Independent Scrutiny and Investigation into the care and treatment of

Ms BK

Commissioned by NHS London

NHS London

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Acknowledgements

The scrutiny team did not meet with the family of the victim, however they have been mindful of the fact that this tragic death caused a great deal of sadness and would wish to offer their condolences on the family's loss.

The scrutiny team wishes to thank Ms BK for consenting to access to her records for the purpose of this scrutiny and the Central and North West London NHS Foundation Trust for providing those records in a timely manner.

We are grateful to the Trust's Deputy Chief Executive and Ms BK's Consultant Psychiatrist for taking the time to meet with the scrutiny team to discuss the issues raised within the information examined by them.

Executive Summary

Introduction

Ms BK was arrested and charged with the murder of an associate in the garden of her home on 1st October 2006. At the time of the incident Ms BK was in receipt of mental health services being provided by Central and North West London NHS Foundation Trust (the Trust).

The Trust commissioned an initial Root Cause Analysis Report into the incident which commenced on 14th April 2008 and completed 16th May 2008. Two further reviews took place, November 2009 and December 2009.

NHS London commissioned this independent scrutiny investigation in January 2010 under HSG (94) 27, "the discharge of mentally disordered people and their continuing care in the community" and the updated paragraphs 33-36 issued in June 2005. An independent scrutiny investigation is a narrowly focussed investigation conducted by one or more investigators who have the relevant expertise. The scrutiny team were asked to assess the Trust's internal reviews and findings and make further recommendations if deemed necessary.

Methodology

The scrutiny team has access to the Trust's internal review report and the case notes relating to Ms BK's care and treatment.

The scrutiny was separated into two parts, a detailed analysis of both the internal reviews and Ms BK's care and treatment as stated in her case records. A workshop with the Trust to discuss the issues raised by the scrutiny team following their review of the documentation took place. No individual interviews took place.

Outline of the case

Ms BK was born in Ireland in 1963, one of nine children. It was reported that she had an unhappy childhood. The family settled in England when Ms BK was 12 years old. She was taken into care at age 13 years but ran away and worked from the age of 14 years. Ms BK reported both physical and sexual abuse which persisted over a significant period of time.

In 1982 she married and with her husband ran a public house. Both were reported as abusing alcohol. In 1988 Ms BK was convicted of having stabbed her husband during a violent incident. She was given a six month probation order. It was at this time that two of her children (aged 8 months and 5 years) were taken into care, a further child was living with Ms BK's mother. Another son had died at the age of 6 years following a road traffic accident.

Contact with the Psychiatric Services

Ms BK's first recorded contact with psychiatric services was in June 1991 when she was admitted to St Charles hospital for detoxification (alcohol). Ms BK was reported as having a "lot of emotional and social problems, low mood" and stating that she had "nothing left to live for." It was recorded that there had been a previous admission following an overdose. She was discharged in her absence in August 1991 having been absent without leave from the ward. Ms BK was diagnosed with alcohol dependency syndrome and depression.

Her next inpatient admission was on 5th March 1994 for alcohol abuse and depression following an attempt to hang herself with a telephone cord.

On 2nd April 1994 she was again admitted for detoxification and discharged 9th May 1994.

During the next three to four years a similar pattern followed of Ms BK being admitted for detoxification from alcohol abuse or following self harm, leaving the ward without permission and becoming intoxicated with alcohol. She did not attend appointments and largely disengaged with services with the exception of Social Services. There were reports of her being assaulted by an ex-partner, and being raped in January 2000.

A Care Programme Approach (CPA) review took place on 15th January 2001 where it was reported that her drinking was escalating, she had cut herself deeply and was fearful. Ranitideine 150 mgs bd, Zopiclone 7.5 mgs at night and Chlorpromzaine 25-50 mgs at night were prescribed. Her case was to be reviewed in two months, and she was to continue to be seen by a community support worker and social worker.

During the year (2001) there were several incidents reported including an assault and possible rape by an unknown assailant. She was taken to St George's hospital for treatment after the alleged rape and the police investigated the incident.

Ms BK is reported to having started to carry a knife in the hope that she would see her attacker to stab him. In July Ms BK showed her social worker an expensive professional knife set in a "briefcase" at her home. She refused to give the knives to the social worker.

At a CPA review on 6th July 2001 Ms BK was diagnosed as having a borderline personality disorder, depression, and drug and alcohol misuse.

During 2003 and 2004, a pattern of intoxication, non-engagement, admissions for detoxification and violent incidents continued. In June 2004 when seen by the CMHT SPr with her new SW, Ms BK reported that she had started to use cocaine again.

During 2005 Ms BK had five inpatient admissions, for self harm, an overdose, feeling suicidal and her first report of hearing voices. Her contact fluctuated between the CMHT and CRT services although at times she was difficult to engage. In May she was seen in A and E with 10 cuts to her wrist, all superficial, plus a further 5-10 cuts to each breast.

The first few months of 2006 followed a similar pattern as the previous years. In August 2nd 2006 Ms BK was arrested for allegedly stabbing the man who she said had raped her. She was discharged home with support from the CRT. Two days later (4th August) at a joint visit from the CMHT social worker and CRT, Ms BK was found to be actively self harming. It was decided to arrange a Protection of Vulnerable Adults (POVA) meeting.

Over the next few months Ms BK continued to refuse admission, was assessed as not detainable, frequently threatened to take her life, continued to abuse alcohol and at times did not engage with the mental health services.

On 1st October 2006 Ms BK was arrested at her home and charged with murder.

The Scrutiny Team Findings and Recommendations

The scrutiny team consider that the Trust's review reports were poorly written, not well balanced and missed opportunities to fully investigate the care and treatment provided to Ms BK. They did not address the majority of issues that the scrutiny team identified through its overview. The recommendations were not tied to the findings and are therefore not measurable.

Positive factors

On examination of Ms BK's case records there were areas of good practice.

- It was considered that the care teams providing services to Ms BK should be commended for their perseverance, in particular the social workers who supported Ms BK throughout, not only with her care but also with her many contacts with the police and criminal proceedings.

- The liaison with other agencies, including the voluntary sector to gain support for Ms BK.

Scrutiny Team Independent Findings

The scrutiny team found that the Trust's review process was not timely, thorough or robust. It did not provide a balanced review of Ms BK's care and treatment.

Ms BK's early life appears to have been very disruptive with allegations of both physical and sexual abuse. There did not appear to have been any attempts by the care teams

to refer Ms BK to psychological services to perhaps explore how this experience impacted on her later life.

There were several references to Ms BK's use of knives, however it did appear that the teams did not feel threatened personally. In view of the actual use of knives in at least three violent incidents, for example, the stabbing of her husband and her frequent intoxication, consideration of the risk to staff should have been made and steps put in place to manage that risk.

During the last two to three months prior to the incident Ms BK appeared to be deteriorating in regards to her alcohol and drug abuse but she was also recognising that she required help. It was noticeable that this seemed to escalate after the sexual assault in July 2006.

Although from the notes the consultant appears to have recognised the need to make a fuller assessment of Ms BK's mental state and behavioural disturbance, a subsequent Mental Health Act assessment did not result in her detention under the Act.

In August 2006 when Ms BK was discharged from hospital the CRT refused to take her back on to their caseload as she had previously been discharged. The process was that Ms BK should be re-referred by the CMHT. There is a reference in the notes that the CRT would be asked to "take her on" Two days later she was referred to the CRT North who considered that she was too high a risk for Home Treatment. The scrutiny team could find no evidence that Ms BK was seen again by the CRT. In view of Ms BK's chaotic lifestyle it is considered that the CRT would have been the ideal service to have attempted to maintain engagement.

Although there were good handover notes and summaries contained within the social work file these were not easily accessible by other members of the team. When transferring Ms BK between services, her history of poor relationships should have also been considered as requiring special attention and some form of continuity within her care team provided.

At the time of the incident the Trust did not have integrated notes and the scrutiny team found it difficult to reconcile the different services and contacts with Ms BK.

Record keeping appeared to be poor and there were significant changes with key pieces of information about her history altered over time. Neither the Trust's clinical, or other records nor the internal review reports reflected the level of contact and support offered to Ms BK.

Although the use of medication such as Chlordiazepoxide, Zopiclone and Chlorpromazine can be justified in patients with borderline personality disorder and alcohol misuse there are risks both physical and behavioural. The rationale for their use in Ms BK's case should have been made explicit so that the team caring for her would have been aware of the potential benefits, limitations and possible dangers. CPA

reviews and the resulting care plans would have been the ideal opportunity for this process.
It is worthy of note that Ms BK was subject to the CPA process and subsequently this was found to have ceased. The scrutiny team were unable to find evidence as to whether this was a planned decision.

Ms BK had contact at various times with a variety of different services, including police and probation. The scrutiny team could find no evidence of consideration for a case conference involving all of these agencies. A plan regarding her alcohol misuse might have proved useful to those agencies as to the boundaries on which their particular involvement could have been based.

When it was decided to hold some type of case conference this was done under the auspices of POVA. The scrutiny team consider that it would have been more appropriate for her to have remained under the CPA process. She was a vulnerable lady and this would have been identified and addressed under the CPA agenda but with more concentration on her mental health issues.

Issues addressed at the Trust Workshop with the Scrutiny Team

Current Internal Review Process

The scrutiny team were informed by the Trust that they had become aware of the poor investigation process that had been followed in this case and have taken action to prevent this from occurring again. Independent panel members are often used.

Family Contact

The Trust have developed a protocol for contacting families after serious untoward incidents but acknowledged that this does require full implementation.

Progress made against the Internal Review Action Plan

The scrutiny team were informed that these had all been completed

Dual Diagnosis Services

The Dual Diagnosis services are currently run by the Local Authority and provided on a contractual basis to the Trust. During the workshop the scrutiny team discussed with the Trust their ambition to run their own Dual Diagnosis service as this would provide them with more control over the philosophy, integration and management of the service. With the increase in mental health service users' use of alcohol and drugs it was considered that this would be likely to enhance services to people with a primary mental health diagnosis and substance problems but also to those with primary alcohol and drug problems who are experiencing more complex psychological difficulties. .

Integration of Records

Although total integration of records between all service areas is not in place currently, there have been several advances towards integration since the time of the incident. The Trust is in the process of rolling out an electronic record keeping system, JADE, and hope that this will be implemented Trust wide shortly.

Service Refusal to take individuals

The Trust now provide a variety of additional specialist services including Dual Diagnosis and Personality Disorder, which would offer individuals similar to Ms BK more choice.

Different staff involvement

There was a reference to a dysfunctional team in the conclusion of the Root Cause Analysis report at the time of Ms BK's involvement. The scrutiny team were unable to find any other reference to this. At the workshop with the Trust this was discussed and the scrutiny team were able to have a fuller understanding of the issues at the time. The Trust has put measures in place to resolve this situation and are confident that the team is now fully operational.

CPA implementation

Both the internal reviews and the scrutiny team considered that the implementation of CPA in Ms BK's case was poor. They agreed that Ms BK's care would have been more appropriately managed under CPA rather than POVA. The criteria for inclusion under CPA have been revised and the Trust now has a policy in place which in compactable with current guidance. The Trust explained that since 2006, CPA and its implementation is regularly audited with the Trust Board receiving the results of those audits on a regular basis.

Risk Assessment Training

The Trust now has a system whereby all frontline staff receive Risk Assessment Training. This is monitored and audited on a regular basis.

Recommendations

Despite having been quite critical of the review processes the opportunity for the scrutiny team to discuss their concerns enabled them to clarify the Trust's current position on these issues. It was particularly helpful to discuss Ms BK's care with her responsible consultant.

It gave the scrutiny team the opportunity to fill in detail that they were unable to access through clinical records or the Trust's internal reviews. It also assured the scrutiny team

of the degree of multi-agency involvement which had not been adequately reflected in the case records. This highlighted the shortcomings of the separation of notes and the lack of an easily comprehensible care plan.

Recommendation One – Integrated Records

It is recommended that following the development of integrated records, and particularly with the imminent implementation of JADE, that regular audits of care plans, summaries and the rationale for decision taking is made. It is particularly important that the information from previous records is not lost when new electronic records are implemented.

Recommendation Two – Dual Diagnosis Services

It is recommended that the Trust follow through their ambition to provide Dual Diagnosis services in-house and training to all staff.

Recommendation Three – Summary Sheet

In Ms BK's case there were found to be omissions and misinformation relating to her clinical history. It is recommended that a summary sheet is developed to be sited at the front of patients' records and updated on a regular basis. This should include:

- Current and Diagnostic History
- Risk History
- Risk Management Plan
- Changing diagnosis if relevant
- What medication worked well and problems with medication including allergic reactions
- Admission history
- Markers for relapse
- Signs of relapse
- Contingency plans to manage relapse
- Current care team and contact details

Recommendation Four – Dual Diagnosis and Personality Disorder Services

It is recommended that the Trust audit the impact of Dual Diagnosis and Personality Disorder Services on the client group held by the CMHTs.

1. Introduction

Ms BK was arrested and charged with the murder of an associate in the garden of her home on 1st October 2006. At the time of the incident Ms BK was in receipt of mental health services being provided by Central and North West London NHS Foundation Trust (the Trust).

The Trust commissioned an initial Root Cause Analysis Report into the incident which commenced on 14th April 2008 and completed 16th May 2008. Two further reviews took place, November 2009 and December 2009.

NHS London commissioned this independent scrutiny investigation in January 2010 under HSG (94) 27, "the discharge of mentally disordered people and their continuing care in the community" and the updated paragraphs 33-36 issued in June 2005. An independent scrutiny investigation is a narrowly focussed investigation conducted by one or more investigators who have the relevant expertise. The scrutiny team were asked to assess the Trust's internal reviews and findings and make further recommendations if deemed necessary.

The case was part of a group of legacy homicides investigations that remained from the formation of the new London Strategic Health Authority (NHSL) from its preceding Authorities. As the incident had taken place several years previously and the associated mental health services had developed and changed within that timeframe it was agreed that an independent scrutiny would take place rather than a full independent investigation. However should the scrutiny investigation team find that a fuller comprehensive investigation is required then this would be recommended and commissioned by NHS London.

The Terms of Reference for this scrutiny and investigation can be found in Section 2.

2. Terms of Reference

Part One - Internal Review

To undertake a detailed scrutiny of the internal review completed by the Trust including identification of: -

- The methodology undertaken
- Appropriateness of the panel members
- Relevance of the evidence considered
- Relevance of those interviewed and information received
- Recommendations of the report and how these would ensure that lessons are learnt
- Clinical management

To determine the Care and Treatment provided to Ms BK by examination of the clinical information available from the Trust.

To compile a chronology of events.

Part Two

To hold a workshop with the Trust to discuss any issues raised from their internal investigation and the analysis of the clinical evidence in order to understand what has changed within the services provided that will minimise risk and improve care.

To jointly agree recommendations and the actions to be taken by the Trust.

To complete a final report for acceptance by NHS London for publication.

3. Purpose of the Scrutiny and Investigation

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

The role of this scrutiny is to gain a picture of what was known, or should have been known at the time regarding the patient by the relevant clinical professionals. Part of this process is to examine the robustness of the internal review and establish whether the Trust has already set out improvements to the delivery of mental health services and to raise outstanding issues for general discussion based on the findings identified by the scrutiny team.

The scrutiny team have been alert to the possibility of misusing the benefits of hindsight and have sought to avoid this in formulating this report. We hope those reading this document will also be vigilant in this regard and moderate conclusions if it is perceived that the scrutiny team have failed in their aspiration to be fair in their judgement.

We have remained conscious that lessons may be learned from examining the care of the individual associated with the incident but also more generally from the detailed consideration of any complex clinical case. The scrutiny team has endeavoured to retain the benefits of such a detailed examination but this does not assume that the incident itself could have been foreseen or prevented.

In addition the scrutiny team is required to make recommendations for outstanding service improvements and if there are further concerns in regard to the Trust and its management of the incident to make a recommendation for a full independent mental health investigation.

The process is intended to be a positive one that examines systems and processes in place in the Trust at the time of the incident. It is not the intention to blame individuals. We can nevertheless, all learn from incidents to ensure that the services provided to people with a mental illness are safer and as comprehensive as possible; that the lessons learnt are understood and appropriate actions are taken to inform those commissioning and delivering the services.

4. Methodology

It was agreed at the start of the scrutiny that the team would examine the internal reviews undertaken by the Trust, setting out its findings in regard to the process undertaken, and the Trust's progress against their internal reviews' findings and recommendations. In addition the scrutiny team was to undertake a detailed analysis of Ms BK case records completed by the Trust's staff prior to the death of the victim. Ms BK did authorise access to these records.

The scrutiny was separated into two parts as per the Terms of Reference. This comprised of a detailed analysis of both the internal reviews and Ms BK's care and treatment as stated in her case records. The template used for analysing the internal review can be found in Appendix One.

A detailed chronology of the events leading up to Ms BK's arrest was compiled and can be found in Appendix Two.

It was agreed that no interviews would take place, however it was planned to hold a workshop with the Trust to discuss the issues raised by the scrutiny team following their review of the documentation. A letter inviting the Trust to attend the workshop that also identified the areas for discussion was sent to the Trust's Chief Executive. The Trust's Chief Executive and Ms BK's Consultant Psychiatrist attended the workshop held on 6th May 2010 and the scrutiny team were informed of the progress made against the recommendations from the internal review.

A draft report with recommendations was shared with the Trust and their comments considered by the scrutiny team and amendments made where relevant.

This report has been drafted to include an analysis of the Trust's internal review, a brief history of Ms BK and a detailed consideration of the care and treatment provided to her by the Trust. It includes the scrutiny team's findings and recommendations of the areas that may need further exploration to ensure processes are put into place to reduce the likelihood of similar incidents happening again.

5. Scrutiny Team Members

The scrutiny was undertaken by management consultants, two of whom were external to NHS London. The scrutiny team comprised of:-

Jill Cox	–	Independent Healthcare Advisor, Mental Health Nurse
Dr Clive Robinson	–	Psychiatrist, Medical Advisor
Lynda Winchcombe Chair	-	Management Consultant specialising in undertaking investigations of serious untoward incidents.

6. Outline of the case

The following is a case outline of the events that relate to Ms BK and her care and treatment. It has been compiled from the records available to the scrutiny team, although in some areas the notes are unclear as to exact dates and times of events. A full chronology can be found at Appendix Two that does reflect the full extent of the records provided to the scrutiny team..

6.1 Background

Ms BK was born in Ireland in 1963, one of nine children. It was reported that she had an unhappy childhood. The family settled in England when Ms BK was 12 years old. She was taken into care at age 13 years but ran away and worked from the age of 14 years. Ms BK reported both physical and sexual abuse which persisted over a significant period of time.

In 1982 she married and with her husband ran a public house. Both were reported as abusing alcohol. In 1988 Ms BK was convicted of having stabbed her husband during a violent incident. She was given a six month probation order. It was at this time that two of her children (aged 8 months and 5 years) were taken into care, a further child was living with Ms BK's mother. Another son had died at the age of 6 years following a road traffic accident.

6.2 Contact with the Psychiatric Services

From the records available Ms BK's first recorded contact with psychiatric services was in June 1991 when she was admitted to St Charles hospital for detoxification (alcohol). Ms BK was reported as having a "lot of emotional and social problems, low mood" and stating that she had "nothing left to live for." It was recorded that there had been a previous admission following an overdose. She was discharged in her absence in August 1991 having been absent without leave from the ward. Ms BK was diagnosed with alcohol dependency syndrome and depression.

There were reports of Ms BK harassing her ex-husband in 1992 and being charged with affray in January 1993. Later that year, in May, Ms BK reported that she had been raped by the landlord of a public house.

Her next inpatient admission was on 5th March 1994 for alcohol abuse and depression following an attempt to hang herself with a telephone cord. She went absent without leave and was found to be intoxicated with alcohol on her return to the ward. Ms BK was discharged on 25th March 1994.

On 2nd April 1994 she was again admitted for detoxification and discharged 9th May 1994.

During 1995 she visited the local A and E department several times requesting medication to counteract the symptoms of alcohol abuse. She had a short detoxification admission in a private unit but refused any community follow up on discharge. Ms BK was seen by Drug and Alcohol team workers at various times during this period.

Ms BK reported having suicidal ideas and was admitted 7th March 1996, she was found to be intoxicated on admission. She was discharged 16 days later. It was reported that she had had a reunion with her mother and daughter after a 10 year period. For the remainder of 1996 Ms BK had minimal contact with the services, often not attending for appointments.

During the next three to four years a similar pattern followed of Ms BK being admitted for detoxification from alcohol abuse or following self harm, leaving the ward without permission and becoming intoxicated with alcohol. She did not attend appointments and largely disengaged with services with the exception of Social Services. There were reports of her being assaulted by an ex-partner, and being raped in January 2000. In a separate incident it was alleged that she hit the rapist over the head with a bottle and in a further incident chased the ex-partner out of her flat with a knife. There were numerous police contacts at her home following complaints of her disruptive behaviour by her neighbours. Her case was closed by Social Services in August 2000.

Early in 2000 she was referred to a Community Psychiatrist nurse (CPN) by her Social Worker (SW) for twice weekly visits. Ms BK was difficult to engage and seen only once in four visits to the home by the CPN. She was then discharged from the CPN's caseload as it was considered that Ms BK would not engage.

On 24th March 2000 Ms BK's SW reported that Ms BK had tried to "fling herself under a bus". She was taken to the police station and held overnight under the charge of being drunk and disorderly. In Early April "Opendoor", a voluntary organisation, requested more support for Ms BK from her SW as they felt that she required more therapeutic input to help with her ongoing issues. In August she was admitted to hospital after presenting there because her drinking was out of control. She was an inpatient for 24 hours.

A Care Programme Approach (CPA) review took place on 15th January 2001 where it was reported that her drinking was escalating, she had cut herself deeply and was fearful. Ranitideine 150 mgs bd, Zopiclone 7.5 mgs at night and Chlorpromzaine 25-50 mgs at night were prescribed. Her case was to be reviewed in two months, and she was to continue to be seen by a community support worker and social worker.

In 2001 Ms BK was living in a block of flats where drug dealing and use was common. A Crime Prevention Officer working with Ms BK reported that she had made attempts to change her lifestyle but to succeed needed to be rehoused. She was "living in fear and constantly disturbed at night." In January she was arrested for possession of a knife following an altercation at a Public House.

During the year (2001) there were several incidents reported including an assault and possible rape by an unknown assailant. She was taken to St George's hospital for treatment after the alleged rape and the police investigated the incident.

Ms BK is reported to having started to carry a knife in the hope that she would see her attacker to stab him. In July Ms BK showed her social worker an expensive professional knife set in a "briefcase" at her home. She refused to give the knives to the social worker.

At a CPA review on 6th July 2001 Ms BK was diagnosed as having a borderline personality disorder, depression, and drug and alcohol misuse. She continued to have problems with her accommodation and alternative housing options were to be explored.

An admission in August for "crisis management" and detoxification resulted in her once again being discharged in her absence. Very little contact was made with Ms BK until April 2002, however it was noted by the scrutiny team that she was placed on enhanced CPA in March. She moved to a new flat in November 2001 causing her care to be transferred to another social worker as she had moved out of the catchment area for her original social worker.

In April 2002 the Crisis Resolution Team (CRT) were called in to visit Ms BK as she had reported to the police that she was going to "top herself" following a fight with her ex-partner and another male. She was found to be intoxicated on assessment.

She came under the care of the CRT again in October 2002 when she presented herself to them after two days of binge drinking. She reported "homicidal feelings towards others and an increasing sense that she wanted to harm herself." The CRT kept her on their caseload for seven days but were unable to engage with her – often she would be absent when they visited her. She was discharged back to the care of the Community Mental Health Team (CMHT).

Her dis-engagement continued and she was discharged by her social worker in April 2003.

During 2003 and 2004, a pattern of intoxication, non-engagement, admissions for detoxification and violent incidents continued. In June 2004 when seen by the

CMHT SPr with her new SW, Ms BK reported that she had started to use cocaine again. Her medical care was transferred to the Dual Diagnosis and Community Addiction Prevention Service and a referral for detoxification and rehabilitation made. However by October 2004 Ms BK was reported as stating that she was not ready for this. She also reported that her flat had been broken into by two men. There was also a report that Ms BK had received head injuries following an assault by a neighbour during a fight in her flat.

During 2005 Ms BK had five inpatient admissions, for self harm, an overdose, feeling suicidal and her first report of hearing voices. Her contact fluctuated between the CMHT and CRT services although at times she was difficult to engage. In May she was seen in A and E with 10 cuts to her wrist, all superficial, plus a further 5-10 cuts to each breast. In July she was given a 12 month community order following an assault on another female. She was taken back to court in January 2006 for not complying with this order.

The first few months of 2006 followed a similar pattern as the previous years. In July 2006 Ms BK informed the social worker that she had been assaulted by two neighbours, one of whom tried to stab her. She was threatened with death by the neighbours and told that both her and her cats would be buried in her garden. The police were informed. Ten days later Ms BK reported that she had been raped the night before by a named individual and the police informed. The individual was charged.

August 2nd 2006 Ms BK was arrested for allegedly stabbing the man who she said had raped her. She was discharged home with support from the CRT. Two days later (4th August) at a joint visit from the CMHT social worker and CRT, Ms BK was found to be actively self harming. It was decided to arrange a Protection of Vulnerable Adults (POVA) meeting. Three days later (7th August) she had shaved her head and cut her scalp and wrists and presented at A and E for treatment but left without waiting for treatment. The CRT arranged for her to be admitted to the Churchill Clinic in Lambeth as she refused to be admitted to St Charles hospital. The following day (8th August) she was transferred to St Charles Hospital but refused to be admitted. The duty SPR on assessment found she was not detainable. The CRT refused to take her back and it was decided to re-refer Ms BK to the CMHT.

On 9th August 2006 Ms BK presented at the Charing Cross hospital, she originally refused to be admitted to St Charles hospital but eventually agreed. One day later (10th August) she left the ward and did not return. The police contacted the ward to report that Ms BK had got into her bath and cut her wrists. She was seen in A and E at Charing Cross but not detained and left before being seen by the Emergency Duty Team. The CMHT referred her to the CRT North who considered that she was too high a risk for Home Treatment and did not take her on their caseload.

On 11th August there was an entry in her notes indicating that if she presented again her consultant recommended that an admission be considered and that she should be assessed under the MHA.

Over the next month Ms BK continued to refuse admission, was assessed as not detainable, frequently threatened to take her life, continued to abuse alcohol and at times did not engage with the mental health services.

On 14th September 2006 the Protection of Vulnerable Adult meeting was held after a delay of six weeks and a plan of care formulated. Ms BK's case to be allocated to another social worker and arrangements made that in the event of Ms BK having to be admitted to hospital her cats would be taken care of by the man she subsequently killed.

Her new social worker visited her at home on 20th and 22nd September 2006 and an assessment appointment with the primary care outreach worker was arranged in relation to an inpatient detoxification admission by her GP, and a home visit by her psychiatrist agreed.

On 1st October 2006 Ms BK was arrested at her home and charged with murder.

7. Consideration of the Internal Review Report

The following comments relate to the internal review reports completed by the Trust, and covers the layout of the reports as well as their content. These have been set out in accordance with the first part of the scrutiny team's Terms of Reference.

7.1 Internal Review Reports – Process Comments

The Trust initially completed a management report which commenced in October 2006 and completed in November 2006 but this report does not appear to have been taken to the Trust Board. Instead of undertaking an internal review of Ms BK's care and treatment a report entitled Root Cause Analysis was commenced 18 months after the incident, in April 2008 and completed in May 2008, authored by two members of staff. It followed a template in use at the time by the Trust.

On 25th September 2008 the Director of Operations reviewed the Root Cause Analysis Report and questioned why it had come to her before being reviewed by the Lead Clinician. As a result the report went back to the Lead Clinician for review. The authors were asked by the Chief Operating Officer to consider the review by the Consultant Psychiatrist and Lead Nurse which was completed in November 2009. The authors were not supportive of some of the revisions. It was for that reason that the Chief Operating Officer then referred the case to the Medical Director and Assistant Director of Nursing for a final review.

There was no evidence that either the family of Ms BK or the victim were contacted and informed of the Trust's internal reviews.

None of the reviews contained or worked to Terms of Reference. The template followed by the investigators undertaking the Root Cause Analysis review led them to look at the more recent psychiatrist history and not take into account Ms BK's fuller contact with psychiatric services. A tabular timeline covering the period of one month prior to the incident did include detailed analysis of the services provided during this time but in reality this detail should have been applied to the whole time period of the care received by Ms BK. CPA and Protection of Vulnerable Adults policies were examined together with the Management (72 hour) report. Although an initial management report followed by a Root Cause Analysis and two further reviews of that work took place, a comprehensive full investigation was not undertaken by the Trust in line with good practice and national recommendations.

The process undertaken by the reviews did not include detailed methodologies and although evidence was obtained from Ms BK's records and the interviews of two members of staff, an analysis of this information was not completed. It did not describe a systematic review of the notes nor any quotes within the

chronology of care. The scrutiny team found no evidence of how the findings were reached. It is unclear whether the information underwent any analysis which could have led to the recommendations that were made.

The initial report Root Cause Analysis, was completed by a CMHT manager and Occupational Therapist and whilst the reviewers in November and December 2009 were at senior clinical and management level, they were all internal to the Trust.

None of the reports refer to having made contact with either Ms BK's family or that of her victim. It is unclear as to whether the families were aware of the reviews or given the opportunity to discuss any of the findings and actions to be taken by the Trust.

It was considered by the scrutiny team that the Trust template in use at the time of the reviews was very limiting and in theory prevented a fuller investigation into Ms BK's care and treatment. The proforma was set out in a prescriptive way which prevented the investigations exploring a wider range of issues that might have provided a better view of the service provision to Ms BK.

The Root Cause Analysis review did look at the Trust's CPA and POVA policies and there is an assumption that there was no breach in compliance with these by Ms BK's care teams.

7.2 Internal Review Reports – General Comments

The scrutiny team considered how well the internal reviews examined and commented on the evidence provided to them. In the view of the scrutiny team it was considered that the delay of 18 months to commence the Root Cause Analysis review was unacceptable.

In view of Ms BK's use of knives as a defence weapon one of the main areas for consideration was the risk to herself and others particularly when she was intoxicated.

There was no evidence of any of the reviews taking into consideration a broader discussion as to whether the events of the incident could have been forseen or prevented.

Ms BK's history, in particular her abuse of alcohol and at various times, drugs, was not fully discussed nor how the care team managed this aspect of Ms BK's personality.

There was a criticism of the prescribed medication over the two months prior to the incident, in particular in the use of Chlordiazepoxide and Zopiclone. The scrutiny team agree that there appeared to be a lack of clarity in the rationale for

prescribing. The drugs appear to have been used as tranquilisers in response to her distress.

The Root Cause Analysis review did acknowledge that the CPA process had been badly managed but did not detail how this conclusion was reached. The scrutiny team concur with this view although are mindful as to how difficult Ms BK was to engage in any of the services or processes. It is also noted that Ms BK complied with services on her terms usually at times when either her alcohol abuse or her lifestyle were out of control.

8. Scrutiny Team Findings and Recommendations

The scrutiny team consider that the Trust's review reports were poorly written, not well balanced and missed opportunities to fully investigate the care and treatment provided to Ms BK. They did not address the majority of issues that the scrutiny team identified through its overview. The recommendations were not tied to the findings and are therefore not measurable.

8.1 Positive factors

On examination of Ms BK's case records there were areas of good practice.

- It was considered that the care teams providing services to Ms BK should be commended for their perseverance, in particular the social workers who supported Ms BK throughout, not only with her care but also with her many contacts with the police and criminal proceedings.

- The liaison with other agencies, including the voluntary sector to gain support for Ms BK.

8.2 Scrutiny Team Independent Findings

The scrutiny team found that the Trust's review process was not timely, thorough or robust. It did not provide a balanced review of Ms BK's care and treatment.

Ms BK's early life appears to have been very disruptive with allegations of both physical and sexual abuse. There did not appear to have been any attempts by the care teams to refer Ms BK to psychological services to perhaps explore how this experience impacted on her later life.

There were several references to Ms BK's use of knives, however it did appear that the teams did not feel threatened personally. In view of the actual use of knives in at least three violent incidents, for example, the stabbing of her husband and her frequent intoxication, consideration of the risk to staff should have been made and steps put in place to manage that risk.

During the last two to three months prior to the incident Ms BK appeared to be deteriorating in regards to her alcohol and drug abuse but she was also recognising that she required help. It was noticeable that this seemed to escalate after the sexual assault in July 2006.

Although from the notes the consultant appears to have recognised the need to make a fuller assessment of Ms BK's mental state and behavioural disturbance, a subsequent Mental Health Act assessment did not result in her detention under the Act.

In August 2006 when Ms BK was discharged from hospital the CRT refused to take her back on to their caseload as she had previously been discharged. The process was that Ms BK should be re-referred by the CMHT. There is a reference in the notes that the CRT would be asked to "take her on" Two days later she was referred to the CRT North who considered that she was too high a risk for Home Treatment. The scrutiny team could find no evidence that Ms BK was seen again by the CRT. In view of Ms BK's chaotic lifestyle it is considered that the CRT would have been the ideal service to have attempted to maintain engagement.

Although there were good handover notes and summaries contained within the social work file these were not easily accessible by other members of the team. When transferring Ms BK between services, her history of poor relationships should have also been considered as requiring special attention and some form of continuity within her care team provided.

At the time of the incident the Trust did not have integrated notes and the scrutiny team found it difficult to reconcile the different services and contacts with Ms BK.

Record keeping appeared to be poor and there were significant changes with key pieces of information about her history altered over time. Neither the Trust's clinical, or other records nor the internal review reports reflected the level of contact and support offered to Ms BK.

Although the use of medication such as Chlordiazepoxide, Zopiclone and Chlorpromazine can be justified in patients with borderline personality disorder and alcohol misuse there are risks both physical and behavioural. The rationale for their use in Ms BK's case should have been made explicit so that the team caring for her would have been aware of the potential benefits, limitations and possible dangers. CPA reviews and the resulting care plans would have been the ideal opportunity for this process.

It is worthy of note that Ms BK was subject to the CPA process and subsequently this was found to have ceased. The scrutiny team were unable to find evidence as to whether this was a planned decision.

Ms BK had contact at various times with a variety of different services, including police and probation. The scrutiny team could find no evidence of consideration for a case conference involving all of these agencies. A plan regarding her alcohol misuse might have proved useful to those agencies as to the boundaries on which their particular involvement could have been based.

When it was decided to hold some type of case conference this was done under the auspices of POVA. The scrutiny team consider that it would have been more

appropriate for her to have remained under the CPA process. She was a vulnerable lady and this would have been identified and addressed under the CPA agenda but with more concentration on her mental health issues.

8.2.1 Issues addressed at the Trust Workshop with the Scrutiny Team

Current Internal Review Process

The scrutiny team were informed by the Trust that they had become aware of the poor investigation process that had been followed in this case and have taken action to prevent this from occurring again. Independent panel members are often used.

Family Contact

The Trust have developed a protocol for contacting families after serious untoward incidents but acknowledged that this does require full implementation.

Progress made against the Internal Review Action Plan

The scrutiny team were informed that these had all been completed

Dual Diagnosis Misuse Services

The Dual Diagnosis services are currently run by the Local Authority and provided on a contractual basis to the Trust. During the workshop the scrutiny team discussed with the Trust their ambition to run their own Dual Diagnosis service as this would provide them with more control over the philosophy, integration and management of the service. With the increase in mental health service users' use of alcohol and drugs it was considered that this would be likely to enhance services to people with a primary mental health diagnosis and substance problems but also to those with primary alcohol and drug problems who are experiencing more complex psychological difficulties. .

Integration of Records

Although total integration of records between all service areas is not in place currently, there have been several advances towards integration since the time of the incident. The Trust is in the process of rolling out an electronic record keeping system, JADE, and hope that this will be implemented Trust wide shortly.

Service Refusal to take individuals

The Trust now provide a variety of additional specialist services including Dual Diagnosis and Personality Disorder, which would offer individuals similar to Ms BK more choice.

Different staff involvement

There was a reference to a dysfunctional team in the conclusion of the Root Cause Analysis report at the time of Ms BK's involvement. The scrutiny team were unable to find any other reference to this. At the workshop with the Trust this was discussed and the scrutiny team were able to have a fuller understanding of the issues at the time. The Trust has put measures in place to resolve this situation and are confident that the team is now fully operational.

CPA implementation

Both the internal reviews and the scrutiny team considered that the implementation of CPA in Ms BK's case was poor. They agreed that Ms BK's care would have been more appropriately managed under CPA rather than POVA. The criteria for inclusion under CPA have been revised and the Trust now has a policy in place which in compactable with current guidance. The Trust explained that since 2006, CPA and its implementation is regularly audited with the Trust Board receiving the results of those audits on a regular basis.

Risk Assessment Training

The Trust now has a system whereby all frontline staff receive Risk Assessment Training. This is monitored and audited on a regular basis.

8.3 Scrutiny Team Recommendations

Despite having been quite critical of the review processes the opportunity for the scrutiny team to discuss their concerns enabled them to clarify the Trust's current position on these issues. It was particularly helpful to discuss Ms BK's care with her responsible consultant.

It gave the scrutiny team the opportunity to fill in detail that they were unable to access through clinical records or the Trust's internal reviews. It also assured the scrutiny team of the degree of multi–agency involvement which had not been adequately reflected in the case records. This highlighted the shortcomings of the separation of notes and the lack of an easily comprehensible care plan.

Recommendation One – Integrated Records

It is recommended that following the development of integrated records, and particularly with the imminent implementation of JADE, that regular audits of care plans, summaries and the rationale for decision taking is made. It is particularly important that the information from previous records is not lost when new electronic records are implemented.

Recommendation Two – Dual Diagnosis Services

It is recommended that the Trust follow through their ambition to provide Dual Diagnosis services in-house and training to all staff.

Recommendation Three – Summary Sheet

In Ms BK's case there were found to be omissions and misinformation relating to her clinical history. It is recommended that a summary sheet is developed to be sited at the front of patients' records and updated on a regular basis. This should include:

- Current and Diagnostic History
- Risk History
- Risk Management Plan
- Changing diagnosis if relevant
- What medication worked well and problems with medication including allergic reactions
- Admission history
- Markers for relapse
- Signs of relapse
- Contingency plans to manage relapse
- Current care team and contact details

Recommendation Four – Dual Diagnosis and Personality Disorder Services

It is recommended that the Trust audit the impact of Dual Diagnosis and Personality Disorder Services on the client group held by the CMHTs.

Scrutiny Template

Appendix One

The Review concerns cases where a homicide has occurred and would have, in other circumstances, triggered an independent investigation into the care and treatment of the perpetrator of the homicide. The initial phase of the review assesses the internal investigation in relation to criteria appropriate to an independent investigation, where possible providing evidence supporting that assessment. Where there is a significant omission, or deviation from good practice within the internal investigation, the independent review makes an assessment based on available evidence. The following table provides a format for this process.

Item under scrutiny	Achieved or not	Evidence	Comments
Was there an Initial Management Investigation within 72 hours			
Was relevant immediate action taken relating to : Staff Notes Equipment Communication with individuals, organizations, carers and families			
In relation to families and carers:			
- was an appropriate member of the Trust identified to liaise with them - was the liaison sufficiently flexible			
- were SHA and other appropriate organizations notified of the homicide			
- was consideration given to an Independent Investigation			

- was there an appropriate description of the purpose of the investigation			
Item under scrutiny	**Achieved or not**	**Evidence**	**Comments**
Did the Terms of Reference include the following:			
To examine all circumstances surrounding the treatment and care of X From …(date).. to the death of …(Victim)… and in particular:			
- the quality and scope of X's health, social care and risk assessments			
- the suitability of X's care and supervision in the context of his/her actual and assessed health and social care needs			
- the actual and assessed risk of potential harm to self and others			
- the history of X's medication and concordance with that medication -			
- any previous psychiatric history, including alcohol			

and drug misuse			
- any previous forensic history			
Item under scrutiny	**Achieved or not**	**Evidence**	**Comments**
The extent to which X's care complied with:			
- statutory obligations			
- Mental Health Act code of practice			
- Local operational policies			
- Guidance from DOH including the Care Programme Approach			
The extent to which X's prescribed treatment plans were:			
- adequate			
- documented			
- agreed with him/her			
- carried out			
- monitored			

- complied with by X			
Item under scrutiny	**Achieved or not**	**Evidence**	**Comments**
To consider the adequacy of the risk assessment training of all staff involved in X's care			
To examine the adequacy of the collaboration and communication between the agencies involved in the provision of services to him/her			
To consider the adequacy of the support given to X's family by the Mental Health team serving the community and other professionals			
To consider such other matters as the public interest my require			

Item under scrutiny	**Achieved or not**	**Evidence**	**Comments**
In terms of the conduct of the Internal Investigation were:			
- carers and relatives of victim and perpetrator involved if they wished to be			
- appropriate statutory bodies involved in the process			
- suitable methodologies identified (for example root cause analysis)			
- these methodologies followed in practice			
- appropriate individuals			

recruited to the panel			
- the case notes reviewed systematically			
- significant events included in a chronology			
- appropriate individuals asked to provide statements and/or interviewed			
- views expressed or information contained in external reports such as forensic reports taken account of (if available at the time of the investigation)			
- the case notes scrutinized in terms of accessibility, legibility, comprehensiveness			

- the case notes identified containing a current risk assessment, CPA documentation, care plan			
Item under scrutiny	**Achieved or not**	**Evidence**	**Comments**
In terms of the Internal Report Recommendations do they:			
- make clear the legislative and other constraints thus providing a realistic yardstick against which clinical decisions were assessed			
- recommend a course of action for each problem identified or indicate why improvement is not possible			
- refer to commendable practices			
- acknowledge that all clinical decisions involve the assumption of risk			

- address whether any application of the MHA was appropriate and completed legally			
Item under scrutiny	**Achieved or not**	**Evidence**	**Comments**
Did the Internal Investigation Report receive Trust Board scrutiny and approval			
Did any action plan address the report recommendations			
Is there evidence that the action plan has been successfully implemented and any identified risks reduced if possible			
Is there evidence that there are significant issues not addressed by the internal report			
Is there evidence that there have been failures to adhere to local or national policy or procedure			
Is there evidence that the care provided for X was inappropriate, incompetent or negligent			
Do the Independent review panel think it appropriate to make additional recommendations			

Chronology of Events Appendix Two

Date	Event
1963	Ms BK was born in Ireland, one of 9 children. It is reported that she had a difficult and unhappy childhood. The family settled in England when Ms BK was aged twelve. She was expelled from school and taken into care at age thirteen. She ran away and worked from age fourteen. Sexually abused from age thirteen.
1982	Extra Contractual Referral for a placement at Bowden House outside London. Ms BK felt that this helped her but no other details are available. Ms BK got married and with her husband ran a pub. It is reported that both drank heavily.
1988	During a particularly violent incident with her husband Ms BK stabbed him (wound required 1 stitch). She was convicted and given 6 months probation.
1988	It is reported that at this time two of her children (aged 8 months and 5 years) were taken into care, a further child was already living with Ms BK's mother. Another son had died at the age of 6 years following a road traffic accident. Ms BK has since made contact with her son who had been adopted.
1990	Admitted to hospital following an overdose. Full family history written in her notes records that adoption proceedings are ongoing in regard to her children.
June- August 1991	First recorded contact with local services. Inpatient admission for detoxification (alcohol). Ms BK was identified as having "a lot of emotional and social problems", "low mood" and self reporting "nothing left to live for". Discharged in absence whilst AWOL.
August 1991	Diagnosed with alcohol dependency syndrome and depression.
1992	Ms BK was reported as harassing her ex husband.

January 1993	Ms BK charged with an affray.
May 1993	Ms BK reported as having been raped by the landlord of a public house.
5-25.03.1994	Ms BK admitted to hospital for "alcohol abuse and depression" following attempt to hang self with telephone cord. Lethality of attempt recorded as low. Discharged following abuse of alcohol whilst AWOL.
April to Sept 1994	Admission for detoxification (alcohol).
30.05.1995	GP referred Ms BK to the Drug Dependency Unit (DDU) to be seen by alcohol specialist nurse. Seen only a few times by DDU workers.
1995	Ms BK used A & E to request medication to counteract symptoms of alcohol abuse. Short admission for detox to private unit – refused community follow-up subsequently.
07.03. – 23.04.1996	Admission to hospital following self-presentation reporting suicidal ideas Ms BK intoxicated on admission. She reported a reunion with her daughter and her mother after a 10 year gap.
May to Dec 1996	Minimal contact with services as she did not attend appointments (DNA).
1997	Ms BK had multiple admissions for a few days each for detoxification or following overdoses. Each episode resulted in her being discharged in her absence or following abuse of alcohol. There are reports of a hanging attempt and self harm out of frustration. No psychotic features identified. Diagnosis: mild depression /prescribed Paroxetine 20 mgs daily.
Sept 1998	Two day admission to hospital as Ms BK had attempted to jump in the canal. Numerous DNA appointments on file. Diagnosis: Disorder of adjustment – brief depression reaction. Dothiepin 75mgs bd/Thioridazine 50 mgs tds/Metoclopromide 10mgs prn prescribed.
30.04 –	Admission for detoxification and support following the

16.05.1999	death of a friend. Ms BK took her own discharge against advice.
1999	Planned detoxification admission from alcohol and psychiatric medication.
August 1999 – Aug 2000	Ms BK largely disengaged with services but retained contact with the social work department. Reports during this periods of her being assaulted by ex-partner (October 1999) and of being raped (January 2000). Ms BK hit the alleged attacker in a separate incident over the head with a bottle (April 2000) when drunk, also reported at chasing her ex-partner out of her flat armed with a knife (undated). Numerous police contacts at home of Ms BK following complaints from neighbours.
07.02.2000	Had been referred by SW to CPN for two weekly visits – out of 4 visits only seen once so discharged. The CPN also forgot to take her Melleril 25mgs which Ms BK did not mind as she was going away and wouldn't need it.
24.03.2000	SW reported that Ms BK tried to "fling herself under a bus", she was taken to the police station and held overnight drunk and disorderly– she complained about police treatment .
10.04.2000	"OpenDoor" asked for more help from Ms BK's SW and it was agreed to see Ms BK once a month to offer a therapeutic role surrounding previous issues.
21.08.2000	Admission (24 hrs) following self presentation as "drinking out of control".
August 2000 – Aug 2002	Ms BK largely disengaged with health services during this period.
05.10.2000	Ms BK's case had been closed by her SW on 7th August 2000 and had lost contact with a "OpenDoor" – referral made to SW for a needs assessment – she DNA three times. Seen by her Consultant Psychiatrist who diagnosed Borderline Personality Disorder and alcohol misuse – no medication prescribed.
2001	During 2001 Ms BK was living in a block of flats where

drug dealing and use was a constant feature. The Crime Prevention Officer who had been working with Ms BK for two years felt that Ms BK had done a lot to change her lifestyle but the only way forward was for her to be rehoused as she was living in fear and constantly disturbed at night. Also during 2001 her daughter tricked the fire brigade to break down Ms BK's front door in order that she could "use the flat to provide a roof over her head and take her drugs" whilst her mother was away.

Jan 2001 — Ms BK arrested for possession of a knife following altercation at a public house.

15.01.2001 — CPA review took place. It was noted that her drinking had escalated, she had cut herself quite deeply and was fearful in her flat.

Prescribed Ranitideine 150 mgs bd/zopiclone 7.5 nocte and chlorpromazine 25-50mgs at night prn. A letter was sent to her GP. For a CPP review in two months and to continue to see the Community support worker and SW.

February 2001 — Self report of being assaulted by 2 women who were known to her.

09.04.2001 — CMHT SW completed a detailed risk assessment covering risks of self harm/self neglect/risk to others/risk from others. He included details of an alleged incident on 24th June 2001 when she was assaulted and possibly raped by an unknown male assailant. He concludes that risk of violence to others and risk of self neglect are low. He does include incident where she stabbed her husband (1990).

Risk assessment signed by her Consultant Psychiatrist.

25.06.2001 — MS BK reported as having been sexually assaulted. Police CID wanted to Ms BK to be examined – SW took her to the Haven at St Georges Hospital.

July 2001 — Latterly reported as "carrying a knife with her in the hope that she would see him and stab him" (unknown assailant).

04.07.2001 — Following a call from Ms BK her SW visited her for one and a half hours – she showed this "briefcase" which was an expensive professional knife set. The SW asked her to give her the knives – she refused. – she was asked to

come into hospital several times – she refused

06.07.2001 CPA review took place, Ms BK now diagnosed with borderline personality/depression/drug and alcohol misuse. Mrs BK expressed a fear of killing someone due to problems with accommodation. The plan was for her to remain in hospital whilst housing options explored. Contingency plan for who and when to contact made.

Medication prescribed of vitamins plus chlorpromazine 25mgs when needed and Zopiclone 75mgs when needed at night.

24.07.2001 Transfer summary SW completed by Ms BK's SW.

20.08-18.09.2001 Admission "for crisis management". Detoxification commenced. CPA review undertaken. Ms BK discharged in her absence following being AWOL and abusing alcohol. Minimal contact with all services following discharge (no access/DNA's).

Nov 2001 Ms BK moved to a new flat.

26.03.2002 Transfer summary sheet to another SW competed. It stated Ms BK had a diagnosis of borderline personality disorder, depression and drug and alcohol abuse.

At this time other services included St Marks Day Centre, Opendoor, also crime prevention officer to provide practical and emotional support. Ms BK is placed on enhanced CPA.

April 2002 A 2 day intervention by CRT following Ms BK self reporting to police that she was going to "top herself" after a fight at her home with ex-partner and another male. She was intoxicated on assessment.

30.10 - 7.11.2002 Remains under the care of the CRT. "Admitted" to CRT following self-presentation after 2 days of binge drinking (self report) and whilst intoxicated. Ms BK reported that she had homicidal feelings towards others and an increasing sense that she wanted to harm herself. Evidence of withdrawal during initial 3 days of CRT involvement. Began drinking again on 2nd November 2002 until her discharge on 7th November. Ms BK only called the CRT when intoxicated and would threaten self-harm but

	when visited she would be absent or fail to answer the door. Discharged to the CHMT again with her agreement.
06.12.2002	CPA meeting arranged, Ms BK did not attend.
April 2003	Discharged by allocated social worker as no role and Ms BK not engaging. No other contact with services identified in 2003.
23.03 – 01.04.2004	Admission following self-presentation reporting feeling unsafe. Evidence of alcohol withdrawal post admission whilst on detoxification. Was brought back to the ward by police on 28th March 2004 whilst on day leave following drunk and disorderly behaviour at a local public house. Discharged in her absence after being AWOL for 2 days. Discharge summary does not include any entry re a CPA review and is not dated.
August 2004	Seen by SPr for the CMHT with allocated social worker. Intoxicated and threatening. Angry with services. Offered weekly appointments with SPr (DNA'd next 3 appointments).
May 2004	Seen by SPr with allocated SW. Intoxicated. Bruised face following assault by partner. Had an appointment with CAPS planned, also adult protection.
18.05 – 11.06.2004	DNA'd all appointments with SPr (4). Messages left by Ms BK however reporting drinkers using her flat and being unable to say "no".
20.05.2004	Comprehensive risk assessment compiled by her departing SW.
26.06.2004	Waiting for inpatient detoxification. A letter from the SPr stated that she was back to using cocaine.
16.06.2004	Seen by the CMHT SPr with her new SW. Intoxicated and angry and reported using cocaine. Medical care subsequently taken over by the dual diagnosis unit and Community Addition Prevention Service with Ms BK referred for detoxification and rehabilitation. CMHT SW remaining involved in joint work case with dual diagnosis.
August 2004 -	Detoxification and subsequent rehabilitation agreed and

	being processed.
13.08.2004	A clear crisis and contingency plan was recorded in Ms BK's progress notes of the CMHT file.
02.09.2004	Ms BK reported using crack during a planned home visit.
04.10.2004	Planned home visit. Ms BK reported that her flat had been broken into by 2 men. Stated she is not ready for detoxification or rehabilitation. Alternative plan made with the local service.
15.10.2004	Ms BK seen as had head injuries following an assault by a neighbour during a fight at her flat.
08.01 – 10.01.2005	Admission to Hammersmith Hospital following an overdose of Temazepam and alcohol after a violent argument with her boyfriend. Self discharged against advice by the medical team. Started on Venlafaxine XL 35mgs. Concern was expressed for her wellbeing.
18.01 – 27.01.2005	Admission following self presentation. Had self-harmed plus reported thoughts of harming partner. Detoxification treatment commenced. Discharged at own request.
02.02 – 15.02.2005	Re-admission following being brought to unit by the police. Ms BK self reported crack use. Continued to use alcohol on leave and requested her own discharge.
27.02.2005	Ms BK self presented to the duty doctor. She was under the influence of alcohol but left before being seen.
13.05 - ?18.05.2005	Admitted to St Mary's via A&E after she presented there requesting an admission to St Charles hospital. The CRT felt unable to take her as her primary problem was alcohol dependency.
25.05.2005	Ms BK seen in A&E, she had 10 cuts to her wrist which were all superficial plus 5-10 superficial cuts to each breast. Diagnosed as alcohol dependence syndrome/emotionally unstable personality/history of depression.
05.07.2005	Community Rehabilitation Order made in relation to a common assault.

02.08.2005	Ms BK's cat reported as having died.
03.08.2005	Ms BK informed her SW that she had been given a 12 month community probation order following an assault on a female. A condition of the probation was to have alcohol treatment.
01.09 – 11.09.2005	Admission agreed at patient's request as she reported feeling suicidal. Ms BK also reported hearing voices (first record of auditory hallucinations found on file). A 5 day detoxification completed. Discharge planned but delayed by one day as Ms BK self harmed. On her discharge summary there was no mention of self harm prior to discharge, but it does state that she was kept longer due to tremors. The summary states that the alleged auditory hallucinations were "not clear enough".
11.09 – 19.09.2005	Ms Bk placed under the care of CRT
22.09.2005	Plan made in CMHT file progress notes.
05.01.2006	Ms BK attended Court for failing to comply with community order – case further adjourned until 23rd October 2006.
16.01.2006	The window to Ms BK's flat was noted as being boarded up during a home visit when access not gained.
19.01.2006	Letter of support written by Ms BK's psychiatrist requesting "leniency" at her probation hearing.
05.02.2006	Ms BK was informed that her cousin had committed suicide on 1st February 2006.
06.02.2006	Probation officer reported Ms BK as suicidal. They also reported concerns regarding her being in a violent relationship currently. "Admitted" to CRT.
06.02 – 27.02.2006	Under the care of CRT. Similar pattern as in 2002 Ms BK not engaging. The CRT visited twice daily to monitor risk of self harm and compliance with medication following the suicide of her cousin.
31.03.2006	Plan documented in CMHT file to hold a strategy meeting to formulate a plan of how to support Ms BK.

07.04 -	Violent partner identified as leaving the country. Ms BK upset.
21.04.2006	Initial meeting under Protection of Vulnerable Adult (POVA) policy held. Plan made for review on 14th June 2006. To be referred to dual diagnosis team and for anger management.
25.04.2006	Note from Ms BK – referring to the meeting on 21st full of promise "know one has phoned just to find out if Im OK" …….."Don't blame B..if I mess up – ive been asking for your help which I HATE doing. If anything happens to me you know why".
04.05.2006	DNA outpatient appointment.
21.05.2006	A patient known to Ms BK committed suicide – funeral held on 8th June.
09.06 – 13.06.2006	Admission following unplanned home visit undertaken by SW when Ms BK very intoxicated (entry in CMHT file is for overnight admission only. Epex shows 4 day admission. CMHT file records admission ending with client going AWOL which may explain difference in dates of discharge).
14.06.2006	POVA review not held (not documented why).
29.06.2006	DNA outpatient appt.
14.07.2006	Ms BK informed the SW that the day before she had been assaulted by 2 neighbours, one of whom kicked her and the other of whom went to stab her with a kitchen knife but was disarmed by friends. The neighbours threatened to kill and bury her and her cats in the garden. Documented plan in CMHT file to arrange a POVA meeting. Her SW reported the incident to the police.
24.07.2006	Ms BK informed the SW that she had been raped the night before in her flat by a named individual and had reported this to the police.
01.08.2006	Call from PC Morrison to advise EDT that Ms BK had been raped a week ago by old friend (age73) who has been charged.

Later states “Ms BK was closed to Substance Use Team last year”. Diagnosed Borderline Schizophrenic and prescribed anti-depressants……”

02.08.2006 Ms BK arrested and taken to the police station for allegedly stabbing the man who allegedly raped her. Interview date set for 15th August. She was discharged home from custody with input from the CRT. Alleged assailant had reportedly been bailed to an address in the same road when Ms BK lived. CRT staff and also staff from dual diagnosis were all there to support her.

04.08.2006 Joint visit between CMHT SW and CRT. Ms BK actively self-harming. Decision regarding need to arrange a POVA meeting documented in notes.

07.08.2006 Ms BK shaved her head and cut her scalp and wrists. She presented at A&E but then left. Was taken by CRT to Churchill Clinic in Lambeth and admitted to Lloyd George Ward as was refusing admission to St Charles hospitall.

08.08.2006 Transferred to St Charles hospital but refused admission. Assessed by the duty SPr on call. Not detainable. CRT declined to accept her back as had discharged her from their caseload and she would need to be re-referred by CMHT.

09.08.2006 At 12.45 hours Ms BK presented at Charing Cross Hospital. Refused admission to St Charles or Patterson hospitals At 21.30 hours she was admitted to Thames Ward at St Charles hospital. Later she stated that she had been to a funeral earlier in the day for a friend “Paul” who had been previously known to services.

10.08.2006 MS BK left the Ward and failed to return. A call from the police who reported that Ms BK had got in the bath and cut her wrists.

Referred to the CRT North who considered that she was too high risk for home treatment. Difference of view that she had been allowed to discharge herself from Churchill Clinic and was seen at A&E Charing Cross and not detained.

11.08.2006 Police informed SW that Ms BK had cut her wrists the night before and had been taken to Charing Cross. She

had left however before EDT had been able to make contact.

Note from care co-ordinator to say Ms BK has been presenting at several departments including Churchill Clinic - she has been assessed and not found to be detainable under MHA. That consultant thinks that if she presents (again) she should be considered for admission.

11.08.2006 CMHT discussion with consultant – agreed that a MHA Assessment should take place – plan written.

13.08.2006 Police contacted the ward. They had found her in her flat under the influence of alcohol. Declined to return to hospital. Note from Ms BK - "knowing him for nearly 4 yrs – I thought he was my friend".

14.08.2006 Long note about how she feels and has" been phoning all the important people asking for help".

Joint home visit by CMHT doctor and SW. Ms BK refused admission. Assessed as not detainable. Ms BK threatened to take her life if forced to be admitted. It was arranged for a friend to collect her medication and also to ask the CRT if they would engage with her.

15.08.2006 Interviewed at police station for incident of 2nd August. Bailed with case referred to the CPS for decision.

23.08.2006 A note – appears to be to her attacker in the records.

25.08.2006 Note from Ms BK – feels dirty all the time and keeps wetting herself. "Feels like dying – or ready".

01.09.2006 Documented note in CMHT file that the POVA meeting had been "put off" as the GP was on holiday and the housing officer also needed to be present. Note of phone calls from MS BK – SW's helpful.

04.09.2006 Joint home visit by CMHT doctor and social worker. Ms BK reported as being upset that POVA meeting had been cancelled.

05.09 - 11.09.2006 Ms BK given a formal caution (incident of 2 August). Note from Ms BK.

	"you all tell me your looking out for me what are you doing about it, are you all waiting for me to die before you all more your ….like all my friends you let go the all dead. Thanks a lot ive cried out for your help but thes know one there what am I gonna do "
14.09.2006	Meeting under POVA held. Plan formulated. Advanced directive recorded. Decision also taken by manager to reallocate case to alternative SW. Full plan written – in advanced directive (3) in the event of Ms BK being admitted to hospital she would like her friend Eddie (her victim) to look after her flat and her cats. He already has keys.
20.09.2006	Home visit by SW. Dossett box of medication, plus copy of minutes and plan under POVA given to Ms BK. Letters/papers taken by SW to photocopy.
22.09.2006	Home visit by SW to return papers. Ms BK recorded as being very abusive.
25.09.2006	Appointment for assessment/discussion with primary care outreach worker re plans for inpatient detoxification (arranged by GP following Network meeting).
29.09.2006	Telephone call to Ms BK by CMHT doctor. Home visit arranged for Monday at 14.30 hours.
01.10.2006	Ms BK arrested for murder of the victim at her home.
02.10.2006	The CMHT informed. The team's Senior SW attended the police station to act as appropriate adult.
04.10.2006	Ms BK remanded into Holloway Prison following appearance at Magistrates Court