An independent investigation into the care and treatment of service user Mr U

March 2013

A report for NHS London
Undertaken by Caring Solutions Ltd

NHS London

ACKNOWLEDGEMENTS

The Independent Investigation Panel would like to extend their thanks for the cooperation and assistance offered to them by a variety of individuals. In particular, we would like to offer our appreciation to the Patient Safety Lead and her deputy at Oxleas NHS Foundation Trust. Also we would like to thank the Serious Untoward Incident System Manager at West London Mental Health NHS Trust, the Crown Courts Administrator at Merrill Legal Solutions, and officers of the Metropolitan Police Family Liaison Service and the Bromley Jigsaw Team.

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1 EXECUTIVE SUMMARY

1.0 Please note that in this report the perpetrator of the homicide is referred to as Mr. U, and the victim as Mr. V.

1.1 The Incident

1.1.1 NHS London has commissioned Caring Solutions (UK) Ltd to conduct an independent inquiry into the care and treatment of Mr. U, who assaulted Mr. V on 31st October 2009. Mr. V later died of his injuries. At the time, Mr. U was under the care of Oxleas NHS Foundation Trust (the Trust) Community Forensic Team. It is also part of our remit to examine the Internal Investigation carried out by the Trust, the action plan produced from that work, and the progress to date in implementing the action plan.

1.1.2 Mr. U was drinking with three friends in a pub in Bromley on the evening of 31st October 2009, when they became involved in a dispute with Mr. V. This altercation broke out into a fight outside the pub and ended with Mr. V receiving head injuries which led to his death three days later.

1.1.3 The four men were charged with murder. Mr. U was convicted of manslaughter, due to lack of intent to kill or cause serious harm, two of the co-accused were acquitted, the other was acquitted of murder but the jury failed to agree on manslaughter, he was to be retried for manslaughter the outcome of this trial is not known to the panel.

1.2 Background

1.2.1 Mr. U had been released from prison on Probation licence on 3rd November 2008 and was living in a Probation Hostel in Beckenham. He had longstanding mental health problems including obsessive compulsive symptoms, alcohol and illicit drug abuse, personality difficulties, and a history of self harm. He registered with a local GP who referred him to the local Community Mental Health Team (CMHT) for fairly urgent assessment. He was first seen about ten weeks after the date of the referral, by the Social Worker from the CMHT. The CMHT also passed the referral on to the Community Forensic Team (CFT). The CFT operate a liaison service to this and other Probation Hostels. Their Forensic Psychologist also became aware of Mr. U and asked the Community Forensic Consultant to see him, which she did for the first time on 28th January 2009.

1.2.2 The Social Worker appears to have left the CMHT in January 2009 (there are no further entries in the clinical notes) but no further follow up was offered to Mr. U, even though he presented to the CMHT office three times in February 2009. A significant stressor was that he was losing his accommodation at the Hostel at the beginning of March 2009 when his Probation licence expired. Bromley Housing Department initially decided they had no responsibility for him and said he should return to Hounslow for help with housing. Mr. U seems to have arranged accommodation for himself in a privately rented flat in Penge, via a local charity. In early March 2009 the CMHT decided to discharge Mr. U from their caseload, but they did not formally hand over his care to another service, and they did not inform his GP until late April.

1.2.3 The CFT formally added Mr. U to their caseload in April 2009 with the main care provider being a Forensic Community Psychiatric Nurse (CPN), supported by a Consultant Forensic Psychiatrist and the Forensic Team Leader.

1.2.4 The CFT provided good quality care to Mr. U. He was seen and spoken to frequently, and assisted with practical problems. When it became clear that Mr. U was being threatened at his privately rented accommodation, and that the lack of safe, clean accommodation was a major stress in his life, the Forensic CPN and Consultant Forensic Psychiatrist did everything they could to work with Bromley Housing Department to assist him to move. Finally a suitable flat was identified in Croydon but it was not going to be available until the end of October 2009. Mr. U had to be moved urgently towards the end of October due to an escalation in the threats made to him by other residents at the block of flats. However he had to share washing facilities at the stopgap accommodation which exacerbated his OCD symptoms, so he was moved again six days later to temporary accommodation in Bromley.

1.2.5 On 21st October 2009 when the threats at his privately rented accommodation reached their height, the Forensic CPN collected Mr. U from Penge in an aroused state. Mr. U was carrying a knife for protection which he handed over to the Forensic CPN. This incident was apparently discussed in supervision with the CFT Leader, but nothing was documented in RiO (electronic patient record) and the incident was not formally notified to the Multi-Agency Public Protection Arrangements (MAPPA).

1.2.6 The assault which led to Mr. V's death occurred on 31st October 2009 when Mr. U had been drinking with friends in a pub in Bromley. The Forensic CPN was informed of Mr. U's arrest on 3rd November 2009 and was advised the following day that Mr. U had been charged with murder. The CPN and the CFT Leader then completed an incident report form. He also liaised with the psychiatric In-reach team at the prison where Mr. U was held on remand.

1.2.7 We have some criticisms of the CMHT and the way in which his care was allowed to drift, without being formally handed over to another service, or discharged to the GP with the GP being informed immediately. Moreover important information which the CMHT had acquired became lost in the transition.

1.2.8 The CFT provided good care to Mr. U. Our only criticism is that they perhaps focused too much on Mr. U being a potential victim of violence, to the exclusion of considering the risk he might pose to others. The fact that there was not a more considered response to the knife incident reinforces our view that they were not adequately focused on his risk to others. If they had regular documented team meetings, this would have given the opportunity to reflect on this event more carefully.

1.2.9 Although outside our remit, we have made comments regarding the Probation Service input, and Bromley Housing Department.

1.3 Context

1.3.1 The Trust is in south east London and provides mental health and learning disability services to the London Boroughs of Bexley, Bromley and Greenwich, including community mental

health services in Bexley and Greenwich, specialist services to Lewisham, and forensic mental health care across south east London and to prisons in Kent.

1.3.2 The Trust has been the main provider of specialist mental health care in these boroughs for over 10 years and has developed a comprehensive portfolio of services in community and hospital settings. It was one of the first mental health trusts to gain foundation trust status in May 2006.

1.4 Terms of Reference - Key Questions

1.4.1 The Independent Investigation Panel developed key questions from the terms of reference as follows:

1. Was the Trust's Internal Investigation adequate in terms of its findings, recommendations and action plan?
2. What progress has been made on the internal report action plan?
3. Was a suitable and accurate chronology of events outlined to assist in the identification of any care and service delivery problems leading to the incident?
4. What mental health services were provided to Mr. U and was all relevant documentary evidence in place? Was the care provided in accordance with statutory obligations, relevant national guidance from the Department of Health, and local operational policies?
5. Was professional judgement exercised in clinical decision making and was the care and treatment suitable in view of the patient's history and assessed health needs?
6. What was the appropriateness and quality of risk assessments, care planning and interventions of the CFT?
7. How effective was interagency working?

1.5 The Investigation

1.5.1 This investigation follows national guidance set out by the National Patient Safety Agency in their guidance document "Good Practice Guide for Independent Investigations of Serious Patient Safety Incidents in Mental Health" (2008).

1.5.2 This is a level 3 Independent Investigation and has been conducted by a Panel of two members.

1.6 Summary of Main Findings – Care and Treatment (CMHT)

1.6.1 It was in November 2008, that Mr. U was referred to the Trust's CMHT. Despite being asked for a 'fairly urgent' appointment, it was nine weeks and two days after the original referral was received before Mr. U was seen and core assessments carried out. The delay was partly as a consequence of a decision to await the arrival of further clinical and forensic history.

1.6.2 Best practice on the receipt of a referral, particularly when an element of urgency is attached, would suggest an immediate triage of the referral, followed quite quickly by an initial assessment.

1.6.3 According to RiO progress notes, a decision was made to offer an appointment on the 23rd December 2008 - the decision was made only the day before (22nd December 2008) at a referrals meeting. Mr. U was not informed of this appointment in person; a message was left with staff at his Probation Hostel at 16.53 hrs on the evening before the appointment date. Perhaps not surprisingly Mr. U did not attend this appointment.

1.6.4 Mr. U was finally assessed by a member of the CMHT on the 14th January 2009, nine weeks and two days after his 'fairly urgent' referral from the GP was received. He was seen again in January by the Social Worker from the CMHT. She also kept in touch with him and the Hostel by phone, and she seemed to have established a good rapport with him.

1.6.5 It is unfortunate therefore that when this Social Worker left the service, no one else in the CMHT took over as Mr. U's Care Coordinator. He was not seen subsequently by anyone else from the CMHT, although he did present himself on three occasions at the CMHT office in February without an appointment, quite stressed about accommodation.

1.6.6 On 2nd March 2009 the CMHT decide to discharge him from their caseload back to the care of his GP.

1.7 Summary of Main Findings – Care and Treatment (CFT)

1.7.1 Mr. U came to the notice of the Trust's CFT at about the same time as the referral to the CMHT as a result of his residence at a Probation Hostel in Beckenham following his release from prison in November 2008.

1.7.2 The CFT provided good quality care to Mr. U. He was seen and spoken to frequently, and assisted with practical problems. When it became clear that Mr. U was being threatened at the accommodation he was residing at, and that the lack of safe, clean accommodation was a major stress in his life, the CFT did everything they could to work with Bromley Housing Department to assist him to move, Including moving him to interim housing whilst his flat was being made ready.

1.7.3 For reasons that remain unclear, perhaps because this was not made available, those involved in the care of Mr. U did not appear to take note of the Probation report written on 18th November 2008 (which had been obtained by the CMHT). This gave details of the offences for which Mr. U had been convicted in 2007; it also detailed their risk assessment and their plans for management when he was released on licence to Beckenham Approved Premises. Previous licence conditions make it clear how seriously the issue of alcohol was regarded.

1.7.4 The assault which led to Mr V's death occurred on 31st October 2009 when Mr. U had been drinking with friends in a pub in Bromley. We believe this incident could not have been predicted or prevented by the CFT.

1.7.5 Our only criticism of the CFT is that they perhaps focused too much on Mr. U being a potential victim of violence, to the exclusion of considering the potential risk he posed to others. This is perhaps reflected in the lack of formal discussion and documentation

regarding the incident of Mr. U carrying a knife, and whether it should be disclosed to MAPPA.

1.7.6 Although outside our remit, we have made comments regarding Probation, and Bromley Housing Department.

1.8 Summary of Main Findings – Internal Investigation Report & Action Plan

1.8.1 The Internal Investigation report was informed by a root cause analysis (RCA) methodology and information was communicated satisfactorily in the report. However, the incident date of 2nd November 2009 appears on more than one occasion throughout the narrative of the Internal Investigation report, but the actual date of the incident was 31st October 2009.

1.8.2 The issue of unnecessary delays in service engagement was addressed in the report, along with delays in communications between agencies. However, we felt that reference was not adequately made in the Internal report to areas of risk assessment and management. Mr. U was a man with a history of violent behaviour.

1.8.3 We would have expected an Internal Investigation into a homicide to have placed more emphasis on assessments of risk. We believe that this is demonstrated in the report by the incident that occurred on 21st October 2009 (10 days before the homicide) when Mr. U was carrying a knife in public. The Internal Investigation Team appeared to mirror the assumptions made by members of the CFT that Mr. U "was at more risk of violence from others… than being responsible for violent acts himself".

1.8.4 The Internal Investigation Team produced an action plan (Appendix 2) which centred on the findings and recommendations contained in the report. The action plan was formulated to tackle "lessons learnt" and sought to address four main areas. The Internal Investigation also suggested a number of recommendations for service change/improvement.

1.8.5 The action plan is written in a standard format identifying actions that need to be taken against recommendations from the internal report. Individuals and groups were tasked to complete or oversee the completion of actions. The internal report was completed in May 2010 and the aim was to have actions implemented between July and November 2010.

1.8.6 A review of documentation supplied to us showed that the Trust has taken the issues raised by the Internal Investigation Team very seriously; discussions relating to this incident have been aired at the highest level, as shown in minutes of Trust Board meetings in June and July 2010.

1.8.7 It was surprising therefore for the Panel to note that the action plan did not appear to have been followed up with the diligence that might have been expected.

1.8.8 A key task of the external investigation is to review the progress made by the Trust in implementing the action plan from the Internal Investigation. However we found it difficult to get documented evidence from the Trust which would show completion of this.

1.8.9 Consequently, we are unable to say confidently that the action plan has been fully completed and deficits rectified. The information sent to us did not, in our view, adequately address all action points, and we are not able to attest that robust and effective systems are in place to ensure that standards and compliance with Trust policies relating to referrals are being regularly audited/measured.

1.8.10 The Internal Investigation Team singled out the practice of the Forensic CPN as being praiseworthy. The Panel does not disagree with this. He clearly had a good working relationship with Mr. U, and he was caring, supportive and very responsive.

1.9 Recommendations

1.9.1 We agree with the Internal Investigation that there should be a Trust policy setting out agreed timescales for seeing urgent and routine referrals. The operation of these timescales by CMHTs should be audited.

1.9.2 We also agree that patients should continue to be reviewed and discussed by the CMHT, until their discharge to another service (GP, CFT etc) has been formally agreed and documented.

1.9.3 When a patient is discharged to another service, there should be clear communication and a formal handover to ensure the receiving service is aware of important background information.

1.9.4 We would recommend that the Trust reviews its processes and protocols for managing referrals, paying particular attention to communication between teams and efficiency/flexibility of response, bearing in mind the following:

- Attention needs to be focused on processing new referrals more efficiently. Processes for referring on to and working with other teams within the Trust should be reviewed in order to clarify the lead responsibility for an individual's care. The Trust would benefit from reviewing its approach to communication with other agencies.

1.9.5 The CFT should redraft their operational policy describing in detail their processes for managing community patients. The policy could extend to cover joint working with the CMHT in certain cases, though this requires negotiation with general psychiatric services.

1.9.6 The CFT should always try to get background information about a patient through other agencies such as Probation, MAPPA, previous providers of psychiatric services etc, so as to get as full a picture as possible of the patient and the risks they present.

1.9.7 We recommend that the CFT has regular documented MDT meetings to discuss patients on the caseload, so that any significant incident can be raised, and the team as a whole can consider what the appropriate response is. Specifically any incidents which may justify referring to MAPPA should be noted, a decision made whether to disclose or not, and the rationale recorded.

1.9.8 Details of contact with the patient, emails and letters by all CFT members should be uploaded to RiO in a timely fashion. Emails and letters can be uploaded directly into the progress notes, which can save time by avoiding writing a separate entry, and means that a

coherent, chronological record about the care of the patient can be found in one place.

1.9.9 We asked that the Trust provide us with documentary evidence that actions which emerged from the Internal Investigation had been acted upon and completed. The information sent to us by the Trust, did not, in our view, adequately address action points 1.1 and 2.3 of the Action Plan. We are not therefore able to attest confidently that robust and effective systems are in place to ensure that standards and compliance with Trust policies relating to referrals are being regularly audited/measured. We would strongly suggest that the Trust revisits its original action plan and seeks validation that actions have been completed and changes in practice have been made**.**

1.10 Conclusions

1.10.1 Mr. U had a long history of mental health issues and offending behaviour. He had spent time in Young Offender Institutions and in prison for a range of convictions including Burglary, Theft, Violent Disorder, Blackmail, Robbery, False Imprisonment, Affray, Perverting the Course of Justice, Assaulting a Woman by Penetration, and 2 counts of Kidnapping.

1.10.2 In October 2009, when the offence occurred, Mr. U had been out of prison for almost a year, he was a patient with the Trust, and he was under the care and supervision of the CFT.

1.10.3 The incident itself was an alcohol fuelled act of violent aggression by a group of men. Although the homicide could not have been predicted or prevented, we have noted some concerns relating to delay, risk assessment and risk management, communication and documentation problems, and we have made some suggestions about the sharing of information with other agencies.

1.10.4 It is our view that Mr. U was receiving proactive management by the Community Forensic Team. The assault by Mr. U and others which led to Mr. V's death was an altercation outside a public house when both perpetrator and victim had been drinking heavily, and which could not have been predicted or prevented.

1.10.5 We agree with the trial Judge who said in his summing up that Mr. U's mental health problems had no more than a slight effect on what took place.

1.10.6 As this incident could not have been foreseen or prevented, there were no actions or interventions by the Trust's Mental Health Services that could have prevented its occurrence.

2 TERMS OF REFERENCE

2.1 Terms of Reference

2.1.1 NHS London's declared terms of reference for the investigation set out the following:

"The aim of the independent investigation is to evaluate the mental health care and treatment provided to Mr. U by Oxleas NHS Foundation Trust and West London Mental Health NHS Trust, via the objectives set out below:

- A review of the Oxleas NHS Foundation Trust's Internal Investigation to assess the adequacy of its findings, recommendations and action plans
- Reviewing the progress made by Oxleas NHS Foundation Trust in implementing the action plan which was generated from the Internal Investigation
- Involving the families of both Mr. U and the victim as fully as is considered appropriate
- A chronology of the events to assist in the identification of any care and service delivery problems leading to the incident
- An examination of the mental health services provided to Mr. U by Oxleas NHS Foundation Trust, including care provided by West London Mental Health NHS Trust and a review of the relevant documents
- The extent to which Mr. U's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies
- The appropriateness and quality of assessments and care planning
- Consider the risk that was posed to others and management of that risk
- Consider other such matters as the public interest may require"

2.2 Key Questions

2.2.1 The Independent Investigation Panel developed key questions from the terms of reference as follows:

- Was the Trust's Internal Investigation adequate in terms of its findings, recommendations and action plan?
- What progress has been made on the internal report action plan?
- Was a suitable and accurate chronology of events outlined to assist in the identification of any care and service delivery problems leading to the incident?
- What mental health services were provided to Mr. U, and was all relevant documentary evidence in place? Was the care provided in accordance with statutory obligations, relevant national guidance from the Department of Health, and local operational policies?
- Was professional judgement exercised in clinical decision making and was the care and treatment suitable in view of the patient's history and assessed health needs?
- What was the appropriateness and quality of risk assessments; care planning and interventions of the CFT?
- How effective was interagency working?

3 INTRODUCTION

3.01 Caring Solutions (UK) Ltd has been commissioned by NHS London the Strategic Health Authority (SHA) for London, to conduct an Independent Investigation to examine the care and treatment of Mr. U. Under Department of Health Guidance, SHAs are required to undertake an Independent Investigation:

"When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event" (HSG (94) 27, amended in 2005).

3.02 This particular Investigation was asked to examine a set of circumstances associated with the death of a member of the public following an assault on 31st October 2009. A patient of the Trust, to be known for the purposes of this report as Mr. U, was subsequently arrested and convicted as the perpetrator of this offence.

3.03 Mr. U received care and treatment for his mental health condition from the CFT and the local CMHT at the Trust. It is the care and treatment that Mr. U received from this organisation that is the subject of this investigation.

3.1 The Incident

3.1.1 Mr. U was released from prison on licence in November 2008, after receiving a three year and four month sentence for Assault by Penetration, Perverting the Course of Justice, and two counts of Kidnapping, and was placed in a Probation Hostel in Beckenham. He was referred by his GP to the CMHT in early November. The CMHT had some contact with him, but by late January 2009, Mr. U had come under the care of the the Trust's CFT, who were continuing to manage him when the homicide occurred.

3.1.2 On 31st October 2009, Mr. U was drinking with three friends in a pub in Bromley. They became involved in a disagreement with Mr. V and this developed into a fight outside in an alleyway. Mr. V was hit over the back of the head with a bottle and then repeatedly kicked and stamped on. The victim was left with severe head injuries and died three days later in hospital.

3.1.3 On 2nd November 2009 Mr. U was arrested as were his three companions. All four were subsequently charged with murder, and were tried at the Old Bailey in July 2010. Mr. U was acquitted of murder but convicted of manslaughter, the jury having specified that the basis for the manslaughter conviction was the lack of intent to kill or cause serious injury. Two of his co-defendants were acquitted, and the jury could not reach a verdict on the third man, who was to have a re-trial, the outcome of this trail is not known by the panel.

3.1.4 Mr. U was sentenced on the 2nd September 2010 to eight years imprisonment.

3.2 Background and Context

3.2.1 The Trust is in south east London and provides mental health and learning disability services to the London Boroughs of Bexley, Bromley and Greenwich, with community mental health

services in Bexley and Greenwich, specialist services to Lewisham, and forensic mental health care across south east London and to prisons in Kent.

3.2.2 It has been the main provider of specialist mental health care in these boroughs for over 10 years and has developed a comprehensive portfolio of services in community and hospital settings. The Trust has a workforce of around 3,300 people providing services across more than 125 sites. It provides services to more than 80,000 patients across south east London and Kent.

3.2.3 It was one of the first mental health trusts to gain foundation trust status in May 2006.

4 THE INVESTIGATION

4.1 Approach

4.1.1 The Independent Investigation Team conducted its work in private and took as its starting point the Trust's Internal Investigation report supplemented as necessary by access to source documents and interviews with key staff and others as determined by the team. In fact, the Panel did not think it necessary to interview any Trust staff, beyond Dr. Romilly having telephone contact with the Consultant Forensic Psychiatrist and email contact with the CFT Leader .

4.1.2 If the Independent Investigation Team had identified a serious cause for concern they would have immediately drawn this to the attention of NHS London and the Trust. In fact, no such concerns were identified.

4.2 Purpose and Scope

4.2.1 Independent investigations should increase public confidence in statutory mental health service providers. The purpose of this investigation is not only to investigate the care and treatment provided to Mr. U, but to put that care and treatment into context. We will look at the care and treatment that he received prior to the incident on 31st October 2009 and, in particular, we will consider whether or not the incident could have been prevented, and to establish if any lessons can be learned for the future.

4.2.2 NHS London has commissioned this Independent Investigation with the full co-operation of Oxleas NHS Foundation Trust and West London Mental Health NHS Trust (WLMHT) who had earlier contact with Mr. U.

4.2.3 It was commissioned in accordance with guidance published by the Department of Health in circular '**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.

4.2.4 The investigation was to evaluate the care and treatment provided by the Trust and to identify any contributory factors to the homicide. The work included a review of key issues identified and focused on lessons to be learned. Where appropriate, recommendations based on best practice in mental health care have been made.

4.2.5 It would be wrong for the Investigation Team to form a view of what should or could have happened based on hindsight, and the Panel has tried throughout this report to base its findings on the information available to relevant individuals and organisations at the time of the incident.

4.3 External Inquiry Panel

4.3.1 Panel member 1: Chair of the Panel – Tom Swan

- Mr. Swan has a Masters degree in Forensic Behavioural Sciences, is an RMHN, RNLD, RNT, DMS, with significant knowledge of (forensic) mental health services and systems.

- He has worked as a senior clinician and manager in both NHS and Independent sector mental health settings. The Investigator has also taken part in several investigations, both as an individual investigator and as a panel member.

4.3.2 Panel member 2: Consultant Forensic Psychiatrist – Dr. Crystal Romilly

- Dr Romilly is a Consultant Forensic Psychiatrist of 9 years standing. Previously a Consultant for the In reach team at HMP Wandsworth, before moving to medium secure services at South West London and St George's Mental Health NHS Trust.
- She has experience of working with both male and female Medium Secure Unit patients as well as community services, currently working with male medium secure inpatients. She has also held the post of Associate Medical Director for the forensic service.
- She also has a degree in Economics from the London School of Economics

4.3.3 Caring Solutions (UK) Ltd – Dr Colin Dale and Ms Maggie Clifton provided advice and support to the investigation.

- Dr. Colin Dale has been an Executive Nurse in three NHS Trusts; has worked as a professional adviser to the Royal College of Nursing, National Institute for Mental Health in England, National Patient Safety Agency and the Department of Health. He is currently the Vice Chairman of a NHS Mental Health Foundation Trust.
- Ms Maggie Clifton has a background in health and social care research and management. She has worked extensively on the analysis of care and delivery and supported a large number of investigations throughout the UK.

4.4 Investigation Process

4.4.1 This is a level 3 Independent Investigation and has been conducted by a Panel of two members. The investigation follows national guidance set out by the National Patient Safety Agency in their guidance document "Good Practice Guide for Independent Investigations of Serious Patient Safety Incidents in Mental Health" (2008).

4.4.2 NPSA guidance includes definitions of 'contributory factors' and 'root causes', which are:

- A root cause is "a fundamental contributory factor which if removed would either prevent or reduce the chances of a similar type of incident happening in the future".
- Contributory factors are "those which affect the performance of individuals whose actions may have an effect on the delivery of safe and effective care to patients and hence the likelihood of Care Delivery or Service Delivery problems occurring".

4.4.3 Contributory factors may be considered to influence either the occurrence or outcome of an incident, or actually to cause it. The removal of the influence may not always prevent incident recurrence but will generally improve the safety of the care system; whereas the removal of causal factors or 'root causes' will be expected to prevent or significantly reduce the chances of reoccurrence".

4.4.4 The process by which the review was conducted:

- Contact and meeting with WLMHT and Oxleas NHS Foundation Trust
- Review of documentation (A summary of all documentation reviewed is listed in Appendix 2)
- Consent to access the medical records of Mr. U was not provided by Mr. U. 'Caldicott Consent' for the disclosure of health records was therefore provided by NHS London.
- Contact with Clinicians and Service Managers at the Trust
- Contact and meeting with Police where appropriate.
- Contact with Crown Court Administrators at MLS Legal Solutions
- Contact with HM Prison Location Service

4.4.5 The investigation team met on a total of four occasions:

8th February 2012	Investigation Start Up Meeting
25th April 2012	Progress Review Meeting
28th June 2012	Progress Review Meeting
3rd September 2012	Colin Dale and Crystal Romilly to finalise report

4.4.6 Throughout the investigation, the team were in regular communication and worked on specific areas of the investigation relevant to their areas of expertise. Dr. Romilly made contact with the Trust's Consultant Forensic Psychiatrist and the CFT Leader, by phone and email.

4.4.7 We would normally expect to offer the perpetrator Mr. U, the opportunity to be interviewed. However after a long delay, the Prison Service advised us that due to their understanding of the Data Protection Act, they were unable to confirm that Mr. U is within the prison system, let alone advise us which prison. So it was not possible for us to attempt to interview him.

4.4.8 We would also normally expect to make contact with the victim's family and offer them an opportunity to contribute to the external inquiry process. In this case, we were informed from the outset that the victim's family was not aware that Mr. U had been a patient of the Trust's mental health services. This seemed surprising at first to the Panel members as we would have expected psychiatric reports to be prepared during the course of the trial. However we established via the Old Bailey and the police, that although psychiatric reports were prepared, they were not used during the trial.

4.4.9 Following advice from NHS London, we made contact with the police family liaison officer in this case, to canvass his opinion. Following consultation with the Senior Investigating Officer involved in the case. They informed us that the victim's family "had to endure two lengthy trials in graphic details which upset them greatly. They are also finding it very hard to come to terms with the verdicts and are presently on medication to help with the loss of their son." They subsequently advised that "any further contact with the family regarding this matter would affect them badly." Following this direction we agreed with NHS London that it would not be in the best interest of the victim's family for us to make contact.

4.4.10 The Independent Investigation began its work 8th February 2012.

5 NARRATIVE RELATING TO MR U

5.1 Personal and Family History

5.1.1 Mr. U is a 39 year old male of Indian/British Indian ethnic descent. He was born in January 1973 in the London Borough of Hillingdon and grew up in the Southall area of Middlesex. He was the middle child of seven (two sisters and four brothers). Mr. U reported that he had been sexually and physically abused by his father as a child, and had witnessed and experienced a number of violent incidents in his youth, including being stabbed in the head.

5.1.2 He describes his parents as hard working people who ran a corner shop. He does not feel that there was any evidence of mental health issues with his parents, but claims that his eldest brother also suffers from Obsessive Compulsive Disorder (OCD). His younger brother has mental health problems and his two sisters both have difficulties managing alcohol intake. No close family relationships have been maintained although Mr. U reports that he has some limited contact with one of his sisters.

5.1.3 Mr. U feels that his development as a child was fairly normal; he says that he did not achieve at a high level at school, leaving at age fifteen without formal qualifications. He believes that his personality changed following being stabbed in the head and badly beaten at school.

5.1.4 He has two children who he believes are still living in Southall, although there has been no direct contact with them since his most recent jail sentence. He is barred from the area where they used to live by order of the court.

5.2 Psychiatric History prior to November 2008

5.2.1 The following information is taken predominantly from the psychiatric court report, dated 29th April 2004. This was prepared by the Clinical Director of WLMHT, a Consultant Psychiatrist, at the request of solicitors when Mr. U was charged with theft of a mobile phone.

5.2.2 Prior to his conviction and prison sentence in 2007, Mr. U had been under the care of WLMHT from 1998 onwards. He was first referred by his GP on 19th November 1998. No psychotic features were elicited at the first assessment, but he returned two weeks later with his brother, when his presentation had changed dramatically, and was compatible with Paranoid Disorder. He was admitted informally in December 1999, partly to clarify the diagnosis. He proved to be uncontainably violent and aggressive, and he refused medication.

5.2.3 On the 18th January 1999 he was detained under Section 3 of the Mental Health Act 1983 and referred to a more secure unit: it not known if Mr U was assessed following this referral. Later he confessed to staff that he had lied about hearing voices so as to gain admission, and that he and his brother had fabricated the story to prompt the GP to make the initial referral. The team's view was that there was no evidence of mental illness; rather he had a longstanding personality difficulty combined with substance misuse.

5.2.4 He was re-referred by his GP in April 2002, with features suggestive of depression and obsessive compulsive behaviour. He was started on anti-depressant medication and referred

to Psychology. He was also referred to Hounslow Substance Misuse team. He was irregular in attending appointments. After taking an overdose and presenting to Accident and Emergency Department, he was admitted informally from 6th– 10th March 2003. He was non-compliant with medication, absconded, and he drank alcohol during his stay. He was referred to the Substance Misuse Service and discharged from hospital.

5.2.5 Mr. U kept neither psychiatric nor substance misuse appointments and was discharged from their service in August 2003.

5.2.6 The Consultant wrote in conclusion that "our clinical knowledge of him over 5 years is that the prominent diagnosis is of personality disorder with principally dissocial and emotionally unstable traits. On at least one occasion (Mr. U) has admitted to us that he has fabricated symptoms of mental illness." She went on "in his case there is an additional diagnosis of mental and behavioural disorder due to alcohol and substance misuse".

5.2.7 Mr. U was in prison from his arrest in 2007 for Assault by Penetration, Kidnapping x 2, and Perverting the Course of Justice, for which he received a sentence of three years and four months imprisonment, until his release on licence in November 2008. As far as we can tell from the limited medical records we have seen from his period of imprisonment, Mr. U did not come to the attention of specialist mental health services in prison. However he was started on Citalopram (anti-depressant) on 2nd October 2008, due to "getting more problems with his OCD (he has had this for 11 years) no specific trigger".

5.3 Forensic History

5.3.1 Mr. U has a long history of convictions dating back to 1989, these include:

- September 1989 – Convicted of being found on Enclosed Premises for Unlawful Purpose, Criminal Damage and Vehicle Interference - Conditional discharge 12 months.
- December 1990 – Found Guilty of Burglary and Theft, Violent Disorder and Being Found on Enclosed Premises for Unlawful Purpose - Young Offender Institution 2 months.
- January 1992 – Convicted of Affray - Conditional discharge 12 months.
- July 1992 – Guilty of Blackmail, Robbery and False Imprisonment - Young Offender Institution 30 months.
- September 1995 – Convicted of Handling Stolen Goods - Imprisonment 18 months reduced to 12 months on appeal.
- December 1995 – Convicted of Affray – 6 months imprisonment, concurrent.
- August 1996 – Convicted of Assault occasioning Actual Bodily Harm – 12 months Probation and 60 hours community service.
- July 1997 – Convicted of Robbery – 2 years imprisonment.
- April 2003 – Convicted of Possessing Controlled Class B Drugs, and Failure to Surrender – Fines & Costs.
- July 2003 – Convicted of Possessing Class B Drug – Fined, Served one day.

5.4 Index Offences Prior to Coming Under the Care of the Trust

5.4.1 In September 2007 Mr. U was convicted of Perverting the Course of Justice, Assaulting a

Woman by Penetration, and 2 counts of Kidnapping. He was given a 3 year and 4 month custodial sentence and was placed on the Sex Offenders' Register (SOR) for 10 years.

5.4.2 The details of what took place are given in the Probation Service report dated 18th November 2008. In summary, Mr. U's was charged alongside two co-defendants. On the night in question one of his co-defendants phoned a mutual friend, a woman aged 17 yrs, and said he was depressed and asked her to come and meet him in a park. The woman went there with her boyfriend and a girlfriend, where they met the three co-defendants, including Mr. U, at a bandstand. One of them assaulted her boyfriend until he ran off, and the girlfriend was allowed to leave at the request of the victim. The victim was then subjected to a serious sexual assault by Mr. U. Approximately four months later, on two separate occasions, all three co-defendants approached two young men who had been witnesses, and threatened them to make them drop their statements to the police. This included coercing both men into a car. This was the basis for the two convictions for Kidnapping.

5.4.3 On his release from prison, Mr U was placed at a bail Hostel in Beckenham, having been barred by the terms of his licence from returning to west London. Mr. U was being monitored, as a consequence of being on the SOR, by the Bromley Police Jigsaw Team (Borough Public Protection Unit). He left the bail Hostel in March 2009 when his licence expired, and moved first to a flat in Anerley, where he stayed for about 7 months, before moving on 21st October 2009 to accommodation in Thornton Health, and then less than a week later, to Bromley on 27th October 2009.

5.5 Summary of the Homicide

5.5.1 The information contained in this section is taken predominantly from the transcript of the Summing-Up to Verdict, and the Sentencing Remarks, by the trial Judge.

5.5.2 On 30th October 2009, after an evening drinking at the Swan and Mitre pub in Bromley, Mr. U, in the company of three male friends, went into an alleyway off Bromley High Street with Mr. V, whom they had met for the first time that evening. It is accepted that Mr. V had been troublesome in the pub. For part of the time he was argumentative, racist and aggressive. An altercation involving all five men began in the pub but continued in the street outside, when Mr. V caught up with Mr. U and his co-defendants in a kebab shop.

5.5.3 By the time they all reached the alleyway, Mr. V was up for a fight, as were the defendants. The four defendants quickly got the better of Mr. V with punches. Then Mr. U struck him over the back of the head with a glass or bottle, causing him to go down on his knees, and to lose consciousness. Then all of the defendants, to a greater or lesser extent, kicked and stamped on him while he lay prone on the ground.

5.5.4 The Judge specifically stated that Mr. U kicked him and stamped on his head. It was a severe head injury from the glass and/or further assaults which led to his death three days later in hospital.

5.5.5 On 2nd November 2009 Mr. U, a patient with the Trust, was arrested and the following day he was charged with murder.

5.5.6 Mr. U stood trial at the Old Bailey, and in July 2010 he was acquitted of murder but convicted of manslaughter, the jury specifying that this was because of lack of intent to kill or cause serious bodily harm. Mr. U was then sentenced on the 2nd September 2010 to eight years' imprisonment.

6 CARE PROVIDED TO MR U BY THE TRUST

6.1 Care Provided

6.1.1 We have prepared a narrative of the psychiatric care provided to Mr. U by the Trust, taken mainly from the electronic progress notes (RiO) dated between 10th November 2008 and 5th November 2009, supplemented by additional information provided to us.

6.1.2 Following release from prison on licence on 3rd November 2008, to the Probation Hostel in Beckenham, Mr. U registered with a new GP, and was seen by him. The GP referred him to the CMHT on 6th November 2008. He wrote that Mr. U had been labelled with Obsessive Compulsive Disorder (OCD), a maladjustment disorder, and bipolar affective disorder, and was taking Citalopram 20mg daily (anti-depressant) and Olanzapine 10mg daily (anti-psychotic). He stated that the rituals and obsessive thoughts could be extremely incapacitating. He added that Mr. U was beaten around the head a lot as a child. He mentioned he was previously under the care of West Middlesex Hospital, West London Mental Health Trust (WLMHT). He asked for a fairly urgent review for his mental health problems.

6.1.3 Mr. U was first discussed by the CMHT on 10th November 2008, when the decision was made to obtain more background information from Probation and from WLMHT before proceeding. Efforts were made by one of the team members to obtain information from Probation and the Hostel, but she was not able to find out much until 21st November 2008, when Probation advised her that Mr. U had been convicted of Sexual Assault (sic) and two counts of Kidnapping, and had received a prison sentence of 3 years and 4 months. At the referrals meeting on 24th November 2008 it was agreed that information from WLMHT was still required.

6.1.4 The next entry is on 16th December when the CMHT member noted that information had now arrived from Lakeside Mental Health Unit at WLMHT, so Mr. U should be discussed at the next Referrals meeting.

6.1.5 Mr. U's GP's secretary phoned on 18th December 2008 and was advised that Mr. U would be discussed on 22nd December 2008. At that meeting it was agreed that two members of the team should assess him the following day (23rd December 2008), and the Consultant would then review him. It was also decided that the team should fax all information to the Forensic Service asking for an urgent forensic assessment. The Social Worker from the team phoned the Hostel in the afternoon to advise of the appointment, but had to leave Hostel staff to pass on the message. Perhaps not surprisingly Mr. U did not attend the appointment on 23rd December 2008.

6.1.6 On 24th December 2008, Mr. U phoned the Social Worker saying he wanted to be seen. He also said he was doing well but he was bored. He was offered the opportunity to be seen that day, but he said he could wait till after Christmas. They agreed an appointment on 30th December 2008. It appears from a later entry that Mr. U did not attend that appointment.

6.1.7 The next entry is on 2nd January 2009, when the Social Worker, having tried to phone Mr. U

and getting no response, phoned the Hostel to offer another appointment on 14th January 2009. Hostel staff said they had no concerns.

6.1.8 At the CMHT referral meeting on 5th January 2009, it was agreed that the GP would be advised that Mr. U was being seen on 14th January 2009. The Social Worker also phoned Probation on 6th January 2009 to find out who his Probation Officer was, but was advised he did not have a Probation Officer in the Bromley area.

6.1.9 The CMHT Social Worker assessed Mr. U on 14th January 2009. Mr. U said that he felt better for being away from his home area of Southall. He spoke at length about physical and sexual abuse by his father. He said that he had completed a plumbing course in prison, but that prison had been difficult and he had no intention of going back. He said he was desperate to finish his plumbing exams. He was upset that his relationship was over and he missed his two young sons. He said that his OCD symptoms were the main problem. He also had flashbacks of an inmate in prison who was unpleasant to him. He said he was less paranoid than he had been before, and he had no thoughts of suicide or self harm. The Social Worker established that he was seeing his Probation Officer, but not often. Her plan was to discuss him at the next MDT meeting, and she planned to see him again on 27th January 2009.

6.1.10 On 27th January 2009, Mr. U asked if the appointment could be put off to the next day, as he had to see the police. Later Hostel staff phoned the Social Worker, they had found Mr. U sitting, expectantly, by the phone, he was hearing voices and they felt generally his mental health was deteriorating. He was also falling out with other residents. She advised the Hostel that she was seeing Mr. U the next day and would seek advice from a doctor. She also advised the case was open to forensic services and that the Consultant Forensic Psychiatrist from the CFT would see Mr. U in February 2009. The CMHT Social Worker then arranged for a doctor to join her for the assessment the next day.

6.1.11 Meanwhile, members of the CFT had become aware of Mr. U in the Probation Hostel, via the consultation input that the forensic service provides to several probation Hostels. The Forensic Psychologist asked the Consultant Forensic Psychiatrist to see Mr. U. (The CMHT had also forwarded the original referral from his GP to the CFT.)

6.1.12 The Consultant Forensic Psychiatrist saw Mr. U on 28th January 2009, and phoned the CMHT Social Worker to tell her that Mr. U's OCD seemed worse and he was a little low, so she had increased the dose of his Citalopram and lowered the Olanzapine. She said that Mr. U was on his way to see the Social Worker, and she was not unduly concerned about him.

6.1.13 The CMHT Social Worker recorded that she saw him later that day. When he first arrived he seemed low, but then got talking about plumbing, and she advised him to contact Lewisham College. Then he became very quiet and started to cry. He was fed up with the thoughts in his head, and seeing colours, and not being normal. He said he had felt like killing himself the previous night. She suggested hospital admission but Mr. U was not willing to consider that. He said he would not act on these thoughts and it helped to have someone to talk to about his feelings. They spoke a lot about his children and his sisters. He said he would spend his time reading his plumbing books and would go to the gym. She arranged to see him in two days time and made sure he had crisis numbers if he needed help in the

meantime. She also phoned the Hostel who said they would keep an eye on him, and specifically check on him every three hours. She spoke to Mr. U himself later in the day and he said he felt rather better after the gym. He asked if she could help him with a housing application, which she agreed to do when they met in two days.

6.1.14 However Mr. U did not attend the appointment on 30th January 2009. The CMHT Social Worker phoned the Hostel who said his mood was stable, and there had been no difficulties. (This is the last entry by the Social Worker, and it was noted in April by an administrative worker that she had now left the CMHT and that Mr. U had not been allocated another Care Coordinator).

6.1.15 The next entry is by the Duty Social Worker on 23rd February 2009. Mr. U had come to the office without an appointment. He was well kempt but appeared stressed. He wanted to find out what was happening with his housing application. He said that he was currently at a bail Hostel and had two weeks remaining. He said he suffered with OCD, depression, and (excess) alcohol intake. He was a bit tearful and said he felt like throwing himself out of a window but that he would not act on it.

6.1.16 He presented again the following day, saying he continued to have intrusive memories of being physically and sexually assaulted by his father ("still plays like a memory card"). He said he also witnessed a friend being shot at. He said he felt depressed and distressed. He reported that he suffered from manic depression and OCD, and was on medication. He said he had seen a Forensic Clinical Psychologist at the Hostel two weeks earlier but did not have another appointment. His next appointment was with a Consultant Psychiatrist on 12th May 2009, but he felt this was too far away as he was at the end of his tether and felt suicidal. He gave a history of past suicide attempts and said that he cuts his chest and arms to relieve anger and pain. He was due to be evicted from the Hostel on 3rd March 2009. He phoned again in the afternoon to say the Housing Department had not received his application form. He also talked about being confused about his sexuality (this seems to have been prompted by ticking "bisexual" in answer to a question on the form).

6.1.17 He turned up again on the 25th February 2009, feeling distressed and wanting to talk to someone, because he was about to lose his accommodation, and he was having flashbacks of his father abusing him. The plan made was to phone him later in the day to see how the meeting with the Housing Department went, to phone the Hostel to see why he was being evicted, and to allocate a Care Coordinator.

6.1.18 It is clear from the records that Mr. U's tenancy at the Probation Hostel finished on 5th March 2009, coinciding with the expiry of his probation licence. He was clearly stressed by the need to find alternative accommodation. Bromley Housing Department appear to have decided that Mr. U would have to approach Hounslow for housing, as he had no local connection with Bromley. They wrote that the "CMHT is going to assist Mr. U with moving back to Hounslow," but in fact on 26th February 2009 the CMHT phoned the Hostel to say that they could not address the housing issue. She was advised by the Hostel Manager that they were helping Mr. U to find accommodation in Camden. Mr. U actually moved to accommodation in Anerley in the Borough of Bromley, and there is a later reference in the notes suggesting he found this himself through the charity St. Giles.

6.1.19 At a CMHT meeting on 2nd March 2009, it was agreed that their team would take no further action, and Mr. U should return to the Probation Service. Two days later they received a phone call from the Patient Advice and Liaison Service, saying Mr. U was not happy about being discharged and wanted to make an official complaint.

6.1.20 On 5th March 2009 the Consultant Forensic Clinical Psychologist recorded that she had seen Mr. U at the Hostel the previous day, by appointment. He was distressed because his licence was ending and no accommodation had been arranged. He was also experiencing distressing intrusive thoughts, about being sexually abused by his father, and seeing two men shot. He complained of OCD symptoms and said he sometimes got relief by self harm. He was feeling quite hopeless about ever getting better, and he indicated he had underlying anxieties about his sexuality. Her impression was he was quite intelligent and was motivated about getting his life back on track. She planned to see him a week later at Stepping Stones clinic.

6.1.21 The next recorded contact was on 13th March 2009 by the Forensic CPN who saw him at his new accommodation. He seemed quite relaxed, and spoke about past and current experiences, describing very clearly how his OCD manifested. He did not think he would ever get rid of it, but spoke of controlling it. He brought up the issue of his index offences, saying that there was no way to dignify the events and they had happened as the prosecution stated, but there was little he could do but try and move on. He also said that his mental health condition and his index offence were a barrier in terms of forming intimate relationships. He also spoke of concerns about the building he was living in, specifically security, his suspicion that people slept rough in the lobby, and the run down look of the place. He was still keen to undertake training as a plumber, and he appeared to have friends. The Forensic CPN reminded him about forthcoming appointments with his Consultant Forensic Psychiatrist, and with the Forensic Psychologist, and he also gave him his contact number.

6.1.22 It is recorded on 1st April 2009 that Mr. U did not keep his next appointment with the Forensic Psychologist. The Forensic CPN saw him later that day, when he appeared relaxed, but also motivated to overcome his mental health problems and engage in training or employment. He was dissatisfied with his accommodation. Other residents were offering him narcotics which he found anxiety provoking as he did not want to become involved in using drugs and this exacerbated his OCD rituals. Other residents had also observed him practising his rituals which made him feel paranoid. He was so concerned about the presence of cockroaches, that he no longer felt able to prepare food in the kitchen. Mr. U also disclosed that he had used crack cocaine the previous evening, for the first time in years, which left him feeling both guilty and anxious in case he used again. He also revealed that recently he had had an altercation with an acquaintance in a bar in Beckenham: he described throwing him across the room. The trigger for this seemed to be a sense of invasion of his personal space. He had since received a call from a mutual friend who said the victim wanted to take him to court for whiplash. The Forensic CPN then wrote that as his input with Mr. U was informal, he would contact him by letter to arrange a further meeting. His intention was to talk to the Consultant Forensic Psychiatrist, the Consultant Clinical Psychologist and the CFT Leader to discuss either re-referring Mr. U to the CMHT, or to consider more formalised Forensic CPN support.

6.1.23 On 14th April 2009 the Forensic CPN phoned Mr. U to offer him an appointment the following day with his Consultant Forensic Psychiatrist and himself. In fact Mr. U did not attend and the Forensic CPN tried to phone but could not contact him. He then received an email from Bromley MAPPA saying they had not found him at home on two occasions, once at 07.30 hrs and once at 21.30 hrs, and they suspected he was staying in Islington at times. The Forensic CPN emailed back to say that so far he had been seeing Mr. U informally as part of his role at Beckenham Probation Hostel, but that he intended to have him formally allocated to his case load later that day. He also advised them that he had seen Mr. U twice at his new accommodation and that it took him a long time to answer the door due to his OCD rituals. His plan was to contact the Jigsaw Team, contact Mr. U advising that he contact the Jigsaw Team, and set up another joint appointment with himself and the Consultant Forensic Psychiatrist. He was formally taken onto the CFT caseload on the 15th April 2009.

6.1.24 On 16th April 2009 he phoned Mr. U and told him that they would visit him together on 22nd April 2009. In fact Mr. U left a message on the Forensic CPN's phone when they were on route to him on 22nd April 2009, to say that he wished he was dead. He also said he had slept in a car the previous night because he was so paranoid about the other residents. He said his OCD had worsened to an unmanageable level and he was unable to cope. The Forensic CPN phoned Mr. U and they agreed to meet later in the day at Mr. U's accommodation because he was out at present. Meanwhile the Consultant Forensic Psychiatrist contacted the CMHT regarding possible (informal) admission, and the Consultant Psychiatrist later confirmed he could be admitted under his care. In fact Mr. U was still not at home when they arrived. The Forensic CPN contacted various people/agencies about their concerns including the GP, and MAPPA.

6.1.25 The Forensic CPN met the GP the next day. The GP said he had kept Mr. U on his case load even though he had moved out of the area, because it seemed prudent to do so. He saw him fairly regularly in relation to medication. He said he had not been made aware that the CMHT would no longer be working with Mr. U, and that he did not feel the GP practice could provide the level of expertise and crisis support that Mr. U needed. He also expressed concern about his accommodation.

6.1.26 The Forensic CPN was able to see Mr. U later that day and conducted a detailed assessment. He presented as far more settled than he had sounded on the phone. He said he had had a bad couple of days and had self harmed by cutting his right arm. He had been very paranoid about other residents who had offered him substances and who had told him they thought he was strange. He was also frightened about a forthcoming operation on his nasal passages. He now felt more hopeful and relaxed. He expressed anxiety about his mental health and his accommodation. The Forensic CPN asked about substance misuse and Mr. U said he only drank alcohol in social situations, though he had got very drunk the previous Sunday 19th April 2009. He denied using illicit substances but said he was tempted sometimes. Mr. U declined the offer of informal admission which the Forensic CPN also felt was not going to be beneficial. He spoke to the Consultant Forensic Psychiatrist while he was still with Mr. U, and she said she would see him the following week when he was in Farnborough Hospital having his nose operation. The Forensic CPN ensured that Mr. U had all the necessary phone numbers. He also recorded in the plan that the Consultant Forensic Psychiatrist would liaise

with the GP and Housing Department.

6.1.27 The Forensic CPN's next entry was on 5th May 2009. He recorded that the Consultant Forensic Psychiatrist visited Mr. U while he was in hospital. The Forensic CPN arranged to see him at his flat on 7th May 2009. In fact the Forensic CPN next saw him on 11th May 2009 and they met in the Forensic CPN's car, as Mr. U had locked himself out of his property. Mr. U was very pleased his Consultant Forensic Psychiatrist had visited him in Farnborough Hospital. He was worried about how he would look when the bandage was removed from his nose. He was more relaxed and positive than he had been at some previous meetings. He was still very despondent about his accommodation and its effects on his mental state. He said he had filled in application forms to Lewisham College to study plumbing and that he intended to stay in the area. He wanted to challenge Bromley's decision that he had no links with the area. The Forensic CPN agreed to help him find a dentist, and arranged to see him weekly. Mr. U was not in when the Forensic CPN tried to visit him on 15th May 2009.

6.1.28 Meanwhile there is reference to the GP sending a letter of complaint (about the CMHT not advising him that they had discharged Mr. U from their care) to the Chief Executive of the Trust, dated 24th April 2009.

6.1.29 On 12th May 2009 a nurse in the CMHT recorded that the case was being reopened. Mr. U was discussed at the CMHT Referrals meeting and it was noted that the Consultant Psychiatrist would contact the Consultant Forensic Psychiatrist to suggest that the Forensic CPN continued care coordination.

6.1.30 The Forensic CPN spoke to Mr. U on 21st May 2009 and arranged to phone him the following week to make an appointment. Mr. U sounded stable and relaxed. The Forensic CPN rang as planned but was unable to arrange the appointment because Mr. U had friends with him. He records that he had prepared a letter for Bromley Housing Department explaining Mr. U's changed circumstances and asking them to review their decision not to re-house him. On 1st June 2009, the Forensic CPN left a message on Mr. U's phone advising him of his Care Programme Approach (CPA) meeting on 10th June 2009.

6.1.31 The Forensic CPN then saw Mr. U on 4th June 2009 when he appeared low in mood initially. He had been experiencing traumatic images and having thoughts of suicide. However he declined admission to hospital and said he felt he would be able to manage. He spoke about a relationship with a woman, which had recently begun, but she was also involved with someone else, so he was planning not to answer any further calls from her. He also said he pictured his children (to prevent him) harming himself. He asked if the Forensic CPN would speak to the mother of his children as he was in touch with her and they had discussed him starting to have contact with his sons. The Forensic CPN said he would do so (though also made a note that he would contact the Jigsaw Team first to make sure there were no exclusions regarding contact with his children). The Forensic CPN showed him the letter he had drafted to the Housing Department and Mr. U was happy for it to be sent. Mr. U said he continued to take his medication though had missed his last appointment with his GP. He also said he had been using alcohol, had used cannabis once, and had not used any other illicit substances. His mood seemed to brighten through the meeting and they talked about his goals for the future. The Forensic CPN recorded both what he planned to do and what

Mr. U planned to do.

6.1.32 There are several entries by the Forensic CPN before he next saw Mr. U on 18th June 2009.

6.1.33 He recorded on 11th June 2009 that a CPA meeting would be held on 24th June 2009, and who had been invited to this meeting. He noted that he had sent the letter to Housing Department requesting reassessment and inviting the Housing Officer to the CPA. He spoke to Mr. U on 17th June 2009 who said he had been up and down. He saw him the next day and Mr. U was in the most positive frame of mind that he had seen. He was in touch with his ex-partner and things looked good in relation to contact with his children. He was using gym sessions to deal with anxiety. He reported a marked decrease in his alcohol intake and said he had not used any illicit substances. He had dispatched his application to Lewisham College. He also said he had stopped taking his medication, which seemed to be because it was difficult to get to his GP's surgery. The Forensic CPN said they could get it on route to the CPA.

6.1.34 The following day the Forensic CPN heard from the Housing Officer that he could not attend the CPA. They would review their decision regarding Mr. U but on the face of it, he would be low priority for moving.

6.1.35 The CPA took place on 24th June 2009 at Stepping Stones. The positive developments described above were noted. It was impressed on Mr. U that it was important to take his medication. Mr. U asked to speak to his Consultant Forensic Psychiatrist about deep seated personal issues. His housing was identified as a key area of concern, and one that exacerbated a number of other problems. Part of the plan was for the Consultant to refer him for psychotherapy, and for the CFT manager to talk to the Housing Department to discuss his accommodation. Later that day the Forensic CPN received confirmation from the GP surgery that Mr. U had contacted them about getting his medication.

6.1.36 The Forensic CPN next saw Mr. U on the 7th July 2009 when he appeared stable and insightful. However he reported that he had been threatened with a knife two days earlier by a resident who lived above him. This was because he was declining to take part in drink and drug sessions, and refusing the advances of female acquaintances of this neighbour. He had been asked why he went to prison but refused to answer. He had approached the neighbour the following day and said he would not put up with such treatment. The Forensic CPN was concerned that Mr. U might be attacked and then retaliate. He informed the Consultant Forensic Psychiatrist and the CMHT of the issues.

6.1.37 The next day Mr. U told the Forensic CPN over the phone that he had found dog excrement outside his door that morning, which he attributed to the neighbour's dog. He said other residents had been knocking on his window the previous evening. The Forensic CPN then contacted various agencies including the CMHT, Housing Department, the police and Social Services. He learned the case was not open to the Housing Department any more as Mr. U had accepted a tenancy through St Giles. It was suggested he should make MAPPA aware of the situation, particularly as any temporary/emergency housing would need to be approved by MAPPA.

6.1.38 On 13th July 2009 he was contacted by the Social Worker from the Jigsaw Team who said they would be contacting the Housing Department to say that they were concerned about the risks to Mr. U and others in his present accommodation, and that this needed to be addressed urgently.

6.1.39 The Forensic CPN met Mr. U at his flat on 14th July 2009, and although he was anxious about his housing and the other residents, he was stable. He was taking his medication. The Forensic CPN advised him that the Jigsaw Team were intervening in relation to his housing. A fellow Forensic CPN joined them halfway through the meeting, to offer to be a point of contact and support while Mr U's Forensic CPN was on leave. The Forensic CPN advised he would arrange an appointment with the Consultant Forensic Psychiatrist. The next day the Forensic CPN heard from the Housing Department, and he contacted Mr. U to say that they were offering to put up the deposit for Mr. U to find privately rented accommodation.

6.1.40 The next day Mr. U phoned the Forensic CPN to say that at 06.00 hrs that morning, the resident above knocked at his door with two friends. Mr. U was accused of contacting the police and he was threatened. Mr. U appeared very distressed but also said he would not be intimidated and would deal with the situation. He said he was considering staying with a friend in North London. The Forensic CPN was concerned this might result in him not signing on the SOR, running out of medication, and disengaging with mental health services.

6.1.41 There are further contacts recorded about the housing issue, including that on 20th July 2009 the CFT Leader tried to contact the Housing Department.

6.1.42 On 20th July 2009 the Forensic CPN covering for Mr. U's own Forensic CPN received a phone call from Mr. U who had not experienced any further difficulties but remained apprehensive about his neighbour. He spoke about his wish to turn his life around but also said he had drunk two thirds of a bottle of vodka the previous day. He seemed quite lonely and the Forensic CPN offered to visit him during the week. Mr. U had received a letter from court about arrears relating to a DSS payment, and she said she would deal with this when she visited with her Manager. She phoned later to leave a message saying she and the CFT Leader would visit on 22nd July 2009. However Mr. U sent a message via text on 22nd July 2009 to say he did not feel like seeing anyone. The CFT Leader spoke to Mr. U later that day and arranged to visit him the next day. Mr. U said he felt unsafe and revealed that he had used crack cocaine the day before to relieve his anxiety. They spoke about strategies for regulating his mood, and strongly advised him against using illicit substances. Mr. U said he wanted to put extra bolts on his door as he feared being broken into.

6.1.43 The CFT Leader then met Mr. U for the first time the next day 23rd July 2009. Mr. U was welcoming though he appeared low in mood, and continued to have difficulties with ritualistic routines. He described the block of flats as a free-for-all, where squatters, alcoholics and drug users frequented the communal areas in the small hours of the morning. Security was non-existent. There was drug dealing by several residents and Mr. U had bought £20 worth of crack cocaine from one of them the day before. He had been threatened by one of the residents. He now kept a hammer by his bed as he feared his flat being broken into. He was consuming 4-6 cans of lager daily, plus occasional spirits, and using cannabis. He was hoping to make a fresh start but needed to feel secure in his

accommodation. He was hoping his own Forensic CPN would be able to help him move when he returned from leave.

6.1.44 On 30th July 2009 the CFT Leader made an entry recording that he had spoken to Mr. U the previous day and arranged to visit him on 30th July 2009. On the phone, he had said that there had been no further incidents with neighbours, but that he was distressed by intrusive thoughts and ruminations. He denied any recent self harm or use of illicit substances. However when the CFT Leader came to his flat on 30th July 2009, Mr. U was reluctant to open the door, though finally did so in order that the CFT Leader could leave some information about housing. He assured the CFT Leader that he was not distressed but just wanted to be left on his own.

6.1.45 On 3rd August 2009, the Forensic CPN noted that he had left messages for Mr. U suggesting he visit the following day. He also noted the receipt of a letter from the GP to the Consultant Forensic Psychiatrist expressing concern about Mr. U's housing, and deterioration in his mental state.

6.1.46 On 4th August 2009 the Forensic CPN was still unable to contact Mr. U. He was told by staff at Beckenham Probation Hostel that two days earlier, they had seen Mr. U walking past the Hostel looking very dishevelled, and "like an old man". He tried to visit him later in the day but Mr. U did not answer. Later he got a text saying "I have been harming myself quite a bit" and that everything in his head was attacking him. He said he would see the Forensic CPN if he returned to the property. The Forensic CPN then discussed the situation with the Consultant Forensic Psychiatrist and the CFT Leader, and agreed he would try to encourage Mr. U to be admitted informally, and failing that, arrange urgent Mental Health Act assessment. He saw Mr. U at 16.00 hrs when he appeared distracted, unkempt, and low in mood. There had been a marked increase in self harming, he was thinking of going to west London to harm his father in connection with past physical and sexual abuse, he was focused on unpleasant memories and mistaking passersby as individuals from his past, he was concerned that if his mental state deteriorated any further he may cause harm to a member of the public. The Forensic CPN discussed the benefit of an informal admission to hospital with Mr. U and he agreed.

6.1.47 The Forensic CPN accompanied him to hospital and he was admitted by the duty doctor. She detailed his OCD symptoms, and noted that three of his six siblings also suffered with OCD. He spoke about his past abuse and other episodes in his life which caused him pain. He was low in mood with thoughts of self harm, was sleeping poorly, and appetite and concentration were poor. She recorded that he was a fairly heavy alcohol drinker (perhaps 30 units per week) and a regular cannabis user. She did not elicit psychotic symptoms though noted he was a little paranoid about his neighbours but this seemed reasonable. She stated that he had a diagnosis of schizophrenia and OCD. The main finding on mental state examination was low mood. She agreed he would benefit from a crisis admission. He had a limited physical examination (his wish). He was advised the next day that he would be having a blood test as was routine for all admissions, but he was adamant he did not want one. He asked to use the gym and to go for a jog, and was not happy when told he would have to be assessed by the Occupational Therapist first. He seemed to accept it and spoke about his

circumstances to the nurse. He was later insistent about taking his medication at the time he was used to, and not when it was prescribed. In the late evening he was insistent about wanting to go home. He was seen by the duty doctor and nurse, and it was agreed that he could go on overnight leave, and return the next morning for his ward round. He left at 22.30 hrs. He did not come back the next day, but spoke to his Forensic CPN. He sounded stable and said one night's respite admission had been helpful but he could now manage in the community. The Forensic CPN informed the ward and Mr. U was formally discharged. The Forensic CPN recorded that he planned to pursue accommodation via a private landlord, chase referral to the Post Traumatic Stress service at the South London and Maudsley NHS Foundation Trust, review himself next week, and arrange transport for him to an appointment with his Consultant Forensic Psychiatrist two days later.

6.1.48 His Forensic CPN spoke to Mr. U on 7th August 2009. Mr. U said that he had found a pile of black refuse bags blocking his door, and had found this difficult to remove as he struggles with refuse that is not his own.

6.1.49 On 10th August 2009 his Forensic CPN phoned Mr. U to say that the CFT Leader was contacting Bromley Housing Department requesting assistance in finding more suitable accommodation. He also confirmed he would collect Mr. U on 12th August 2009 for his appointment with his Consultant Forensic Psychiatrist. However on that day the Forensic CPN learned that there had been some confusion and the appointment was now booked for 26th August 2009.

6.1.50 On 13th August 2009 the Forensic CPN spoke to someone at the Housing Department, who said she was now Mr. U's Housing Worker. She appeared confident they could re-house Mr. U in the Penge/Beckenham area within 2 weeks. Mr. U was pleased to hear this when the Forensic CPN phoned him the next day.

6.1.51 The Forensic CPN then saw Mr. U on 18th August 2009 when he appeared stable, but a little anxious as there had been a fight amongst other residents outside his door the previous night. They drove past a potential property in Croydon. He reminded Mr. U to attend his appointment with his Consultant Forensic Psychiatrist the next day. However Mr. U did not attend, and when his Forensic CPN saw him on 20th August 2009, this proved to be because he had not been able to sleep the previous night and had finally fallen asleep about 06.00 hrs, and so had slept through. It was re-booked for the following week. Otherwise he seemed stable but was anxious to spend some time away from his property. They drove through Sydenham where another flat might become available, but Mr. U said that the neighbour he had trouble with in his private rented flat in Penge, had family in Sydenham, and he would not want to bump into him or his family.

6.1.52 On 27th August 2009 the Forensic CPN spoke to the potential landlord in Croydon. Mr. U phoned the Forensic CPN to say he could not keep his appointment that day. On 3rd September 2009, the Forensic CPN collected Mr. U in Penge and they went and sat in a park. Mr. U was stable and insightful. He was taking his medication. They talked about him enrolling at Lewisham College. He said he had not been drinking excessively and had abstained from illicit substances. He had been invited to join a local football team. They discussed that he found it difficult not having any contact with his sons.

6.1.53 On 7th September 2009, the Forensic CPN accompanied Mr. U to meet the Mental Health Coordinator at Lewisham College. They discussed alternatives to the plumbing course which was full (though he could apply the following year), including Personal Training. Mr. U felt it was a very worthwhile visit. There were no issues of concern to document.

6.1.54 On 11th September 2009 the Forensic CPN learned that the Croydon property would not be renovated until the end of October, but that it was definitely allocated to Mr. U. The Forensic CPN saw Mr. U on 15th September 2009 and he was settled and relaxed. He found the thought of moving to safer accommodation very helpful. He reported that he was compliant with medication.

6.1.55 The Forensic CPN tried to phone Mr. U on 22nd September 2009 following Mr. U leaving a message the previous day. He had reported experiencing visual disturbances, abnormal dreams and paranoia. When they spoke they agreed that the Forensic CPN would come and see him on 23rdSeptember 2009. Mr. U said he had been experiencing what he thought were unpleasant side effects of the medication, i.e. disturbed sleep, vivid dreams, night sweats, increased paranoia and lethargy.

6.1.56 The Forensic CPN saw Mr. U on 24th September 2009 when he appeared relatively stable but anxious about a substantial leak in his kitchen ceiling. Despite this he said that many practical things in his life were improving, but he struggled with his past, and with not having access to his sons. They also addressed an issue regarding unpaid council tax. The Forensic CPN planned to consider the possibility of re-referral to the Forensic Psychologist, arrange an appointment with his Consultant Forensic Psychiatrist, and speak to the potential Croydon landlord. Over the next few days, the Forensic CPN made various attempts to resolve the council tax issue.

6.1.57 Mr. U seems to have missed his next appointment with the Consultant Forensic Psychiatrist. He phoned his Forensic CPN on 6th October 2009 to say that he was experiencing unpleasant thoughts, was being reminded of his young sons crying, and he had been drinking heavily over the past week. He denied using illicit substances. He said he planned to go for a jog. The Forensic CPN advised him that he and the Consultant Forensic Psychiatrist would visit him at home the next day. When they saw him, he presented as low in mood and uncommunicative initially. He said he had been drinking heavily, was thinking of his sons, and having vivid flashbacks and nightmares relating to experiences when he was younger. He denied suicidal thoughts. He looked more dishevelled than usual, and he said he had allowed his personal care to slip, and that he had not done any laundry for over a month. The Forensic CPN offered assistance with this. They also spoke about college/vocational training, and his Consultant Forensic Psychiatrist advised him to pursue contact with his sons. Their plan was to assist him with daily living until he was feeling better, refer him to the Consultant Clinical Psychologist for psychology input, chase up the possible flat in Croydon, and arrange for him to see his Consultant Forensic Psychiatrist again in 4 weeks time.

6.1.58 The Forensic CPN reviewed Mr. U on 7th October 2009 when he appeared much brighter in mood, which had been the case for several days. He was focusing on his forthcoming move, he knew he had to stay out of trouble, and he had received a phone call from his ex-partner telling him of their sons' progress. He was well groomed and said he had not drunk alcohol

for a week. They drove past another potential property, but the Forensic CPN had also been advised the Croydon one would be available in less than a month, and Mr. U wanted to wait for that one. Mr. U mentioned that the flat upstairs was being squatted and a number of dogs were being kept there, mainly puppies (Staffordshire terriers). He found their constant whining very distressing, and he thought they were not being exercised. He reported that some of them were caged and he was concerned they were being bred for dog fighting. He thought they were being beaten to toughen them up. He thought of phoning the RSPCA but was frightened of reprisals. The Forensic CPN said he would contact the RSPCA the next day, which he did.

6.1.59 On 21st October 2009 the Forensic CPN came into work to find several text and phone messages from Mr. U in an extremely distressed state, reporting that at least 3 men were attempting to break down the door of his flat, threatening to shoot him, slash him and set fire to the property. The messages had been left late on 20th October and into the early hours of 21ST October 2009. When the Forensic CPN reached him on the phone, Mr. U said he was in Penge, very frightened, and carrying a kitchen knife for protection. He reported that he was unharmed and had not hurt anyone else. The Forensic CPN collected him from Penge, and Mr. U gave him the knife which was wrapped, and the Forensic CPN put it in the boot of his car. He presented as very frightened and distressed. However he appeared to relax as they drove away from the area. They went to Bromley Housing Department to request emergency accommodation. The necessary steps were completed which included Mr. U reporting to the police what had taken place, and the Jigsaw Team speaking to the Housing Department. Bromley then agreed to provide emergency accommodation in Thornton Heath, until the property in Croydon was ready. The Forensic CPN then drove Mr. U there.

6.1.60 The Forensic CPN wrote that his mental state seemed stable but that he was struggling with the events of the last 24 hours. Although the Forensic CPN felt Thornton Heath was safer in the short term, he also thought it would not be conducive to Mr. U's mental health to stay there in the longer term, and he was concerned whether Mr. U should be around other vulnerable residents, and also whether the accommodation accorded with his licence conditions. (The Forensic CPN was not apparently aware that Mr. U's probation licence had expired in March.)

6.1.61 The next day his Forensic CPN, with a student nurse, met Mr. U at his flat in Penge and they gathered all his property and drove it to his new address. The Forensic CPN advised he must sign the SOR within 3 days or he would be subject to arrest. Mr. U said he was very pleased to be out of his flat in Penge but he was struggling with the shared washing facilities, which were increasing his symptoms of OCD.

6.1.62 The day after, the Forensic CPN recorded that Mr. U had left very distressed messages that morning and the previous evening. He was crying uncontrollably on the phone, and seemed to be finding the environment very difficult. The Forensic CPN made several attempts to contact him. Later he got a text from Mr. U saying he felt a bit better, and was going to get some sleep before going to Croydon police station. Later he informed Mr. U he needed to attend the Housing Department on Monday 27th October 2009. After various email

discussions, with the Jigsaw Team and the Housing Department among others, about the risks of the current placement, the Forensic CPN advised Mr. U he might need to come temporarily back to Bromley while the Croydon flat refurbishment was completed.

6.1.63 On 26th October 2009 Mr. U left a message saying he was finding Thornton Heath unbearable, was concerned he might be breaking his licence conditions by being there (Mr. U must have known his licence had expired so maybe this was said to increase the pressure on the Forensic CPN and others to find him alternative accommodation), and he would not be returning. The Forensic CPN emphasized the efforts that were being made by a number of people to resolve the situation, advised him to be patient, and warned him that if he did not return to the Bed and Breakfast, he might risk losing the continued support of Bromley Housing Department. Then the Forensic CPN continued his efforts to find more suitable housing. Later that day he was phoned by the Housing Department to say they had identified a more appropriate temporary property in terms of minimizing his risk, and lessening the symptoms of OCD. The Forensic CPN then arranged to transport Mr. U from Thornton Heath to the property in Bromley later that day. In fact Mr. U was moved the following day, and although he appeared quiet, he said that it was a positive development for him. He then appeared a little disheartened when he saw his new address, and was unhappy that he was on the top floor, up three flights of stairs. The Forensic CPN emphasized that it was a temporary move. He was again advised to register with the police within three days.

6.1.64 Two days later on 29th October 2009, the Forensic CPN received a phone call from Mr. U in which he said he had considered contacting the Crisis Team and turning up at Green Parks House (Admissions Unit) the previous night, due to thoughts of harming himself. However he had contained these feelings and had begun writing a journal about his past and how he was feeling. The Forensic CPN encouraged him in this, saying it could be very helpful when he starts psychotherapy. Mr. U also said he was going to see a solicitor that day about getting access to his sons. He was a bit more positive about his future than on previous occasions. He said he was finding the environment beneficial but that the building was spooky. The Forensic CPN reminded him to sign on with the police, and to let him have a copy of his licence conditions.

6.1.65 On the evening of 31st October 2009 Mr. U was drinking in the Swan & Mitre pub in Bromley with three friends, an evening that culminated with the attack on Mr. V, who was left unconscious in the alleyway.

6.1.66 The next entry in RiO by the Forensic CPN stated that he had received an email from someone in the Housing Department, advising that his landlord had informed her that Mr. U had been arrested and was in prison, following someone being stabbed (sic) and in a critical condition in hospital. It was confirmed to him the following day by the Jigsaw Team that Mr. U had been charged with murder and was in custody. He was in touch with the In-reach team at HMP High Down the next day, and he faxed them the relevant information about Mr. U. He later completed and submitted a level 5 incident report.

6.2 Commentary on Care provided by the Trust

6.2.1 There were no significant contributory factors regarding the care provided which may have

contributed to the homicide which occurred.

6.2.2 By the time the homicide occurred in October 2009, Mr. U had been receiving proactive thoughtful psychiatric management by the CFT since the beginning of the year. The assault by Mr. U and others which led to Mr. V's death was a fracas outside a pub when both perpetrator and victim had been drinking heavily. As the Judge said in his sentencing remarks, Mr. U's mental health problems had no more than a slight effect on what took place.

6.2.3 Although the homicide could not have been predicted or prevented, this review affords the opportunity to consider ways in which the provision of mental health services by the Trust can be improved.

6.3 Commentary on Psychiatric Care Provided by the Trust's Community Mental Health Team (CMHT)

6.3.1 Mr. U was referred to the CMHT by his GP on 6th November 2008, who asked for a fairly urgent assessment.

6.3.2 He was first discussed at a team meeting on 10th November 2008. The decision was made not to offer him an appointment until they had gathered background information from Probation and WLMHT.

6.3.3 Finally they received information from the Probation Service and WLMHT, and at a meeting on 22nd December 2008 they decided to offer him an appointment the next day. As he was only advised of the appointment by a phone message left with Hostel staff on 22nd December 2008, it is not surprising that Mr. U did not attend.

6.3.4 However the CMHT Social Worker spoke to Mr. U on 24th December 2008 and to the Hostel on 2nd January 2009, and established that there were no acute concerns.

6.3.5 It was 14th January 2009 when he was assessed for the first time by the CMHT. It seems to us that a delay of over two months in seeing a "fairly urgent" referral is unacceptably slow.

6.3.6 **Recommendation:** we agree with the Internal Investigation that there should be a Trust policy setting out agreed timescales for seeing urgent and routine referrals. The operation of these timescales by CMHTs should be audited.

6.3.7 As well as offering an appointment to Mr. U, the CMHT simultaneously sent the referral on to the CFT on 22nd December 2008. This seems to us a confusing way of going about things. Either the CMHT should decide quickly that the referral is more suitable for the Forensic Service, and should attempt to pass it on to them, or they need to assess the patient themselves, and then refer him on to the Forensic Service if appropriate.

6.3.8 To have the two services assessing him in parallel allowed a lack of clarity about which service was responsible for the patient, and created circumstances in which the CMHT could withdraw their support without clear communication with others, such as the CFT and the GP, which is exactly what happened. It appears from RiO that the CMHT Social Worker, who

saw Mr. U twice in January 2009 and made a relationship with him, left the CMHT about the end of January 2009. Thereafter no one in the CMHT took responsibility for Mr. U, despite him presenting several times to the CMHT offices in February without an appointment.

6.3.9 On 2nd March 2009 the CMHT decided to discharge Mr. U from their caseload back to the care of his GP, just as he was facing the crisis of being evicted from the Probation Hostel. They were under the impression that Mr. U was to be re-housed in Hounslow (which was not in fact the case).

6.3.10 Mr. U was, perhaps understandably, unhappy when he found he had been discharged and wanted to make a complaint. The CMHT did not inform the GP that they had discharged Mr. U until sometime in April 2009. According to RiO, Mr. U's GP wrote a letter of complaint about this to the Chief Executive of the Trust, dated 24th April, though we have not seen the letter.

6.3.11 **Recommendation:** again we agree with the Internal Investigation that patients should continue to be reviewed and discussed by the CMHT, until their discharge to another service (GP, CFT etc) has been formally agreed and documented.

6.3.12 The information the CMHT had obtained, in particular the Probation report relating to Mr. U's most recent set of offences, seemed not to be available to the CFT. It was not clear to us whether it was not uploaded on RiO, or whether it was uploaded but the CFT did not know it was there. If the Forensic CPN had seen this report, he would have been familiar with the details of the previous offences, the issues which the Probation Service thought were particularly important, the licence conditions, and when his licence expired.

6.3.13 **Recommendation:** when a patient is discharged to another service, there should be clear communication and a formal handover to ensure the receiving service is aware of important background information.

6.3.14 None of the recommendations above has any bearing on the homicide which occurred seven months later. However, implementing the above is in accordance with best practice and may avoid other incidents in the future.

6.4 The Community Forensic Team (CFT)

6.4.1 The Consultant Forensic Psychiatrist saw Mr. U for the first time on 28th January 2009. She did not make an entry in RiO but the CMHT Social Worker recorded her input.

6.4.2 According to an entry in RiO on 2nd March 2009, the CMHT planned to advise the Consultant Forensic Psychiatrist and the Consultant Clinical Psychologist of their intention to discharge Mr. U from their care. His Forensic CPN then met Mr. U for the first time at his new accommodation in Penge on 13th March 2009. From then on Mr. U was effectively under the care of the CFT, and care was provided mainly by the Forensic CPN and the Consultant Forensic Psychiatrist.

6.4.3 We have previously given a very full account of the care provided by the CFT to Mr. U, as we think that the notes speak for themselves in demonstrating that the care provided - in terms

of frequency of contact in person and by phone, following up when Mr. U did not keep appointments, recording detailed assessments, holding a CPA, addressing relevant issues such as accommodation and substance misuse, working as a team, and keeping good records – was of a high standard.

6.4.4 The Forensic CPN very properly realised that the level of input he was providing meant that Mr. U should be formally taken onto his caseload, which happened in April 2009.

6.4.5 When it was clear that safety issues at his housing in Penge were causing an acute crisis for Mr. U, his Forensic CPN and his Consultant Forensic Psychiatrist worked hard with Bromley Housing Department to arrange alternative accommodation which was safe and clean. They identified a suitable flat in Croydon for Mr. U which was to become available at the end of October 2009. Unfortunately Mr. U was moved twice as a stopgap towards the end of October 2009, first to Thornton Heath and then to Bromley.

6.4.6 It seemed to us from RiO entries that members of the CFT communicated and worked well together. For instance, although there is criticism in the internal inquiry report that the Forensic Clinical Psychologist's notes were not available to the CFT, it seemed clear that communication between her and the other members of the CFT was good. The Forensic CPN and the Consultant Forensic Psychiatrist communicated about Mr. U and supported each other in managing him. Moreover the Forensic CPN was well supported by his Team Leader, with whom he had supervision, and by a colleague when he was having a period of leave.

6.4.7 Although the CFT functioned well, we have some recommendations about how the CFT could improve their management of high risk individuals in the community, which we describe below. Again we want to make it clear that we do not believe implementing these recommendations would have prevented the homicide.

6.4.8 Having looked at the Forensic Community Work Policy and the Operational Policy for Clinicians Providing Input to Approved Premises, it did not seem to us that the CFT has an adequate operational policy describing how the team will carry out its core function of managing mentally disordered patients who cross the risk threshold for being managed by the Forensic Service.

6.4.9 The Forensic Community Work Policy seems to be written more from a managerial perspective of minimizing use of medium secure beds, and looking at the activity of the team, rather than describing what the CFT does to manage high risk individuals. For instance, there is nothing about CPAs, risk assessments/HCR-20s, (The HCR-20 is a 20 item checklist to assess the risk for future violent behaviour in criminal and psychiatric populations), regular MDT meetings and documenting of such, managing home visits, and information sharing with other agencies such as MAPPA - all of which one would expect to find in a Community Forensic Team operational policy.

6.4.10 **Recommendation:** the CFT should redraft their operational policy describing in detail their processes for managing community patients. The policy could extend to cover joint working with the CMHT in certain cases, though this requires negotiation with general psychiatric services.

6.4.11 Regarding the care of Mr. U specifically, there is a sense that the CFT did not focus sufficiently on the risk he posed to others.

6.4.12 In the Care Plan arising from the CPA meeting on 24th June 2009, there was relatively little mention of risk to others. It seemed they did not have access to the Probation Service report of 18th November 2008 which gave details of the offences for which Mr. U had been convicted in 2007, namely Assault By Penetration, Kidnapping x 2, and Perverting the Course of Justice. Reading the detail of past offences is a useful corrective to seeing a patient as predominantly vulnerable. Furthermore the licence conditions in that report made it clear how seriously the issue of alcohol was regarded. It was a condition that Mr. U be totally abstinent from alcohol while resident in Approved Premises, he was to cooperate with breathalysing if requested, and cooperate with any treatment directed by his supervising officer. There were signs that he was abusing substances intermittently, including alcohol, during the period when he was under the care of the Trust's CFT.

6.4.13 **Recommendation:** the CFT should always try to get background information about a patient through other agencies such as Probation, MAPPA, previous providers of psychiatric services etc, so as to get as full a picture as possible of the patient and the risks they present.

6.4.14 The fact that Mr. U was carrying a knife in a public place, should have been discussed within the team (whether in an MDT meeting or in supervision), the discussion documented, and a decision made about disclosing the information to MAPPA. Reading the RiO notes and seeing the context, it is understandable that the Forensic CPN did not formally advise MAPPA. However if there had been a culture of documented MDT meetings and discussions, the significance of this incident and the need to consider informing MAPPA, would probably have been clear to the team.

6.4.15 One of the interviewees said to the Internal Investigation that many of their patients probably carried knives in the community. But here was someone who was definitely doing so, and in a state of arousal and fear, and who handed the knife to his CPN. The incident reinforced the sense that the CFT may have given too little weight to the fact that Mr. U was a perpetrator of serious violence, as well as a potential victim.

6.4.16 **Recommendation:** we recommend that the CFT has regular documented MDT meetings to discuss patients on the caseload, so that any significant incidents can be raised, and the team as a whole can consider what the appropriate response is. Specifically any incidents which may justify referring to MAPPA should be noted, a decision made whether to disclose information or not and the rationale recorded.

6.4.17 The Consultant Forensic Psychiatrist did not make entries in RiO, although her input to Mr. U's care was clearly conveyed in the Forensic CPN's entries. She also wrote letters which captured her input, though some of these may not have been uploaded to RiO.

6.4.18 **Recommendation:** details of contact with the patient, and emails and letters by <u>all</u> CFT members, should be uploaded to RiO in a timely fashion. Emails and letters can be uploaded directly into the progress notes, which can save time by avoiding writing a separate entry, and means there is a coherent, chronological record in one place about the care of the

patient.

6.5 Probation Service

6.5.1 There is nothing in RiO to suggest any input by the Probation Service, even though Mr. U was in a Probation Hostel and on licence until early March 2009.

6.5.2 The CMHT did obtain the Probation Service report which gives details of the offences, the licence conditions, and the date of expiry of his licence. They seemed to be unsuccessful when they tried to identify his Probation Officer and thereafter there is no mention of contact with Probation. This seems a curious absence. We gather there has been a Probation Service inquiry but information relating to this has not been made available to us.

6.5.3 By the time that the CFT took over Mr. U's care, his licence was expiring. It is clear from entries in RiO, that the Forensic CPN did not know what the conditions of Mr. U's licence were, or when it expired. This information is lost in the transition from CMHT care to the CFT. We were uncertain as to whether the report was uploaded in RiO, as it would seem that the CFT/ Forensic CPN did not know about it.

6.5.4 It seems unfortunate that Mr. U was so abruptly evicted from the Probation Hostel at the beginning of March, and that the Probation Service did not play a role in helping Mr. U to find suitable housing. However we accept all services have to have boundaries or their workload would become unmanageable. We are not suggesting the Probation service did not meet its requirements, or that their actions or omissions contributed to the homicide.

6.6 Housing Department

6.6.1 Our remit is to examine the psychiatric care received by Mr. U, not that of other agencies.

6.6.2 Nevertheless it seems reasonable to us to comment that the only factor which might have made any significant difference to the outcome in this case, was that if Mr. U had been provided with safe, clean accommodation at an earlier stage, he may not have been in the vicinity of the Swan & Mitre on 31st October 2009, and may not have been minded to go on a drinking spree with friends. However this is entirely speculative, and is certainly not intended to suggest that anyone in the Housing Department was at fault.

7 COMPLIANCE WITH STATUTORY OBLIGATIONS AND RELEVANT NATIONAL GUIDANCE FROM THE DEPARTMENT OF HEALTH AND LOCAL OPERATIONAL POLICIES.

7.1 Local and national policy and procedure guidance is in place to provide a framework for the benefit of patients, and to guide and inform the practice of health and social care professionals.

7.2 Whilst under the care of the Trust, Mr. U's care was provided mainly by the CFT. The CFT appears to have been functioning at a high level. There were systems in place for ensuring that the outcomes and clinical pathways for patients were routinely and effectively reviewed, the team appeared robust and well managed. The involvement of clinical medical staff in the running of the team was well integrated.

7.3 We have reviewed details taken from Mr. U's documented care notes, documents from the Internal Investigation into the incident plus the report itself, and transcripts of the interviews taken at the time (including written clarifications from those interviewed). We have also examined relevant policies and procedures from the Trust along with a variety of other documents provided for clarification. A full list of the documents reviewed is given in Appendix 2.

7.4 The Government has produced a number of publications, which set out its vision for Mental Health Services across the country.

7.5 We are satisfied that the Trust had local policies in place which addressed national requirements, particularly in relation to the Mental Health Act statutory requirements; care planning, Care Programme Approach and risk assessment.

7.6 The Panel believe that Mr. U received care which met with all requirements in terms of mental health law, national guidance, and local policies and practices as they relate to the provision of care, supervision and services provided. He was managed in line with enhanced CPA principles; he was assigned to an appropriately qualified professional who had the necessary skills and experience to meet his identified needs

7.7 The Panel are therefore satisfied that the agencies and professionals involved with Mr. U's care provided appropriate care and support, which met with local and national guidance.

8 REVIEW OF THE TRUST'S INTERNAL INVESTIGATION

8.1 The Audit Tool

8.1.1 The Independent Investigation Panel applied the HASCAS audit tool that was developed in conjunction with mental health trusts in the North West of England, and further refined for work carried out by Caring Solutions (UK) Ltd for NHS North West, and adapted specifically for use in respect of the internal audit into the care and treatment of Mr. U.

8.1.2 The Independent Investigation Panel was supported by Caring Solutions (UK) Ltd staff who have expertise in the application and analysis of the audit tool.

8.1.3 The audit tool contains standards which address

- how the incident was recorded,
- the way in which the investigation was conducted,
- the quality of the investigation and analysis described in the report,
- the actions identified and implemented, clarity over accountability and responsibility,
- the structure of the report.

8.1.4 The audit tool also provides both a quantitative judgement as to the extent to which each standard was met in the Internal Investigation report, and a qualitative commentary.

8.1.5 Following the audit, the Panel has highlighted the main areas of interest and concern. The completed audit document including scoring is available on request only, as it is not anonymised.

8.2 Incident Reporting

8.2.1 The basic information and data relating to the Serious Untoward Incident (SUI) was sought by and provided to the Internal Investigation in a systematic way. The content of the data and information was communicated satisfactorily in the reports. The opportunity to make relevant comment in areas of specific relevance was taken by the reviewers, and a root cause analysis (RCA) methodology was adopted. However, the date 2nd November 2009 appears on more than one occasion throughout the narrative of the Internal Investigation report although the actual date of the incident was 31st October 2009

8.2.2 That said, we felt that the process of the investigation was initiated and planned in a systematic and methodical way.

8.2.3 As part of the terms of reference set out for the Internal Investigation the Panel was asked:

- To examine the circumstances of treatment and care given
- Assess the quality and scope of care and risk assessments
- Analyse the appropriateness of care, treatment and supervision regarding:
  a. Assessment of needs
  b. Risk of potential harm to self and others
  c. Previous psychiatric history

d. Previous offending behaviours

8.3 Establishing the Internal Investigation Process

8.3.1 Clear terms of reference were set for the Internal Investigation. The Internal Investigation report described key findings from the examination of available documents, clinical progress note entries and supporting information.

8.4 Undertaking the Internal Investigation

8.4.1 The report followed National Patient Safety Agency (NPSA) guidance on the establishment of internal investigations.

8.4.2 The Trust Identified a Chairman and Team members to produce the report. The people selected had the professional backgrounds and the necessary skills to undertake the investigation. A relevant, albeit very brief, history of Mr. U's previous treatment and care prior to the incident was described.

8.4.3 The Internal Investigation report listed six people, who were interviewed by them:

- Mr. U's GP
- Mr. U's Consultant Forensic Psychiatrist
- Mr. U's Forensic Clinical Psychologist
- The CFT Leader
- Mr. U's Forensic CPN
- CMHT Consultant Psychiatrist

8.4.4 Relevant supporting information was used and this, in turn, captured elements required to fulfil the demands of the report. This information included:

- RiO Progress notes relating to Mr. U
- Forensic Psychology file
- The Consultant Forensic Psychiatrist's paper records
- Forensic CPN's supervision records
- CMHT file relating to Mr. U
- Chronology of events (time line)
- Written questions relating to operating policies were submitted to the CMHT Team Manager.

8.4.5 The letters sent to staff inviting them for interview by the Internal Investigation Team were not included in the documents that accompanied the report so it was not possible to comment on their content and approach. However, the interview transcripts that were provided to the Panel demonstrated that the process was open and transparent.

8.4.6 No family members of either the perpetrator or the victim were seen by the Internal Investigation Team. The opportunity to do so was very limited as Mr. U had little or no contact with his immediate family, and had been estranged from his ex-partner and his two sons for some time. Engagement with the victim's family was not thought appropriate as

they were unaware that Mr. U was a patient of the Trust, and it was thought that contact with them prior to the court hearing may be a breach of Mr. U's confidentiality.

8.4.7 We considered that the Internal report had been informed by a systematic and professional approach to retrieving information, and that it presented factual elements in a transparent way.

8.5 Understanding the Patient and his Care and Treatment

8.5.1 The attempt to understand Mr. U and his treatment issues was addressed.

8.5.2 The Internal Investigation Team appeared to subject the evidence and documentation available to them to an appropriate level of scrutiny. They may have been hampered in some aspects as it seemed that a number of documents contained a paucity of information. The overall report, however, reflected an understanding of the pattern and chronology of Mr. U's life and his mental health problems.

8.5.3 The issue of unnecessary delays in service engagement as a result of Mr. U's referral being treated as a transfer (from an existing mental health provider i.e. WLMHT) rather than a new GP referral, was addressed in the report, along with delays in communication between agencies.

8.5.4 However we did not feel that adequate attention was paid to areas of risk assessment and management in the internal report. Mr. U was a patient with a long history of violent behaviour. The Internal Investigation recognised this and stated in their report that a "risk assessment had been completed by the team". The risk assessment recognised Mr. U's forensic history and consequent underlying potential for violence. However, the clinical judgement of the team whilst Mr. U was under their care was that as "a result of his housing environment, risk of substance abuse and OCD rituals Mr. U was currently more at risk of violence from others rather than being responsible for violent acts himself".

8.5.5 We would have expected an Internal Investigation into a homicide to have placed more emphasis on assessments and management of risk. The Internal Investigation Team appeared to mirror the assumptions made by members of the CMHT that Mr. U "was at more risk of violence from others… than being responsible for violent acts himself".

8.5.6 The National Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) in their 2010 report, identified issues around transition. They suggest that transitional times in a patient's care can be times of increased risk. "For example when a patient is discharged from inpatient hospital treatment to the community there will be a decrease in the protective factors associated with being in hospital and an increase in the potential risk factors associated with a move into less supervised accommodation within the community".

8.5.7 They advise that it is vital that risk assessment/management and care planning need to be fluid and dynamic processes, and that procedures should be put in place to ensure that these are reviewed at regular intervals and at key transitional stages. They go on to recommend that at transition points, such as from ward to community or forensic to general

services, there should be a care plan review including future risk management involving representatives from the receiving services/ agencies.

8.5.8 The Internal Investigation Team seemed satisfied that the consultant in charge of Mr. U's care had direct contact with other agencies, police, MAPPA etc. However communication between members of the CFT and other agencies was not as formal as it could have been.

8.5.9 The Internal Investigation Team was satisfied that there had been no contributing factors or root causes that may have led to the incident. They did, however, suggest that some lessons may be learned from the process:

i. RiO Notes:

- Patient engagement and progress notes (particularly psychology notes) not available to all members of the Multi–Disciplinary Team (MDT)
- MDT decision making relating to care not clearly articulated and documented.
- Delays in updating notes identified

ii. Delay in action following referral to the CMHT – two month delay between receiving the fairly urgent GP referral and seeing the patient

iii. Poor communication between CMHT, CFT and other agencies – decision by the CMHT to discharge Mr. U made at a meeting (2nd March 2009), not communicated to GP until (27th April 2009), two months later.

iv. CFT did not properly document discussion concerning the instance when Mr. U carried a knife in public, which he later handed over to his Forensic CPN.

8.5.10 We agree with the Internal report that the homicide could not have been foreseen, and there were no actions or omissions that would have contributed to the incident.

8.5.11 We would still however have expected greater investigation around the issue of formal assessment of risk in relation to Mr. U, and examination of any formulated management plan which may have been put in place in the event of a crisis.

8. 5.12 The CFT may have underestimated the potential risks posed to others by Mr. U.

8. 5.13 Also, the Internal Investigation Team did not examine compliance with local and national policies in any detail. There was limited evidence of scrutiny of the application of contemporary guidelines, policies and procedures. The report did not list the relevant local and national policies that may have assisted them in identifying a benchmark for specific areas of practice.

8. 5.14 Although the internal report did not identify specific staff training issues, it did focus on areas which may well become drivers for improvement plans and staff training i.e.

- Record keeping
- Communication between agencies

8. 5.15 The Internal Investigation Team appeared confident about the root cause methodology which they relied on for their report (the Fishbone model). Their analysis identified action

and communication problems which were reflected in their recommendations and subsequent action plan.

8.6 Development of an Action Plan

8.6.1 Following completion of the Internal Investigation, the Investigation Team produced an action plan (Appendix 3) which centred on the findings and recommendations contained in the Board level Internal Investigation report.

8.6.2 The action plan is formulated to tackle "lessons learnt" and seeks to address four main areas:

- **RiO Usage –** during the internal investigation there were a number of concerns raised regarding the co-ordination, uploading and storage of information.
- **Delays in Initial Appointment** – the Internal Investigation Team expressed concern regarding the timeliness of response to the referral of Mr. U to the CMHT.
- **Delayed Communication by the CMHT to the Community Forensic Team and referring GP that they were discharging Mr. U** – the Internal Investigation Team also picked up issues of "poor communication" and delays within the system in relation to patient discharge from caseload.
- **Lack of formal notification to MAPPA** - the Internal Investigation also highlighted concerns regarding the contact with other agencies, particularly relating to consideration of formal exchanges of information.

8.6.3 This led to the Internal Investigation suggesting the following recommendations for service change/improvement:

- A Trust policy setting out the agreed standards and timescales for urgent, semi urgent and routine appointments for all CMHT referrals should be established. This should be reflected in local CMHT operational policies. An audit tool should be developed to support this.
- All Oxleas generated correspondence must be uploaded onto RiO.
- All decisions taken about referrals and the ongoing care of patients with the Community Forensic Tteam should be documented on RiO.
- All clinicians should document any contact with patients on RiO using the progress notes in a timely fashion.
- All significant documentation received from outside the Trust should be kept on a single paper file. Its receipt and location should be noted on RiO. Ideally all externally generated documentation should be scanned into RiO.
- When reporting serious incidents to MAPPA, staff should ensure that they are properly noted by the recipient, and that a record of the exchange is made on RiO. Such incidents should also be discussed in supervision.
- Patients should continue to be discussed at team review whilst on the CMHT caseload until they have been formally discharged and a letter detailing their future care has been sent to all interested parties.

8.6.4 The action plan is written in a standard format identifying actions that need to be taken against recommendations from the Internal report. Individuals and groups who have been tasked to complete or oversee the completion of actions are identified along with a clear timescale for completion. The internal report was completed in May 2010 and the aim was to have actions implemented between July and November 2010.

8.7 Clarity of Accountability and Responsibility for Action

8.7.1 The Internal Investigation Team was unable to establish any root causes or other contributory factors to the incident from the service delivery problems identified.

8.7.2 They did note that Mr. U had been subject to a risk assessment and that this risk assessment had taken account of Mr. U's forensic history and consequent underlying potential for violence. The Internal report noted that in the clinical judgement of the team, Mr. U, as a result of his housing environment, risk of substance abuse and OCD rituals was, at the time, more at risk of violence from others than being responsible for violent acts himself.

8.7.3 It may be worth noting that in his sentencing remarks the Judge recounted Mr. U's record of violence to others, which included previous convictions for violent disorder, two convictions for affray, one assault occasioning actual bodily harm, and two convictions for robbery. He also stated that, although he believed that Mr. U had not intended to kill his victim, by using a weapon and kicking and stamping on his victim's head, he had intended to cause actual bodily harm "significantly beyond the trivial".

8.7.4 We do not feel that anyone could have predicted the incident that occurred on 31st October 2009. We are aware from entries in RiO progress notes that engagement with Mr. U had increased in frequency from the 21st October 2009 (10 days before the incident). We are aware that Mr. U was in possession of a knife in a public place, and that this intelligence was not formally shared with partner agencies. We now know, from the Judge's summing up, that Mr. U had not been taking his medication for a number of days before the offence was committed. However even if the clinicians had been armed with this information, we believe that it would not have been possible for them to predict what would happen that night.

8.7.5 The Independent Panel believes that more emphasis should have been put on Mr. U's risk to others. Specifically the knife incident should have been more formally discussed within the team, and whether to refer to MAPPA. Discussions and actions should have been documented on RiO.

8.7.6 However, even allowing for the reflections above, it remains our view that the homicide could not have been predicted or prevented.

8.7.7 The Internal Investigation report identified shortfalls in some areas of care and service delivery.

8.7.8 They felt that there were issues that needed to be addressed with regard to decision making within the CMHT. This was characterised by a distinct lack of organisation and planning in relation to the initial referral received.

8.7.9 Concern was also expressed regarding the delayed communication from the CMHT to the referring GP and the CFT.

8.7.10 The Internal report was also critical of the perceived deficit by the CFT to use RiO adequately to coordinate and organise care.

8.7.11 The Internal Investigation Team singled out the practice of the Forensic CPN as being praiseworthy. The Panel does not disagree with this. He clearly had a good working relationship with Mr. U, and he was caring supportive and very responsive.

8.8 Progress on Implementing the Internal Investigation Report Recommendations

8.8.1 Appendix 2 lists the documentation supplied by the Trust to the Independent Panel by way of evidence of change to practice and associated organisational learning, which has been effected by the roll out of the Internal Investigation action plan.

8.8.2 This specifically relates to:

- Improving standards and monitoring arrangements for the use of the Trust's electronic documentation system RiO. Ensuring that correspondence is uploaded, that all decisions are documented and recorded on RiO, that all contacts with patients are documented and that all hardcopy paperwork is maintained and filed in one single file.
- The development of improved processes of decision making in the CMHT, using an audit tool to identify deficits and inform the adoption of enhanced standards of response and communication.
- The system for ensuring accurate reporting of serious incidents to MAPPA.

8.8.3 The Panel was able to scrutinise documents from the Trust which demonstrated important aspects of organisational learning and the actions taken on recommendations, following the Internal report being completed. Most of these were contemporary and some were highly detailed. We would accept that they form part of a formal approach to lessons learned.

8.8.4 Although the Trust acknowledges that serious untoward incidents will occur, the Panel is reassured that the Trust is committed to ensuring that all incidents are recorded and analysed, that root causes are identified, and that systems are put in place to improve the quality of care, risk assessment and risk management. It is clear to the Panel from the documentation supplied to us, that the Trust has taken the issues raised by the Internal Investigation Team very seriously; discussions relating to this incident have been aired at the highest level, evidenced in minutes of Trust Board meetings in June and July 2010.

8.8.5 It was surprising therefore for the Panel to see that the action plan which was produced as a consequence of the Internal Investigation had not been fully followed up with the diligence that might have been expected.

8.8.6 The Internal Investigation report was produced in May 2010; all actions were given timescales for completion and, according to the documentation supplied to the Panel, all actions were to be completed by November 2010.

8.8.7 A key task of the Independent Investigation in the Panel's terms of reference from NHS London is to review the progress made by the Trust in implementing the action plan from the Internal Investigation. On the 2nd March 2012 the Panel asked our contact at the Trust for information and evidence of completion relating to the Internal Investigations action plan.

- Policy for receiving referrals.
- A copy of the protocol document and audit of compliance.
- The standard that was produced to ensure that all clinicians are documenting any contact with patients on RiO using the progress notes.

8.8.8 Scrutiny of this evidence however does not, we feel, provide us with evidence that all actions have been addressed. The information sent to us did not, in our view, adequately address action points 1.1, 1.2, 2.2 and 2.3. We are therefore unable to say confidently that the action plan has been completed and deficits rectified.

8.8.9 On the 22nd June 2012 we received further documentation from the Trust:

- Operational Policy East Recovery Team Orpington CMHT, (last updated March 2010, pre dating by 2 months the publication of the Internal report with associated action plan).
- Referral Meeting Policy (undated)
- Evaluation of a caseload zoning tool in Community Mental Health Teams (undated).
- Bromley Adult Mental Health Services, Referral and Initial Assessment Information Form (dated 2010).
- Clinicians' Checklist – to decide urgency of response (dated 2010).

8.8.10 The Panel has been provided with a copy of the Community Forensic Work Policy (June 2011). This is not the most robust or comprehensive policy that the Panel has seen and the Team may wish to review this in the future. It has not been written in response to the incident or the Internal Investigation action plan and, it does not appear to adequately cover the concerns regarding the process referrals identified in as action 1.2 in the action plan. Equally, without documented evidence of the audit of compliance relating to action 2.2 and sight of the standard that was produced to ensure that any contact with patients was being comprehensively documented on RiO, it would be difficult to sign off action 2.3 as complete.

8.8.11 The Panel was more recently provided with a copy of the Operational Policy for Clinicians providing input to Approved Premises (August 2012). This policy relates to the input provided by forensic clinicians to the Approved Premises (accommodation provided by the Probation Service for clients placed there by the Courts or by the Parole Board), namely: consultation and advice; brief mental health assessments involving face-to-face screenings. The policy makes clear that the former need not be recorded as referrals on RiO; but that any face-to-face contacts must be entered on RiO as new referrals. The policy confirms that, in this specific context, actions 2.1, 2.2 and 2.3 in the action plan are being addressed.

8.8.12 The receipt of this additional documentation therefore was still not adequate to satisfy the Panel that robust and effective systems were in place to ensure that standards and compliance with Trust policies relating to referrals were being regularly audited/measured.

8.9 Action Plan Progress

No.	Event or activity	Progress on Implementation
1.1	An agreed Trust policy setting out the standards and timescales for urgent, semi urgent and routine appointments for all CMHT referrals should be developed. These standards should be reflected in local CMHT operational policies. An audit tool should be developed to support the above.	A Policy covering Referral Meetings and outlining a systematic process for the actions to be taken on the receipt of a referral is in place. An operational Policy for Orpington CMHT is in place but predating the Internal Investigation by 2 months. It remains unclear to the Panel if an adequate audit tool has been designed and utilised.
1.2	Patients should continue to be discussed by the team and reviewed whilst on the CMHT caseload until they have been formally discharged and a letter detailing their future care has been sent.	Transfer of Care and Discharge arrangements are fully stated in the Trust's CPA Policy (v8.2 dated March 2011). Community Forensic Work Policy does not relate adequately to the receipt of referrals
2.1	All Oxleas generated correspondence must be uploaded onto RiO	Clearly evidenced in Guide to uploading documents to RiO V5 (v8 July 2010)
2.2	All decisions about referrals and the ongoing care of patients with the Community Forensic Team should be documented on RiO	We were provided with a copy of the policy specifically relating to forensic clinicians input to Approved Premises being recorded on RiO but no evidence of audit of compliance. *The Community Forensic Work Policy does not refer to documenting information on RiO.*

2.3	All clinicians should document any contact with patients on RiO using the progress notes	The policy in respect of forensic clinician input to Approved Premises addresses input of all contact with patients on to RiO using the progress notes. We did not receive a evidence of any audit of compliance
2.4	All significant documentation received from outside the Trust should be kept on a single paper file. Its receipt and location should be noted on RiO. Ideally, all external generated documents should be scanned into RiO.	Incorporated into the RiO Clinical Guidance Policy as (March 2011) Appendix A (The Secondary Care Record)
3	When reporting serious incidents to MAPPA, staff should ensure that they are properly noted by the recipient and a record of the exchange is made on RiO and discussed in supervision	Incorporated in the Professionals Meeting Guidance produced by the RiO Standards Group January 2011

8.9.1 The Panel did note progress on some areas in relation to lessons learnt, and we endorse the practice of continuous monitoring and utilising the process to inform Trust policies and working protocols for the future. We would urge the Trust to ensure that ongoing monitoring takes place which includes qualitative issues, as well as the necessary quantitative measures and data collection.

8.9.2 **Recommendation:** We suggest that the Trust revisits its original action plan and validates that all actions have been completed and changes in practice have been made**.**

9 OVERALL CONCLUSIONS

9.1 NHS London commissioned this Independent Investigation with the full co-operation of Oxleas NHS Foundation Trust and West London Mental Health NHS Trust.

9.2 The investigation was asked to evaluate the care and treatment provided by the Oxleas NHS Foundation Trust and to identify any contributory factors to the homicide. The work was to include a review of key issues identified and focus on lessons to be learned.

9.3 Mr. U had a long history of mental health issues, and offending behaviour. He had spent time in Young Offender Institutions and prisons for a range of convictions including, Burglary, Theft, Violent Disorder, Blackmail, Robbery, False Imprisonment, Affray, Perverting the Course of Justice, Assaulting a Woman by Penetration, and 2 counts of Kidnapping.

9.4 In October 2009, when the homicide occurred, Mr. U had been out of prison for almost a year. He had previously served a 3 year and 4 month sentence and had been placed on the SOR for a period of 10 years. He was a patient with the Trust, and he was under the care and supervision of the CFT.

9.5 Mr. U's risk behaviour on the 31st October 2009 could not have been predicted. The incident itself was an alcohol fuelled act of violent aggression by a group of men. Although the homicide could not have been predicted or prevented, this review does afford the opportunity to consider ways in which the provision of mental health services by the Trust can be improved.

9.6 We have noted the delay which occurred between referral and initial assessment by the CMHT, and the confusion which surrounds two teams assessing one patient at the same time.

9.7 We have highlighted the communication difficulties which were created by not having all documentation available to team members, and having information stored in different formats. We have made suggestions relating to the sharing of information with other agencies and we have offered some thoughts about the assessment of risk.

9.8 It is our view that Mr. U had been receiving proactive management by the CFT, and the assault by Mr. U and others which led to Mr. V's death was an altercation outside a public house when both perpetrator and victim had been drinking heavily. As the Judge said in his sentencing remarks at Mr. U's trial, his mental health problems had no more than a slight effect on what took place.

9.9 As no one could have foreseen this incident, there are no actions or interventions that could have prevented its occurrence. Mr. U's behaviour on 31st October 2009 could not have been predicted. The assault which led to the death of Mr. V was of a different type and severity in comparison with previous violence by Mr. U. However, the findings of this Independent Investigation have determined that there are some key areas which have the potential to improve the delivery of effective care to patients.

10 RECOMMENDATIONS

10.1 We agree with the Internal Investigation that there should be a Trust policy setting out agreed timescales for seeing urgent and routine referrals. The operation of these timescales by CMHTs should be audited.

10.2 Patients should continue to be reviewed and discussed by the CMHT, until their discharge to another service has been formally agreed and documented.

10.3 When discharging a patient to another service, clear communication via a formal handover should be arranged.

10.4 The Trust should review its processes and protocols for managing referrals, in particular the communication between teams and its efficiency/flexibility of response.

10.5 Processes for referring on to and working with other teams within the Trust should be reviewed in order to clarify the lead responsibility for an individual's care.

10.6 The Trust would benefit from reviewing its approach to communication with other agencies.

10.7 The CFT operational policy should be redrafted to include processes for managing community patients.

10.8 The CFT need to identify the processes by which they acquire background information about a patient through other agencies such as Probation Service, MAPPA and previous providers of psychiatric services etc.

10.9 The CFT need to develop a protocol for the documentation and communication of the decision making process within the MDT, which includes significant incidents raised, appropriate response to these, referral to other agencies e.g. MAPPA.

10.10 All documentation including emails and letters by all CFT members, should be uploaded to RiO in a timely fashion, in order to produce a coherent, chronological record about the care of the patient in one place.

10.11 Action points 1.1 and 2.3 of Oxleas Internal Investigation action plan remain incomplete. The action plan should be reviewed and outstanding actions completed.

APPENDIX 1 ABBREVIATIONS

Abbreviation	Meaning
CMHRC	Community Mental Health Resource Centre
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CFT	Community Forensic Team
DSS	Department of Social Services
Jigsaw Team	Bromley Police Jigsaw Team (Borough Public Protection Unit)
MAPPA	Multi-Agency Public Protection Arrangements
MDT	Multi-Disciplinary Team
OCD	Obsessive Compulsive Disorder
RiO	Electronic patient records system
SOR	Sex Offenders' Register
SUI	Serious Untoward Incident
WLMHT	West London Mental Health NHS Trust
WMH	West Middlesex Hospital

APPENDIX 2 PEOPLE INTERVIEWED AND DOCUMENTATION REVIEWED.

The Independent Investigation Panel did not interview any staff from the Trust. We did however read transcripts of recorded interviews with the Internal Investigation Team.

The Panel was advised by representatives of the Police Family Liaison Service that it would not be in the best interests of Mr. V's family to make contact with them.

The following key documents were read:

The National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, National Patient Safety Agency, (NPSA).

The Internal Inquiry Report dated 10th May 2010, written by the Director of Human Resources and Organisational Development, including terms of reference, tabular timeline and report action plan.

Incident Form completed by Forensic CPN on 5th November 2009.

SUI Service Management Review Report compiled by Forensic CPN and the Community Forensic Team Leader dated 10th November 2009.

Risk Assessment for Mr. U

Core Assessment for Mr. U

Care Plan and Review for Mr. U, completed 24th June 2009

Referral screening document

RiO Progress Notes from 10th November 2008 – 5th November 2009.

Letter to the referrals co-ordinator at the Bracton Clinic from CMHT Sector 1 dated 22nd December 2008.

Letter to the Consultant Forensic Psychiatrist from CMHT dated 27th April 2009

Letter to the Housing Department from Care Coordinator dated 15th May 2009.

Ward documentation relating to Mr. U during informal admission 4th – 6th August 2009.

West London Mental Health NHS Trust discharge summary dated 10th March 2003

Probation Assessment completed by Probation staff at Acton Probation Office 17th November 2008.

Prison Healthcare record from 22nd December 2007 – 11th November 2008.

CPA review documentation dated 24th June 2009.

Medical report prepared by Consultant Psychiatrist and Clinical Director at WLMHT for KCP Law Solicitors and Advocates dated 29th April 2004

Various other miscellaneous letters and correspondence

Additional Information requested by the Panel:

Transcripts of Interviews with the following staff from the Internal Investigation were supplied to the Panel for review.

- Mr. U's GP
- Mr. U's Consultant Forensic Psychiatrist
- Mr. U's Forensic Clinical Psychologist
- Team Leader CFT
- Mr. U's Forensic CPN
- CMHT Consultant Psychiatrist.

Documents relating to the trial of Mr. U at the Old Bailey in July 2010. The Judge's Summing Up to the Jury.

Medical Records relating to Mr. U when under the care of West London Mental Health NHS Trust

Documents supplied by the Trust relating to their Internal Report action plan (See Appendix 3)

Minutes of the meeting of the Board of Directors (3rd June 2010) and (1st July 2010)

Minutes of the Information Governance Group meeting (15th March 2012)

Minutes of the RiO Clinical Standards Group meeting (17th January 2011)

Guidance document from RiO Clinical Standards Group entitled "Crisis/Contingency Plans, Professional Meetings, Guidance for Completion".

Information Pack entitled "Integrated Offender Management Framework"

Guidance document for uploading documents to RiO

Operational Policy for Clinicians Providing Input to Approved Premises (last review date November 2010).

Forensic Community Work Policy (June 2011)

Assessment and Care Planning including Care Programme Approach (CPA) for all Oxleas Service Users (May 2012).

RiO Clinical Guidance Policy (March 2011)

Operational Policy East Recovery Team Orpington CMHT (March 2010).

Referral Meeting Policy (undated)

Evaluation of a caseload zoning tool in Community Mental Health Teams (undated).

Bromley Adult Mental Health Services, Referral and Initial Assessment Information Form, (2010).

Clinicians' Checklist – to decide urgency of response, (2010).

Operational Policy for Clinicians providing input to Approved Premises (2012)

APPENDIX 3 FORENSIC AND PRISONS DIRECTORATE ACTION PLAN.

Action Plan arising from the Level 5 Inquiry into the homicide committed by Mr. U

	Recommendation	Action	By Whom	When
1	**CMHT issues**			
1.1	There should be a Trust policy setting out the agreed standards and timescales for urgent, semi urgent and routine appointments for all CMHT referrals. These standards should be reflected in local CMHT operational policies. An audit tool should be developed to support the above.	• A short-term project group with representative from each borough is commissioned to develop a Trust policy and set standards. • The project group to oversee implementation. • Local CMHTs to incorporate it into their operational policies. Develop and audit a pilot audit tool (initially in Bromley) which measures if the standards are being met	Patient Safety group Service directors Service Manager (Bromley)	October 10
1.2	Patients should continue to be discussed by the team and reviewed whilst on the CMHT caseload until they have been formally discharged and a letter detailing their future care has been sent.	• Ensure this is clearly stated in the Trust CPA policy. • Community Forensic Team incorporate this standard into their operational policy/practice for receiving cases.	Named staff member to liaise with the Trust CPA lead. To be monitored through local audit.	July 10 August 10
2	**RiO issues**			
2.1	All Oxleas generated correspondence must be uploaded onto RiO	To be addressed by the RiO clinical standards group with a timescale in which all services must demonstrate compliance.	Named staff member	October 10
2.2	All decisions about referrals and the ongoing care of patients with the forensic	Directorate RiO lead to work with the Community Forensic Team to ensure that their documentation practice is in line	Practice Development	September 10

	Recommendation	Action	By Whom	When
	community team should be documented on RiO	with RiO clinical standards, follow up with local audit.	(Bracton)	
2.3	All clinicians should document any contact with patients on RiO using the progress notes	The Rio clinical standards group to develop a standard for all disciplines on inputting patient contact information onto RIO contemporaneous records.	Named staff member	November 10
2.4	All significant documentation received from outside the Trust should be kept on a single paper file. Its receipt and location should be noted on RiO. Ideally, all externally generated documents should be scanned into RiO.	• Ensure compliance with the Trust standard to maintain a single paper file. • The panel recognises the significant practical difficulties that scanning would entail and recommends that the trust continues to explore options to make external documentation available electronically.	Local audit Named staff member	October 10 November 10
3	**MAPPA issues**			
	When reporting serious incidents to MAPPA, staff should ensure that they are properly noted by the recipient and a record of the exchange is made on RiO and discussed in supervision.	• The Rio clinical standards group to develop a standard for all disciplines on the inputting of professional communications information onto RIO contemporaneous records. • Forensic directorate to ensure that staff attending MAPPA implement this recommendation.	Named staff member Named staff member	November 10 July 10

APPENDIX 4 DETAILED CHRONOLOGY

Date	Event or activity
January 1973	Born in Hillingdon district of London, to Indian parents. Normal birth achieving milestones. Grew up as the middle child of seven (5 x brothers and 2 x sisters) in the Southall area of Middlesex. Left school at 15 years of age with no formal qualifications.
7th September 1989	Convicted of being Found on Enclosed Premises for Unlawful Purpose, Criminal Damage and Vehicle Interference. Conditional discharge 12 months.
18th December 1990	Found Guilty of Burglary and Theft, Violent Disorder and being Found on Enclosed Premises for Unlawful Purpose. Young Offender Institution 6 months.
3rd January 1992	Convicted of Affray. Conditional discharge 12 months.
23rd July 1992	Guilty of Blackmail, Robbery and False Imprisonment. Young Offender Institution 30 months
7th September 1995	Convicted of Handling Stolen Goods. Imprisonment 18 months reduced to 12 months on appeal.
1996	Assault occasioning Actual Bodily Harm. Probation order 12 months, Community service order 60 hours.
11th July 1997 to 10th March 1998	Served a 2 year sentence of Imprisonment for Robbery, at HMP Wormwood Scrubs.
18th December 1998	Admitted as an informal patient to West Middlesex Hospital, Lakeside Mental Health Unit (WLMHT) at the age of 25 years. Section 3 Mental Health Act applied 18th January 1999, discharged 25th January 1999
June 2000	Referred to North West Thames Forensic Psychiatric Services, failed to attend for 3 x outpatients appointments – discharged.
April 2002	Referred by GP to Lakeside Mental Health Unit.
6th March	Admitted informally to Lakeside Mental Health Unit following presentation at

2003	Accident and Emergency Department having taken an overdose. Non-compliant with medication during stay also absconded on several occasions, discharged on 10th March 2003
2003	Possessing controlled drug – Class B Cannabis, failing to surrender to custody at appointed time – forfeiture/confiscation and £40 fine
2003	Possessing controlled drug – Class B Cannabis. Imprisonment 1 day
28th August 2003	Discharged from all services at West Middlesex Hospital (WLMHT), after failure to keep Psychiatric and Substance Misuse Service appointments.
19th January 2005	Referred to Hounslow Community Mental Health Team, seen on 2 x occasions before being discharged back to Social Services.
December 2005	Further contact with West Middlesex Hospital (WLMHT) – regarded as an inappropriate referral – no psychiatric symptoms evident.
18th January 2006	Referral from GP to Ealing Lammas Centre Community Mental Health Resource Centre (CMHRC)
1st March 2006	Discharge referral from GP to Ealing Lammas Centre (CMHRC)
7th June 2006	Referral from GP to Ealing Lammas Centre (CMHRC)
29th January 2007	Arrested and interviewed by police regarding charge of Common Assault
5th September 2007	Convicted on two charges of kidnapping, one charge of Assault on a female by penetration, and one charge of perverting the course of justice, receiving a cumulative sentence of Imprisonment for 3 years and 4 months

By the time Mr. U was discharged from Prison on 2nd November 2008, he had an extensive criminal record behind him, he had served a number of custodial sentences, and he had been a patient of WLMHT as both inpatient and outpatient.

Following completion of the custodial component of his sentence, Mr. U was referred to Oxleas NHS Foundation Trust by his GP on 6th November 2008.

Date	Event or activity
2nd November 2008	Discharged from Prison
6th November 2008	Letter of referral sent by GP to the Oxleas Community Mental Health Team (CMHT)
10th November 2008	Patient discussed at CMHT referrals meeting – Action, requests made for more information prior to proceeding, to be discussed at next meeting.
21st November 2008	Record made on RiO progress notes that information received from GP and Probation, case for discussion at next Referrals meeting 24th November 2008
24th November 2008	CMHT referrals meeting – Action, more information requested from West Middlesex Hospital (WLMHT), to be discussed at next referral meeting.
16th December 2008	Record on RiO progress notes that information requested on 24th November 2008 from Lakeside Mental Health Unit, West Middlesex Hospital (WLMHT) had been received, to be discussed at next referrals meeting.
22nd December 2008	Discussed at CMHT referrals meeting: agreed assessment to be arranged for 23rd December 2008.
23rd December 2008	Mr. U failed to appear for assessment at time arranged.
24th December 2008	Telephone communication took place between CMHT Social Worker and Mr. U rearranging assessment for 30th December 2008.
2nd January 2009	Social Worker attempts to contact Mr. U to arrange another appointment date for assessment, unable to make contact. Social Worker made contact with Probation Hostel and informed staff there of the new appointment, namely, 14th January 2009 at 14.00 hrs.
5th January 2009	Mr. U's case discussed at CMHT meeting. Mr. U failed to attend for appointments on 2 previous occasions, decision referred until assessment has taken place, scheduled for 14th January 2009.

14th January 2009	Core mental health assessment carried out by CMHT Social Worker. Next appointment scheduled for 27th January 2009.
27th January 2009	Mr. U rang Social worker to rearrange appointment for next day 28th January 2009. Telephone call received by Social Worker from Probation Hostel staff, expressing concern over Mr. U's deteriorating mental health. Case discussed by Social Worker with Psychiatrist, who agreed to see Mr. U when he arrived for his appointment the following day to provide an opinion.
28th January 2009	Telephone call received by CMHT Social Worker from Consultant Forensic Psychiatrist who had visited Mr. U at his Probation Hostel that morning. The Doctor made some changes to Mr. U's medication. Mr. U arrived as planned for his appointment with CMHT Social Worker. Patient is recorded as presenting low in mood and tearful at times, talked about wanting to hurt himself, further appointment made to be seen in two days time. Contact made with Probation Hostel staff to update them of situation – Actions noted, patient placed on high alert, Social Worker to have telephone contact with patient the following day and appointment arranged for day after that.
30th January 2009	Mr. U did not attend meeting with Social Worker as planned. Mr. U unable to be contacted, not answering his phone. Message left with Probation Hostel staff asking Mr. U to call back.
23rd February 2009	Mr. U seen by Duty Social Worker having presented himself at the office, said to appear stressed and unkempt. Mr. U is recorded as having poor eye contact and very tearful during the review.
24th February 2009	Mr. U presented himself again unannounced, very tearful and talking about intrusive thoughts relating to physical and sexual abuse suffered as a boy. Mr. U was worried about the time period until his next appointment with the Psychiatrist (12th May 2009) stated that he is "at the end of his tether and feels suicidal". Mr. U was worried that he was to be evicted from his current accommodation at the Probation Hostel on 3rd March 2009.
25th February 2009	Again presented himself at the CMHT office (3rd time in last 3 days) in a distressed state and looking for someone to talk to. Patient was concerned about losing his accommodation at the Probation Hostel and troubled by flashbacks of past abuse by his father.
26th February 2009	A number of telephone conversations recorded on RiO progress notes supporting Mr. U in relation to clarifying his accommodation situation.
2nd March 2009	Decision made at Duty and Assessment Clinical Team meeting that no further action would be taken by the team in relation to Mr. U and he should return to the care of the Probation Service. Action recorded in the minutes to discharge Mr. U's care back to the GP.

4th March 2009	Duty Social Worker received a call from Patient Advice and Liaison Service representative to say that Mr. U was unhappy with the discharge decision and he would be raising a formal complaint.
5th March 2009	Mr. U attended for his Psychology appointment, said to be in a fairly distressed state, worried that his licence was about to end and the accommodation issue was still unresolved. Mr. U talked about his intrusive thoughts and his urges to harm himself.
13th March 2009	Visited by CPN
25th March 2009	Attended for Psychology session, discussions centred around his OCD and his move to a flat which is causing him concerns regarding security and the fact that he believes that it is surrounded by 'drug dealers'.
1st April 2009	Failed to turn up for Psychology appointment. Visited in his flat by CPN, Mr. U expressed concerns about the negative effect that his physical environment may have on his mental well being. He confessed to having used illicit drugs the previous night for the first time in many years. The temptation provided by having a number of 'drug dealers' close by appeared too great and Mr. U was concerned that he may regress. He stated that he had been involved in an altercation with another person in a bar in Beckenham recently. This clearly raised concern in the mind of CPN whose notes indicate the need to change his relationship with Mr. U from informal to a more formal basis
14th April 2009	Mr. U contacted by CPN to arrange a meeting for the following day at 10.30 hrs between themselves and patient's Consultant. CPN would like to formalise his relationship with Mr. U.
15th April 2009	Mr. U failed to attend meeting as agreed. Concerns raised by MAPPA regarding Mr. U, it seemed that the police Jigsaw Team had visited Mr. U on two occasions at his flat but he had not been in, they were concerned that he may be frequenting the Islington area, in breach of his conditions.
16th April 2009	Contact made with Mr. U to rearrange meeting with Consultant for 22nd April 2009 at 10.15 hrs.
22nd April 2009	Whilst on route to meet with Mr. U at his flat as planned, CPN and Consultant receive a message from Mr. U saying that he wished that he was dead, and that everything was getting worse, He said that he was unable to cope, his OCD was unmanageable and he was paranoid about other residents in the flats. He said that he was not at the property having slept in a car last night. Following discussions plan to admit Mr. U to Green Park House was agreed.
23rd April 2009	Following a meeting between CPN and Mr. U's GP, CPN met with Mr. U at his flat. Mr. U is recorded as appearing more settled, he had experienced a bad couple of days previous where he had engaged in some superficial self harm but it is recorded by CPN that Mr. U's mental state seemed more settled and that he was both hopeful

	about the future and more relaxed. CPN discussed the possibility of an admission into Green Parks House but Mr. U did not wish to go and CPN is recorded as feeling that an admission was far less necessary then it was the previous day.
11th May 2009	Meeting with CPN
15th May 2009	Failed to attend for arranged meeting with CPN
21st May 2009	Telephone conversation between CPN and patient.
29th May 2009	Brief telephone conversation between Mr. U and CPN
1st June 2009	Brief message left by CPN on patient's answer phone informing of pending CPA meeting 10th June 2009.
4th June 2009	Patient and CPN met, initially appeared low in mood, reporting suicidal thoughts, having difficulty coping. The thought of admission to hospital was reintroduced but patient reluctant. Patient said that he had been in a relationship recently which at first seemed good but he had found out that she was also seeing another man so he was intending to break up the relationship. Patient did ask if he would be able to reopen his relationship with his sons and asked CPN if he would act as go between/mediator which was agreed as this would be viewed as beneficial to Mr. U's mental health.
11th June 2009	CPA now scheduled for 24th June 2009.
17th June 2009	CPN received a telephone call from Mr. U agreeing a meeting between them both for the next day 18th June 2009.
18th June 2009	Seen by CPN, appeared in a very positive frame of mind, looking forward to re-establishing his relationship with his children and although still has thoughts of self harm he is using attendance at a gym as a distraction from these.
24th June 2009	CPA meeting attended by Mr. U. **Actions** – continue regular support by CPN. Continue current medication. Referral to psychotherapy. Social Worker to look into housing issues.
7th July 2009	Meeting between patient and CPN, patient appeared stable. Despite his settled presentation he informed CPN that he had been having trouble with one of his neighbours who had threatened him with a knife a couple of evenings before. This prompted CPN to note that he was concerned that Mr. U may become a victim of violence.

8th July 2009	Mr. U telephoned CPN to say that he had found dog excrement outside his front door that morning; he attributes this to the neighbour with whom he had been having trouble. CPN made several calls that day informing people of his concerns regarding Mr. U and the suitability of his accommodation.
13th July 2009	Police Jigsaw Team raised the issue of Mr. U's current accommodation; they were concerned about the risk to him living in that neighbourhood.
14th July 2009	Mr. U met with CPN, although presenting as anxious in relation to his current accommodation and difficulties with other residents in the flats, he appeared mentally stable
16th July 2009	Mr. U contacted CPN to say that he had been threatened and verbally intimidated early that morning by the neighbour with whom he had been having difficulties, who had knocked upon Mr. U's door in the company of two other men. Although distressed, patient said that he refused to be intimidated and was considering visiting a friend in north London for a while in order to remove himself from the situation.
22nd July 2009	Mr. U was to be seen by another CPN in the absence of his regular CPN who was on leave in the company of her manager but Mr. U cancelled the meeting by text that morning. Mr. U was later contacted by CFT Team Leader to arrange a meeting the following day 23rd July 2009, Mr. U confided to Team Leader that he was feeling unsafe and anxious having used crack cocaine the day before, patient advised against the use of illegal substances.
23rd July 2009	Visited in his flat by CFT Team Leader - no concerns recorded
30th July 2009	Visited in his flat by CFT Team Leader – no concerns recorded
4th August 2009	During a routine visit by CPN to the Probation Hostel where Mr. U used to reside, staff at the Hostel expressed concerns regarding Mr. U's current mental state having seen him on occasion outside the Hostel in previous few days. CPN visited Mr. U in his flat, patient appeared unkempt and distracted, seemed very low in mood and mental state appeared to have deteriorated significantly. Patient was expressing urges to self harm. Following discussions between CMHT and Forensic Team a bed was sought for crisis admission. At 21.00 hrs, accompanied by CPN, Mr. U was admitted on an informal basis for a brief period to an inpatient ward, Green Parks House. He was placed on regular observations.
6th August 2009	Mr. U asked if he could leave the ward as he was not finding his stay there beneficial, agreement made for Mr. U to have overnight leave but to return to the ward the following morning at 11.30 hrs for ward round. At 15.45 hrs Mr. U contacted CPN to say that he was not going to return to the ward. Decision communicated to ward staff by CPN. Patient discharged.

13th August 2009	Notification from Housing Department that Mr. U was to be re-housed possibly within the next two weeks.
18th August 2009	Mr. U met with CPN for their regular two weekly meeting
20th August 2009	Mr. U viewed a potential property in Sydenham in the company of CPN.
27th August 2009	Mr. U did not turn up for his appointment with CPN.
3rd September 2009	Mr. U met with CPN for their regular two weekly meeting – no concerns.
7th September 2009	Mr. U, accompanied by CPN, attended for interview at Lewisham College to discuss courses that may be available to him.
11th September 2009	Telephone call from Mr. U received by CPN patient sounded agitated and distressed having received a council tax demand for £1,400. CPN made a number of calls to clarify the issue; patient informed that he would need to complete some forms and CPN will assist.
15th September 2009	Mr. U met with CPN for their regular meeting – no concerns
22nd September 2009	CPN attempted to make contact with Mr. U, following messages left by him the day before expressing concern regarding visual disturbances and abnormal dreams, patient believed that these were unpleasant side effects of his medication. When CPN made contact with Mr. U he arranged a meeting in order to follow up, but also suggested Mr. U make an appointment with his GP to discuss medication.
24th September 2009	Mr. U met with CPN at his flat. Mr. U was worried about a leak that had appeared in his kitchen ceiling. CPN records that during the time he was with Mr. U, a neighbour knocked the door looking to sell cannabis to Mr. U.
30th September 2009	Mr. U did not turn up for his appointment with Consultant Psychiatrist (3rd DNA). Home visit by Consultant considered.
06th October 2009	Mr. U contacted CPN to inform him that he was experiencing unpleasant thoughts; patient stated that he had been drinking heavily over the previous week. Patient informed to expect a joint visit from CPN and Consultant the following day.
7th October	Mr. U visited by CPN and Consultant, patient presented low in mood, admitted that

2009	he had been drinking heavily and had been thinking a lot about his sons, he had been experiencing 'flashbacks' and nightmares. Appearance was dishevelled and he had let his personal care slip.
14th October 2009	Mr. U and CPN met, appeared brighter and more stable, says that he had received a call from his ex-partner updating him on the progress of his sons
21st October 2009	On arrival at the office CPN received a number of messages from Mr. U, from the previous evening, reporting three men had been trying to break in through his door. When CPN met with Mr. U he was carrying a knife (difficult to ascertain the dangerousness of this implement, CPN in his interview with the Internal Investigation Team described it as a "paring knife" with a "4" x 2" blade". CFT Team Leader in his interview described it as a "potato peeler". Mr. U handed over the knife to the CPN who then drove him to Bromley Housing Department office to complete a form for emergency housing, taken to new address in Thornton Heath. (CPN did not make formal notification to MAPPA or the police about Mr. U carrying a knife).
22nd October 2009	Mr. U was visited by CPN and Student Nurse, assisted to move his property from his former address, in Penge to Thornton Health.
23rd October 2009	Several messages received by CPN from Mr. U, very distressed finding his environment very difficult.
26th October 2009	Communications received by CPN from Mr. U who was complaining about his accommodation, "finding it unbearable".
27th October 2009	Assisted by CPN to move from Thornton Health to new accommodation in Bromley
29th October 2009	Mr. U contacted CPN by phone to say that he had considered contacting the out of hours Crisis Team or just turning up at Green Parks House the night previous as he had thoughts of harming himself. Mr. U reported that he had managed to contain these thought without resorting to self-harm. CPN reminds Mr. U to inform police of his new address and CPN asks for information regarding his licence conditions – which expired 7 months earlier (March 2009).
31st October 2009	Mr. U and three other men are involved in the assault of Mr. V outside the Swan and Mitre public house in Beckenham.
3rd November 2009	Mr. V the victim of an assault by Mr. U and three other men dies in hospital following the removal of life support functions.
4th November 2009	Mr. U charged with three other males of Murder, remanded in custody, to appear at the Old Bailey
9th July 2010	Mr. U found guilty and convicted of Manslaughter at the Old Bailey

2nd September 2010	Mr. U sentenced to eight years in prison for the Manslaughter of Mr. V following an incident on the night of 31st October 2009.