Independent Scrutiny and Investigation into the care and treatment of

Mr LM

Commissioned by NHS London

NHS London

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Acknowledgements

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

The scrutiny team wishes to thank Mr LM for consenting to the team having access to his records for the purpose of this scrutiny and the West London Mental Health NHS Trust for providing those records in a timely manner.

We are grateful to the Trust's Director of Nursing, Deputy Chief Executive and Clinical Director for attending the workshop with the scrutiny team to discuss the issues they raised from the information examined by them.

Executive Summary

Introduction

Mr LM, a resident of a residential hostel was arrested and charged with the murder of a fellow resident on 4th February 2006. The victim had been found in the lounge of the hostel with stab wounds to his chest. At the time of the incident Mr LM was in receipt of mental health services from West London Mental Health NHS Trust (the Trust).

An internal review was commissioned by the Trust to examine Mr LM's care and treatment. A multi-agency panel undertook the review which was completed in January 2007.

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

Methodology

The scrutiny team had access to the Trust's internal review report and the case notes relating to Mr LM's care and treatment.

The scrutiny was divided into two parts, a detailed analysis of the internal review and Mr LM's case notes and a workshop with senior Trust staff to discuss any issues raised by the scrutiny team. No individual interviews took place.

Outline of the Case

Mr LM, an only child, was born in 1952. His father is reported as having been killed in the war in Korea.

There is very little history about his early years except that after being expelled from school aged 13 years he attended a boarding school for maladjusted children. It is known that he had a history of drug and alcohol misuse with 52 criminal convictions between March 1969 and May 2003 mainly drug and alcohol related.

In 1975 Mr LM married and had four children by this marriage. Mr LM and his wife divorced in 1992.

Contact with Psychiatric Services

Mr LM's first contact with psychiatric services was in 1980 when he was referred by his GP for drug addiction. Six years later he was again referred to a substance misuse consultant.

In 1992 Mr LM was admitted to the West Middlesex Hospital with an acute psychotic episode. This was diagnosed as either drug induced or due to Bipolar Affective Disorder and he was detained under Section 2 of the Mental Health Act 1983.

The next hospital admission took place in August 1992 after Mr LM allegedly chased his mother down the street with a knife. He reported hearing voices in his head. His diagnosis was again a probable drug induced psychosis.

He continued to abuse drugs and alcohol and had personality disorder added to his previous diagnosis in April 1993 when he was commenced on depot medication. Schizophrenia was diagnosed in 1998.

Mr LM was admitted as an inpatient seven times in the period from April 1993 to May 2003. He remained an inpatient from May until November 2003. Mr LM was homeless at that time and when discharged from the inpatient admission was placed in a residential hostel. He remained at the hostel until his arrest in February 2006. During this period of time Mr LM's general behaviour deteriorated and at the time of the incident he was under notice to terminate his tenancy at the hostel.

Scrutiny Team Findings and Recommendations

The scrutiny team found that the internal review report was a well prepared balanced review of the care and treatment provided to Mr LM. It addresses the majority of the issues that the scrutiny team identified through its overview. The findings and recommendations were appropriate and the Trust have progressed and implemented their action plan.

In particular the scrutiny team wish to commend the areas of good practice found by the internal review by those providing care to Mr LM.

Positive Factors

On examination of Mr LM's case records there were areas of good practice.

- Liaison between the CMHT and Substance Misuse Service
- Compliance with local policies
- Record keeping as part of the CPA process
- Regular care planning meetings and multi-disciplinary reviews of Mr LM's care
- Regular liaison by the CPN during 2005-2006 with the psychiatrist, hostel staff and other related services.

Scrutiny Team Independent Findings

The scrutiny team commends the report completed by the internal review for its thoroughness and content. There were, however, a few areas that we feel were not given enough prominence in their report.

We would comment that Mr LM's lengthy forensic history was not fully explored by the mental health services and there were often omissions in sharing key information. This was a particular issue as the hostel were not aware of Mr LM's past violence and two separate incidents with a knife when he chased his mother, and stabbed a flatmate in the stomach. This information would have informed his care plan and future risk assessments. The hostel was not designated "High Support" but perceived so by the mental health team as providing high support to the residents including Mr LM. This led the team to believe there was a level of support of expertise and care which in fact the hostel could not provide.

At the time of Mr LM's placement in the hostel he had had a CT scan which showed Cerebral and Cortical Atrophy affecting his short and long term memory. It has to be considered that this was a man with some cognitive impairments, a history of mental illness and substance misuse who was homeless and isolated from his family. It is possible that his cognitive difficulties contributed to his failure to keep to agreed plans.

Mr LM appeared to deteriorate in 2004 -2005 with an increase in substance misuse, verbal abuse towards staff and other residents in the hostel. By November 2004 his behaviour resulted in him being given a written warning. A second warning was issued by the hostel in April 2005. It was at this time that he cut his neck with a razor blade.

The CMHT did recognise the situation and referred Mr LM to the Home Treatment Team (HTT). They also recognised the significant social pressures that he was experiencing but we were unclear as to whether they did consider that he might have been experiencing psychotic symptoms. An admission to hospital was arranged to assess Mr LM's mental state but it is unclear as to the outcome.

During the period of Mr LM's contact with the psychiatric services there were several occasions when drug induced psychosis was diagnosed but the scrutiny team found no evidence of drug screening tests having been taken on his admissions to hospital. The scrutiny team questioned the Trust in regards to the availability of drug screening kits on the wards and were assured that these were available and used as necessary.

The scrutiny team considered the possible significance of Mr LM ceasing to take his depot medication in June 2005. In their view it is unclear as to whether the team looking after Mr LM at the time took into account the possibility of a psychotic relapse as a consequence of stopping the depot medication.

Issues addressed at the Trust Workshop with the Scrutiny Team

Family Contact

The Trust have developed a Protocol for families and relations of victims and perpetrators which sets out the contact to be made with them. It is implemented and the current internal reviews adhere to this.

Internal Review Panels

Internal investigations undertaken by the Trust currently include independent panel members from outside the Trust.

Case Records

Case records are now held centrally and not separately as at the time of Mr LM's care and treatment.

Substance Misuse

The scrutiny team were informed that drug induced psychosis was not a diagnostic category now used by the Trust.

We were assured that drug screening tests are readily available to Trust staff for use on all inpatients. A Dual Diagnosis Policy has been developed and implemented across the Trust's inpatient services. It has been found to be more difficult to implement the policy in the community and more work is in progress.

The policy does contain a section on how staff should act if drugs are found on the premises. The Trust also have a half time police officer on the site at St Bernard's hospital.

Disseminating the Lessons learnt from Reviews and Investigations

The Trust has a Trust wide Incident Review Group which meets on a regular basis. In addition a newsletter "Risky Business" is distributed across the Trust's services. A bi-annual Trust wide review on individual reports takes place to inform the staffing teams involved.

An overarching database of incidents is regularly reported to the Trust Board.

Residential Placement Panel

The Residential Placement Panel is now annexed to the Police Liaison meeting. The highest risk patients would have had a completed HCR20 assessment undertaken and any risks to themselves or others identified. The panel also takes in the opinion of the multidisciplinary team currently working with the individual requiring a placement as well as a full risk assessment.

Scrutiny Team Recommendations

The scrutiny team make the following recommendations and ask that the West London Mental Health NHS Trust implement these.

Recommendation One - Criminal Records

It was found that the criminal records relating to Mr LM were not readily available or known by the care teams involved in his treatment. It is recommended that when an individual is admitted via the police that information regarding criminal activity is requested by the admitting team. To facilitate that it is further recommended that a joint protocol between the police and Trust be developed.

Recommendation Two - Summary Sheet

In Mr LM's case there were found to be omissions and misinformation relating to his clinical and forensic history between the teams within the Trust. It is recommended that a summary sheet is developed to be sited at the front of patients' records and updated on a regular basis. This should include:

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

Recommendation Three – Interview Process

In accordance with best practice and to ensure that staff have the opportunity to check that the evidence they have given to internal reviews is accurate and reflects the issues that they wish to raise it is recommended that all interviews undertaken for internal reviews are recorded and transcribed.

1. Introduction

Mr LM, a resident of a residential hostel was arrested and charged with the murder of a fellow resident on 4th February 2006. The victim had been found in the lounge of the hostel with stab wounds to his chest. At the time of the incident Mr LM was in receipt of mental health services from West London Mental Health NHS Trust (the Trust).

The Trust commissioned an internal review of the incident which was completed in January 2007. The internal review was conducted by a multi-agency panel consisting of a non-executive director, associate director of the Trust, deputy director, substance misuse services, service manager for inpatient and community services, a service manager for integrated adult services, non-executive director from "Together" residential care provider, and an Independent Consultant Rehabilitation Psychiatrist.

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

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

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

2. Terms of Reference

Part One - Internal Review

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

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

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

To compile a chronology of events.

Part Two

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

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

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

3. Purpose of the Scrutiny and Investigation

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

The role of this scrutiny is to gain a picture of what was known, or should have been known at the time, regarding the patient by the relevant clinical professionals. Part of this process is to examine the robustness of the internal review and to establish whether the Trust has subsequently implemented changes resulting from the internal review's findings and recommendations. The purpose is also to raise outstanding issues for general discussion based on the findings identified by the scrutiny team.

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

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

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

The process is intended to be a positive one that examines systems and processes in place in the Trust at the time of the incident working with the Trust to enhance the care provided to their service users. We can nevertheless, all learn from incidents to ensure that the services provided to people with a mental illness are safer, and as comprehensive as possible; that the lessons learnt are understood and appropriate actions are taken to inform those commissioning and delivering the services.

4. Methodology

It was agreed at the start of the scrutiny that the team would examine the internal review undertaken by the Trust. The scrutiny team would set out its findings in regard to the process undertaken and the Trust's progress against their internal review's recommendations. In addition the scrutiny team was to undertake a detailed analysis of Mr LM's case records held by the Trust prior to the death of the victim. Mr LM did authorise access to these records.

The scrutiny was separated into two parts as set out in the Terms of Reference. This comprised of a detailed analysis of both the internal review and Mr LM's care and treatment as stated in his case records. The template used by the scrutiny team for analysing the internal review can be found in Appendix One.

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

It was agreed that no individual interviews would take place, so our report was based purely on the written documentation provided. A workshop was held with the Trust to discuss the issues raised by the scrutiny team following their review of the documentation. A letter inviting the Trust to attend the workshop that also identified the areas for discussion was sent to the Trust's Chief Executive. The Trust's Director of Nursing, Deputy Chief Executive and Clinical Director attended the workshop held on 8th April 2010 and the scrutiny team were informed of the progress made against the recommendations from the internal review.

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

This report has been drafted to include an analysis of the Trust's internal review, a brief history of Mr LM and a detailed consideration of the care and treatment provided to him by the Trust.

5. Scrutiny Team Members

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

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

6. Outline of the Case

The following is an outline of the events that relate to Mr LM and his care and treatment. They have been compiled from the records available to the scrutiny team. A full chronology can be found in Appendix Two.

6.1 Background

Mr LM was an only child, born on 23rd June 1952 with a congenital hip deformity. His father was reported as having been killed in the war in Korea. His mother remarried when he was three and he described himself as being on good terms with his stepfather although he was 11 years old when he discovered that his stepfather was not his real father. Mr LM's grandparents were also very involved in his upbringing.

There is very little history about his early years but it is known that he was expelled from school when he was 13 years old and then attended a boarding school for maladjusted children. It was reported that he apparently attended a Child Guidance Clinic in Staines but only went once or twice. No other details were available regarding this. From age 15 years Mr LM had a history of drug and alcohol misuse and had 52 criminal convictions between March 1969 and May 2003 mainly drug and alcohol related but there were some offences against the person. See Appendix Three for a full Forensic history.

In 1967 Mr LM had a job for 6 months as an apprentice mechanic. He started to take amphetamines aged 19 years and continued on and off with this for 36 years.

At the age of 23 years, in 1975, Mr LM married and had four children by this marriage. Seventeen years later they divorced having been separated for four years.

6.2 Contact with the Psychiatric Services

Mr LM was 54 years old at the time of his arrest for murder in February 2006. His first contact with psychiatric services had been in 1980 when he was seen initially for drug addiction. The scrutiny team found no other information available regarding this contact although as noted above he had started to abuse drugs and alcohol from the age of 15 years. In July 1980 he commenced a two year prison sentence for Burglary and theft.

In 1986 Mr LM's GP referred him to a Consultant Psychiatrist at Ashford hospital. The referral stated that Mr LM reported being "delirious and taken over by the devil". In view of his use of amphetamines he was referred to a substance misuse consultant.

In April 1987 Mr LM was diagnosed as being a chronic drug abuser when seen in outpatients at Ashford hospital.

In 1988 Mr LM separated from his wife and they obtained a divorce in 1992.

Over a three year period between 1987 and 1990 Mr LM was involved in criminal activity and in 1990 was charged with criminal damage and breach of conditional discharge receiving a six month prison sentence. A Probation Report in September describes what would appear to be delusional symptoms. It was at this time that he also suffered a head injury after head butting a door and jumping through a window in a stranger's house. He reports suffering with headaches from this time.

In 1992 Mr LM was admitted to the West Middlesex hospital with an acute psychotic episode which was noted as either drug induced or due to Bipolar Affective Disorder. When admitted he did not give any details of his past psychiatric history and therefore staff were not aware of his previous contact with mental health services. Following assessment Mr LM was detained under Section 2 of the Mental Health Act 1983 (MHA). This resulted in an eight day admission at Ashford hospital. It is reported that he had previously been arrested for breaking into a house and trying to strangle a female there. The scrutiny team were unable to find any further details about this.

Five months later, on 24th August 1992, Mr LM was alleged to have chased his mother down the street with a knife. He was taken to Ashford hospital A & E department by the police. It was reported that he had told his mother that he was hearing voices in his head and that he was sorry but he had to kill her. When arrested he tried to attack the police with broken glass. The psychiatric duty doctor noted that Mr LM reported that he wanted to die but denied hearing voices. The doctor noted that Mr LM appeared to be responding to a voice which he stated was coming from the next room and was talking about him. He was diagnosed as suffering from a probable drug induced psychosis. The scrutiny team did not find any evidence of a drug screen having been taken at this time.

The following year, in April 1993 Mr LM was again admitted to Ashford hospital with a psychotic episode after taking amphetamines. He was diagnosed as suffering from a drug induced psychosis, personality disorder and alcohol abuse. Mr LM was commenced on depot medication and discharged to the community eight weeks later (4th June 1993) remaining on depot medication. The scrutiny team would question the rationale of making a diagnosis of drug induced psychosis in a patient being treated with depot medication.

In April 1998 he was admitted to Ashford hospital and formally diagnosed, this time as suffering from schizophrenia.

The depot medication was continued and a drug screen taken. This showed positive for Benzodiazepines and cannabis but negative for all other non prescription drugs. He was discharged three weeks later into the community and continued on the existing medication regime of depot medication. The discharge diagnosis was given as schizophrenia, drug and alcohol dependence.

Thirteen months later Mr LM was admitted to Ashford hospital following an overdose reported as being 112 Nitrazepam tablets. He took his own discharge against advice two days later, 22nd June 1999.

On 14th December 2000 Mr LM was again admitted to Ashford hospital complaining of feeling depressed and suicidal. He is reported as having injected heroin for several months and continuing with his prescribed medication. He did not disclose his forensic history to the hospital staff. Whilst an inpatient his treatment remained unchanged. Five days later he was discharged back into the community and once again the discharge diagnosis was given as Schizophrenia, drug and alcohol dependence. Depot medication continued.

On 18th October 2001 Mr LM was reported, in a letter written by his CPN, as having stabbed a flatmate in the stomach (the injury was not life threatening). He was arrested and charged.

In April 2002 he was admitted to Ashford hospital after a psychotic breakdown suffering from paranoid delusions, auditory hallucinations and describing the TV talking about him. This admission lasted for six weeks (discharged 6th June 2002). At this time he was referred to the substance misuse services and a CPA review meeting was held.

Whilst in the community Mr LM became non-compliant with his depot medication and started to have problems with his accommodation, being placed in a number of different short term placements. The substance misuse team were seeing him during this period but he continued to use amphetamines.

On Boxing Day 2002, Mr LM was admitted to a medical ward at West Middlesex Hospital following an overdose of Paracetamol and assessed under the Mental Health Act (MHA) but found not to be detainable. Ashford hospital were contacted in regard to his previous history. The assessing doctors were wrongly informed by Ashford Hospital staff that Mr LM's diagnosis was personality disorder and poly substance abuse and that there had been no clear evidence of psychosis or mood disorder. This may have influenced the decision not to detain him under the MHA. He was discharged back to the community remaining on his depot medication.

On the 8th May 2003 a letter from his care coordinator to the team set out potential risks to the staff describing his forensic history.

Twenty two days later, 30th May 2003, Mr LM was admitted to West Middlesex hospital with relapse of psychotic symptoms following non-compliance with medication. He was describing noises coming at him from the TV at 40 mph making fun of him. He remained in hospital until 28th November 2003. The discharge summary states that Mr LM's legal status was detention under Section 3 MHA but this is not stated in the notes and the scrutiny team assumed that this is an error. Had Mr LM been admitted under Section 3 MHA this would have resulted in Section 117 MHA responsibilities. A CT scan taken during the admission shows cerebral and cortical atrophy with clinical findings of poor short term and long term memory. At the time of admission Mr LM was homeless. On discharge Mr LM was placed for a six month trial in a residential hostel (where the incident later occurred).

The undated transfer summary from hospital describes an earlier prison sentence for Grievous Bodily Harm but does not mention the stabbing of a flatmate nor chasing his mother with a knife. The scrutiny team were unsure if this summary related to the time of his discharge from hospital or later following the six week hostel placement trial. His medication regime was to continue with depot medication together with Chlorpromazine 10 mgs twice daily, Diazapam 2.5 mgs three times daily, Venlafaxin 75 mgs daily and Nitrazepam 5 mgs at night.

In March 2004 whilst living in the hostel Mr LM started to take heroin again. At this time his care was transferred to another Consultant Psychiatrist as he was living out of the previous team's catchment area in the hostel. A handover letter dated 20th April 2004 did not mention his forensic history. Mr LM was allocated to a CPN in the new team and was seen regularly by both the CPN and Staff Grade psychiatrist.

By November 2004 Mr LM's behaviour had deteriorated at the hostel and he was issued with a written warning regarding verbal abuse towards the staff and other residents and he was monopolising the television and playing loud music at night. In April 2005 he was sent a second written warning, this time regarding lighting a candle in his room which activated the fire alarm and burning a hole in a lounge chair. He also was reported as having kicked a door causing damage.

Over the next four months he continued to be threatening and his behaviour disruptive. In June 2005 Mr LM was sent a written warning about his behaviour in a community meeting when he had become threatening, shouting and intimidating staff.

At this time, in a discussion with the Staff Grade doctor he refused to take his antipsychotic medication as he thought that this was causing abnormal liver function tests. However he did agree to take oral amisulpride for a month.

On 1st August 2005 Mr LM cut his neck with a razor blade during the night and was treated in A & E at Charing Cross hospital.

On 4th August 2005 it was decided to admit him to hospital for assessment. It is uncertain as to how long this admission was but on 2nd September 2005 he was readmitted due to concerns about his level of suicidal ideation. Following a CPA review he was discharged from hospital on 20th September 2005**.**

During this period because of his difficult behaviour, the hostel staff prepared a list of the problems they were experiencing with Mr LM and on 21st October 2005 he was placed on a six week trial period.

In early December 2005 he returned to the hostel intoxicated and the manager informed his CPN that as a result of his intimidating and aggressive behaviour they intended to terminate his tenancy at the end of December. Due to this being the Christmas period his notice period was extended until the end of January 2006 at the request of the CMHT.

On 3rd January 2006 Mr LM's case was referred to the Mental Health Housing and Support Panel by his CPN seeking an alternative placement.

Disturbances took place at the hostel on 10th-11th January 2006 between one member of staff and Mr LM in front of the other residents and staff. Mr LM's CPN made a complaint to the hostel managers about the member of staff.

Mr LM was referred to the Home Treatment Team (HTT) by his CPN for more support and proactive interventions within the hostel and was accepted by them on 12th January 2006. He was seen by the HTT and a CPA review took place on 20th January 2006

On 4th February 2006 Mr LM was arrested and charged with the murder of another resident at the hostel.

7. Consideration of the Internal Review Report

The following comments relate to the internal review report which was completed by the Trust and covers the report layout as well as content. It has been set out in accordance with the first part of the scrutiny team's Terms of Reference.

7.1 Internal Review Report – Process Comments

Overall the scrutiny team found that the report was robust, well written and showed a good analysis of the issues identified. It was extremely detailed and worked to agreed Terms of Reference that were appropriate for the case under consideration.

A detailed methodology was set out as an Appendix after the main body of the internal review report. It gave details of the documentation seen, described a systematic review of the notes and the report contained comprehensive quotes from those notes within the chronology of events. It largely followed the Root Cause Analysis methodology and it was considered by the scrutiny team that the evidence seen was relevant and enabled the internal review to fully assess the care and treatment provided to Mr LM.

There was a list of the witnesses interviewed although it was unclear as to whether transcripts of the interviews were made or statements provided by the witnesses. No transcripts or statements were provided to the scrutiny team and it has to be assumed that these did not exist.

The composition of the panel with two independent members, two non executive directors, the relevant service manager and chaired by an associate director of the Trust is commended and in accordance with good practice. It included a substance misuse professional and met the requirements in particular, of Mr LM's long standing substance misuse. The panel membership reflects the multi-disciplinary organisational connection with Mr LM.

The report states that both families were contacted and that there were plans to provide an outcome report to them if they wished to have the opportunity to discuss the internal review's findings. There were no details as to how this contact was made with the victim's family although there are details regarding a meeting with Mr LM's mother.

The internal review commented specifically on the issue of adherence to local policies and provides evidence to support the conclusion that there was no breach in compliance with these by Mr LM's care team.

7.2 Internal Review Report – General Comments

The scrutiny team considered how well the internal review panel examined and commented on the evidence provided to them. In view of the actions taken by Mr LM, when the victim died, one of the main areas for consideration was risk to others and himself. The internal review panel did enter into a broader discussion in their report as to whether or not the events of the incident could have been foreseen and therefore prevented. This included a consideration of broader themes than solely defined by their Terms of Reference.

There was specific mention in the report of Mr LM's forensic history and past violence which was not always available in the written documentation completed by the mental health services, nor considered in risk assessments undertaken by the services on Mr LM. The internal review concludes that Mr LM's history of violence was not an immediate indicator of the incident in 2006, and therefore not predictable.

The scrutiny team concurs with the view that Mr LM's history of violence was not an indicator of the incident but does wish to highlight the importance of forensic history and serious violence being included in summaries of care. This relates particularly to times of the transfer of care. In Mr LM's case there were transfers of care between three Consultant Psychiatrists in the period between May 2003 and May 2004.

In our view the history of psychotic presentations and violence became less prominent over time and was therefore considered less when issues of diagnosis and appropriateness of medication were in question. At various stages there were omissions in detailing past violence and forensic history.

Mr LM's treatment history of medication and concordance with this was described and commented upon in the internal review report. His non compliance was a frequent management problem for the mental health services and both the report and the scrutiny team's consideration indicates the frequent reviews and Care Programme Approach meetings that were held to try and deal with the problem. We agree with the internal review's report's commendations regarding the persistence undertaken by the mental health services to ensure that Mr LM took his medication.

As indicated in the Case Outline and full Chronology of Events Mr LM had a significant substance misuse problem. This was identified and discussed in the main body of the internal review report. It concluded that the liaison between the Community Mental Health Team (CMHT) and Substance Misuse Services was an example of good practice and the scrutiny team wishes to endorse this conclusion.

Although not set out under a separate heading, issues relating to the Mental Health Act and Community Care assessments are discussed. The internal review does not suggest any failure to comply with statuary obligations.

The internal review report discusses the extent to which care plans were adequate and specifically questions Mr LM's placement in the hostel. This includes the question of placing someone with Mr LM's complex needs compared with the availability of suitable accommodation. Recommendations were made in reference to a High Resource Placement Panel which operated between the agencies involved in placing service users into suitable hostels. Further recommendations relate to the hostel's operational policies and rehabilitation services.

Although the internal review does discuss some issues relating to aspects of risk assessment and staff training it does not specifically address the question of training for risk assessment and management.

8. Scrutiny Team Findings and Recommendations

The scrutiny team found that the internal review report was a well prepared balanced review of the care and treatment provided to Mr LM. It addresses the majority of the issues that the scrutiny team identified through its overview. The findings and recommendations were appropriate and the Trust have progressed and implemented their action plan.

In particular the scrutiny team wish to commend the areas of good practice found by the internal review by those providing care to Mr LM.

8.1 Positive Factors

On examination of Mr LM's case records there were areas of good practice.

- Liaison between the CMHT and Substance Misuse Service
- Compliance with local policies
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- Regular care planning meetings and multi-disciplinary reviews of Mr LM's care
- Regular liaison by the CPN during 2005-2006 with the psychiatrist, hostel staff and other related services.

8.2 Scrutiny Team Independent Findings

The scrutiny team commends the report completed by the internal review for its thoroughness and content. There were, however, a few areas that we feel were not given enough prominence in their report.

We would comment that Mr LM's lengthy forensic history was not fully explored by the mental health services and there were often omissions in sharing key information. This was a particular issue as the hostel were not aware of Mr LM's past violence and two separate incidents with a knife when he chased his mother, and stabbed a flatmate in the stomach. This information would have informed his care plan and future risk assessments. The hostel was not designated "High Support" but perceived so by the mental health team as providing high support to the residents including Mr LM. This led the team to believe there was a level of support of expertise and care which in fact the hostel could not provide.

At the time of Mr LM's placement in the hostel he had had a CT scan which showed Cerebral and Cortical Atrophy affecting his short and long term memory. It has to be considered that this was a man with some cognitive impairments, a history of mental illness and substance misuse who was homeless and isolated

from his family. It is possible that his cognitive difficulties contributed to his failure to keep to agreed plans.

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The CMHT did recognise the situation and referred Mr LM to the HTT. They also recognised the significant social pressures that he was experiencing but we were unclear as to whether they did consider that he might have been experiencing psychotic symptoms. An admission to hospital was arranged to assess Mr LM's mental state but it is unclear as to the outcome.

During the period of Mr LM's contact with the psychiatric services there were several occasions when drug induced psychosis was diagnosed but the scrutiny team found no evidence of any drug screening tests having been taken on his admissions to hospital. The scrutiny team questioned the Trust in regards to the availability of drug screening kits on the wards and were assured that these were available and used as necessary.

The scrutiny team considered the possible significance of Mr LM ceasing to take his depot medication in June 2005. In their view it is unclear as to whether the team looking after Mr LM at the time took into account the possibility of a psychotic relapse as a consequence of stopping the depot medication.

8.2.1 Issues addressed at the Trust Workshop with the Scrutiny Team

Family Contact

The Trust have developed a Protocol for families and relations of victims and perpetrators which sets out the contact to be made with them. It is implemented and the current internal reviews adhere to this.

Internal Review Panels

Internal investigations undertaken by the Trust currently include independent panel members from outside the Trust.

Case Records

Case records are now held centrally and not separately as at the time of Mr LM's care and treatment.

Substance Misuse

The scrutiny team were informed that drug induced psychosis was not a diagnostic category now used by the Trust.

We were assured that drug screening tests are readily available to Trust staff for use on all inpatients. A Dual Diagnosis Policy has been developed and implemented across the Trust's inpatient services. It has been found to be more difficult to implement the policy in the community and more work is in progress. The policy does contain a section on how staff should act if drugs are found on the premises. The Trust also have a half time police officer on the site at St Bernard's hospital.

Disseminating the Lessons learnt from Reviews and Investigations

The Trust has a Trust wide Incident Review Group which meets on a regular basis. In addition a newsletter "Risky Business" is distributed across the Trust's services. A bi-annual Trust wide review on individual reports takes place to inform the staffing teams involved.

An overarching database of incidents is regularly reported to the Trust Board.

Residential Placement Panel

The Residential Placement Panel is now annexed to the Police Liaison meeting. The highest risk patients would have had a completed HCR20 assessment undertaken and any risks to themselves or others identified. The panel also takes in the opinion of the multidisciplinary team currently working with the individual requiring a placement as well as a full risk assessment.

8.3 Scrutiny Team Recommendations

The scrutiny team make the following recommendations and ask that the West London Mental Health NHS Trust implement these.

Recommendation One - Criminal Records

It was found that the criminal records relating to Mr LM were not readily available or known by the care teams involved in his treatment. It is recommended that when an individual is admitted via the police that information regarding criminal activity is requested by the admitting team. To facilitate this it is further recommended that a joint protocol between the police and Trust be developed.

Recommendation Two - Summary Sheet

In Mr LM's case there were found to be omissions and misinformation relating to his clinical and forensic history. It is recommended that a summary sheet is

developed to be sited at the front of patients' records and updated on a regular basis. This should include:

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

Recommendation Three – Interview Process

In accordance with best practice and to ensure that staff have the opportunity to check that the evidence they have given to internal reviews is accurate and reflects the issues that they wish to raise it is recommended that all interviews undertaken for internal reviews are recorded and transcribed.

Scrutiny Template

Appendix One

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

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

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

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

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

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

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

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

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

Chronology of Events Appendix Two

1980	Mr LM's first apparent contact with services for drug addiction. No further details are known.
11.02.86	Seen by Dr B, a Consultant Psychiatrist from Ashford Hospital, following a referral from Mr LM's GP. He had apparently become "delirious and taken over by the Devil". His wife reported that his personality had recently changed and he was taking illegal drugs again. In view of his use of amphetamines he was referred to a substance misuse consultant.
24.04.87	Mr LM was seen in outpatients at Ashford Hospital. Diagnosed as being a chronic drug abuser.
12.05.87	A request was made to the Trust for a court report, but the offence is not detailed.
1988	Mr LM separated from his wife of 17 years.
24.09.90	Request for court report made, Mr LM had been charged with criminal damage and breach of conditional discharge. A Probation report in his notes describes what appear to be delusional symptoms and gives an account of his previous convictions.
1990	Mr LM suffered a head injury through head butting a door and jumping through windows in a stranger's house. He reports having suffered with severe headaches since that time.
1992	Mr LM and his wife divorced.
11.03.92	Admitted to West Middlesex Hospital with an acute psychotic episode that was either drug induced or due to Bipolar Affective Disorder. He was treated with Haloperidol. At presentation Mr LM would not give any details of his past psychiatric history. As a result the staff at the hospital were not aware of his psychiatric history at Ashford hospital. Mr LM assessed and detained under Section 2 MHA. Arrested for breaking into a house by smashing windows and trying to strangle a female at the house. Admitted to Ashford hospital for 8 days.
19.03.92	Discharged from hospital.
24.08.92	Mr LM allegedly chased his mother down the street with a knife. He was taken to Ashford Hospital A&E department by the police. He had told his mother he was hearing voices in his head and that he was sorry but he had to kill her. He tried to attack police with broken glass. He told the psychiatric duty doctor he wanted to die. He denied hearing voices when the doctor asked him but the doctor witnessed him appearing to respond to a voice which the patient thought was coming from the next room and was talking about him. Mr LM was

diagnosed as suffering from a probable drug induced psychosis but there was no evidence of a drug screen having been performed.

26.4.93 Mr LM admitted to Ashford Hospital after a psychotic episode after taking amphetamines. Diagnosed with Drug-induced Psychosis, Personality disorder and Alcohol Abuse. Started on Clopixol 500 mgs, 2 weekly and Diothiepin.

04.06.93 Discharged to the community on depot medication.

27.04.98 Mr LM admitted to Ashford hospital under Dr (1) and diagnosed as suffering from schizophrenia. Depot medication continued, Clopixol changed to Trazodone. The results of a drug screen from 28th April 1998 was positive for Benzodiazepines and Cannabis but negative for all other non prescribed drugs.

15.05.98 Discharged to the community under Dr (1), medication regime maintained. Discharge diagnosis given as Schizophrenia, drug and alcohol dependence.

20.06.99 Admitted to Ashford under Dr (1) following overdose of 112 Nitrazepam tablets. Discharged himself against advice on 22nd June 1999.

14.12.00 Admitted to Ashford Hospital under Dr (1) after complaining of feeling depressed and suicidal. Had been injecting Heroin for several months. Taking Clopixol IM and oral Venlafaxine. Mr LM did not disclose his forensic history. Treatment remained the same.

19.12.00 Discharged back into the community. Discharge diagnosis given as Schizophrenia, drug and alcohol dependence.

18.10.01 Allegedly stabbed a person (flatmate) in the stomach. Letter from CPN dated 24th October 2001 confirming knife incident and arrest. Due in court 2nd November 2001.

27.04.02 Admitted to Ashford Hospital under Dr(1) after a psychotic breakdown. At time of admission paranoid delusions, auditory hallucinations, describes T.V. talking about him. Referred to the substance misuse services.

05.06.02 CPA meeting.

06.06.02 Discharged to the community but became non-compliant with his depot medication. Also started to have problems with his accommodation and was placed in a number of different short term placements.

October 2002 Being seen by substance misuse team. On Subutex, still using Amphetamines.

26.12.02 Admitted to medical word at West Middlesex hospital following overdose of Paracetamol. Assessed under the MHA but not detained. Assessment included a discussion with ward staff at Ashford Hospital. The assessing doctors were told the diagnosis was Personality Disorder, Poly Substance Abuse and in addition were told there had been no clear evidence of psychosis or mood disorder.

08.05.03 Letter from Mr LM's Care Coordinator regarding risks to staff and describing his forensic history.

30.05.03 Admitted to West Middlesex Hospital – non-compliance with medication and had relapsed – schizophrenia. Described noises coming at him from T.V. at 40 mph and T.V. making fun of him. Discharge summary (dated 2nd January 2004) gives admission date as 30th May 2003 and discharge date as 28th November 2003. Also gives legal status as Section 3 MHA but this is not commented on in the rest of the notes and is presumable an error in the summary. Mr LM was homeless at this time.

24.10.03 Letter describing results of C.T. Head Scan showing cerebral and cortical atrophy. Also describes clinical findings of "poor short term and long term memory"

28.11.03 Mr LM placed in Garthown residential hostel. Undated, but presumably contemporary, transfer summary describes prison sentence for GBH but no mention of stabbing or chasing mother with knife.

Discharged from West Middlesex Hospital to Garthowen residential hostel home following a 6 week trial period.

Moved to Garthown Residential hostel for a 6 week trial. Medication Clopixol 400 mgs 2 weekly. Chlorpromazine 10mgs bd, diazepam 2.5 mgs tds, venlafaxin 75 mgs od, procyclidine 5 mgs bd and nitrazepam 5mgs nocte.

March 04 Started to refuse his depot medication but took Clopixol 100mgs, 3 weekly.

March 04 Started to take heroin again.

20.04.04 Letter from consultant 2 to consultant 3 asking him to take over care of Mr LM as he was now living in consultant 3's area. No mention of forensic history in letter.

21.05.04 Transfer CPA to new team.

Nov 04 His behaviour had deteriorated and he was sent a written warning about verbal abuse towards staff and patients at his hostel, monopolising the television and playing loud music at night.

April 05 Mr LM was sent a written warning about lighting a candle in his room and going to sleep with it still burning causing the fire alarm to be activated. He had also burned a hole in a chair in the lounge with a cigarette and kicked a door causing damage.

June 05 He was sent a written warning about his behaviour in a community meeting, being threatening, shouting and intimidating staff.

July 05 He refused to take his antipsychotic medication as he thought that this was causing abnormal liver function tests. He did agree to take amisulpride for a month.

01.08.05	Mr LM cut his neck with a razor blade during the night and was taken to Charring Cross Hospital where he was medically treated in A&E and sent home to hostel.
04.08.05	Following intensive liaison between the CPN Care Coordinator and Hostel Staff Mr LM was assessed by the team doctor and arrangements were made for his admission to hospital. Uncertain how long he remained in hospital on this occasion
02.09.05	Admitted to ward because of concerns about level of his suicidal ideation.
19.09.05	CPA meeting on ward. Discharge arranged for 20th September 2005.
21.09.05	Visited at hostel by CPN who was informed that Mr LM had been drinking on night of discharge.
19.09 to 09.10.05	Staff at hostel prepared a list of problems with Mr LM at the hostel and wrote to psychiatric team.
21.10.05	CPA review, Mr LM appeared more settled having been placed on a 6 week trial of behaviour at the hostel. That evening he returned to the hostel intoxicated.
04.12.05	Letter from manager at hostel letting CPN know that as a result of aggressive and intimidating behaviour the hostel intended to terminate Mr LM's tendency on the 29th December 2005.
19.12.05	Letter from hostel care worker to CPN saying date for Mr LM to leave hostel has been postponed until end of January because of Christmas period.
03.01.06	Referral to Mental Health Housing and Support Panel by CPN.
10 01.06	10th and 11th January disturbance at hostel with one of the members of staff shouting at colleagues and Mr LM in front of other residents. This leads to a complaint to the hostel management.
12.01.06	Mr LM accepted for treatment with Home Treatment Team.
?20.01.06	DICES Risk Management Plan Dated January 2006 and probably completed for the CPA on the 20th January. Main risks identified relate to Mr LM's thoughts of suicide.
4.02.06	Mr RD (62 yrs) died of multiple stab wounds in the hostel.
	LM arrested on suspicion of murder by police.
	The police called to the hostel after a report of a man having been stabbed. Mr RB was found in the lounge with stab wounds to his chest. He was not breathing. He was pronounced dead at the scene. LM was arrested for murder.

Forensic History

Appendix Three

Date	Offence	Sentence
07.03.69	Housebreaking and stealing.	Probation order, 2 years discharged on 14.04.69. Restitution £50
14.04.69	1. Taking conveyance without authority. 2. No insurance. 3. Driving whilst disqualified by reasons of age. 4. Theft	1-3 Probation order, 3 years. Driving licence endorsed. 4. Probation Order 3 years, concurrent.
19.06.69	1. Taking conveyance without authority. 2. Driving whilst disqualified. 3. Theft 4. Breach of Probation Order.	1. Borstal Training Driving licence endorsed. 2. Borstal Training. 3. Disqualified from driving 12 months and licence endorsed consecutive to present disqualification. 4. Borstal Training.
18.02.71	Burglary.	Borstal Training.
19.02.71	1. Taking conveyance without authority. 2. Driving whilst disqualified.	1-2. Borstal Training disqualification from driving 2 years and licence endorsed.
04.03.71	Possessing offensive weapon in public place.	Fine £1 or one day imprisonment (served)
10.08.73	1. Possessing offensive weapon in public place. 2. Minor Road Traffic Offence. 3. No insurance. 4. Minor Road Traffic Offence.	1. Fine £4 2. Fine £4 3. Fine £7 Driving licence endorsed. 4. Fine £3 Driving licence endorsed.
18.03.75	1. Taking conveyance. 2. Driving without due care and attention. 3. No insurance.	1. Imprisonment 6 months wholly suspended. 2 years disqualification from driving 18 months consecutive. 2. Fine £75 Driving licence endorsed.

	4. No driving licence.	3. Fine £50 Driving licence endorsed. 4. Fine £10 Driving licence endorsed.
16.09.75	1. Criminal Damage 2. Breach of suspended sentence.	1. Imprisonment 1 month. 2. Imprisonment 6 months concurrent resulting from original conviction of 18.03.75.
22.09.75	Taking conveyance (a boat) without authority.	Imprisonment 3 months wholly suspended 2 years.
27.02.77	1. ABH 2. Criminal Damage.	1. Fine £50. 2. Probation Order 1 year. Restitution £66.92.
20.06.77	Breach of Probation Order.	Fine £5 resulting from original conviction of 27.02.77.
09.05.78	Possessing controlled drug. Possessing controlled drug.	Each offence £50.
09.05.78	Possessing controlled drug. Possessing controlled drug.	Each offence £50.
18.12.78	1. Wounding (Section 20). 2. Possessing offensive weapon in public place.	1. Imprisonment 18 months wholly suspended 2 years Supervision Order 12 months. 2. Imprisonment 12 months concurrent, wholly suspended 2 years.
10.05.79	1. Failing to surrender to bail. 2. Criminal Damage. 3. Breach of suspended sentence.	1. Fine £10 2. Fine £25 Compensation £30 3. No separate penalty resulting from conviction of 18.12.78.
10.07.80	1. Burglary and theft (dwelling). 2. Reckless driving. 3. Breach of suspended sentence.	1. Imprisonment 2 years. 2. Imprisonment 3 months consecutive. 3. Imprisonment 12 months consecutive resulting from original conviction of 18.12.78.
10.06.85	1. Criminal Damage.	1. Compensation £10 conditional discharge 12 months.

	2. Common assault on adult. 3. Common assault. 4. Common assault.	2. Conditional Discharge 12 months. 3. Conditional Discharge 12 months. 4. Conditional Discharge 12 months, cost £57.20.
14.10.85	1. Driving whilst disqualified. 2. No insurance.	1. Fine £150 driving licence endorsed. 2. Fine £75 driving licence endorsed.
06.07.87	1. Attempt/burglary with intent to steal (non-dwelling). 2. Attempt/burglary with intent to steal (non-dwelling)	1. Imprisonment 3 months wholly suspended 2 years. Compensation £24.95. 2. Imprisonment 3 months concurrent, wholly suspended 2 years. Compensation £20, costs £35.
08.12.88	ABH	Fine £50, compensation £50, costs £20.
03.04.89	ABH	Compensation £150, costs £75.
10.07.89	Criminal Damage	£100.
06.02.90	ABH	Fine £150 Compensation £50 Costs £20
30.10.90	1. Criminal Damage. 2. ABH 3. Criminal Damage 4. Criminal Damage	1. Conditional Discharge. 2. Imprisonment 6 months wholly suspended 2 years. 3. Conditional Discharge 1 year 4. Conditional Discharge 1 year
04.12.90	1. Criminal Damage 2. Breach of suspended sentence 3. Breach of conditional discharge	1. Imprisonment 7 days. 2. Imprisonment 6 months consecutive resulting from original conviction of 20.10.90. 3. Imprisonment 7 days concurrent on each charge resulting from original conviction of 20.10.90.
26.02.99	Possessing controlled drug – class B – amphetamine.	Fine £50 costs £40

27.07.01	Taking motor vehicle without consent.	Fine £100 costs £55
03.05.03	Destroy or damage property (value of £5000 or less)	Fine £60