BM is reported to have had with the staff at Able Housing was more positive than from the other two placements from which he had been evicted, and to some extent compensated for the lessened contact with the CMHT.

Opportunity to reflect on work within the CMHT

14.62 From the evidence given to the Investigation Panel it appeared that within the busy CMHT there were few opportunities for the staff to reflect on their work and to review their actions. The CPA meetings seemed to be the main vehicle for this, and there was no clear evidence of regular supervision, although staff could seek advice from senior colleagues.

14.63 Some of the handovers of care with Mr BM seem to have been a little perfunctory with little formal introduction to the new member of staff or a formal handover session. TL did discuss the situation with AD, but there was not a formal handover meeting other than the CPA meeting which AD did not attend. Similarly AD did not have a handover session with EP.

14.64 Some discussion took place at the medical reviews and the multidisciplinary team had the opportunity to discuss cases but without the benefit of the consultant psychiatrist being present. At the Newham Centre for Mental Health Mr BM's situation and presentation had been closely monitored and a case review and presentation was held. There was no such discussion or review within the CMHT.

Task factors

Long untreated period with little or no medication – effect on Mr BM's attitude to mental health services

Prison and Hospital

14.65 Mr BM was first admitted to the Newham Centre for Mental Health on 16 June 2004. Prior to this he had been in Feltham Young Offenders Institute for five months. During his stay at the Young Offenders Institute it was clear that Mr BM exhibited unusual behaviour and that there was evidence of a psychotic symptomatology. He was seen by a forensic psychiatrist on 27 May 2004 and recommendations were made for him to be transferred to psychiatric care. The forensic psychiatrist wrote that he was "in the throes of a first episode of psychotic illness he is grandiose circumstantial and has frank delusions about himself and his identity". It was unclear at this stage whether illicit drugs were relevant in the generation of the symptoms and concerns were also raised about a previous serious head injury and how much that might have contributed to the psychosis.

14.66 The forensic psychiatrist at this point made the point that Mr BM had been untreated in prison. A recommendation was made to send Mr BM to a psychiatric intensive care unit (PICU) and it was suggested that he might respond very well to quite low doses of medication. In the Trust's Internal Report it states that Mr BM may have been prescribed Risperidone and potentially Olanzapine whilst in prison, but it is unclear whether this was ever administered. The Feltham case notes suggest not, with several references to Mr BM not taking medication. The prison staff would not have been able to enforce the taking of medication as Mr BM was not subject to the Mental Health Act 1983.

14.67 On 15 June 2004 Mr BM was admitted to Crystal Ward (the PICU) under the care of the East London and the City Mental Health NHS Trust. The nursing notes thereafter mention that there were incidents of verbal altercations on the ward and that Mr BM was non compliant with prescribing medication. He was on the ward for three months before being transferred to an open ward, Sapphire Ward, on 06 September 2004. It was noted that the reason for Mr BM being transferred was because his behaviour had improved, yet he had not had any medication at this time.

14.68 Four weeks after the transfer, on 04 October 2004, Mr BM became threatening towards a member of staff on the ward and thereafter received some Haleperidol, an antipsychotic, and Lorazepam. From this date he was started on oral Haleperidol and continued on this for a month, when this was changed to a depot on 19 November 2004 which was to be 50 mgs every four weeks. This dose is a reasonable starting dose but the usual maintenance dose is 100-150mg every 4 weeks.

14.69 It is unclear why Mr BM remained without prescribed medication during his time on the intensive care unit. There are several possible explanations. It would appear that staff were waiting to see whether his behaviour improved without any medication. He was non compliant with medication so any medication would have had to be given against his wishes under the Mental Health Act. It would appear that Mr BM's behaviour improved over his admission as the episodes of difficult behaviour decreased. It is not clear however how different his mental state was over this period. Certainly, at the point of admission from the prison, Mr BM was described as having grandiose and delusional ideas. These symptoms are not described during his admission and the clinical entries in the case-notes suggest that psychotic symptoms were not elicited. It would therefore appear that his mental state did improve as well as his behaviour during his admission. However it is also possible that Mr BM was concealing symptoms.

14.70 The reason for Mr BM's apparent improvement in mental state and behaviour is unclear. Possible explanations include the stability and security of the environment and the lack of illicit substances. Although he did improve and was moved to an

open ward in October 2004 Mr BM's behaviour was very threatening towards staff on at least two occasions. Twenty five days after the start of his medication it was noted that his behaviour was more reasonable whilst he was on medication and at this point talk about 'leave' began and plans for his discharge were commenced.

14.71 Whilst Mr BM was on the intensive care unit, although he was noted not to show any evidence of psychotic illness, there were episodes of difficult behaviour. He was noted to be uncooperative at times, he became irritated occasionally, he would not sign for his money, he did not interact with other people very well and there was evidence that he might be cutting himself occasionally.

14.72 He spent long periods in the bathroom. He had collected pens and broken pieces from a comb in his pocket and there were concerns expressed that these might be used as a weapon. On one occasion he became quite hostile with members of staff when a television channel was changed. He became aggressive in August again when he could not use some computers he wanted to use. It was noted that he stopped allowing his mother to come to his ward round and he had stopped interacting with friends who had been visiting him. Whilst he was on the open ward his behaviour did become more aggressive and when medication was started it was noted that this had "a remarkable effect on him and he became less grandiose, less aggressive and more in keeping with the person his mother recognised before he had had his road traffic accident".

14.73 The whole of this episode suggests that Mr BM may have been suffering from a psychotic illness which was left untreated for several months whilst he was in prison. (Feltham YOI) His transfer to hospital was delayed as the psychiatrists at the Newham Centre for Mental Health and their forensic colleagues could not agree on the appropriate placement. Once he was in the psychiatric hospital he was not actively treated for his psychosis for several months.

14.74 All this occurred despite the fact that his behaviour was abnormal, he did show irritability and he clearly did not come across as the person that his mother recognised prior to the attack on the train ticket collector. Although Mr BM denied many symptoms of psychotic illness, he clearly was behaving in a suspicious and

odd manner at times, and he clearly improved a great deal when he was put on antipsychotic medication.

14.75 This begs the question of why Mr BM's psychosis went untreated for such a long time and whether there were any adverse consequences as a result. It may have been quite reasonable whilst Mr BM was in hospital for him not to be treated for a short time to see if his mental state would improve when illicit drugs were withdrawn. However, at a certain point it would have seemed reasonable to have treated him and to look and see whether the treatment improved his mental state and also to alter the dose of medication to see whether this further improved his state. This did not in fact happen and he remained on the same dose of Haleperidol depot from the time that he left hospital until the events preceding the homicide.

14.76 The fact that he remained psychotic and quite paranoid with high degrees of irritability throughout his early stay in psychiatric services may have contributed to his poor engagement with services. There may have been a lost opportunity when better engagement could have been achieved and a better understanding of some of the factors and ideas which were driving Mr BM and his behaviour.

14.77 It is important to note that Mr BM is of mixed race and there is evidence to suggest that individuals from his background do receive a high dose of antipsychotic medication more often than white individuals. There may have been a concern that a young man with a first episode of psychosis should not receive a high dose of antipsychotic medication too readily. Staff may have almost been overcompensating for this risk. The diagnosis was not clear. The differential diagnosis being first episode psychosis induced by severe psycho-social stress possibly complicated by his head injury. Alternatively his condition could have possibly been drug induced, or a first episode psychosis that was in fact the first episode of a schizophrenic illness. As time continued and Mr BM continued to have psychotic symptoms and altered behaviour in the absence of illicit drugs, a diagnosis of a schizophrenic illness is more likely.

In the Community

14.78 Following his discharge from NCMH Mr BM had several medical reviews by junior medical staff working for the consultant and by the consultant herself. The first

review was in March 2005, there was a second review in May 2005 then a further in September 2005. At all these three reviews Mr BM's mental state was seen as stable, positive psychotic symptoms were not elicited, and therefore his depot medication was not increased. In December 2005 Mr BM was seen again by one of the doctors on the team. Although he was not considered to be more psychotic than usual, he appeared to be low in mood but he refused an antidepressant.

Lack of Medical Review in June/July 2006 and no date for September CPA

14.79 In March 2006 there was a CPA meeting and reports at that meeting were extremely positive, particularly about Mr BM's social functioning and also his mental state. Following this the care co-ordinator was changed and there were various other changes in the level of support that Mr BM received as described above. In terms of the medical input the consultant at the CPA in March 2006 asked for a medical review to occur three months later. This did not occur and no reasons were given for this.

14.80 It was also agreed at the March 2006 CPA Meeting that there would be a further one in six months, in September 2006. No firm date appears to have been set for this meeting which did not take place.

Medication

14.81 The dose of Haleperidol 50 mgs every four weeks is lower than the dose often used. It would appear that when Mr BM was seen, his mental state was not considered as showing signs of an acute psychosis therefore there was no need in the view of the people that saw him to alter the medication. It is however not clear how forthcoming Mr BM was about his mental state and whether some of his abnormal thinking was concealed from the staff who were undertaking the assessment. There is certainly some suggestion that his behaviour was more difficult at times than that which was reported to the medical staff. For example the consultant, Dr A, mentioned that she did not remember if some of the difficult behaviour that was mentioned in the notes by other staff was available to her at the March 2006 CPA meeting. In her interview Dr A said that if she had known the real extent of the concerns at that time she may have considered an increase in the dose

of medication. This did not occur. It is impossible to say whether a higher level of medication would have been helpful to Mr BM.

14.82 There were some entries in the notes indicating that Mr BM was sometimes seen to be more unsettled, cautious and suspicious towards the end of the four weeks since the last depot injection. This does not appear to have always been the situation as the nursing comments illustrate. For example on the depot injection days from February to August 2006 the following observations were made in the notes:

27/02/2006 – had had to be phoned to attend as he had forgotten appointment. He was lethargic and seemed slightly hostile and suspicious.

27/03/2006 – Rang to be reminded to attend. Staff report that he still refuses to keep his room tidy. Still smoking cannabis. No signs of psychosis.

24/04/2006 - BM had not got his prescription – he had to collect this and get the medication before going to the CMHT for the depot injection

27/04/2006 - Depot available as staff had got it. BM refused urine test.

18/05/2006 – Mr BM was seen briefly as he attended the CMHT a week before his depot was due – he was asked to return the next week.

25/05/2006 - depot. He had been phoned in advance to ensure he would remember to come.

21/06/2006 - depot. BM appeared paranoid and suspicious. There were issues with Able Housing about prescription

19/07/2006 - depot. BM appeared mentally stable - he was receptive and accommodating

18/08/2006 - BM was phoned as he was two days late for his depot. The next one was due on 15/09/2006. BM was upset that AD had written to say he would not be his care coordinator anymore - it was explained that this was due to team reorganisation.

15/09/2006 - Depot due – Mr BM did not attend. Date of homicide.

Other Issue

14.83 The other issue of note is that Mr BM clearly abused cannabis during his care by services and possibly other substances as well. He was not well motivated to deal with his substance abuse. It is not clear whether the fact that he was abusing other drugs which are known to exacerbate psychotic illness was considered by the medical staff when they were thinking about the medication.

14.84 Mr BM was not referred to an early intervention service at any time. The Panel asked why this had not been considered, and it appeared that the service was only just being established and that Mr BM would not have met the criteria for acceptance.

Main Points about the Medical Treatment

14.85 The main issues highlighted in terms of the medical treatment that Mr BM received were that:

- Treatment was delayed whilst Mr BM was at Feltham YOI as he was not subject to a Section of the Mental Health Act 1983. It is not clear why this was the case after he was admitted to hospital;
- When the treatment was instigated one dose of depot was used and higher levels were not considered. There was no change in dose to see whether it had any extra benefit on his mental state;
- It is not clear whether knowledge of Mr BM’s drug use when he was out in the community affected medical views as to whether medication should be altered or not;
- Medical reviews took place every three or four months, between the CPA meetings. However there does not appear to have been a review after the March 2006 CPA meeting, the last prior to the incident which led to the

homicide. It is unclear why there was not a further medical review as the CPA meeting suggested one in three months (ie in June);

- Mental state examinations were carried out by different medical staff on each occasion so that any deterioration or improvement in mental state would have been much more difficult for medical staff to see any changes. Medical staff would have been reliant on other staff to feed them information as to Mr BM's mental state and behaviour and it would appear that the quality of that information was not always as good or as comprehensive as it might have been in order to inform decision making.

14.86 The lack of a referral to the Early Intervention in Psychosis Team was because the service was still relatively new and untried. Dr B, the consultant forensic psychiatrist mentioned that in 2005 the Early Intervention Service was only just evolving and was not an established service. In view of the newness of the service it was reported that it was apprehensive about accepting referrals of service users with a forensic history.

Recommendation 4

When patients are with a service for a period of three months or longer the timely introduction of treatment and medication and the review of dosage and type of medication should be reviewed on a regular basis. This should also be discussed at CPA Meetings.

Liaison between the Newham Centre for Mental Health and Forensic Mental Health Services

14.87 It was noted in the section above that following his admission to the Feltham Young Offenders Institute on 29 December 2003 Mr BM was not transferred to the

local mental health services until 15 June 2004. Some of this delay was due to the Newham Centre for Mental Health being unable to agree the level of security Mr BM needed, and whether he should be on the PICU or if he required a medium secure setting which would be run by the forensic psychiatric services.

14.88 The forensic reports were clear that Mr BM did not really require the security of a medium secure unit. In his interview Dr B (Consultant Forensic Psychiatrist) stated that Mr BM was typical of many people referred for a forensic psychiatric assessment, and the issue was in deciding which had the specific features where a forensic placement was indicated. It was felt that Mr BM did not warrant a forensic placement, but it was considered helpful if TL, the community forensic CPN was involved with the local CMHT to assist in the care given to him.

14.89 Dr B explained that when he became the first sector consultant in the forensic service, the pattern was that the two forensic CPNs (based in West Newham and East Newham) were linked with the Community Mental Health Teams. Dr B and his team decided that they could be more effective if the consultant psychiatrist, the CPNs, the social worker and the psychologist dealt with Newham and therefore had the opportunity to build up local relationships, so a sector based approach was adopted.

14.90 It was reported by Dr B that this model had worked well and, had it been in place when Mr BM was in Feltham YOI, would have saved the time taken to obtain the forensic opinion that Feltham required from Newham. This was confirmed as TL, the forensic CPN, provided a different level of care to Mr BM and appeared to have a good rapport with him. His role was to give Mr BM his depot injection and to monitor his mental state. He also tried to introduce a psycho-education approach to his work with Mr BM.

14.91 TL explained that he always tried to engage Mr BM in conversation and he usually responded positively with this approach. This enabled TL to get a glimpse of what Mr BM was thinking about and there was any hint of any paranoia or psychosis present.

14.92 The Independent Investigation Panel concluded that whilst the relationship with the Forensic Services had been somewhat distant prior to February 2004, once

the sector arrangement with Newham was established and had bedded down, there was a much greater degree of cooperation and liaison. The initial delay of over six months was unacceptable, and the local clinicians should have had a face to face meeting to decide what care and treatment Mr BM required. They should have then agreed locally how this could be provided, rather than referring back to the Forensic Service by suggesting he needed a medium secure unit.

14.93 The Investigation Panel concluded that as the relationship between the Forensic Service and the Newham Centre of Mental Health has been addressed since the difficulties in 2004 there was no need to make a specific recommendation about this issue.

No Carer's Assessment

14.94 During this Independent Investigation it was not possible to talk to Mr BM's mother. Messages were left on her mobile phone and a letter delivered to her home but no response was forthcoming. The number was confirmed from staff at Broadmoor where Mr BM is currently a patient.

14.95 As was clear from the Inpatient Notes and the Community Mental Health Team records, Mrs C, Mr BM's mother, was involved in his care and was a good source of information regarding her son's mental health. Despite her obvious involvement and her seeing her son regularly she was not offered a Carer's Assessment into her own needs.

14.96 Under The Carers Act (Equal Opportunities) 2005 and the Carers and Disabled Children Act 2000, all carers have a right to an assessment of their needs. This is mandatory and all Local Authorities have a duty to advise carers of their rights to an assessment. There was no evidence in the records that Mrs C was ever offered such an assessment.

Recommendation 5

The carers of patients must be offered an assessment of their own needs and any help that they may require in order to fulfil their caring role. The ELFT should undertake an audit of case records to determine whether Carers' Assessments are being offered and whether their identified needs are being met.

Education and Training Factors

Safeguarding Children Issues

14.97 In July 2005 CS discovered from Mrs C that Mr BM had obtained a job working with children. She described it in her interview as being a sort of "after school club." The CMHT did not appear to be clear about how they should react. In the event it did not matter as Mr BM soon lost the job, but there were clear Safeguarding Children implications given Mr BM's situation. Staff assumed that a Criminal Records Bureau check would have been undertaken, but the offence may not have been recorded due to Mr BM being transferred to psychiatric care. TL was also uneasy about the situation as if Mr BM was working with children when he could potentially be volatile and violent if put under pressure, his employers should be made aware of his risk.

14.98 The Independent Investigation Panel was concerned that neither CS nor TL had shown an understanding of the Safeguarding Children Policy. The overall aim of the Safeguarding of Children Policy is to ensure that children and young people are healthy, safe, enjoy life and achieve their potential and make a positive contribution to society and are well prepared to secure their economic well-being in future years. (Every Child Matters (2003) and Section 11 of the Children Act 2004).

14.99 All local authorities are required to have a Local Safeguarding Children Board which replaced the Area Child Protection Committee. The prime objective of the Safeguarding Children Board is to coordinate and to ensure the effectiveness of their member agencies in safeguarding and promoting the welfare of children. NHS Trusts are important member agencies and as such have responsibilities to assist the local

authorities in their work and to identify any children where their safety is considered to be at risk, and to help assess and promote their safety.

14.100 Given the mental ill health of Mr BM since December 2003 he clearly presented a potential risk to children due to his known violent history and his current mental health problems and substance misuse. The situation should have been discussed with the Children's and Families Department of the Local Authority. It was perhaps fortuitous that Mr BM lost this job soon afterwards.

14.101 It is noted that the Internal Investigation raised this issue and made recommendations about the training of mental health staff on their obligations under the Safeguarding Children legislation. It is understood that this issue has been dealt with by the East London NHS Foundation Trust and that all staff are now receiving mandatory training in the duties of staff in the NHS under the Safeguarding Children legislation.

14.102 The Independent Investigation Panel considers that the effectiveness of the training put in place should be tested. It is therefore recommended that an audit should be undertaken to ensure that all staff in CMHTs and other community mental health settings have received training about Safeguarding Children and are aware of their responsibilities.

Recommendation 6

The ELFT should audit the training on Safeguarding Children to ensure that all relevant community staff have received the training and any follow-up or updating training and that they are sure of their responsibilities under this legislation

Patient Factors

Mr BM's presentation

14.103 BM had sustained a serious head injury caused when he was involved as a pedestrian in an accident with a mechanical road sweeper. It is clear from the clinical notes that his personality changed at this time and he became more insular and stayed at home a great deal. One of the features of his head injury was that his

executive function was impaired which left him being impulsive with a deficit in the skills of thinking things through. Dr A commented that “before I came to work in the services, he had already had a CT scan, the result of which was normal; an EEG, which showed an electrical activity in some regions of the brain, compatible with a previous head trauma; and the neuropsychological assessment after the head injury, showing some kind of temporal lobe dysfunction, some kind of cognitive impairment – not in the sense of intelligence, because BM was very intelligent. He had an IQ of 118, something like that, and was very articulate. But there were some results in the neuropsychological testing that he had at the time of the head trauma that actually showed a mild degree of dysfunction.”

14.104 Mr BM himself explained that he found it difficult to come to terms with his mixed race. It is noteworthy that one of his ‘heroes’ was Donnie Darko, the eponymous character in a film who seeks the meaning and significance of his troubling end-of-the-world visions. The film acquired cult status amongst young people, and was about a young man who does not fit anywhere in society, surrounded by people who are very much inferior to him, who simplify the things of life with simple explanatory models and who do not understand the complexity of life. In the end Donnie does detach from reality and becomes more and more destructive against society but he thinks he is justified acting in this way. There are obvious parallels with Mr BM and the way he came across to some of his clinicians.

14.105 Features of his psychosis included him appearing very guarded and withdrawn, and also secretive as evidenced by his reluctance and sometimes refusal to sign papers, even when not to do so meant the lack of benefits or things he valued.

14.106 Mr BM used cannabis and his regular use of this constituted his having a dual diagnosis of mental ill health and substance misuse. He never sought help for the substance misuse.

14.107 There was no clear psychological formulation so it was unclear what was driving Mr BM’s behaviour. Despite the issues outlined above Mr BM managed to do well at music and had an ability to articulate well and gained paid employment. No

staff appeared to have a sufficient overview of his history, which would have made developing a treatment plan and predicting risk more difficult.

14.108 TL appeared to have the most significant relationship with Mr BM, but he too found the task of trying to engage him and provide him with an understanding of his mental illness difficult. He had tried help Mr BM to identify and recognise early warning signs of relapse, and to try and relate these to the present to see how he could prevent any further relapses. The work was hard as Mr BM did not have any insight into his mental health.

Organisational and Strategic Factors

The arrangements for prescriptions

14.109 As is only too evident from the case notes Mr BM found it difficult to always remember to attend his monthly (every four weeks) depot clinic appointments at the North West CMHT. The Independent Investigation Panel found it hard to blame him as the system in place in 2005/2006 required the patient to undertake a three part process to:

- visit the GP and obtain the prescription for the Haleperidol
- visit the pharmacist to exchange the prescription for the Haleperidol
- take the Haleperidol to the CMHT for the depot clinic.

14.110 It appears that this system was in place to ensure that the cost of the medication for the patients being treated in the community was met by Primary Care and was not paid for by the specialist mental health services. Whatever the reason the process was extremely cumbersome for the individual patient, and it is to Mr BM's credit that he usually managed to attend the depot clinic having been reminded of the appointment. The process over the prescriptions appeared to the Panel like a rigmarole to test the motivation and engagement of the patient but it served no useful purpose. The Panel was pleased to learn that this system is no longer practised and that the medication is stored at the CMHT so all the patient has to do is to go to the CMHT for their appointment and receive their medication.

14.111 As with some other potential recommendations, the Independent Investigation Panel appreciate that action has been taken to eradicate this cost shifting practice, and will not make a specific recommendation about it. It would only comment that:

Recommendation 7

Any systems of care and treatment for service users with severe and enduring mental ill health should be as simple as possible and encourage the individual to engage and cooperate with mental health services and *not* place unnecessary and cumbersome barriers in their path. The processes in place within the community should be regularly tested to ensure that there are no disincentives to active engagement with the mental health services.

Working Conditions Factors

14.112 The two Working Conditions Factors have been discussed elsewhere in this Report under other headings of the Root Cause Analysis Fishbone process. The two areas are:

- Staff Changes and Vacancies (See Page 52)
- Keeping 75 open cases on the Duty System (See Page 58)

14.113 The Independent Investigation Panel considered that both these factors contributed to the change in staffing experienced by Mr BM in the period from March to September 2006 and the reduction in active support he received from March 2006. The details have been explored in section 13.1

Equipment and Resource Factors

Accommodation

14.114 Mr BM had not experienced a period of living independently in his later teenage or early twenties due to his head injury and the onset of his mental illness. As a direct result he had not gained many skills in independent living and when he

was ready for discharge from hospital it was decided that he would need supported accommodation.

14.115 He had worked quite well with the occupational therapist at the Newham Centre for Mental Health. In the case record the assessment states that Mr BM presented as “an independent person who is able to take care of himself. Although he has not been living by himself in the past he was leading an independent life regarding work and finances, and he has no difficulties caring for himself. He describes the possibility of living by himself in the future as ‘something he is looking forward to and that it will give him more focus in life.” Some additional cooking sessions were arranged for Mr BM as a result of this assessment.

14.116 Finding accommodation for young men like Mr BM is often a challenge due to the nature of their mental ill health and their use of illicit drugs, and in his specific case his tendency to be impulsive due to his previous head injury. The CMHT staff are to be commended for managing to find Mr BM three types of accommodation. At Deter Lodge and Newham House the placements failed largely due to Mr BM using cannabis on the premises. He had also tended to ignore the rules and regulations and to annoy some of the other residents. Mr BM never really appeared to settle at these two placements.

14.117 At the third placement with Able Housing Mr BM appeared to settle well and had a good relationship with the staff. There appears to have been a more tolerant attitude to some of his behaviour than at the other two placements. Able Housing is a supported accommodation unit for three people with mental health problems. It provides 24-hour support with one member of staff on the premises all the time.

14.118 Mr BM still abused some of the rules and smoked cannabis, but appeared relaxed and happy. The staff helped him over his medication, but changed his GP to a local one thinking this would be easier for him as it was so close to his home. As they had not consulted him about this change Mr BM was upset by this and wanted to stay with his usual GP when the new one wanted to give him a physical examination. He was reinstated with his previous GP as quickly as possible.

14.119 The two Able Housing staff the Investigation Panel met appeared genuinely fond of Mr BM. They had been shocked by what he had done as they had not seen any real change in the way he was behaving until the evening after the homicide when he attacked one of the staff, but almost immediately apologised for his actions. FO, a care worker at the home was in the garden with another resident having a cold drink when Mr BM came from the lounge to him and punched him once and tried to hit him a second time. When challenged as to why he had attacked him Mr BM stated “you should be representing black people!” He had also looked wild and ill the following morning before the police arrived to arrest him. The Able Housing staff had never known him carry a knife before nor seen any violence from him.

15. Findings

15.1 The Independent Investigation Panel examined all the evidence and concluded that there were four main contributory factors leading to the homicide of Tom - Louis Easton at the EC1 Music Project on Friday 15 September 2006.

Contributory Factor 1: CMHT Workload, Staffing and having 75 Cases managed through the Duty System

Workload

15.2 The Independent Investigation Panel was assured that there was no forced reduction in staff due to the financial savings the East London and the City Mental Health NHS Trust (ELCMHT) were required to make by the London Strategic Health Authority. The need for managers to seek permission to fill vacant posts was only introduced a week before the homicide, and no posts had been removed from the CMHT at this time.

15.3 The Investigation Panel did hear conflicting evidence about the workload of the North West Newham CMHT. Staff and managers stated that it was the busiest in Newham and served a larger and more deprived area with higher mental health morbidity than the other three CMHTs. The senior management of the ELCMHT refuted this and stated that the areas were roughly the same size, and that the CMHT was in the middle of the four in terms of the number of cases it was dealing with at this period of 2006. Mention was made of statistics on caseloads which would demonstrate that this CMHT was not as hard pressed as the staff had indicated, but the Investigation Panel was not provided with the data showing the complexity of the caseloads but only those showing the actual numbers.

Staffing and Duty

15.4 The North West Newham CMHT was the only one of the four CMHTs in Newham to adopt a Duty Caseload system due to the pressure of work and the absence of three members of staff due to sickness and attending training courses. Mr BM was one of the cases held on Duty. This did not affect his attendance at the

depot clinic at the CMHT, but it did mean that unless he called at the CMHT he would be seen only once a month by a member of staff at the CMHT.

15.5 The level of support provided to Mr BM was reduced after he had made good progress in the six months leading up to the CPA Meeting held on 30 March 2006. TL, the community forensic CPN, had decided to withdraw (as had been intended from the outset) as Mr BM had improved and was in employment and appeared to be doing well. It was not planned for the other changes to be made at the same time. In the event other changes did occur and CS decided she would no longer be the care coordinator and AD, who had taken over as CPN from TL became both care coordinator and CPN and saw Mr BM monthly for his depot.

15.6 The Newham Locality Manager enforced a policy of not employing any agency staff as part of the cost cutting exercise, but he did not discuss this with senior managers. The upshot was that AD was no longer the CPN and Care Coordinator for Mr BM who then had MP for a short time, and was then seen on the Duty System where he coincidentally saw AD who had been re-employed. Mr BM had been annoyed with the withdrawal of AD. The handing over to AD by TL had been planned and was handled well with a handover session. The other changes were less well handled.

15.7 Mr BM was relatively settled in his accommodation with Able Housing and was supported by their staff and frequently had contact with his mother. At this stage no one noticed that Mr BM might be relapsing, although he was described as ‘paranoid and suspicious’ on 21 June 2006, but by the next depot on 19 July 2006 he was described as ‘mentally stable and he was receptive and accommodating.” It was on the next occasion, 18 August 2006, when Mr BM met AD and was upset that he had written to him to say he would not be his CPN/Care Coordinator any longer. He did not attend for the next depot on 15 September 2006, the day the homicide occurred.

15.8 The Independent Investigation Panel considered that whilst the changes in staffing and being held on ‘Duty’ were far from ideal, Mr BM did appear to be more settled during this period. More frequent contact might have enabled staff to be more aware of any fluctuations in Mr BM’s mental state, as would him being seen by the same member of staff who could detect a pattern of presentations during the six

month period. Mr BM was seen in rather a perfunctory way over the six months prior to the incident (from March to September 2006) and the planned medical review did not happen so not only did he have less care, but his mental state was not formally monitored other than by the CPN who administered the monthly depot. It is possible that some deterioration in his mental state may have escaped unnoticed in these circumstances. More probing might have given the opportunity for detecting a worsening state but even then, symptoms may or may not have been elicited.

15.9 Staff at Able Housing did see Mr BM regularly and had not noticed any deterioration in his mental health until the evening after the homicide.

15.10 The Independent Investigation Panel considers that the actual outcome could not have been predicted.

Contributory Factor 2 : Internal Communications within the CMHT

15.11 The workload of the consultant psychiatrists required them to cover the inpatient wards and the CMHTs plus other duties leaving only two sessions a week for them to be part of the CMHT, two sessions equating to one day. Less senior medical staff within the CMHTs undertook the medical reviews. This arrangement did mean that patients in the community were only seen by their consultant every six months at their CPA Meeting. They were seen by other medical staff if required during the period between CPA Meetings.

15.12 Within the North West Newham CMHT the care coordinator for Mr BM did not communicate with her consultant psychiatrist, Dr A, other than through entries in the case-notes. Dr A was surprised to learn at the time of the Trust's Internal Investigation into the homicide of Tom - Louis Easton by Mr BM that CS had a 'gut feeling' that he was dangerous and always ensured that she could get out of the room when she saw him alone. Dr A thought she might have reviewed his medication or undertaken a medical review herself if she had been informed of his being evicted from two supported accommodation placements.

15.13 The Independent Investigation Panel consider that the lack of consultant oversight of Mr BM was less than ideal, but accepts that the Medical Director at the

time did review, and then alter, the psychiatrists' work-plans to enable them to spend an extra half day with the CMHTs. Mr BM did take his depot regularly despite being a day or two late on occasions, but was reminded by his care staff at Able Housing to get his prescription and medication and attend the CMHT depot appointments.

15.14 The lack of regular supervision and the absence of regular caseload management within the CMHT was not best practice, but there was no evidence that it directly led to the homicide.

Contributory Factor 3 : Length of Time without regular Anti-Psychotic Medication

15.15 Mr BM may have been suffering from a psychotic illness which was left untreated for several months whilst he was in the Youth Offenders Institution. His transfer to hospital was delayed as the psychiatrists at the Newham Centre for Mental Health and their forensic colleagues could not agree on the appropriate placement which went on for six months with Mr BM in the prison environment. Once he was in the psychiatric hospital he was not actively treated for his psychosis for a further several months.

15.16 It is possible that the lack of assertive treatment and engagement with Mr BM at the start of his mental ill health may have set the pattern for his partial engagement with services, and his refusal to accept that he had a mental illness. He was often described as having little or no insight into his condition. Mr BM did not respond positively to intense engagement, and it is noted that the two supported accommodation placements with firmer rules were unsuccessful, whereas Able Housing with a more flexible approach was able to work more positively with him.

15.17 Mr BM tolerated the depot clinics as he realised that this was the only way he would be allowed to be in the community. He had difficulty in accepting that he did have a mental illness and frequently denied the existence of psychotic symptoms prior to the attack on the train ticket collector.

15.18 The Independent Investigation Panel considered that whilst the lack of full engagement and the delay in prescribing anti-psychotic medication may have

influenced the way in which Mr BM reacted to 'treatment' there was no evidence to suggest that it led to the homicide.

Contributory Factor 4 : Continued Use of Cannabis

15.19 Mr BM was often warned about the dangers of using illicit drugs, and cannabis in particular as it was his drug of choice, but he took no notice and continued to use it. The Independent Investigation Panel considered that his use of cannabis did make the probability of a relapse in his mental health more likely, and that this may well have played a part in the homicide, although his relapse was not noticed by anyone. He had appeared 'normal' at his supported accommodation until he attacked one of the staff in the evening after the homicide.

Other Factors

15.20 In the preparation of this report several other factors were examined and discussed. These included:

- The prescribing arrangements
- The lack of understanding about the Safeguarding Children Policy
- The lack of a Carer's Assessment for Mr BM's mother.

15.21 Comment has been made on these issues within the Report and recommendations have been made to help improve practice. These issues, whilst important and needing attention in order to improve the care and treatment of service users, were not regarded as critical as they had either been addressed following the homicide and the Internal Investigation Report, or were seen as of less significance than the four contributory factors discussed above.

Conclusion

15.22 The Independent Investigation Panel consider that the tragic homicide of Tom - Louis Easton by Mr BM could not have been predicted. The care and treatment of Mr BM could have been better, and several factors have been improved since September 2006 as a result of the Internal Investigation. The Independent Investigation Panel has recorded some other areas where improvement is required, and it is anticipated that the ELFT will similarly address these.

15.23 There was no single cause of the homicide other than the fact that Mr BM did have a serious mental illness for which he was being treated. He did regularly attend for his monthly depot injections, often after being reminded by his care staff where he lived. He was regularly seen at least once a month, and although a slight fluctuation in his mental state was observed he was generally found to be well with no psychotic ideas present. This ‘formal’ observation by staff of the North West Newham CMHT was confirmed by the information provided to the CMHT by his mother and the staff at Able Housing.

15.24 Mr BM’s mental ill health was identified as the only causal factor, and this linked with the four contributory factors of the CMHT workload and staffing, internal communication within the CMHT, the length of time without regular anti-psychotic medication at the onset of mental ill health and Mr BM’s continued use of cannabis combined to contribute to the homicide taking place.

16. East London and the City Mental Health NHS Trust Response to the Incident and the Internal Investigation

16.1 ELCMHT set up an Internal Investigation into the care and treatment of Mr BM once managers had ascertained that there were no immediate actions to be taken to safeguard other patients, members of the public, or staff. The Internal Investigation was conducted in accordance with the Department of Health Guidance EL (94)27, LASSL(94) 27.

16.2 The Inquiry Panel comprised:

- Dr C O'Driscoll - Associate Medical Director (Clinical Governance)
- Ms M Groves - Sector Manager (Tower Hamlets)
- Ms S Balmer - Borough Director (City and Hackney Locality)

16.3 The Terms of Reference for the internal Investigation were that "the remit of the Inquiry will encompass at least:

- the care that Mr BM was receiving at the time of the incident;
- the suitability of that care in view of his history and assessed health and social care needs;
- the extent to which that care corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies;
- support offered to the family members of Mr BM after the incident."

Conclusions and Recommendations

16.4 The Internal Investigation interviewed staff and managers and made the following seven recommendations:

1. ***Prescription, dispensing and administration of depot injections***

- the development of a standardised Trust-wide Policy and Protocol for the prescription, dispensing and administration of depot medication – taking into account the recommendations of another inquiry in a different part of the Trust; (and stopping the cumbersome arrangements which Mr BM had been subjected to.)

2. ***Access to Specialist Psychological Services***

- there should be a Trust-wide review of the access to specialised psychology services by inpatient and CMHTs to ensure that specialist psychological diagnostic and treatment services such as neuro-psychological and forensic psychology are readily available in appropriate cases;

3. ***Safeguarding Children***

- CMHT staff should have a clear understanding of their roles and responsibilities for safeguarding children;

4. ***Supported Accommodation***

- there should be a review of the standards expected of providers of residential care and supported accommodation before the Newham Partnership place service users in their care. Providers should have clear lines of communication to cover crisis and contingency planning;

5. Review of practice issues in the Newham CMHTs

- there should be a thorough review of practice issues within the CMHTs in Newham in the light of serious untoward incident inquiries and the recent Community Services Review. The review should encompass areas such as the consultant/team interface, the provision of holistic and comprehensive treatment packages and the care of high risk service users;

6. A Review of CMHT Resources

- there should be a review of the resources available to the Newham CMHTs to ensure equity of provision, contingency planning in the event of future savings plans and proper staffing for the Access and Assessment Teams and for the monitoring of physical health;

7. Forensic Services liaison

- Forensic sector teams should maintain a list of patients linked to team members with the name/role of the forensic staff member.

Conclusion

16.5 The Internal Investigation concluded that Mr BM's mental state was always very difficult to elucidate due to his suspicious and guarded relationships with mental health professionals and his unwillingness to disclose his beliefs and intentions. The Internal Investigation also felt that Mr BM was not adequately treated with anti-psychotic medication either in Feltham Young Offenders Institution, in the Newham Centre for Mental Health or in the community. It considered that sufficient notice of the previous head injury and its effect on Mr BM and further investigations could have proved useful.

16.6 It further concluded that the care to Mr BM was reduced following the CPA Meeting on 30 March 2006, and that there had not been a sufficiently rigorous risk assessment at this stage. Despite these findings the Investigation Panel concluded that "with this level of guardedness around psychotic symptomatology, it would have been very difficult to predict the alleged assault (this was published prior to the end of the legal process for the homicide of Tom - Louis Easton) even with a more

intensive level of engagement with Mr BM. For this reason, it is hard to say clearly that this incident could have been prevented."

Action Taken as a Result of the Internal Investigation

16.7 An Action Plan was produced as soon as the Internal Investigation had published its report and has been regularly reviewed to ensure that the recommendations were implemented. The Independent Investigation Panel interviewed both the current Chief Executive of the ELFT and the Newham Borough Director and discussed the Action Plan and the work that had been undertaken as a result. The action taken is described in the Table below:

Rec. Number	Agreed Action	Action Taken	Complete Yes a No X
1	Trust Policy for the prescription, dispensing and administration of depot injections	To ensure safe administration of depot injections allied to regular physical health checks	a
2	Equitable and reliable access to specialist psychological services across the Trust	All PSI workers recruited and in post. Follow-up to Community Services Review advocates better access to psychological therapies. Further work linked to the IAPT work programme. External contracts provide access to specialist services.	a Further work and progress is continuing
3	Staff to be clear about their Safeguarding Children roles and responsibilities	Access to relevant training available An integrated training data base has been produced to assist governance and assurance processes	a
4	Review of standards expected of residential care and supported accommodation providers	Review undertaken and results disseminated to all community teams. An Accreditation Scheme for Newham private sector implemented	a
5	Review of practice issues in the Newham CMHTs	An extra session for consultant psychiatrists with their CMHTs. New Access and Assessment Teams in place. Strengthened clinical leadership and integration of Outpatient and CMHT caseloads.	a
6	Review of resource issues in the Newham CMHTs	Sickness levels reviewed and monitored and greater openness and discussion about staffing issues with locality HR arrangements in place.	a
7	Forensic team list development and regular service user review	Forensic services are more accessible with good liaison with local services. Named consultant psychiatrist on call.	a

Comment

16.8 The Internal Investigation conducted a full review of the services available to Mr BM and of his overall care and treatment. Its recommendations mirror those of the Independent Investigation to some extent, and in some places in this Report the fact that the issue has been rectified since the Internal Investigation has been highlighted. This can be seen in the Table on the previous page.

16.9 It is clear from the Internal Investigation that the family of Mr BM received support from the CMHT following the homicide, and his mother was interviewed by phone as part of their Investigation. The family of Tom - Louis Easton were not provided with support and it appears that no support was offered until they contacted NHS London 18 months later in connection with the “Embedding the Learning” publicity. This concerned the backlog of independent investigations following homicides committed by people being actively treated by the mental health services or discharged from them less than six months prior to the homicide.

16.10 LH, the Trust Director of Nursing, explained in an interview with the project manager of this Independent Investigation that the Trust had made contact with the police and were informed by one of the family support workers that support was being offered. No direct contact was made until NHS London passed a message on from Mrs Altaras and Mr Sinclair. They produced a timeline of the involvement they had had with various agencies since the homicide of Tom - Louis Easton. Some relevant dates to this Independent Investigation include:

- **7 July 2007**: Mr Sinclair telephoned Verita Consultants, acting for the SHA requesting to be involved in the review of all killings by people being treated for mental illness in London having seen details in the London press.
- **16 August 2007**: Ms LH, Deputy Chief Executive, East London and City Mental Health NHS Trust, wrote to Ms Altaras via DC Shenoy concerning Mr Sinclair’s request, advising her that Tom - Louis Easton would be included in the review and to contact NHS London’s Helpline if she wanted to discuss it further.

- **14 October 2007**: Ms Altaras wrote to LH requesting what progress had been made with the review.

- **10 December 2007**: Mr Sinclair telephoned TH at Verita Consultants requesting what progress had been made with the review. Three days later a reply was received by phone explaining that the review was delayed to February and was unlikely to include Tom - Louis Easton because Mr BM was awaiting trial.

- **22 January 2008**: The *Stratford and Newham Express* published an article stating that "Health and council chiefs have expressed condolences to the family of a man stabbed to death by a deranged killer and have told them they have ordered an inquiry." No messages of condolence had been received by Ms Altaras from the East London NHS Foundation Trust or Newham Borough Council. Mr Sinclair telephoned Ms Janet Flaherty, Head of Communications, at the East London NHS Foundation Trust.

- **28 February 2008**: Ms LH emailed Ms Altaras and Mr Sinclair confirming an arrangement to meet her on 26 March to discuss the East London NHS Foundation Trust's internal investigation into the care and treatment of Mr BM, and to confirm that NHS London would be in contact with them about an Independent Investigation.

- **26 March 2008**: Ms Altaras and Mr Sinclair met Ms LH, Ms F, and Dr TL, Medical Director, at which the Trust formally conveyed its condolences to the family. Ms LH explained that the internal investigation took place immediately after the death of Tom - Louis Easton, but it was confidential. She and Dr Lambert offered to share some of the key findings, which would be summarised and sent to Ms Altaras and Mr Sinclair with the notes of the meeting.

- **29 April 2008**: Ms AD, Head of Clinical Governance, NHS London, wrote to explain that Dr Androulla Johnstone of HASCAS would be contacting Ms Altaras and Mr Sinclair about the Independent Investigation.

16.11 It is evident from the above details that no face to face contact between the ELFT and Mrs Altaras and Mr Sinclair took place until 26 March 2008 which was 18 months after the homicide. Written contact was first made via the police in August 2007 following Mr Sinclair having contacted Verita Consultants about the NHS London investigations. No condolences were made until 26 March at the meeting with Trust staff on that day.

16.12 It would have been good practice to inform the family of Tom - Louis Easton that an Internal Investigation was being undertaken and to offer to meet them, and to have offered to meet with them after the Internal Investigation to discuss the findings, the recommendations and the Action Plan arising from it.

16.13 The ELCNHST did not make contact with Tom - Louis Easton's family as they were informed that they were being helped by a Police family Support Worker. The Memorandum of understanding : *Investigating Patient safety Incidents involving Unexpected Death or Serious Harm* – a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006 was not clearly understood by either the trust or the Police Service in this situation.

Recommendation 8

The East London Foundation Trust should take steps to identify the family of any person murdered or injured by a patient in the care of the Trust and to offer them any help and support they feel they would like. The Trust should also be open about the Internal Investigation and provide details of the findings and recommendations. Identification of any family of the victim and making contact them should occur within one week of the incident.

Recommendation 9

The ELFT should liaise with NHS London to ensure that discussions take place between the NHS in London and the Metropolitan and City Police Forces to ensure that in future the Memorandum is implemented effectively.

17. Notable Practice

17.1 Whilst the emphasis of this Independent investigation Report is to examine the care and treatment provided to Mr BM and to highlight areas where processes could be improved, during its work the Independent Investigation Panel noticed some good practice and would wish to mention examples of this.

Close Working between the Newham North West CMHT and the Community Forensic Community Psychiatric Nurse

17.2 Whilst the relationship between the CMHT and the Forensic Service had not been at its best when failing to agree where Mr BM should be transferred when moved from Feltham Young Offenders Institution, the work between TL and CS is worthy of mention. The two staff worked closely together and kept each other informed about how they thought Mr BM was responding to treatment. They staggered their monthly visits so that Mr BM was being seen at least once fortnightly.

17.3 From the case records it appears that Mr BM engaged more with TL than other community staff, and did to a limited extent try to address some of the issues about his mental ill health in discussions with him.

The Care and Support Offered by Able Housing

17.4 In reading the case records concerning the three placements made for Mr BM it appears that the one he preferred was Able Housing. The staff made a good relationship with Mr BM and tried to engage with him socially. The manager did write Mr BM a formal letter about his continued use of cannabis on the premises, but this did not affect the good relationship Mr BM had with the staff. They continued to prompt him to obtain his medication for the depot appointments.

17.5 Mr BM responded well to the less restrictive environment and to the style of management which, despite the mistake of changing his GP without his permission, was genuinely trying to help him. The relationship between Able Housing and the Community Mental Health Team was good, and they were adept at reminding Mr BM about his depot injections and the need to obtain the prescription and the medication in advance of the depot injection appointment. There was also a good relationship with Mr BM's mother.

18. Lessons Learned

18.1 One of the main lessons to be drawn from this Independent Investigation is the lack of a full and detailed picture of Mr BM being easily available in the notes. The concerns of the CMHT were mainly centred about him becoming ill again and neglecting himself, rather than reflecting the fact that he had fairly rapidly become violent during the first onset of his illness.

18.2 The list of violent acts was available but did not appear sufficiently prominently within the risk assessment. Similarly the fact that Mr BM had a secretive side to his character was not fully recognised and he never really said how he was feeling. In addition he often denied his mental ill health and lacked insight into his situation.

18.3 Mr BM had generally presented well when he had his depot injection, and when he was seen by medical staff for mental state examinations and at CPA Reviews. As identified in the report, he was seen by different staff for his mental state assessments and only saw the consultant at CPA reviews every six months. There was therefore a lack of consistency in the staff reviewing his mental health, and from March 2006 this was mirrored in his support from the CPN and social worker from the CMHT. Continuity of care by the same staff would have made any alteration in his mental state easier to identify. As it was he was seen by different staff and therefore the current assessor had to rely on the notes of someone else's review.

18.4 There is no reason to suppose that such a set of circumstances led to the homicide, but not having a full risk assessment and a clear and obvious case summary highlighting the violent onset of his first episode on mental illness, helped to obscure this part of his case history should he relapse.

19. List of Recommendations

The following recommendations are made in the Report:

Recommendation 1

The ELFT should undertake a joint strategic needs assessment of the population of each CMHT catchment area and link this to a review of the workload of each of the four CMHTs to determine the actual workload of each and then adjust the staffing to better reflect the known needs as indicated by the statistics and information gathered. The information should include population size, morbidity, weighted caseload analysis, turnover data, referrals and assessments.

Recommendation 2

The Operational Service Manager, Clinical Leader (Consultant) and the Associate Clinical Director should make sure that they regularly discuss the running of the CMHT and how it functions. Their discussion should include how risk is assessed and managed, how work is prioritised, the management of particularly complex cases and whether there are any issues which adversely affect the expected flow of communication between members of the multidisciplinary team. If such issues cannot be resolved locally they should be 'escalated' to the Borough Director for resolution. There should also be a system to ensure that all cases are regularly reviewed.

Recommendation 3

The consultant psychiatrists should hold regular medical reviews and routinely see their patients at CPA meetings. If there are significant concerns about the patient's health or social care, then the consultant psychiatrist should ensure a full review is undertaken by him/her or a senior deputy.

Recommendation 4

When patients are with a service for a period of three months or longer, the timely introduction of treatment and medication and the review of dosage and type of medication should be reviewed on a regular basis. This should also be discussed at CPA Meetings.

Recommendation 5

The carers of patients must be offered an assessment of their own needs and any help that they may require in order to fulfil their caring role. The East London Foundation Trust should undertake an audit of case records to determine whether Carers' Assessments are being offered and whether their identified needs are being met.

Recommendation 6

The East London Foundation Trust should audit the training on Safeguarding Children to ensure that all relevant community staff have received the training and any follow-up or updating training and that they are sure of their responsibilities under this legislation

Recommendation 7

Any systems of care and treatment for service users with severe and enduring mental ill health should be as simple as possible and encourage the individual to engage and cooperate with mental health services and *not* place unnecessary and cumbersome barriers in their path. The processes in place within the community should be regularly tested to ensure there are no disincentives to active engagement with the mental health services.

Recommendation 8

The East London Foundation Trust should take steps to identify the family of any person murdered or injured by a patient in the care of the Trust and to offer them any help and support they feel they would like. The Trust should also be open about the Internal Investigation and provide details of the findings and recommendations. Identification of any family of the victim and making contact with them should occur within one week of the incident.

Recommendation 9

The East London Foundation Trust should liaise with NHS London to ensure that discussions take place between the NHS in London and the Metropolitan and City Police Forces to ensure that in future the Memorandum is implemented effectively**.**

20. GLOSSARY

Approved Mental Health Practitioners : staff working in mental health services who are approved and thereby able to work under the Mental Health Act 2007.

Broadmoor Hospital : one of three high secure psychiatric hospitals (the others are Ashworth and Rampton Hospitals). Most of the patients suffer from severe mental illness, and many have either been convicted of serious crimes, or been found unfit to plead in a trial for such crimes.

Caldicott Guardian : a senior manager in the NHS and Social Services to protect patient information.

Cannabis : is the most widely used illegal drug in Britain. Made from parts of the cannabis plant, it's a naturally occurring drug. It is a mild sedative (often causing a chilled out feeling or actual sleepiness) and it's also a mild hallucinogen (meaning you may experience a state where you see objects and reality in a distorted way and may even hallucinate).

Care Coordinator : this person is usually a health or social care professional who co-ordinates the different elements of a service users' care and treatment plan when working with the Care Programme Approach

Care Programme Approach (CPA) : this is a national systematic process within mental health services to ensure that assessment and care planning occurs in a timely and user centred manner.

CMHT : Community Mental Health Team providing health and social care to people with mental health problems being treated in the community.

Depot Injection : a specially prepared antipsychotic medication which is given by injection. The medication is slowly released into the body over a number of weeks.

Early Intervention in Psychosis Teams : specialist teams for people aged 18-35 experiencing their first onset of psychosis.

Forensic Psychiatry : covers the interface between psychiatry/mental health and the law, for example fitness to plead and stand trial.

Glasgow Coma Score : The GCS is scored between 3 and 15, 3 being the worst, and 15 the best.

Haldol Decanoate : a form of Haloperidol which releases itself slowly in the body and lasts for four weeks (used for depot injections).

Haloperidol : a medication used to treat psychosis.

Kemedrine : an effective medication to reduce the tremor and rigidity sometimes a side effect with antipsychotic medication.

National Patient Safety Agency (NPSA) : An 'arm's length body of the Department of Health which seeks to lead and contribute to improved and safe patient care by informing, supporting and influencing organisations and people working in the health sector.

National Service Framework (1999) : The National Service Framework addressed the mental health needs of working age adults up to 65. It set out national standards; national service models; local action and national underpinning programmes for implementation, and new teams for crisis resolution and home treatment, for people who find it hard to engage with services, and for people facing their first episode of psychosis.

Occupational Therapist : actively engages people in purposeful activities to promote, regain or maintain health and wellbeing, using occupations as therapy and enabling individuals to do work or training for work.

Paranoia : is a thought process characterised by excessive anxiety or fear, often to the point of irrationality and delusion. Paranoid thinking typically includes persecutory beliefs concerning a perceived threat towards oneself.

PICU (Psychiatric Intensive Care Unit) : a unit where service users who are displaying aggressive and disruptive behaviour can be managed away from the acute ward by a greater ratio of staff to patients.

Primary Care Trust : provides some primary and community services or commission them from other providers, and are involved in commissioning secondary care, such as services provided by Mental Health Trusts.

Psychosis : is a loss of contact with reality, usually including false ideas about what is taking place.

Safeguarding Children Policy : multi-agency arrangements to ensure that the NHS and the Local Authority work together to safeguard children who may be at risk of physical and emotional harm and sexual abuse.

Schizoaffective Disorder : an illness that is defined by mood disorder and psychosis.

Schizophrenia : is a psychiatric diagnosis that describes a mental disorder characterized by abnormalities in the perception or expression of reality. Distortions in perception may affect all five senses, including sight, hearing, taste, smell and touch, but most commonly manifests as auditory hallucinations, paranoid or bizarre delusions, or disorganized speech and thinking with significant social or occupational dysfunction.

APPENDIX 1

BM Timeline

1999	BM had received 3 Police cautions for offences against property and one drug offence.
KEY ISSUE 2001	BM (aged 16) was hit by a road-sweeper lorry as a pedestrian and suffered a head injury. He had a fracture of the skull with right frontal and left temporal contusions and an external haematoma. This was treated conservatively. He was in a coma rated 8 on the Glasgow Scale. He is reported to have had one epileptic seizure during his recovery. BM's mother, Ms C, sees the accident as the turning point for BM. He made slow recovery and struggled a little with speech and word finding. About 6 months after the accident he started getting aggressive, would lose his temper and punch the wall. He stopped going out and spent much of his time in his room.
31/05/2001	A neuropsychological report stated that BM had a verbal IQ of 84 and a performance IQ of 119 using the WAIS-R test. His visual recognition memory was said to be in the very superior range.
06/06/2001	BM had a language assessment which said he had moderate receptive and expressive dysphasia.
24/12/2003	BM left home and the next day phone his mother to say he was in Nottingham.
29/12/2003	BM attacked a ticket collected on a train when he was challenged for not have a ticket. He ran off the train at St Pancras and assaulted two police constables, a British Transport Policeman and later his solicitor. He was remanded to HMYOI Feltham.

30/12/2003	BM assessed as having no suicidal thoughts.
02/01/2004	BM assaulted another prisoner and attempted to assault staff. He was placed in the segregation unit
03/01/2004	BM was agitated and irritable and appeared very suspicious. He appeared lethargic but would suddenly become very active and was laughing inappropriately. A bed was sought in the Health Care Centre but there was no bed available. Later that day he was admitted to the Health Care Centre – he admitted using cannabis very now and then.
19/01/2004	Psychology assessment – BM cooperated well. He was tending to seclude himself by staying in his cell and participating in the association times.
20/01/2004	Referral to the Newham Centre for Mental Health (NCMH) was considered.
23/01/2004	BM was referred to NCMH.
12/02/2004	BM sent his family a letter detailing his wishes for a funeral and the distribution of his belongings.
19/02/2004	BM was fit to attend court and duly appeared.
27/02/2004	BM was keen to attend the 1:1 Music Therapy session and started to attend groups and take part in Association – he appeared to be more involved in the routine of Feltham.
02/03/2004	BM became very loud and noisy overnight singing at the top of his voice.
03/03/2004	Dr W, Staff Grade Psychiatrist to Dr Be saw BM and prepared an assessment regarding his transfer to NCMH. BM later had a verbal altercation with another prisoner.

18/03/2004	NCMH had not accepted BM and wanted to undertake another assessment and an ECR was mooted.
19/03/2004	BM was not taking his medication and was uncooperative in seeing Dr Be.
22/03/2004	Dr McA completed a court report on BM – saying he was suffering from a mental illness.
23/03/2004	BM was not taking his medication and was uncooperative in seeing Dr Be. Dr Be assessed BM as requiring transfer to the PICU (Crystal Ward) at NCMH as soon as possible.
24/03/2004	BM attempted to stab another prisoner with a knife without provocation – the attacked person had minor lacerations on both forearms and the left shoulder. He was restrained but attacked a prison officer who received a superficial laceration to his right inner thigh. The prison felt BM needed to be in hospital urgently. BM was deemed unfit to return to court and was placed in Cell 29 (safe and low stimulus).
28/03/2004	BM painted the window of his cell which hindered observation by staff – he ignored advice to clean the window and was restrained and placed back in Cell 29. Over the weekend BM smeared toothpaste over the observation camera in Cell 29. BM attempted to assault staff during Association using a table.
30/03/2004	BM refusing medication. At the MDT Meeting it was felt that BM had no insight into his illness or the need for treatment. He was deemed to pose a high risk of violence. Prison rang Dr L (in charge of the PICU at NCMH) to see if there was news on when BM would be transferred there.
	A series of delays took place at NCMH – Dr L was off sick so no decision could be taken until the next week. Dr Be was on leave from 02/04/2004 so again no decisions were able to be taken. Nothing happened until 07/05/2004.

02/04/2004	BM punched a prison officer.
06/04/2004	BM dismissed his solicitor as he did not trust him.
07/05/2004	Dr L referred BM for an assessment by the John Howard Unit (Medium Secure Unit).
19/05/2004	West London MHT makes a formal complaint to East London and the City MHT about the delay in dealing with the referral to NCMH.
24/05/2004	Dr LI (Consultant Forensic Psychiatrist from John Howard Unit) assesses BM
02/06/2004	Feltham Health Care Centre recorded that a decision from Dr LI was still awaited. The report had been written but was not signed.
02-08/06/2004	BM was allowed to use an acoustic guitar in his cell. He refused to sign a 'compact' to accept this privilege so he was not allowed to use the guitar in his cell but could during Association time.
14/06/2004	BM placed under a Section 48/49 MHA.
15/06/2004	**BM transferred to NCMH.**
	On admission his medical stated that he had eczema, hay fever and asthma. The head injury was reported. It was thought that he possibly had paranoid schizophrenia/organic schizophrenia. He was placed on 2:1 observations.
17/06/2004	BM was said to appreciate that his thinking and planning ability has slowed down and that this adds to his frustration – he described it as being like "having all the right ingredients for making a cake, but the process of putting them together is just so slow, almost to a frustrating level." He denied all paranoid feelings and all mental illness

	symptoms.
20/06/2004	Observation reduced to 1:1 as BM presenting a low risk of violence and aggression.
21/06/2004	1:1 Observation ceased and BM placed on 15 minute nursing observations.
22/06/2004	A full needs assessment was carried out. BM's behaviour had been appropriate – he preferred to rest a lot and kept himself to himself. He was not complying with prescribed medication. When he leaves hospital he would like to live on his own despite having previously lived with his mother. He said he had the skills for independent living. He maintained contact with his circle of friends. He did not believe that he had a mental health problem.
23/06/2004	BM very engaged in the Talking Group and mentions how boring he finds the ward. He is also active in the Games Group with an OT. BM is seen by NS, a psychologist – he had a good conversation about his experience – saying he has less confidence since his accident and is more self-conscious. He was violent as he felt he had something to prove but doesn't feel this anymore. He denied having ever had any symptoms of mental ill health. Dr Ak states that BM has a diagnosis of Organic Mood Disorder on a background of head injury. The symptoms are irritability, a low threshold for tolerance, mood swings and poor impulse control. BM was said to exhibit both expressive and receptive messages/voices.
24/06/2004	BM still refusing to take medication. BM in Court and was made subject to a S37 Hospital Order – he refused to have his rights read to him. (but agreed the next day). Moved from 15 minute observation to general observation.

	BM refused to speak to his mother and brother on the phone
27/06/2004	Behaviour described as unpredictable at times – he threw a ball over the PICU fence. There were also a couple of confrontations with other patients and staff intervened and it was easily resolved. It appeared that BM tried to wind some patients up.
28/06/2004	Engaged well with OT. He wrote on the walls and was seen to space his food out during the dinner period.
30/06/2004	BM spoke to another psychologist – MS. He admitted that he had paranoia and it had all blown up when he was challenged by the ticket inspector – he regrets it now. He used Feltham for reflection. He grew with a mixed race/dual heritage background and not having a male role model. He was encouraged to write his own account of what has happened in the recent past and how it has influenced the present situation.
02/07/2004	BM asked for some money but refused to sign for it. The guitar he had been using was handed back damaged.
05/07/2004	BM refused to remove his hands from inside his trousers at lunchtime in the queue for dinner. He appears to want an immediate response to his requests and is pushing the boundaries.
07/07/2004	BM was slightly confrontational about eating in the TV room and not the dining room – he apologised later.
11/07/2004	BM had incisional marks on his left forearm. He shouted and refused to show or discuss injuries. He said he had superior views and was too clever for society and therefore has his own rules. Eventually he said the self harm was impulsive and due to internalised anger. He agreed it would be useful to have an opportunity to ventilate his feelings daily. Placed on 15 minute observation.
12/07/2004	No longer wants to self harm. Returned to general observation.
19/07/2004	BM banged on the nursing office door – shouted abuse at staff nurse as he wanted something – calmed down (it was over a lost T shirt)

20/07/2004	The nurses contacted a neurological nurse specialist for information about the possible effects of BM's head injury. FS thought that BM's behaviour might be affected if something suddenly happens out of the blue and unexpectedly. BM had an altercation with JA (another patient) – BM is unpredictable and quick to anger.
22/07/2004	Phone call from Sgt P from BT Police. BM was due in court in Cumbria and he wanted to know if he was fit enough to go. Dr Ak felt BM was not fit for such a long journey.
23/07/2004	06.30 – BM spent over 2 hours in bathroom and was checked by staff. He was upset and mentioned to one of the staff that he would punch him if he ever challenged him over any of his actions again.
24/07/2004	BM entered the TV room and immediately changed the channel. A nurse asked if BM could see that this action could be perceived as being rude. BM became abusive and swearing "You don't tell me what to do!!" He repeatedly refused to go to his room for 30 minutes to reflect. Staff removed him to his room and told him he would have an hour to reflect. Given Lorazepam to calm him down.
25/07/2004	BM was described as trying to dominate others with little sensitivity.
26/07/2004 **CPA Meeting**	His mother has stated that she is pregnant and would not BM to live with her as it would be too risky with his temper. The Plan was for BM to be admitted to an open ward for further assessment and to plan for the future including accommodation. She described how BM's behaviour had changed after his accident and resulting head injury. It was agreed that he should have regular psychology sessions. BM was annoyed that someone had been in his room and had taken a sweatband. A search of the ward was undertaken but no trace was found of the sweatband. A sharpened toothbrush was found inside the hood of a jacket in BM's room. When confronted about the weapon he was hostile to staff but there was no actual overt aggression – he stayed in his room and did not want to interact with staff. It was agreed that BM should only be given one pencil at a time and only get another when the first had been handed back.

27/07/2004	BM refused to sign the form about MHA Rights under S37. Had a 1:1 OT session – it was agreed these should be regular in order to help him prepare for independence and to discuss the situation on the ward. He was interested to hear more about a voluntary sector organisation called Working Well which helped people gain employment.
29/07/2004	**Psychology Session –** BM talked about the ward round and his need for a weapon. He felt he no longer needed it so he would not overreact. He wanted to have a job, different from the music, but he was worried about the effect of prison and mental ill health on his employment chances. Discussion about his mother's pregnancy – BM felt it was OK – "Mum knows what she's doing and if she wants me out of the parenting role this is fine." BM said that he could see that his "sort of arrogance" might make some people dislike him.
31/07/2004	BM upset as he had lost some rubber bands. He said he knew who had them and the T shirt and sweatband – but would not say who it was. He spent 3 and a half hours in the bathroom during the night.
02/08/2004	Phone from Inspector B wanting an update on BM's position. In the ward round Dr L challenged BM on the time he spends in the bathroom. He said it was for reflection and he cannot be observed – feels it is character building. A forensic opinion would be requested from Dr Bo.
03/08/2004	BM asked why he was not allowed to use the computers, when he would be discharged and he argued and disagreed with all explanations – the discussion had to be terminated due to BM's aggressive attitude.
04/08/2004	**Talking Group –** BM very positive and engaged with the group – planning discharge (OT). Discussion about sleeping patterns as BM was staying up to 00.30 and was awake much of the night and slept for

	most of the morning. He was given a leaflet about sleep. He went to bed at 00.30 as usual and stayed in the bathroom until 02.00.
05/08/2004	BM refused to speak to his mother when she rang the ward – she left a message to say she had had a baby boy and was on Oak Ward. BM didn't want the message and said he didn't believe his mother would have called him.
06/08/2004	Dr W – Staff Grade – wrote a report on BM. The report is hard to read being in long-hand. It appears to comprise a thoughtful review of his psychiatric history.
09/08/2004	**Ward Round –** Dr W's report was considered. The plan was to transfer BM to Sapphire Ward from the PICU. BM stated that he wanted to alter his sleep pattern and to be 'relentlessly' persuaded to get up at 09.00. He did not put this into practice in the next few days.
13/08/2004	BM abusive when staff tried to wake him for meals. Two of BM's friends, R and L, wanted to speak to BM and to visit him on his birthday on 14th. BM refused to speak to them and said he did not want them to visit or listen to their message.
GAP TO 20/09/04	**CPA on Sapphire Ward –** BM was to remain on Section 37.
12/10/2004	The ward phoned Ms C (BM's Mother) to ask about his behaviour after the accident and head injury.
25/10/2004	**CPA Meeting –** BM had started taking Halerpendol 5mg a day which had made him calmer. It was felt that brain injury and cannabis may have contributed to the mental health problems. BM felt the medication made him "feel strange" and to have "vivid dreams". BM said he was pleased he saw his best friend and his brother on the ward.

	The Plan was: • Referral to OT for assessment • Investigate a placement for BM in semi-supported accommodation • 15 minutes escorted leave – remain on S37. Dr Bo had recommended that BM needs medication and could be 'quite dangerous' if he does not comply.
11/11/2004	BM was mentioned to TL (Forensic CPN) who agreed to see him.
19/11/2004	BM on depot injection.
24/11/2004	TL saw BM. Discussed his history – and BM was told if he did not have medication he would not be allowed to leave hospital. BM had tried to leave hospital and had kicked a female nurse when he was being restrained. BM said that using cannabis made him more suspicious of people.
03/12/2004	BM reported to have refused a supported placement at Dickens Road.
14/12/2004	CG (Commissioner) felt BM needed a placement where staff have an understanding of forensic issues or a very tight care plan.
23/12/2004	**Ward Round –** BM had taken cannabis whilst on leave to his mother's – his girlfriend had given him some – he said he had to use it again to realise that he should refrain from doing so. Plan – Day leave to Deter Lodge on 04/01/2005 and overnight leave there on 10/01/2005.
17/01/2005	**CPA Discharge Meeting S117 –** on discharge to Deter Lodge care would be managed by CS (SW) and TL. Trial leave at Deter Lodge had gone well – BM was positive to cannabis on return. Having Haldol Deconate 50mg every 4 weeks – had side effects of restlessness and a tremor so was also

	prescribed Kemedrin %mg BD. BM has been calm, pleasant and friendly unlike prior to the last Depot when he kicked a nurse in the face. Charges of battery prior to his S37 have been dropped. ***Early Warning Signs*** • Irritable • Quick tempered • Aggressiveness It was agreed that there should be a low threshold for admission to hospital due to his high potential for violence. A MHA assessment should be undertaken should BM not comply with medication or stops engaging with services. BM will be randomly tested for drugs at Deter Lodge. He will be seen two weekly – four weekly for depot- four weekly by CS. The position was to be reviewed in four weeks with a further CPA in two months.
24/01/2005	Home Visit by TL to Deter Lodge – saw R the proprietor. She felt BM has settled OK. He has spent time visiting friends, going to the recording studio and looking for work.
26/01/2005	BM reported to have settled in but will not agree to sign his contract of residence. R had no copy of BM's care plan.
21/02/2005	BM staying out late – staff reported this to TL. They were not happy with his progress. There was no depot as BM had not got the prescription from the GP, taken it to chemist to get medication, and then handed it to staff for safekeeping (See Recommendation from Internal Review)
07/03/2005	BM called in to CMHT NW as agreed on 21/02. He remained mentally stable – he was working as a volunteer from 07.30 to 02.30.
18/05 and 19/05/2005	BM not collecting his prescription despite many reminders from staff at Deter Lodge. Staff got his medication so he had depot. He denied refusing a drug urine test – he stays out late and sleeps during the day.
26/05/2005	**CPA Meeting -** Support worker to help BM collect prescription. Deter Lodge want to end his placement.

16/06/2005	BM – dna for depot.
20/06/2005	BM to CMHT NW – had failed to get medication. He denied he has ever had a mental illness and never had symptoms in prison. He does not want to have medication.
27/06/2005	BM interviewed for possible vacancy in Newham House Supported Living
12/07/2005	BM accused of damaging property at Deter Lodge – he denies this. BM is to leave Deter Lodge on 28/07/2005.
13/07/2005	BM visited CMHT NW – asked about accommodation – he wondered if he could stay with his mother until Newham House room is available.
18/07/2005	BM feels worthless – denies symptoms and ever having had mental illness. TL uses session for psycho-education.
03/08/2005	Deter Lodge extended BM's stay – he brought two girls home who stayed in his room overnight – he refuses to tidy up – keeps sneaking out of fire door late at night.
08/08/2005	BM moves to Newham House.
22/08/2005	BM refusing to complete his Housing Benefit forms.
01/09/2005	**CPA Review –** BM dna
05/09/2005	Newham House staff think BM is using cannabis in his room (smell).
09/09/2005	BM has no food and staff ring CS as he needs money – request agreed.
14/09/2005	BM cannot budget. Hates being in mental health system – wants to live independently.

19/09/2005	BM reported to be working part time on a building site.
10/10/2005	BM felt the future was "quite bleak". Denies cannabis use but refused urine test . Noted that he seemed to lack motivation to take his life in hand – needs more support from supported housing staff. BM states he has never had mental illness and does not believe that there are any harmful effects from using cannabis.
19/10/2005	BM refusing to pay rent. He has lost his mobile phone. Stole a Freedom Pass from another resident's room by climbing a ladder and entering through window.
07/11/2005	Appointment with Shaw Trust re employment.
30/11/2005	BM refusing to pay rent – he is £300 in arrears. Given notice to leave Newham House by 10/12/2005. Notice is due to not paying rent and not working with staff.
01/12/2005	HV by CS. BM refuses to pay rent and thinks he has no responsibility to find other accommodation. Plan – ring RF about housing.
05/12/2005	BM forgot depot. Doing up a flat with a friend – will come for depot tomorrow.
06/12/2005	BM comes for depot.
08/12/2005	**CPA Meeting**
12/12/2005	BM moved to Able Housing
03/01/2006	
30/01/2006	BM to CMHT NW – No change. Placement OK. Work as above.

27/02/2006	BM to CMHT NW – had had to be phoned to attend as he had forgotten appointment. He was lethargic and seemed slightly hostile and suspicious.
27/03/2006	BM to CMHT NW – Rang to be reminded to attend. Staff report that he still refuses to keep is room tidy. Still smoking cannabis. No signs of psychosis.
30/03/2006	**CPA Meeting – Plan**: • BM to remain in contact with workers and carers at Able Supported accommodation • To refer to RMO/SCMO if BM fails to continue medication • Liaise with his mother. The Crisis Planning section stated that a relapse could be indicated by: • Non compliance with medication • Being over-argumentative • Being very suspicious • Having increased obsessive traits. TL was no longer going to be involved and AD was taking over. BM stated that he would probably not engage if he lived on his own.
24/04/2006	BM had not got his prescription
27/04/2006	BM to CMHT NW - Depot available as staff had got it. BM refused urine test. AD took over role as care coordinator from CS. Able Housing had changed GP for BM although he did not want this.
18/05/2006	BM to CMHT NW - a week before depot was due.
25/05/2006	BM to CMHT NW - depot. He had been phoned in advance to ensure he would remember to come.

21/06/2006	BM to CMHT NW - depot. BM appeared paranoid and suspicious. There were issues with Able about prescription.
19/07/2006	BM to CMHT NW - depot. BM appeared mentally stable - he was receptive and accommodating.
18/08/2006	BM was phoned as he was two days late for his depot. The next one was due on 15/09/2006. BM was upset that AD had written to say he would not be his care coordinator anymore - it was explained that this was due to team reorganisation.
15/09/2006	BM attended a community music recording studio in Old Street and stabbed the technician working there (Tom - Louis Easton) using knives he had bought that morning. BM was arrested at the Able Housing address the following day.

Mental Health Issues

Substance Misuse Issues

Other Significant Issues

Violence