Independent Scrutiny and Investigation into the care and treatment of

Mr ME

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.

Mr ME did not feel able to consent to the scrutiny team having access to his case records. They therefore wish to thank the Trust's Caldicott Guardian authorising access to his records for the purpose of this scrutiny and the East London NHS Foundation Trust for providing those records in a timely manner.

We are grateful to the Trust's Chief Executive, Acting Director of Nursing and Associate Director of Governance for taking the time to meet with the scrutiny team to discuss the issues raised within the information examined by them.

Executive Summary

Introduction

On 20th December 2005 Mr ME was arrested and charged with the murder of a drinking associate. Mr ME, who was with his brother and the victim, (a distant relative), demanded money from the victim to buy drugs. When the victim refused Mr ME kicked him in the head and stabbed him in the neck. He threatened his brother with violence if he intervened. Mr ME was receiving mental health services from the East London NHS Foundation Trust at this time.

The incident was reported to the Trust in June 2006 and the investigation completed in August 2006. The internal review was conducted by two members of the Trust.

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 ME's care and treatment.

The scrutiny was divided into two parts, a detailed analysis of the internal review and Mr ME'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

The following outline is based on the accounts of Mr ME as recorded in the notes.

Mr ME, one of three children, was born on 15th March 1970. At the age of three years he was separated from his brothers and placed in a foster home. He was returned to his mother aged 11 years for one year and then adopted. It is reported that Mr ME left school aged 13 years and completed a bricklaying course. He then became a long distance lorry driver in Russia from 1991-1992.

He was known to be dependent upon alcohol and drugs and that he spent three years in a French prison for smuggling drugs in 2000.

A girlfriend in Russia died of an overdose and he is noted as stating that his life changed for the worse from that time.

Contact with Psychiatric Services.

Mr ME first came into contact with local mental health services when he presented at A & E, Newham General hospital on 7th July 1998 having taken an overdose. There was some contact during this period with the Community Mental Health Team (CMHT) but it is unclear as to how or when this contact was established. He was next admitted to East Ham Memorial hospital having been referred by the CMHT for a period of two months in 1999. He was diagnosed with depression and post traumatic stress disorder (PTSD). Mr ME reported having witnessed violent incidents during the coup in Russia which included the shooting of children. At this time (February 1999) he had been unemployed for nine months and also was experiencing housing and financial difficulties.

Whilst an inpatient it was reported that he continued to abuse alcohol and four incidents of violence occurred during this admission, three towards others and one self harm.

On 6th April 1999 he was discharged to the care of the CMHT and was to be seen by the Homeless Outreach Support Team and a Post Traumatic Stress Disorder Counsellor. His diagnosis on discharge was PTSD.

Mr ME's GP referred him to the mental health services on 20th September 2002. he had reported being depressed following his release from prison in France. He did not attend the outpatients appointment arranged for November.

In January 2003 Mr ME's GP once again referred him to the mental health services outpatients' clinic and he was seen on 18th February 2003 for an initial assessment by an Associate Specialist Psychiatrist.

A trainee Clinical Psychologist assessed Mr ME on 17th June 2003 and identified that he would benefit from psychotherapy. He failed to attend two further sessions to complete his assessment and was discharged from the service.

No further contact with Mr ME was recorded until September 2004 when he presented at Newham General hospital's A & E department reporting that he was at the end of his tether. He expressed suicidal thoughts, was drinking heavily and taking cocaine. He was admitted to a psychiatric ward but took his own discharge the following day.

The following month, October 2004, Mr ME was admitted to Newham General hospital because of alcohol intoxication, abuse of cocaine and overdosing on his mother's medication which contained Warfarin, an anti blood clotting medication.

On 2nd November 2004 Mr ME was seen by his consultant psychiatrist in outpatients. He reported having stopped taking drugs and alcohol. No psychopathological symptoms were identified. The consultant wrote a letter to Mr ME's GP stressing that his problems were due to life events and not mental illness. He was discharged from the mental health services caseload with a plan to receive counselling via his GP practice. He subsequently refused to attend this counselling.

In March 2005 (2nd), Mr ME again presented at A & E with suicidal and homicidal thoughts. He claimed that he would kill someone if he was not helped. He was not eating or sleeping, using 1 gram of cocaine and drinking eight cans of lager a day. He was given a letter of referral for the Drug and Alcohol service as they felt he was not suitable for an inpatient admission..

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On 9th November 2005 an SHO saw Mr ME in outpatients. He was accompanied by his mother who described him as becoming verbally abusive and very aggressive when he was having panic attacks. These were occurring on a daily basis. He also was drinking heavily and was referred to the Drug and Alcohol service. A follow up appointment was arranged for two months time. A letter from the SHO to Mr ME's GP suggests that his personal history had not been reviewed as the SHO states that Mr ME had "no siblings". The doctor suggested that his outbursts of anger were more related to his drinking with resultant paranoia rather than panic attacks. "Attacks only happen when drunk".

On 20th December 2005 Mr ME was arrested and charged with murder.

Scrutiny Team Findings and Recommendations

The scrutiny found that the internal review report did not provide an in-depth structured review of the care and treatment provided to Mr ME. It addresses some of the issues that the scrutiny team identified through its review of the available data but the internal review's findings and recommendations did not systematically deal with all of the issues arising from its Terms of Reference.

Scrutiny Team Independent Findings

The scrutiny team considers that the Trust's response to the incident was not timely nor did it reflect good practice. The investigation commenced after the

Trust were informed of the incident in June 2006 and completed in August 2006. The internal review report did not make any recommendations with regard to how similar incidents should be dealt with in the future. The scrutiny team would wish to stress the need for the Trust to ensure future internal reviews are produced within an acceptable timeframe and that such reviews are designed to be useful to improve Trust services.

It was unclear whether the Trust considered that this incident would be further investigated under the auspices of HSG (94) 27 and there was no evidence to suggest that this had been acted upon.

The scrutiny team found that there had not been any contact with the families of either the victim or Mr ME and this issue was not sufficiently addressed in the internal review report. National guidance recommends that families are contacted and involved with investigations both internal and independent.

The history contained in Mr ME's notes suggests an unhappy extremely difficult childhood and adulthood, which obviously left him vulnerable and disturbed. Although he saw a PTSD counsellor he did not take the opportunity to participate in the sessions on offer. This was not further explored nor was additional help offered at times when he was engaging with services. His only other firm diagnosis was mild depression and it was thought that this might have been attributable to his adverse life events.

The scrutiny team were unable to find any evidence to suggest that the team caring for Mr ME had considered the possibility of an underlying personality difficulty. Mr ME's presentations in crisis, the range of psychological difficulties he experienced, his disrupted early history, use of drugs and alcohol and disturbed relationships all point to the possibility of an unstable personality disorder.

One consequence of not considering an underlying personality disorder was that each presentation was considered in isolation.

The scrutiny team were unable to find evidence of a formal risk assessment since his admission in 1999. Suicidal ideation was considered during his presentation to A & E and in outpatients. During his assessment in the clinic on 9th November 2005 this was also the case and he was described as not suicidal. Despite his mother giving a history of violence particularly when her son had been drinking Mr ME's risk to others did not appear to have been considered. There was no evidence that Mr ME's mother was seen as a carer and the episode in November 2005 was the first mention of her having been involved in her son's care. No one identified the risk that he posed to her.

Issues addressed at the Trust Workshop with the Scrutiny Team

Progress made against the Internal Review Action Plan

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A Psychological Trauma Unit which provides a Post Traumatic Stress Disorder service has now established by the Trust and individuals such as Mr ME would receive a service from this unit.

Personality Disorder Services

Personality Disorder services are provided across the Trust in all localities except Newham currently.

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Assessments of new patients is now undertaken by a Triage team and a panel decides which clinicians is the most appropriate to undertake the first assessment of the individual.

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

Housing requirements

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Scrutiny Team Recommendations

Investigations of Serious Untoward Incidents

The scrutiny team were informed by the Trust that they do now undertake robust investigations into serious untoward incidents on a case by case basis. and it was indicated that staff being interviewed were able to respond to written notes of that interview. The scrutiny team make the following recommendation.

Recommendation One

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. These transcripts should not be included in the internal review reports, however they should be kept securely and made available to any subsequent independent investigation.

Information Sharing

There was evidence that Mr ME's past history was not always shared and formulated.

Recommendation Two - Summary Sheet

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 with a detailed history of all violent incidents and any link to abnormal mental state
- 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

Alcohol Services

Recommendation Three - Alcohol Services

It is recommended that the Trust follow through their ambition to provide Alcohol services in-house.

Care Programme Approach

Mr ME was considered to meet the criteria for Level 1 CPA, in practice there was no evidence that any CPA process was followed.

Recommendation Four

It is recommended that the Trust receive evidence of the actual practice of CPA within clinical settings through regular audit. These audits should specifically include risk assessment, the use of risk management plans and evidence of the support given to carers.

Personality Disorder

Mr ME's history and presentation were consistent with a possible diagnosis of Personality Disorder but this was not considered by the clinical team caring for him.

Recommendation Five

It is recommended that Newham locality is included in the Personality Disorder services provided by the Trust.

Recommendation Six

It is recommended that clinical staff should have access to training in the management of personality disorders. This training should include diagnosis and management strategies for working with patients with personality disorders within their services

1. Introduction

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

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

2. Terms of Reference

Part One - Internal Review

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

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

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

To compile a chronology of events.

Part Two

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

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

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

3. Purpose of the Scrutiny Investigation

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

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

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

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

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

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

4. Methodology

It was agreed at the start of the scrutiny that the team would examine the internal review undertaken by the Trust setting out its findings in regard to the process undertaken and the Trust's progress against their internal review's findings and recommendations. In addition the scrutiny team was to undertake a detailed analysis of Mr ME's case records completed by the Trust's staff prior to the death of the victim. Mr ME did not consent to access to these records, however the Trust's Caldicott Guardian did authorise access to the records.

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

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

It was agreed that no interviews would take place, however it was planned to hold a workshop with the Trust to discuss the issues raised by the scrutiny team following their review of the documentation. A letter inviting the Trust to attend the workshop that also identified the areas for discussion was sent to the Trust's Chief Executive. The Trust's Chief Executive, Acting Director of Nursing and Associate Director of Governance attended the workshop held on 11th May 2010 and the scrutiny team were informed of the progress made against the recommendations from the internal review.

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

This report has been drafted to include an analysis of the Trust's internal review, a brief history of Mr ME and a detailed consideration of the care and treatment provided to him by the Trust. It includes the scrutiny team's findings and recommendations of the areas that may need further exploration to ensure processes are put into place to reduce the likelihood of similar incidents to state that incidents like this will never happen again. 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.

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 outline is based on the accounts of Mr ME as recorded in the notes.

The following is a case outline of the events that relate to Mr ME and his care and treatment. It has been compiled from the records available to the scrutiny team. A fuller chronology can be found at Appendix Two that does reflect the extent of the records provided to the scrutiny team.

6.1 Background

Mr ME, one of three children, was born on 15th March 1970. At the age of three years he was separated from his brothers and placed in a foster home. He was returned to his mother aged 11 years for one year and then adopted. It is reported that Mr ME left school aged 13 years and completed a bricklaying course. He then became a long distance lorry driver in Russia from 1991-1992.

He was known to be dependent upon alcohol and drugs and it is reported that he spent three years in a French prison for smuggling drugs in 2000.

A girlfriend in Russia died of an overdose and he is noted as stating that his life changed for the worse from that time.

6.2 Contact with Psychiatric Services.

Mr ME first came into contact with local mental health services when he presented at A & E, Newham General hospital on 7th July 1998 having taken an overdose. There was some contact during this period with the Community Mental Health Team (CMHT) but it is unclear as to how or when this contact was established. However as a result of a referral from the CMHT he was admitted to East Ham Memorial hospital for a period of two months in 1999. He was diagnosed with depression and post traumatic stress disorder (PTSD). Mr ME reported having witnessed violent incidents during the coup in Russia which included the shooting of children. At this time (February 1999) he had been unemployed for nine months and also was experiencing housing and financial difficulties.

Whilst an inpatient it was reported that he continued to abuse alcohol and following one incident had to be sedated as he started punching doors in the hospital. A second incident took place during this admission when he became involved in a fracas with three youths visiting another patient. Mr ME was cautioned by the police.

On 20th March 1999, whilst still an inpatient Mr ME cut his forearm with a razor blade. A further incident of violence associated with him drinking alcohol took place in April just prior to his discharge. On 6th April 1999 he was discharged to the care of the CMHT and was to be seen by the Homeless Outreach Support Team and a Post Traumatic Stress Disorder Counsellor. His diagnosis on discharge was PTSD.

Mr ME's GP referred him to the mental health services on 20th September 2002. He had reported being depressed following his release from prison in France. He did not attend the outpatients appointment arranged for November.

In January 2003 Mr ME's GP once again referred him to the mental health services outpatients' clinic and he was seen on 18th February 2003 for an initial assessment by an Associate Specialist Psychiatrist. She noted that he was suffering from symptoms of a moderate depressive episode as a reaction to a series of negative and traumatic life events over the past 12 years. It was also noted that Mr ME had probable residual symptoms of PTSD and Floxetine 20mgs, an antidepressant medication was prescribed. Mr ME was referred to the Institute of Psycho Trauma for an assessment and to the Homeless Persons Unit.

A trainee Clinical Psychologist assessed Mr ME on 17th June 2003 and identified that he would benefit from psychotherapy. He failed to attend two further sessions to complete his assessment and was discharged from the service.

No further contact with Mr ME was recorded until September 2004 when he presented at Newham General hospital's A & E department reporting that he was at the end of his tether. He expressed suicidal thoughts, was drinking heavily and taking cocaine. He was admitted to a psychiatric ward but took his own discharge the following day.

The following month, October 2004, Mr ME was admitted to Newham General hospital because of alcohol intoxication, abuse of cocaine and overdosing on his mother's medication which contained Warfarin, an anti blood clotting medication. He admitted that the overdose was impulsive. A vitamin, Thiamine 100mgs, was prescribed and he was discharged with the diagnosis of substance misuse.

On 2nd November 2004 Mr ME was seen by his consultant psychiatrist in outpatients. He reported having stopped taking drugs and alcohol. No psychopathological symptoms were identified. The consultant wrote a letter to Mr ME's GP stressing that his problems were due to life events and not mental illness. He was discharged from the mental health services caseload with a plan to receive counselling via his GP practice. He subsequently refused to attend this counselling.

In March 2005 (2nd), Mr ME again presented at A & E with suicidal and homicidal thoughts. He claimed that he would kill someone if he was not helped. He was not eating or sleeping, using 1 gram of cocaine and drinking eight cans of lager a day. He was given a letter of referral for the Drug and Alcohol service as they felt he was not suitable for an inpatient admission..

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On 9th November 2005 an SHO saw Mr ME in outpatients. He was accompanied by his mother who described him as becoming verbally abusive and very aggressive when he was having "panic attacks". These were occurring on a daily basis. He also was drinking heavily and was referred to the Drug and Alcohol service. A follow up appointment was arranged for two months time. A letter from the SHO to Mr ME's GP suggests that his personal history had not been reviewed as the SHO states that Mr ME had "no siblings". The doctor suggested that his outbursts of anger were more related to his drinking with resultant paranoia rather than panic attacks. "Attacks only happen when drunk".

On 20th December 2005 Mr ME was arrested and charged with murder.

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

The report was undated and there did not appear to be an action plan. Subsequently following a request by the scrutiny team an undated action plan was provided.

The scrutiny team found that the internal review report did have agreed Terms of Reference which were appropriate for the case under review. It was found that some areas included in the Terms of Reference were not sufficiently explored within the body of the review.

There was no section in regard to the methodology used although there was a section on Contributory Factors taken from the Root Cause Analysis process in the main body of the report.

The composition of the review panel with two members, both staff working within the Trust was not in accordance with best practice. It did not reflect the multi-disciplinary organisational connection with Mr ME.

There appeared to be two witnesses interviewed for the purpose of the internal review. A précis of the interviews was included in the internal review report that also includes the witnesses' full names and titles and appears to directly quote from their evidence. It is unclear whether the internal review panel interviewed anyone else or received additional statements. No transcripts or statements were provided to the scrutiny team and it has to be assumed that these did not exist.

There is no mention of family contact with either the victim or Mr ME's direct family. Mr ME did have close contact with his mother and two brothers, his mother had accompanied him to his outpatient appointment one month prior to the incident.

The internal review's Terms of Reference did refer to adherence to local and national policy and procedures. There was no specific reference to these in the report and the scrutiny have to assume that no breach in compliance with these by Mr ME's care team was found. The lack of any discussion in regard to Care Programme Approach (CPA) however is of concern given Mr ME's admissions to psychiatric units.

The body of the internal review report includes information covering the whole period that Mr ME was known to the local mental health services.

7.2 Internal Review Report – General Comments

The scrutiny team considered how well the internal review examined and commented on the evidence provided to them. In view of the manner in which the victim died, one of the main areas for consideration was risk to others and himself, in particular when Mr ME was intoxicated. There was some discussion of risk and assessment of risk in the main body of the report. It also refers to a care plan and risk assessment documentation from Mr ME's admission in 1999. He was at this time identified as being suitable for the Care Programme Approach (CPA) Level One on a discharge liaison form but there was no subsequent mention of the CPA process within the context of Mr ME's care. This was not discussed by the internal review panel in their report.

The internal review does refer to gaps in the notes after 1999 but does not seem to link this up with Mr ME's arrest and detention in France during this period.

There was some discussion in regard to the treatment provided to Mr ME but no comments relating to whether the prescribed medication of Chlorpromazine, an antipsychotic was suitable. Although there is no rationale in the notes, the Chlorpromazine was prescribed "for sleeping tablet", but was continued as a prescribed medication on discharge. The use of a powerful neuroleptic drug in this way, while not unknown, is inappropriate without some rationale justifying the risk.

There were several other services involved in Mr ME's care, the Homeless Support Team, Home Treatment Team, GP and Drug and Alcohol service, however there is no evidence that the internal review panel asked for representatives from these services to be involved with the review either by interview or by providing statements.

The Trust were only aware of the incident and the arrest of Mr ME three months after it had occurred. The internal review did not explore or question this. The internal review describes an incident report being submitted in June 2005, another two months after the incident came to light and six months after the actual incident.

8 Scrutiny Team Findings and Recommendations

The scrutiny found that the internal review report did not provide an in-depth structured review of the care and treatment provided to Mr ME. It addresses some of the issues that the scrutiny team identified through its review of the available data but the internal review's findings and recommendations did not systematically deal with all of the issues arising from its Terms of Reference.

8.1 Scrutiny Team Independent Findings

The scrutiny team considers that the Trust's response to the incident was not timely nor did it reflect good practice. The investigation was commenced after the Trust were informed of the incident in June 2006 and completed in August 2006. The internal review report did not make any recommendations with regard to how similar incidents should be dealt with in the future. The scrutiny team would wish to stress the need for the Trust to ensure future internal reviews are produced within an acceptable timeframe and that such reviews are designed to be useful to improve Trust services.

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8.2 Scrutiny Team Recommendations

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8.2.3 Alcohol Services

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Recommendation Four

It is recommended that the |Trust receive evidence of the actual practice of CPA within clinical settings through regular audit. These audits should specifically include risk assessment, the use of risk management plans and evidence of the support given to carers.

8.2.5 Personality Disorder

Mr ME's history and presentation were consistent with a possible diagnosis of Personality Disorder but this was not considered by the clinical team caring for him.

Recommendation Five

It is recommended that Newham locality is included in the Personality Disorder services provided by the Trust.

Recommendation Six

It is recommended that clinical staff should have access to training in the management of personality disorders. This training should include the diagnosis

and management strategies for working with patients with personality disorders within their services

Scrutiny Template

Appendix One

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

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

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

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

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

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

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

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

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

Chronology of Events Appendix Two

Date	Event
07.07.1998	Mr ME first came into contact with mental health services following an overdose when he presented at A&E Newham General hospital.
09.02.1999	Mr ME was admitted as an Informal admission to East Ham Memorial hospital following a referral from the CMHT. He described as being low in mood, denied suicidal thoughts even though he had thoughts of self harming and was abusing alcohol and cocaine. Diagnosed with depression and post traumatic stress disorder. Whilst working in Russia he had witnessed violent incidents during the coup including the shooting of children. He had been unemployed for nine months and had housing and money difficulties. He settled quickly, no specific health problems. He did continue to abuse alcohol whilst an inpatient.
12.02.1999	Mr ME was referred to the Newham Independent Counselling service from the hospital.
17.03.1999	Mr ME restrained by ward staff when involved in a fracas with 3 youths who were visiting another patient on the ward. The Police were informed and he was cautioned.
26.03.1999	Mr ME cut his forearm with a razor blade as he felt low about his mother being ill (she had had a stroke in 1998) and the past.
05.04.1999	A further episode of violence took place due to his having become intoxicated with alcohol.
06.04.1999	Discharged from hospital to the care of the community team, to be seen by Homeless Outreach Support Team and PTSD Counsellor. His diagnosis was Post Traumatic Stress Disorder.
20.09.2002	Mr ME was referred to the mental health service by his GP. He was described as being very depressed following his release from prison in France.
November 2002	Mr ME was offered an appointment in the outpatients clinic. He did not attend (DNA).
January 2003	Again the GP referred Mr ME to the outpatient mental health clinic.
18.02.2003	Seen in outpatients for an initial assessment by an Associate Specialist who noted that he was suffering from “symptoms of a moderate depressive episode as a reaction to a series of negative and traumatic life events over the last 12 years. Probable residual symptoms of Post Traumatic Stress

Disorder. Prescribed anti-depressants, Floxetine 20mgs and referred to the Institute of Psycho trauma for an assessment and to a Homeless Persons Unit.`

14.04.2003 Attended Psychotherapy for an assessment.

17.06.2003 Letter from a trainee Clinical Psychologist regarding the assessment of Mr ME. It was felt that he would benefit from psychotherapy. He failed to attend two further sessions to complete his assessment and was discharged from the service.

September 2004 Mr ME presented at Newham General hospital's A&E feeling "at the end of his tether". He was expressing suicidal thoughts, had been drinking heavily and admitted to taking cocaine. Admitted as an inpatient but discharged the following day with an outpatient appointment.

22.10.2004 Admitted to Newham General hospital because of intoxication with alcohol and cocaine and an overdose of his mother's tablets which contained Warfarin via A&E. He admitted the overdose was impulsive and unplanned.

On examination he was diagnosed as suffering from substance misuse. Thiamine 100 mgs was prescribed and he was discharged.

02.11.2004 Seen in outpatients by the consultant psychiatrist. He had stopped taking drugs and alcohol. No psychopathological symptoms were identified. He was discharged from the mental health services with a plan to receive counselling in the GP practice. This was subsequently refused by Mr ME.

02.03.2005 Mr ME presented at A&E with suicidal and homicidal thoughts. Found on assessment to not require hospital admission and a letter given for him to present to the Drugs and Alcohol Service.

September 2005 Re-referred by the GP suffering from panic attacks and depression. Had been abusing alcohol. His mother was in hospital and father in prison at the time.

9.11.2005 Seen in outpatients by an SHO accompanied by his mother. She described him as becoming verbally abusive and very aggressive when he was having panic attacks – on a daily basis. He also continued to drink heavily. Mr ME referred to the Drug and Alcohol Service. To have a follow up appointment in two months.

20.12.2005 Mr ME, his brother and victim were drinking and Mr ME demanded £10 from the victim to buy drugs. When this was refused he assaulted the victim, kicking him in the head, and later stabbing him in the neck. Mr ME threatened his brother with violence if he tried to stop him.