An Independent Investigation into the care and treatment of MO

A report for NHS London

February 2010

NHS London

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1. Introduction

1.1 Mohammed Osman (MO) stabbed Camille Remy to death in December 2006. MO admitted manslaughter on the grounds of diminished responsibility and was ordered to be detained indefinitely at Broadmoor Hospital, where he remains.

1.2 East London and the City Mental Health Trust (now East London NHS Foundation Trust) and Barnet, Enfield and Haringey Mental Health NHS Trust commissioned a joint internal investigation into the care and treatment they had provided for MO. MO had briefly been an inpatient at North East London Mental Health NHS Trust (now North East London NHS Foundation Trust) two weeks before the killing. However, the other two trusts did not know this, so North East London NHS Foundation Trust was not made a party to the internal investigation.

1.3 NHS London commissioned this independent investigation into the care and treatment of MO as part of its responsibilities for performance managing the NHS locally. It was commissioned in accordance with guidance published by the Department of Health in circular HSG (94) 27 "*The discharge of mentally disordered people and their continuing care in the community"* and the updated paragraphs 33-36 issued in June 2005.

1.4 MO is Somalian. He was 31 at the time of the killing and had been living in England for about five-and-a-half years. His first language is Somali. He also speaks French and some English. From about October 2005 until the end of August 2006 MO was housed as a homeless vulnerable person by Newham council. He then spent a number of months travelling and went to Belfast, Dublin and Stranraer. Newham council re-housed him at the beginning of December 2006.

1.5 MO had contact with many different services and agencies. In addition to the NHS trusts mentioned and Newham council's housing services, these included the British Transport Police, the Metropolitan Police, Whipps Cross University Hospital NHS Trust, North Middlesex University Hospital NHS Trust, and Dumfries and Galloway council's social services department. At the request of NHS London, Newham council and the Metropolitan Police have also cooperated with the independent investigation process. They have shared information and their records of their involvement with MO with us.

1.6 The investigation team met with Camille Remy's family on 30 May 2008 to share the terms of reference of the investigation, to explain the investigation process and to listen to their concerns. We were told by Madame Mireille Cluzeaud, Camille's mother, that she had not heard the full story of events leading up to her daughter's killing. In order to give as full a picture as possible of those events we have developed an extensive chronology.

1.7 In compiling our report we have taken into account that Camille's family live in France that their first language is not English and that services and arrangements for mental health care and treatment may differ between France and England. We have provided written explanations of terms and services that are likely to be unfamiliar to Camille's family. We have arranged for this report to be translated into French.

1.8 We also met with MO at Broadmoor Hospital to explain the independent investigation procedure and to hear his evidence in relation to his care and treatment in the period leading up to the killing.

2. Terms of reference

2.1 Our terms of reference, were agreed by the commissioners of the investigation and also Newham council and the Metropolitan Police. The terms of reference are set out below.

2.2 The aim of the independent investigation is to evaluate the care and treatment of MO and to identify what, if any, contributory factors led to the homicide of Camille Remy and whether they were avoidable. The investigation will also review the trusts' internal investigation report and the progress that the trusts have made in implementing the action plan arising from it. Where appropriate recommendations based on best practice in mental health care will be made.

Specifically, the independent investigation will:

1. Compile an accurate chronology of events from MO's first point of contact with psychiatric services and any other services which may have impacted on his care and treatment up to and including the events immediately following the homicide.

2. Investigate and comment on the mental health care and treatment offered and provided to MO.

3. Assess the adequacy with which MO's risk was assessed and the adequacy of any actions consequent upon the assessment(s).

4. Review the extent to which organisations and agencies whose work impacted on the care of MO, including police and housing was appropriate and adhered to statutory obligations, relevant national guidance and local operational policies in the way which they worked with the PCT.

5. Review the actions taken by the trusts in response to the death of Camille Remy and comment on the way in which the trusts managed this incident, including the quality of any contact that the trusts had with the families of MO and Ms Remy.

6. Review the trusts' internal investigation and assess the adequacy of its findings and recommendations and the progress made in the implementation of those recommendations.

7. Establish and make reference to any other relevant investigations relating to MO and his family which are being and have been undertaken by organisations outside the trusts such as the police and housing.

8. Make clear, sustainable and targeted recommendations based on the contributory factors/root causes of the events leading to the homicide of CR and aimed at ensuring that any lessons are learned, acted upon and shared.

9. Provide a written report including recommendations to NHS London.

3. Executive summary and recommendations

Executive summary

Introduction

3.1 NHS London commissioned this independent investigation into the care and treatment of MO as part of its responsibilities for performance managing the NHS locally. It was commissioned in accordance with guidance published by the Department of Health in circular HSG (94)27 "*The discharge of mentally disordered people and their continuing care in the community"* and the updated paragraphs 33-36 issued in June 2005.

3.2 MO stabbed Camille Remy to death in December 2006. He admitted manslaughter on grounds of diminished responsibility and was ordered to be detained indefinitely at Broadmoor Hospital, where he remains.

Overview of MO's contact with services

3.3 MO was in contact with many different public service organisations between October 2005 and 20 December 2006, when he killed Camille Remy. These services included a number of different NHS trusts, police forces, and local authority social services and housing departments. Most of these organisations had only brief contact with MO, but three of them, (East London and the City Mental Health NHS Trust – now East London NHS Foundation Trust (ELC NHS trust); Barnet, Enfield and Haringey Mental Health NHS Trust (BEH NHS trust); and Newham council's homeless persons unit (HPU)) dealt with MO for longer. Although East London and the City Mental Health NHS Trust is now East London NHS Foundation Trust we continue to refer to the trust as ELC NHS trust in the report as this was the name of the service when MO received care there.

3.4 The first known contact between the services and MO was in October 2005. MO was living at Anchor House, a homeless persons' hostel in London, where he chased another resident with a knife. He was arrested and taken to Newham police station. He received a caution, and the forensic medical examiner (FME) at the police station told MO that he

needed a psychiatric assessment. MO was asked to leave the hostel and became homeless.

3.5 MO went to the ELC NHS trust's south east Newham community mental health team (SE CMHT). He was seen and assessed and it was decided that his mental state should be monitored in ELC NHS trust's outpatients' department. The SE CMHT also undertook a vulnerability assessment on the basis of which Newham council's housing department gave MO emergency accommodation.

3.6 In November 2005 MO went to Plaistow police station and told the police he had been drugged and raped. The police referred MO to the SE CMHT and MO was seen and assessed the same day. The assessment revealed a range of psychotic symptoms and MO was started on anti-psychotic and anti-depressant medication. A follow-up appointment was made and the SE CMHT continued providing support for MO until March 2006. MO told the SE CMHT he had stopped taking his medication and was fine. He did not want further help from mental health services. He was offered outpatient follow-up but he refused. His case was therefore closed.

3.7 In April 2006 MO went to the accident and emergency (A&E) department of Whipps Cross Hospital complaining of a pain in his anus and that someone was trying to poison his food. A psychiatric liaison nurse saw him and an appointment was made for him to return to the hospital the next day to be seen by a psychiatric senior house officer (SHO). MO failed to keep that appointment.

3.8 Newham council moved MO to temporary accommodation in early May 2006 but he requested a review of that decision on the grounds that his new accommodation was on the ground floor. He said this was unacceptable to him because "*over one hundred people"* were pursuing him day and night and someone with a lot of money was trying to "*eliminate"* him.

3.9 At the end of May 2006 MO went to the A&E department of the North Middlesex Hospital. He alleged that he had been put to sleep by some kind of anaesthetic gas while in his own room. He believed that he had been sexually abused and was complaining of pain in his anus.

3.10 Newham council's agents inspected the property where he was staying and found that electric fittings and lighting had been tampered with and pulled out, the kitchen sink had been damaged and was leaking. Newham council's agents concluded that the damage had been caused deliberately by MO.

3.11 In June 2006 MO presented at the A&E department at North Middlesex Hospital. This time he complained about pain behind his eyes but he left before he could be examined by medical staff.

3.12 The day after this visit to A&E MO had a fight with Mr A, a fellow resident at the property where he was living. The police crime report of the incident discloses that the scene was heavily bloodstained, and that two knives were recovered. MO had several stab wounds to his chest and was admitted to North Middlesex Hospital. Mr A had knife wounds to his left shoulder and right arm. MO gave a brief account of what had happened. He said Mr A had come to his door armed with a knife, but he could not explain how Mr A was injured. Mr A's version of events was that MO had jumped out of his door as he was passing and had lunged at him with a kitchen knife and a violent struggle had ensued.

3.13 While MO was in North Middlesex Hospital he was agitated, asking to be transferred to another hospital and refusing some treatments. A doctor who carried out a mental health act assessment concluded that MO was suffering from paranoid psychotic experiences in that he felt he was being persecuted and pursued. MO was detained under section 5(2) and then section 2 of the Mental Health Act 1983 and transferred to Northumberland ward at St Ann's Hospital part of the Barnet, Enfield and Haringey Mental Health NHS Trust.

3.14 MO applied for a Mental Health Review Tribunal (MHRT) hearing to appeal against his detention under section 2 of the Mental Health Act 1983. On 18 July 2006 the MHRT concluded that there was no evidence that MO was suffering from mental disorder, although he may have previously suffered from a psychotic episode induced by taking khat, the leaves of a shrub which is chewed like tobacco and acts as a stimulant. The MHRT discharged MO's section.

3.15 Newham council gave MO bed and breakfast accommodation when he left St Ann's Hospital on 25 July 2006. However, within a few days he was moved to different accommodation after complaining that "*some people*" had been "*spraying something*" on his door. In the following weeks MO had to be moved again on a number of occasions, including once when he was involved in an argument with a neighbour and once when he set fire to curtains because the hostel manager would not give him a different room.

3.16 Following a request from the HPU, the SE CMHT saw and assessed MO on 7 August 2006. The SE CMHT offered him a follow-up appointment for the end of August but before that date MO left his accommodation and travelled to Ireland.

3.17 He went first to Dublin where he stayed at a refugee reception centre. He exhibited signs of paranoia and was seen by a GP who prescribed medication. On 10 October 2006 he assaulted a fellow resident at the reception centre by punching him in the mouth and threatening him with a knife. As a result MO was detained in hospital under Irish mental health legislation until 31 October 2006.

3.18 At the beginning of November 2006 MO travelled to Belfast where police detained him for slapping a woman on a train. From Belfast he travelled to Stranraer where social services gave him emergency accommodation and assessed him as fit to travel. He was put on a train to travel back to London. Police files show that during his journey he assaulted a deaf man on a train travelling to Sheffield. The victim did not want to pursue the matter with the police.

3.19 On 15 November 2006, almost immediately after he arrived back in London, MO was arrested for punching a passenger on a bus and charged with assault. He appeared at the magistrates' court on 17 November and was bailed until 7 December.

3.20 On 30 November 2006 MO visited a housing options centre in Lewisham in order to find accommodation. He smashed a window and police detained him.

3.21 MO went to the A&E department at Whipps Cross Hospital on the evening of 2 December 2006 and was assessed by a psychiatrist. MO was thought to have persecutory delusions and delusions of reference. He was transferred to Naseberry court, an acute psychiatric unit that is part of the North East London NHS Foundation Trust.

3.22 In the morning of 3 December 2006 MO demanded to go home. He was seen by the duty doctor who concluded that MO was not sectionable under the Mental Health Act 1983. MO discharged himself against medical advice.

3.23 On 4 December 2006 MO went to the HPU and was offered emergency accommodation at the Metropolitan hostel in Hackney. An appointment was made for an assessment officer to interview MO at the HPU on Friday 8 December. MO failed to attend. The assessment officer who was to have seen MO agreed with his principle officer that they would extend MO's booking at the Metropolitan hostel over the weekend until 11 December. On that day the HPU extended MO's booking at the Metropolitan hostel indefinitely.

3.24 MO was arrested on 12 December for possessing a knife. He was held in custody and seen by a FME who said he was not fit to be interviewed. A few hours later, however, police did interview him. He was charged and he appeared before magistrates the next day. The case was adjourned and MO was released.

3.25 On 19 December 2006 MO went to the HPU saying that his neighbours were spying on him and attacking him. After discussions between the HPU duty manager and the manager of the Metropolitan hostel, MO was told he would not be given another room. He became abusive and left the HPU offices.

3.26 On 20 December MO fatally stabbed Camille Remy at the Metropolitan hostel. Camille Remy was a French student who had recently travelled to England. She was staying at the Metropolitan hostel and had booked through a company specialising in accommodation for foreign students.

3.27 MO's case presented particular problems to the services that had contact with him. He is an intelligent man, able for a period to mask his symptoms. He has periods of lucidity. English is not his first language. He was homeless and did not have a family or other network that could have helped with his diagnosis and care. Above all, no one service or practitioner had the chance to observe MO over an extended period nor were they able to build up a full picture of his mental health.

3.28 We find a number of weaknesses relating to the management and procedures of the services that had most contact with MO. These include the fact that the staff of both the ELC NHS trust and the BEH NHS trust had to contend with challenging workloads and this may have affected patient care. They had no formal opportunity to reflect as teams on their practice and patient care. There were weaknesses in information sharing and record-keeping.

3.29 We also find that in dealing with MO the staff of the SE CMHT and the BEH NHS trust did not implement the care programme approach (CPA) appropriately and did not undertake proper risk assessments. This meant that they missed the opportunity to build up as full a picture as possible of MO's mental state and to devise appropriate care plans for him.

3.31 Opportunities were missed to assess MO and to devise better care for him. However, given the nature of MO's illness and the circumstances of his contacts with services we cannot say that the killing of Camille Remy could have been avoided.

Recommendations

R1 The ELC NHS trust should keep the staffing levels of the SE CMHT under review to ensure that casework pressures do not adversely influence the way patients are managed and to ensure that individual caseloads are manageable and allow staff to fulfil all their professional obligations, including record-keeping, satisfactorily.

R2 The SE CMHT should consider holding regular team meetings to discuss and review individual case-handling and any issues and lessons arising.

R3 ELC NHS trust should review the effectiveness of its arrangements for ensuring and verifying that consultants appropriately fulfil their responsibilities for supervising and appraising other medical staff.

R4 ELC NHS trust should ensure that all staff with responsibility for the care of patients are subject to compulsory and ongoing training in risk assessment and risk management.

R5 ELC NHS trust should amend its clinical risk assessment and management policy to set out the requirement for training of the kind recommended in recommendation 4 above.

R6 BEH NHS trust should keep the patient numbers of individual medical staff under review to ensure that they are at all times manageable and allow staff to fulfil their professional obligations, including allowing them to have an appropriate grasp of the issues relating to their patients.

R7 BEH NHS trust should keep the occupancy rates of its wards to the levels recommended by the Royal College of Psychiatrists and other professional bodies in order to ensure a safe environment.

R8 BEH NHS trust should ensure that staff have regular planned opportunities for in depth consideration of and reflection on issues and challenges relating to their professional practices and the care of individual patients.

R9 BEH NHS trust should devise a system for ensuring that each patient has a named nurse who is available to:

- provide comprehensive nurse assessment
- share and communicate that assessment appropriately
- ensure appropriate nursing care planning and management.

R10 Where the named nurse is not available for a significant time or is unable to fulfil the requirements referred to at recommendation 9 above, another named or associate nurse should be appointed.

R11 The BEH NHS trust should continue to monitor the implementation of the internal inquiry recommendations with regard to the need for compulsory and continuing training in risk assessment and risk management.

R12 Newham council's housing services should develop a multi-agency memorandum of understanding setting out the terms on which they can share information about clients thought to pose a risk to themselves or others with other relevant agencies and bodies, (including landlords), so that appropriate CPA and risk management plans for such clients can be devised and delivered.

R13 The HPU should develop a process under which a pivotal person or persons within the HPU ensures on an ongoing basis that relevant information about clients' mental health needs is gathered and reported back (in accordance with the suggested memorandum of understanding) to CMHTs, and any other relevant agency, as well as to Newham's accommodation team and other staff in Newham council's housing services.

R14 In discussion with the CMHTs, Newham's housing department should review the risk documentation that it receives in respect of clients with mental health needs to ensure that it encompasses and focuses on relevant housing issues, including:

- the suitability of certain types of accommodation
- risks that the client might pose to housing workers, landlords, their employees and other tenants
- the oversight or other input to the client's care plan that is required from housing workers
- the need to share information.

R15 The HPU should amend its '*procedure for mental health clients*' document to require that the risks relating to housing a client are reassessed in the event of a significant change in the client's circumstances, such as a period in hospital, or a lengthy unexplained absence.

R16 The ELC NHS trust should ensure that all staff caring for patients undertake robust care planning in line with current policy and best practice in relation to the care programme approach, which includes risk assessment and risk management, and that they understand where responsibility for such assessments and plans lies.

R17 The ELC NHS trust should amend its clinical risk assessment and risk management policy to reflect the fact that the risk assessment and management process begins the moment a person is first assessed and not merely when they are registered for CPA or are deemed to be receiving specialist mental health care.

R18 Adherence to the requirement for proper CPA planning (see recommendation 16 above) and the need to begin risk assessment and risk management from the time a person is first assessed by services (see recommendation 17 above) should be monitored through

regular audits undertaken as indicated in the ELC NHS trust's response to the internal investigation.

R19 The ELC NHS trust should continue to monitor the implementation of the internal investigation recommendations in relation to patient discharge.

R20 The BEH NHS trust should ensure that risk assessments and risk management plans are discussed in multidisciplinary team meetings so that all professions can contribute relevant information and understand any plans devised.

R21 North East London Mental Health Foundation Trust should ensure that medical staff carry out a physical examination on patients as part of the admission procedure.

R22 ELC NHS trust, BEH NHS trust and the HPU should remind all staff of the need to keep a full record of the contacts that they have with a patient and all significant discussions that they have in relation to a patient.

R23 BEH NHS trust should ensure that staff required to prepare reports or give evidence before a MHRT are informed immediately of any application to the MHRT and of any date fixed for a MHRT hearing so they can prepare for the hearing.

R24 BEH NHS trust should ensure that trust staff required to prepare reports or give evidence to a MHRT are adequately:

- trained
- supervised
- supported
- updated on new developments

in relation to the practice and procedure of the MHRT, report writing for the MHRT and presenting evidence and argument to the MHRT.

4. The method the investigation team used

4.1 NHS London commissioned Verita, a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations, to undertake the independent investigation.

4.2 The investigation team consisted of Kate Lampard and Chris Brougham. Kate Lampard is qualified as a barrister and is former chair of Kent and Medway Health Authority and of Invicta Community Care NHS Trust. Chris Brougham was a nurse and has held senior management positions in the National Health Service and the National Patient Safety Agency. Dr Jayanth Srinivas, a consultant forensic psychiatrist at the Hatherton centre in Stafford, provided professional advice.

4.3 The investigation team worked in private and gathered documentation and written evidence from East London NHS Foundation Trust (ELC NHS trust), Barnet, Enfield and Haringey Mental Health NHS Trust (BEH NHS trust), North East London NHS Foundation Trust, Newham council's housing services, the British Transport Police, the Metropolitan Police, Whipps Cross University Hospital NHS Trust, North Middlesex University Hospital NHS Trust and Dumfries and Galloway council's social services department. We also interviewed staff from these organisations. Good practice was adhered to by, for example, offering interviewees the opportunity to be accompanied to their interviews and to comment on the factual accuracy of transcripts of their interviews.

4.4 We have analysed the evidence received and made findings and recommendations based on our interviews and the information available to us.

4.5 It was intended that the independent investigation would build on the internal investigation, not replicate it. However the quality of the interview transcripts from the internal investigation was poor and they did not provide a reliable or complete record. This meant that we had to interview some people who had already been interviewed for the internal investigation in order to obtain a full and accurate record of their evidence. Our

findings sometimes overlap with those of the internal one.

4.6 Our findings from interviews and documents are set out in ordinary text. Comments, opinions and explanations are in bold italics. Quotations from interviews and evidence are written in italics and indented.

4.7 We have reviewed the trusts' internal investigation report and the progress that ELC NHS trust and BEH NHS trust have made in implementing the action plans arising from it. We comment at relevant points throughout this report on the progress the trusts made. We attach a full copy of the trusts' action plans in appendices A and B.

5. The services that had contact with MO

5.1 Between October 2005 and 20 December 2006, when he killed Camille Remy, MO was in contact with many separate public service organisations. These included a number of different NHS trusts, police forces, and local authority social services and housing departments. As we describe in the chronology in chapter 7, most of these organisations had only brief contact with MO, but three of them, East London and the City Mental Health NHS Trust; (ELC NHS trust) Barnet, Enfield and Haringey Mental Health NHS Trust (BEH MHT); and Newham council's homeless persons unit (HPU), dealt with MO over a longer period. In this chapter we give relevant background information about them.

South East Newham community mental health team of East London and City NHS Foundation Trust (ELC NHS trust)

5.2 ELC NHS trust's operational policy for community mental health teams (CMHTs) was drafted in September 2005 and revised and amended in April 2006. Under the policy the CMHTs provide a service for adults with mental health problems and of working age, normally 18 to 65 years.

5.3 Paragraph 2.3 of the operational policy states:

> "*People requiring treatment, care and monitoring may include the following:*
> *1. Severe and persistent mental disorders often associated with significant disability and poor quality of life, predominantly psychotic disorders.*
> *2. Longer term conditions of lesser severity but which are characterised by poor treatment adherence or requiring proactive follow up.*
> *3. Any disorders where there is significant risk of self harm or harm to others or where the level of support required exceeds that which primary services are able to provide.*
> *4. Disorders requiring skilled or intensive treatments not available in primary care.*
> *5. Complex problems of management of engagement such as presented by service users requiring interventions under the Mental Health Act.*
> *6. Severe personality disorders where there has been shown to be benefit by continual contact and support."*

5.4 ELC NHS trust set up the CMHT that serves the south east region of the London Borough of Newham (the SE CMHT) in 2004. The SE CMHT serves patients from the 12 GP practices in its catchment area. It is based at Passmore Edwards building, Shrewsbury Road, Forest Gate, London E7 8QR. The SE CMHT is made up of four community psychiatric nurses (CPNs), including CPN 1 who had contact with MO, four social workers, a senior practitioner social worker, a clinical nurse lead, an occupational therapist, a psychologist, a support worker, and a clinical nurse lead. The team manager CA, a registered mental nurse (RMN).

5.5 Medical input to the SE CMHT is provided by two consultant psychiatrists who act as the responsible medical officers (RMOs) for the team's patients, the consultants' two senior house officers (SHOs), who work part-time for the CMHT, and two associate specialist psychiatrists. Patients are allocated to one of the consultant-led sub-teams of the SE CMHT according to which GP practice they are registered with.

5.6 The SE CMHT's team manager told us that the team's consultants were contracted to work two sessions per week with the team, and spend the rest of their time dealing with ELC NHS trust's inpatient service users. She told us that the consultants attended the SE CMHT each Thursday afternoon for a clinical multidisciplinary team meeting when all cases open for assessment were discussed. They attended for a further session for care programme approach (CPA) meetings and medical reviews of patients who had been allocated to a care coordinator.

5.7 Whatever the practical arrangements for consultants to attend to CMHT work, the ELC NHS trust's operational policy for community mental health teams in fact states that the consultants will undertake a further session on a flexible basis for "*clinical reviews as required,1:1 meetings with care coordinators, senior nurses/[social worker] and CMHT manager, admin work".*

5.8 Throughout the time that MO was in contact with the SE CMHT, the consultant responsible for him was Dr F and the associate specialist was Dr G. SE CMHT staff told the investigation team that Dr F had chosen to spend more of his time at their offices than the contracted two sessions. Dr G described Dr F as there "*most of the time*". Dr F left the ELC NHS trust during 2007. We believe he returned to Spain, his native country, but it has not been possible to trace him and he has not given evidence to us. Dr G is still with the SE CMHT.

Referral and assessment

5.9 The SE CMHT screen any referrals to the service. Some patients are taken on for assessment, while others may be referred to psychological treatments the team cannot provide. Patients not taken on for assessment by the SE CMHT can be seen as outpatients at the clinics the team's two associate specialist psychiatrists run for the ELC NHS trust. These clinics are held at a health centre in Canning Town and in the Shrewsbury clinic in the building next to the one the SE CMHT occupies.

5.10 Paragraph 11 of the operational policy states:

> *"11.1…all referrals thought to require an assessment by CMHT will be discussed at the weekly allocation meeting.*
> *11.2 Referrals for assessment will be allocated to a worker, who will take a lead on the assessment, and another worker will be identified to jointly assess.*
> *…*
> *11.6 Users who do not meet the criteria for CPA will be referred to other services or will be passed back to the original referrer. Any advice or recommendation as to the future action will be clearly documented and feedback will be given to professional referrers. All decisions will be reviewed if additional information comes to light that informs the risk assessment."*

Northumberland ward at St Ann's Hospital

5.11 Between 10 July and 25 July 2006 MO was an inpatient on Northumberland ward, St Ann's Hospital in St Ann's Road, London N15 3TH. The hospital is part of BEH NHS trust. We understand that Northumberland ward was set up in about May 2005. At the time that MO was an inpatient there were three consultants on the ward and each had responsibility for a different part of the trust's catchment area. Each consultant also had responsibility for providing medical input to the CMHT for their patch.

5.12 In about May 2006 Dr L, the consultant with responsibility for the Tottenham area went on long-term sick leave. In June 2006 Dr V, who covered the Hornsey and Highgate area, agreed that he would give up most of his community work for that area and take on Dr L's

Tottenham inpatient and community workload. Dr V was assisted in dealing with that Tottenham area workload by Dr N, a trust grade senior house officer (SHO), and another part time SHO. As the consultant responsible for patients from the Tottenham area, Dr V became the RMO for MO.

5.13 Dr V told us that he used to spend Tuesdays doing an all-day ward round at St Ann's Hospital and would then visit the ward again either on a Thursday or a Friday, sometimes both. At other times Dr V dealt with community patients. On Monday mornings he and Dr N attended a meeting of the Tottenham area CMHT.

5.14 In July 2005 SA was appointed temporary ward manager of Northumberland ward, a post he held until October 2006. Two charge nurses worked under SA. He told the investigation team that the ward had been without a manager for quite some time before he joined and there had been many staff changes. Sickness among staff was high. We were also told that although Northumberland ward was a 19 or 20-bed unit, it had about 28 patients while MO was there, and some patients had to "*sleep out*" on home leave.

5.15 In autumn 2006, Northumberland ward was moved into specially refurbished premises in the main St Ann's Hospital building. At the same time BEH NHS trust restructured its patient care and staffing so that all the patients on the ward were under the care of one consultant.

Newham council's homeless persons unit

5.16 At the time that MO was first provided with accommodation by Newham council, the provision of accommodation was managed through what was known as the homeless persons unit (HPU). The HPU was responsible for assessing whether the council had an obligation under the Housing Act 1996 as amended to accommodate individual applicants for housing. In March 2006 the council merged its homelessness response service with its homelessness prevention and advice service and the HPU became part of a larger service team called the housing options service. We refer to it throughout this report as the HPU. Its offices have always been at 3 Pragel Street, Plaistow, London E13 9HB.

5.17 Newham council's obligation to accommodate an applicant arises if he or she is

eligible, in terms of their immigration and financial status, and has a priority need such as dependent children or is deemed vulnerable because, for example, they have mental health problems.

5.18 Newham council's housing staff explained to us that an applicant who appeared to be entitled to accommodation would be offered emergency bed and breakfast accommodation while their application was investigated and assessed. Where an applicant is eligible for emergency bed and breakfast accommodation but has a vulnerability, such as mental health problems, which makes it inappropriate for them to share facilities, they can be offered a self-contained studio or small flat. Once it has been determined that an applicant meets the criteria for being housed by the council, they can be offered long-term temporary accommodation. We were told that in Newham, where demand for local authority housing is the highest in London, it can take many weeks for such accommodation to become available. Once in temporary accommodation, the tenant can apply for permanent accommodation as it becomes available.

5.19 The process of finding suitable emergency and temporary accommodation for a particular applicant and managing the letting process is undertaken by Newham council's accommodation team. That team is housed in separate premises from the HPU.

5.20 In the period up to March 2006, when the HPU combined with the homelessness advice and prevention service, the HPU staff was divided into a number of teams each under its own team leader. One of the team leaders, AC, acted as the mental health coordinator. She had particular experience of dealing with mental health issues and took responsibility for liaising with local mental health services. Other members of the HPU staff would refer mental health queries and assessment matters to her. After the housing options service was set up the number of teams in the service reduced to two - one dealing with homelessness prevention and advice and the other with the assessment of homelessness. The role of mental health care coordinator was taken on by MT who is also a homeless assessment officer and AC remained as a team leader.

5.21 Newham council's "*HPU casework procedure manual*" refers to mental health under paragraph 2.9. That paragraph states:

"For the purposes of sec189 (1)c Part VII of the Housing Act 1996, a person is considered vulnerable if s/he has long and enduring mental illness and has no accommodation s/he is entitled to occupy.

Newham homeless persons unit will require the following information before accepting referrals from hospitals.

1 The reason s/he was admitted to hospital. Was s/he sectioned-Formal or Informal.

2 Length of time spent in hospital.

3 Reason why s/he cannot return to their accommodation…

…

5 Nature and extent of illness which may render the applicant vulnerable.

…

7 Has the patient been referred to any of the community mental health teams?

…

10 If the patient is known to be violent, has a risk assessment been carried out?

…"

5.22 In October 2006 Newham council adopted a new procedure for mental health clients. It states:

"*All clients who approach as homeless following discharge from hospital have to provide the following:*

1 Risk Assessment/Care Plan

2 Vulnerability Assessment

…

It is imperative that a risk assessment is provided so we can determine whether a client is a risk to others in terms of violence, aggression or at risk to themselves i.e. self harm, suicidal tendencies. We need to be satisfied that our other clients will not be at risk from mental health clients placed in bed and breakfast accommodation.

The same applies if applicant has been referred by local service centre/community mental health teams

…

Where possible all cases should be allocated to mental health coordinator.

…

All cases where clients have stated mental health issues an appointment will need to be made with the community mental health for a vulnerability assessment to be carried out."

6. MO's personal history

6.1 Our only available source of information about MO's personal history before May 2001 is what he told the various agencies with which he had contact after that time. The accounts are not consistent. The facts that appear most regularly in them are that he was born on 8 December 1975 in Somalia, he has a number of brothers and sisters, his father was killed during the war in Somalia and MO and other members of his family fled Somalia to Ethiopia. MO has said he was married in Somalia and had two children, but he was divorced and his children live with their mother in Ethiopia. At some stage MO travelled to France where he said he obtained a university degree. MO has also said that he has brothers and sisters living in France but his mother still lives in Ethiopia. MO has spoken of chewing significant quantities of khat, the leaves of a shrub that acts as a stimulant, over a number of years.

6.2 According to the chronology the police compiled during their investigation into the killing of Camille Remy, on 22 May 2001 MO attended at the Home Office's immigration centre in Croydon to claim political asylum. During an interview with Home Office officials on 20 June 2001 he said he had arrived in the UK on 16 May 2001. The police reports state that on 26 June 2001 MO's asylum application was refused but on 28 June 2001 he was granted exceptional leave to remain in the UK valid until 28 June 2005.

6.3 We do not know for certain what MO's immigration status was after 28 June 2005. MO told the SE CMHT that in or about August 2005 he had been granted indefinite leave to remain in the UK. In any event, on 19 October 2007, the judge who ordered him to be detained under section 37 Mental Health Act 1983 for the killing of Camille Remy also recommended that MO should be deported at the appropriate time.

6.4 MO told the mental health services that dealt with him from autumn 2005 that once in the UK he had made contacts and friends within the Somali community in London. He said he had found work in a warehouse and as a teaching assistant for a homework project for the Somali community in Newham. He had lived in a studio flat but when he could no longer afford the rent he had moved into a hostel.

7. Chronology of MO's contact with services

October 2005 to 23 June 2006

7.1 At the beginning of October 2005 MO was living at Anchor House, a homeless person's hostel in Barking Road, London E16.

7.2 On 3 October MO was arrested for affray at Anchor House. He had tried to force his way into the room of a fellow resident and had then chased the other resident along a corridor armed with a knife. MO was detained overnight at Newham police station. The police detention log shows that MO claimed that the reason for the disturbance was that his fellow resident "*had attempted to implant 'probes' into [MO's] nose"*. MO also claimed that Anchor House was full of cameras that were being used to monitor him.

7.3 Forensic medical examiners (FMEs) saw MO twice during his detention at Newham police station. At 11.55pm on 3 October 2005 he was seen by Dr T. The detention record shows that Dr T told police he believed that MO was suffering from "*some kind of mental illness"* and needed to be referred to his doctor when the police investigation finished. Dr T noted on the forensic examination form kept as part of the police records that MO was fit to be detained but not fit to be interviewed at that time. We contacted Dr T by telephone and wrote to him requesting an interview but he did not make himself available.

7.4 MO was examined again at about 8.00am on 4 October 2005, this time by Dr R. She told us that her notes of her interview with MO show she had found nothing to indicate mental illness in MO. Dr R noted on the forensic examination form that MO was fit to be detained and fit to be interviewed.

7.5 The police interviewed MO on 4 October 2005 and released him with a caution.

7.6 On 5 October 2005 MO presented at the offices of the SE CMHT at Shrewsbury Road, Newham. MO was seen first by CPN 1, a CPN who was the duty worker that day, and then by CPN 1 and Dr G, associate specialist with the SE CMHT. Both CPN 1 and Dr G recalled that MO had claimed that the police had told him to go to the SE CMHT to get help. MO had had a letter with him with a police heading which did not identify any particular police station.

Neither CPN 1 nor Dr G could remember what the letter said. MO took it away with him. No one at the SE CMHT photocopied it.

7.7 CPN 1's note of the interview with MO on 5 October 2005 sets out a few details of MO's personal history and also records that MO:

> *"Feels paranoid and believes this started when the relationship with his girlfriend-a married woman-ended. Denies any illicit drug/alcohol use and admits to chewing khat during weekends only approximately £10 only…"*

7.8 She also noted the fact that MO's communication in English "*was not clear"* and that she and Dr G had agreed that they would see MO again on 10 October with a French speaking interpreter. In the referral information document CPN 1 completed on 5 October 2005 she recorded:

> *"States he was involved in an incident at the hotel he has been living at …chased another resident with a knife. Thought the person wanted to harm him. Taken to police station and cautioned. Now homeless. Has no history of mental illness…states that he has not slept [for] past 3 weeks. Keeps himself awake drinking lots of coffee, this is because he fears to be attacked by others*
> *Would like to see Doctor to find out whether there is something wrong with him.*
> *Fearful of his actions and reactions.*
> *Does not consider himself a risk to others at the moment."*

7.9 CPN 1 told us that during the interview on 5 October MO:

> *"…was quite guarded in the way he presented, it was very difficult to get any information from him, he wasn't forthcoming. When he presented the letter and then we started asking questions he spoke a lot but he said nothing".*

7.10 CPN 1 explained that she and Dr G had not been able to make up their minds about whether MO was suffering from a mental illness. They doubted that the police had told MO to present to the CMHT rather than follow the usual course of having him assessed and referred to services via an FME. CPN 1 told us that at that stage she had believed that MO had probably

presented in order to get his social rather than his mental health needs addressed.

7.11 Later on 5 October 2005 MO went to the offices of the HPU at Pragel Street in Newham. He told the duty worker there he had been "*evicted*" from his accommodation. He also appears to have told the duty worker about his appointment with the SE CMHT scheduled for 10 October 2005. The duty worker spoke on the telephone with the manager of Anchor House who told him about the incident in which MO had chased a fellow resident with a knife. The manager said that as a result of that incident MO's licence agreement at Anchor House had had to be terminated. The duty worker's hand-written note of the conversation with the manager of Anchor House records the manager as having said:

> *"The behaviour was totally out of character. He is not known with [sic] such behaviour. But it is not tenable for him to continue his stay at the hostel."*

7.12 The note also records:

> *"12ins knife being used. He was slightly agitated"*

7.13 The duty worker discussed MO's case with his manager and they agreed that MO appeared to have some mental health problems and they would need a vulnerability report from the SE CMHT before they could consider offering him accommodation. They advised MO to keep his appointment with the SE CMHT and in the meantime they referred MO to a night shelter.

7.14 MO was late for the interview with the SE CMHT on 10 October 2005. The interpreter had left by the time he arrived. The interview was rearranged for 12 October. MO attended at the CMHT on 12 October but no interpreter was available. CPN 1 noted in the contact record that MO had told her that he was sleeping on the streets, going to the mosque to get food and attending college twice a week. He spoke about having difficulty sleeping, paranoid ideas and low mood. CPN 1 also noted that MO was to be given a vulnerability assessment report to present to the HPU in support of his housing application and that a further appointment would be made for him to be seen with an interpreter.

7.15 The vulnerability report CPN 1 compiled for MO at this time was dated 13 October

2005 and is on the HPU's standard form. CPN 1 made reference on the form to the incident that had led to the termination of MO's licence at Anchor House, including the fact that it had involved MO using a knife. CPN 1 assessed MO as vulnerable for the purposes of the Housing Act 1996. She gave the following reasons:

> *"MO has suffered several losses …this has led him to becoming low in mood (depressed) and having paranoid thoughts. Although he is not an allocated case to this team, his mental state is being monitored and he is required to attend this office. His current situation is affecting his depressive/paranoid mental state".*

7.16 CPN 1 recommended that local accommodation would be preferable because MO had connections in the area.

7.17 On 13 October 2005 MO returned to the HPU with the vulnerability report. The duty senior officer who dealt with MO's case that day decided to contact CPN 1 to ask her to provide more information about the psychiatric assessment of MO's mental health and a risk assessment that clearly stated whether or not MO posed a risk to himself or others. CPN 1 was not available on the telephone and a message was left for her to ring back. In the meantime the duty senior officer authorised accommodation for MO for seven days in self-contained annex accommodation "*for his/others safety*". The caseworker who undertook to find the accommodation made a file note which states *"Having considered this applicants circumstances the nearest most suitable accommodation available from the list of vacancies today is 73 Fairlop Road, E11… [MO] agreed to accept the offer of interim accommodation".* Fairlop Road is in Leytonstone, outside the borough of Newham.

7.18 It appears that the booking at Fairlop Road was extended on 20 October and then again on 26 October and 3 November 2005 because the HPU had received no further assessment of MO. A note in the HPU file for 3 November suggests that a member of HPU staff was to pursue the CMHT to provide the assessment sought but no note appears in the CMHT file of any request for CPN 1 to ring the HPU at this time or for the SE CMHT to provide a further assessment of MO. There is no evidence that the SE CMHT gave the HPU any further assessment of MO's mental health or the risks that he posed to himself or others. On 11 November 2005 MO's booking for his accommodation was extended "*indefinitely*".

7.19 It appears from the SE CMHT file that an interpreter was booked for an interview with MO scheduled to take place on 24 October. There is no entry in the contact record about that meeting. However, given the further details about MO in the full needs assessment and the discharge letter that CPN 1 subsequently prepared, including the fact that Dr G had prescribed the antidepressant Citalopram for MO at about this time, it seems likely that he and CPN 1 did conduct a further interview with MO on 24 October 2005.

7.20 CPN 1 completed ELC NHS trust's standard full needs assessment form for MO at the end of October 2005. CA, the SE CMHT manager, told us that there was no requirement to complete such a form because MO was still only being assessed and had not been accepted for treatment under the CPA. The form that CPN 1 completed is dated 28 October 2008. In it she records what she knew of MO's history at that time, including, under the section headed 'contact with police':

> "*Taken to police station and released with a caution, following an incident at the hotel he was living at. The incident was that he chased another resident along the hotel corridor with a 12 inch knife."*

7.21 In completing the form CPN 1 did not indicate any identified needs or the need for any further assessments.

7.22 Under the section headed 'thought content', CPN 1 recorded that MO:

> "*…thinks he talks to himself when sitting alone, hence people are running away from him because of his mental problem. The Somali community have no respect for him. When outdoors thinks he is hearing voices talking to him when nobody is around. Believes these problems are due to stress and being away from his country".*

7.23 Under the section headed 'service user views of mental health state', CPN 1 noted: *"Believes he is depressed and needs help".* In respect of MO's drug use CPN 1 recorded: "*Denies use of illicit drugs. Admits to chewing Khat on a daily basis for 4 years and for past 1.5 months only uses it sporadically".* The section for recording a care plan notes:

"1. To start to commence citalopram 20mg mane
2. To follow up at the outpatient clinic
3. Case to be closed to the CMHT"

7.24 On 28 October 2005 the senior practitioner with the SE CMHT noted in the contact record that the case of MO had been closed to the SE CMHT. On the same day Dr G wrote a discharge letter to MO's GP, Dr B referring to the incident on 3 October 2005 at Anchor House as well as to MO's accommodation arrangements, his history and family background. Under the heading 'mental state examination', Dr G stated that MO was: "*low in mood, mildly depressed, difficult to assess, as his command of English is poor*". Dr G also stated in relation to thought content*:*

"Depressive themes in terms of negative cognitions, lack of confidence and low self esteem. No suicidal ideation or homicidal ideas could be elicited. No psychotic psychopathology could be elicited. Intact cognitive functions and good insight."

7.25 Dr G concluded his letter by saying:

"*In terms of the paranoid symptoms he has expressed on a few occasions, I feel that they were Khat related."*

7.26 Dr G also set out the care plan referred to under paragraph 7.23 above.

7.27 Dr G, CPN 1 and CA told us that the decision to close MO's case to the SE CMHT and for him to be followed up merely by appointments with an SHO in the outpatients' clinic would have been discussed and agreed by them and the SE CMHT consultant Dr F as a multidisciplinary team. This discussion does not appear to have happened in any formal meeting. CPN 1 told us:

"*These are people who are on assessment, not people who are allocated* [for care under CPA to a care coordinator]. *In an allocated case it would be a formal meeting, but this is…just an assessment".*

7.28 Dr G suggested that the decision to close the case would have been discussed in the SE CMHT's Thursday afternoon clinical meeting. In any event there is no record on file of the parties involved in that decision, or the terms of their discussions about it.

7.29 In a letter dated 7 November 2005, Dr B, the GP to whom Dr G had addressed the discharge letter of 28 October, told MO that he would have to find another doctor because he was now living outside the GP's catchment area.

7.30 On 14 November 2005, MO reported to police at Plaistow police station that he had been drugged and raped on the night of 5 October 2005. MO suggested that the alleged suspect was connected with a man called BB, a Somalian whose brother had been in dispute with MO's brother in Somalia. MO also alleged to the police that members of Mr BB's 'gang' followed him wherever he went and had members living in the property occupied by MO at Fairlop Road. MO said during subsequent interviews with police that he had received treatment from the SE CMHT.

7.31 On 21 November 2005 Plaistow police referred MO to the SE CMHT with his consent. It appears that CPN 1 and Dr G saw MO later that day. Dr G's typed note of the interview shows that MO repeated the allegations that he had made to Plaistow police. Dr G also recorded:

> *"It seems that he is also hearing voices…*
> *He said that he has not used Khat for nearly 45 days. He was distressed by the whole experience and tearful.*
> *When asked about how he knew about the rape. His answer was suggestive of delusional misinterpretation….He also believes that some police officers are colluding with the persecutor…*
> *He has not been eating properly due to the persecutory delusional beliefs.*
> *He denied experiencing either suicidal or homicidal thoughts.*
> *Plan:*
> *Commence Aripiprazole 10mg mane and should continue on citalopram 20mg od."*

7.32 CPN 1 also noted that MO needed to be registered with a GP and needed help applying for a Freedom bus pass. On 28 November CPN 1 saw MO and helped him to complete his application.

7.33 An HPU file note shows that AC, the mental health coordinator for the HPU, considered MO's case on 2 December 2005. She noted her agreement that MO was vulnerable and therefore entitled to be housed by Newham council and that he needed to be given low-rise accommodation. In a separate file note she wrote "*2 officers to visit at all times*". AC told us:

> *"The reason I put that is accommodation officers had to go and visit them and they didn't have much information, they didn't have access to the vulnerability report, they wouldn't know what to look for so, for safety reasons I would put down that two officers should really visit, just in case."*

7.34 On 5 December the HPU formally accepted a duty to provide MO with accommodation under the Housing Act 1996 as amended by the Homelessness Act 2002.

7.35 Dr G and CPN 1 together with a French speaking interpreter saw MO again on 5 December 2005. Dr G's note of that meeting says:

> *"[MO] said he was compliant with the prescribed psychotropic medication. Complained of feeling slow and drowsy at times.*
> *He admitted chewing Khat 10 days ago following his last appointment with us. He appeared more cheerful and relaxed. There has not been a significant change in his mental state….*
> *Plan:*
> *To continue on Citalopram 20 mg od and Aripiprazole 30 mg mane*
> *To be reviewed in two weeks time."*

7.36 CPN 1 telephoned MO on 12 December 2005 to give him the contact details for GP2, a GP who was taking on patients in Leytonstone.

7.37 Dr G and CPN 1 saw MO again, in the presence of an interpreter, on 19 December 2005. Dr G's note of the meeting records that MO was preoccupied by paranoid delusions and police investigations of his allegations but his paranoia appeared to be lessening. Dr G prescribed the same medication as before. During the meeting MO also told Dr G and CPN 1 that he had an appointment arranged for the next day with the GP CPN 1 had suggested. We

found no evidence that MO saw a GP on 20 December and it was not until 4 January 2006 that MO was registered with GP3, a GP with a separate practice but occupying the same building as GP2.

7.38 On 11 January 2006 the management at Fairlop Road hotel cancelled MO's licence to occupy interim accommodation there because other residents said he had been causing fights. MO denied the allegations and the HPU were able to negotiate the continuation of his licence.

7.39 On 7 February 2006 MO went to see the GP, GP3. MO was first seen by a nurse who recorded a family history of depression and diabetes. MO asked GP3 for an HIV test. GP3 also gave MO a blood test. All results were normal. GP3 noted that MO was taking aripiprazade and citalopram but he did not detect signs of depression or psychosis.

7.40 On 21 February CPN 1 contacted MO to arrange for him to attend an interview with the SE CMHT. On the same day she completed a CPA registration form for MO. CPN 1 explained to us that this meant that MO was officially allocated or taken on as a patient. However she said she had taken this step only in order to comply with the ELC NHS trust's requirement that all patients are treated under CPA within three months of the beginning of the assessment process. We have found no reference in the CPA policy to the three-month standard. CPN 1 told us she had not made arrangements to draw up a CPA plan at the time because she had not been sure that MO should be taken on as a patient. She said that in this respect she had been "*influenced by the fact that we were still assessing".*

7.41 CPN 1 saw MO on 28 February 2006. At that meeting she told MO that she wanted to complete some forms for his file but according to her note, MO told her:

> "*…he did not want further input from the CMHT. Believes he is well and stopped taking medication [one] month ago and has been fine since."*

7.42 MO told CPN 1 that he had stopped the medication because he had mistakenly taken an excessive dose of Aripiprazole. She asked MO if he would attend for one more appointment with Dr G and he agreed. The appointment was arranged for 22 March 2006.

7.43 On 1 March 2006 CPN 1 completed a risk checklist form for MO. She made entries

under the headings 'aggression/violence to others', 'substance misuse' and 'poor nutrition', but did not indicate whether these were current risks. She did, however, identify "*non-compliance with medication*" and "*disengagement from mental health services*" as current risks. Further, although she indicated on the form that she was "*lacking appropriate information or unable to fully assess for other reasons*", she answered "*no*" to the question "*Is a detailed risk assessment indicated?*" When asked about the apparent errors and omissions in the form she completed, CPN 1 told us that although the risk checklist form had been in use for some time, she and her colleagues had not been trained how to use it and found it confusing.

7.44 According to CPN 1's record of the meeting that took place on 22 March between herself, Dr G and MO:

> *"[MO] stated that he is fine, stopped taking medication 1 month ago and has been able to continue with his studies.*
> *Denies hearing voices or having paranoid thoughts, added that he has learnt to distinguish between his ideas about other people and reality….*
> *Believes he needs to get on with his life and does not wish to engage with the CMHT at this stage. Aware of what to do should he need help. He was offered outpatient follow up but he also refused as he does not intend to continue taking medication*
> *Stated he has stopped chewing khat since this has an impact on his mental health*
> *Plan:*
> *Close case to CMHT*
> *Letter to GP and consultant*
> *We agreed to close case to team."*

7.45 Dr G told us he had considered with MO the possibility of changing his medication to a depot Risperdal Consta or lower dose of Aripiprazole to see if it made MO less drowsy but MO was "*adamant*" that he would not continue with medication.

7.46 The SE CMHT staff told the investigation team that the decision to close MO's case would have been taken at an informal meeting between them to which the consultant Dr F would also have been a party. CPN 1 said the thinking behind the decision to discharge was that MO:

"*…had by then moved out of the area and he decided that he wasn't going to have any treatment. But I think what swayed us, and it was very important, is that at that stage he was not sectionable*."

7.47 Dr G confirmed that at the time he had not detected signs of paranoia, nor had MO appeared acutely psychotic. He told us:

"*I felt he wasn't sectionable…he wasn't acutely psychotic…There wasn't much you can do at that stage"*

and

"I offered him an outpatient appointment but he wasn't interested, so what we decided, there wasn't much we can do…"

7.48 On 3 April 2006 CPN 1 wrote a letter addressed to GP2, the GP who shared premises with GP3, MO's registered GP. She enclosed a copy of Dr G's discharge letter to MO's previous GP dated 28 October 2005, referred to in paragraph 7.24 above, and gave an update on the history of MO's involvement with the SE CMHT. She concluded by saying:

"In view of MO voicing that he will not engage with the services his case will now be closed to this team. He is aware of the self-referral procedure and has been advised to contact you in the event of needing CMHT help, since he is out of our catchment area."

7.49 On 4 April 2006 MO went to the A&E department of Whipps Cross Hospital complaining of a pain in his anus and that someone was trying to poison his food. He was seen by PLNA a psychiatric liaison nurse. PLNA made an appointment for him to return to the hospital the next day to be seen by a psychiatric SHO, but MO failed to keep that appointment. PLNA then wrote to MO's GP giving him a summary of his assessment of MO including his risk assessment. The summary stated that MO:

"…reported that a rich Somalian man BB has been using people to poison his food thus causing pain in the anus…He said that his brother and BB's brother were working

together…in Somalia. They were both…charged with stealing…His brother was set free but [BB's] brother was sent to prison and had subsequently died…As a result BB is using his wealth to pay other people to poison his food. He said BB does not want him dead but only wants to torture him."

7.50 The summary went on to state that MO had denied suicidal thoughts, intent or plans and that he posed no immediate threat to himself or others. Under the heading 'plan of care', PLNA noted that when he had phoned MO after his failure to attend for the appointment on 7 April 2006, MO had said that he was feeling fine and no longer believed that people were trying to poison him and he had rejected the suggestion of a further appointment. PLNA noted that the GP was to follow up and MO had been "*discharged from a psychiatric point of view*".

7.51 PLNA told us that:

"*MO was lucid at the time…there was nothing to make me think it was necessary to alert the GP by phone at that point in time. He did not give me cause for great concern."*

"He didn't seem psychotic-more suffering with paranoid ideas."

7.52 On 28 April 2006 a member of Newham council's housing department visited Fairlop Road and found that MO had removed the lock from the door to his accommodation there and that the door was kept open while MO was out. The staff member wrote in a file note that Veni properties, the agents who managed lettings on behalf of Newham council, had been made aware.

7.53 A note on the housing department's file shows that on 2 May 2006 an officer from Glasgow city council contacted the HPU to say that MO was at their offices making a housing application. On being told that MO had a live housing application with the HPU the officer in Glasgow agreed that she would direct MO back to the HPU. We have received no evidence about the circumstances of MO's trip to Glasgow.

7.54 On 8 May 2006 MO was given temporary accommodation at a ground-floor studio at 20

Howard Road, London N15, South Tottenham, outside the borough of Newham. MO immediately requested a review of the decision to re-house him at Howard Road. On his application form, which was written in French and translated, MO said he was seeking the review because "*over a hundred people*" were pursuing him day and night and that someone with a lot of money was trying to "*eliminate*" him, so he had asked not to be accommodated on a ground floor.

7.55 He also said he did not want to deal with Veni properties "*because some of the staff working for them have connections with my enemy. At the present time he already has a copy of my keys as well as his camera in my studio flat".* The medical assessment officer who considered the suitability of Howard Road as accommodation for MO noted that, given MO's mental health history, it would be best if he were placed "*where appropriate supervision can be given*" and that "*N15 might not be the best place for him given the nature of his previously established support".*

7.56 Newham council told MO on 30 June that his application for review had been successful and that the HPU would contact him as soon as they had found alternative accommodation.

7.57 On 29 May 2006 MO went to the A&E department of the North Middlesex Hospital. The handwritten notes of the doctor who saw MO on that occasion record:

> *"- Alleged to have been put to sleep by some kind of anaesthetic gas while in his room and believes to have been sexually abused*
> *-Now complaining of pain in anal region…*
> *Examination not done to avoid interference with forensic evidence*
> *Plan*
> *Patient has been advised to report matter to police"*

7.58 The letter subsequently sent to MO's GP states that the treatment given was "*advice only*" and MO had been discharged.

7.59 An inspector from Veni properties visited the property at Howard Road on 22 May 2006 and found it was dirty. The inspector visited the property again on 5 June 2006 and found

that the carpet had been soiled by water and the lights, a table and the front door lock had been damaged. Newham council's accommodation staff advised Veni properties in an email on 15 June 2006 to visit the property again to ascertain the extent of the damage and whether it had been caused maliciously. Veni properties were asked to carry out the necessary repairs immediately. The email ended "*Please note that two officers must visit this tenant at all times, for confidential reasons I cannot disclose".*

7.60 The two builders sent to the property at Howard Road on or about 20 June found that the electrics and lighting had been tampered with and that the kitchen sink had been damaged and was leaking. Veni properties concluded that MO had caused the damage deliberately.

7.61 Veni properties told Newham council's accommodation staff in an email dated 21 June 2006 that the landlord of the property at Howard Road had tried the day before to gain access to studio 4 at the property to repair a shower leak which was affecting MO's accommodation in studio 2 below, Mr A, the tenant of studio 4, had refused to allow the landlord access. The landlord had been unable to gain access to MO's accommodation because MO had changed the locks.

7.62 MO went to the A&E department at North Middlesex Hospital again on 22 June 2006 complaining about pain behind his eyes. The letter sent by the A&E department to MO's GP said that MO had not waited to be seen and had been discharged.

7.63 On 23 June 2006 there was a fight between MO and Mr A in the communal hallway outside MO's studio at 20 Howard Road. The police crime report of the incident says the scene was heavily bloodstained and that two knives were recovered. MO suffered several stab wounds to his chest. Mr A had knife wounds to his left shoulder and right arm. MO was taken to the A&E department at North Middlesex Hospital. A police crime report entry for 3pm on 23 June states:

> *"The latest update from the hospital is that the victim [MO] is stable and has been moved onto a ward. He has been heavily sedated so is unfit to make a statement…He gave a brief account to [a police officer] in which he stated that the suspect (Mr A) came to his door armed with a knife, he could not explain how the suspect was*

injured. The victim [MO] was also arrested for GBH.

"Enquiries made on [the police national computer] tend to suggest that our victim [MO] suffers from mental illness and has attacked persons in the past with knives."

7.64 An entry on the police report for later in the day of 23 June states:

"Suspect gave a full account interview. He stated that the victim [MO] had visited his room at about 20 minutes before the fight. He was saying 'come outside', he had his hand behind his back and the suspect thought he might have been in possession of some sort of weapon. He just shut the door on him. He got dressed…he placed a small lock knife in his pocket as he thought there might be some trouble. As he walked past the victim's door he jumped out and lunged at him with a kitchen knife. He then became involved in a violent struggle with the victim. During this attack the suspect received injuries to his right hand and left shoulder. At one point he managed to break free from the victim…he did not have time to escape out of the front door, but he did take out his knife and open the blade…He does not know how the victim got his injuries but accepts that it must have happened during the struggle."

7.65 DC RO a training detective constable at Tottenham police station in June 2006, took charge of the investigation into the fight involving MO from the time that the decision was taken to charge Mr A. He gave the following explanation of the decision not to charge MO:

"At the time that MO was at the hospital he was under arrest; that's another reason why the police were with him. It was only when we found that the injuries were quite serious to [MO], and on consultation with the CPS [Crown Prosecution Service] representative, it was decided that [MO], due to the seriousness of his injuries and the high amount of his injuries, and of the story given by the suspect, that [MO] would be de-arrested and treated as the victim rather than to be pursued…"

"With consultation, it was deemed that without getting the account from [MO], we couldn't possibly say who had started it, but as the investigation moved on and we started finding out various things about [MO], it was quite conceivable that [MO] could have been the aggressor and the instigator of the incident…"

"We can convey our thoughts to a CPS representative but at the end of the day the choice of charging and how we treat the defendants and the people involved…ultimately resides with the CPS."

23 June 2006 to 10 July 2006 – inpatient care at North Middlesex Hospital

7.66 The multidisciplinary care notes for MO's time as an inpatient on Nightingale West ward at North Middlesex Hospital show that MO was uncooperative with staff who tried to care for him. He refused medication, and a magnetic resonance imaging scan (MRI). He also refused to allow observations or blood tests to be taken. The note of a ward round conducted by a consultant on 3 July 2006 shows that MO wanted to be moved to a different hospital. The consultant asked for MO to be examined by the hospital's locum psychiatric liaison consultant Dr D.

7.67 MO was prescribed Metformin, used to treat diabetes, while he was in North Middlesex Hospital. We have received no evidence to show when or how MO was diagnosed with diabetes.

7.68 Dr D saw MO on 4 July 2006. His hand-written note of the interview records:

"Has been intermittently agitated on the ward and asked to be transferred to a different ward. Also refusing some medical investigations and nursing care.
Described mood as low. Denied suicidal ideation.
Paranoid persecutory delusions…Has incorporated hospital staff into delusions-guarded about details.
No insight into illness or need for treatment
Impression: appears to have one year history of social isolation, auditory hallucinations and persecutory delusions.
Plan: Organise {Mental Health Act] assessment
Try to get corroborating/ background information."

7.69 Dr D told us that MO presented as "*mentally unwell*" and "*psychotic*". He did not recall any particular problem in communicating with MO. He told us:

"…He told me quite a lot about his background. The way he described it was jumbled up chronologically, so I had to establish what he told me was going on and then put it in the right order, and sometimes go backward and forward and then say, 'Was it like this?'. After a while we were able to reach an account that he agreed upon. I remember that being difficult but I felt that was largely due to his psychotic thinking rather than a language problem. He was having trouble making sense of his experiences rather than having trouble making sense of them in English…there were some things that he was guarded about and didn't want to reveal and there were some things that he wasn't particularly interested in."

7.70 MO told Dr D that he had seen a psychiatrist about two years earlier and had been prescribed medication that he had taken for three weeks and then stopped. He said he had never been admitted to hospital.

7.71 Dr D explained his decision to seek a Mental Health Act assessment:

"…I felt that he was ill, and I felt there was risk involved. I felt that he was primarily a risk to himself. He had clearly been suffering from paranoid psychotic experiences in that he felt he was being persecuted, pursued, and things were being done to him by other people in order to harm him. As well as that they had gone one stage further in that he had started to act on those beliefs. I was concerned that he told me someone had been releasing gas on the tube train and as a result he felt his only course was to pull the emergency cord. This indicates another level of risk in someone who both has beliefs and acts upon them. There was another element of risk in that there had been some kind of altercation. I had only had his account of it, but I felt it was likely that his mental illness had been involved in that altercation, so perhaps his account was not right and he might have gone to harass the neighbour, or the neighbour might have asked him to do something, but due to his irritability, he had reacted in a way that inflamed the neighbour. So I felt that, given something like that had gone on, there was a risk."

7.72 Dr D explained that he had not felt it appropriate to treat MO in the community because he had little insight.

7.73 Dr D's notes show that he rang MO's GP practice who told him that MO had attended at Whipps Cross Hospital's A&E department on 12 April 2006 and had seen a psychiatrist there. When Dr D contacted the psychiatric liaison team at Whipps Cross Hospital they told him they had no records for MO and Dr D concluded that MO may have been seen by a SHO on call. Dr D told us he had not contacted the police to ascertain the full circumstances of MO's fight with Mr A because MO was likely to be treated for his mental illness in a specialist hospital and he had expected the hospital to work with the police. Dr D explained that he was the sole member of the psychiatric liaison team in North Middlesex Hospital and had to make a judgement about how much of his resources he put into dealing with any one patient.

7.74 The multidisciplinary clinical notes for 5 July 2006 show that MO continued to be unsettled. He demanded to be moved to a different ward and then left the hospital. Hospital staff found him walking near the North Circular Road. As a result on 6 July 2006 Dr D arranged for MO to be detained under section 5 (2) of the Mental Health Act 1983. On 7 July 2006 MO was detained under section 2 of the act.

7.75 MO remained at the North Middlesex Hospital until 10 July 2006 when a bed became available on Northumberland ward at St Ann's Hospital. Dr D's discharge letter to the duty team on Northumberland ward outlined what MO had told Dr D in their interviews, including the incidents of MO acting on his beliefs by pulling the emergency cord on an underground train on more than one occasion; the fight with Mr A; and the fact that MO had seen a psychiatrist a year or so previously. Dr D gave an account of his mental state examination of MO saying "*His affect was frightened, suspicious and guarded. He described ongoing persecutory delusions and has incorporated staff and other patients into his belief system*". In his conclusion Dr D wrote:

> *"[MO] gives a one year history of increasing social isolation, decreasing function and active psychotic symptoms. It seems that this has been largely untreated. Recent events would suggest that there is considerable risk associated with his illness and that he warrants treatment in hospital."*

10 July 2006 to 25 July 2006 – inpatient care at St Ann's Hospital

7.76 On admission to St Ann's on 10 July 2006, MO was seen by Dr E, the on-call SHO. Her note of that interview includes the following:

> *"[Discharged] from [North Middlesex Hospital] today. Admitted 10 days ago with multiple stab wounds after altercation with neighbour.*
> *Stab wounds in back; now healing*
> *Brace around torso and walking with crutches. Neighbour also stabbed.*
> *Seen by orthopaedics who want to follow up with MRI of lumber spine to assess damage (won't consent so far).*
> *…Stated neighbour attacked him because he told him not to let dog sit in front of door…*
> *States he has never seen a psychiatrist before? Not what says on letter…*
> *Please see attached letter*
> *…Difficult historian and difficult to understand language*
> *Guarded*
> *[Speech] difficult to understand*
> *…*
> *[Impression] psychosis*
> *?Schizophrenic illness*
> *Plan*
> *S2 already*
> *15 minute observations tonight please*
> *…*
> *Refused physical examination*
> *…*
> *To be seen by team."*

7.77 MO's named nurse on Northumberland ward was Nurse 1 who was on night duty throughout MO's stay. As Nurse 1 explained to us, this meant he had the chance to see MO only from when he came on duty at 8.45pm, until MO went to bed.

7.78 On 10 July, MO's first night on Northumberland ward, Nurse 1 made an entry in the multidisciplinary clinical notes that contained the following:

"*[MO] appears calm in mood and manner….*
He is guarded not willing to give any details of why he needs to be in hospital. He says he needs help and he wants a single room. He is paranoid that patients may try to harm him…He is not clear but made threat that if he is not given a side room he will try to kill himself. He is diabetic and has been prescribed Metformin".

7.79 On the same night Nurse 1 filled out a standard form '72 hour assessment care plan' for MO. Under the heading 'identified problem(s) by admitting nurse', Nurse 1 entered "*paranoid that other people want to harm him".* And under the heading 'agreed goals and objectives' he entered*:*

"1. To keep safe on the ward
2. To stabilise mental health
3. To stabilise physical health (diabetic)"

7.80 Nurse 1 told us that he learned that MO was diabetic either from MO or from the records that came to St Ann's Hospital from the North Middlesex Hospital.

7.81 When we asked Nurse 1 about his recollection of MO at the time that he first met him, he told us:

"What I can remember was that there was a patient…who needed a lot of attention because he was frightened, he was injured, so it wasn't just mental health, it was physical as well. Who at the same time was so frightened he was not forthcoming, he was untrusting, and there were communication problems. Whether he was Somalian – speaking or French or English speaking you couldn't get a communication or proper conversation going with him."

7.82 However, Nurse 1 pointed out that MO had later told him about being sexually abused and in doing so made it plain that he was *"able to make what he wants clear".*

7.83 On 11 July 2006 MO was seen in a ward round by his RMO, Dr V, and his SHO, Dr N. Dr N's notes of the ward round include the following:

"*[Dr V] needs information about stabbing*

…

[MO] says in skull has a metal plate as in France 5 yrs ago had an accident
Alleges in ward patients trying to kill him…does not want to stay on the ward…
Discussed brother in Somalia, his friend in jail and his brother in Newham trying to harm him…
Quetiapine prescribed
Interpreter requested"

7.84 We asked Dr V what he had thought about MO's mental state at this time. Dr V's recollection was:

> *"I thought he was psychotic still. I didn't know what we were dealing with. There was a story of one year, I didn't know if it was longer. I didn't know if rememberings had been part of an illness. I thought there was an awful lot that was unknown, and in terms of his mental disorder it was of a degree that he was acutely psychotic still, because he was talking about people on the ward wanting to kill him and abuse him and so on."*

7.85 MO's solicitors wrote on 11 July 2006 to the Mental Health Act Office of the BEH NHS trust asking for a Mental Health Review Tribunal (MHRT) hearing to appeal against his detention under section. The Mental Health Act office wrote on the same day to ask staff on Northumberland ward and ASWB, the approved social worker (ASW) who had given a report at the time that MO was sectioned, to prepare reports for the hearing. On Thursday 13 July the Mental Health Act office wrote to the same people to tell them that the MHRT hearing had been fixed for the following Tuesday 18 July 2006.

7.86 ASWB saw MO on Northumberland ward on 13 July. Her note of that meeting shows that MO said he no longer thought that people were trying to harm him. She recorded MO as saying: *"He says all the things about the man in Somalia were rubbish. He doesn't think the brother put anyone up to harassing him".* During the interview MO told ASWB among other things about having been accommodated by Newham council and that he had had a "*small depression*" while living in Newham.

7.87 On 14 July 2006 DC RO, the detective with responsibility for investigating MO's fight with Mr A, went with another officer to Northumberland ward to discuss the possibility of interviewing MO. The ward staff contacted Dr V who told them that MO should not be in contact with the police because of his mental state. The police officers left without talking to MO. Dr V had earlier asked for more information about the stabbing but none of the staff on duty took the opportunity to ask the police about it.

7.88 Later on 14 July MO was seen again by Dr N along with Nurse 2, a French speaking nurse who acted as interpreter. Dr N's note records that during the interview they discussed MO's history in greater detail. They discussed MO's refusal to have examinations because he claimed to have a metal plate in his skull as a result of an accident in France. MO denied that BB was trying to harm him. MO also said that he had previously seen a psychiatrist in Newham, although he had asked to see a psychologist.

7.89 The plan of care recorded by Dr N was "*More information from France, family, East Ham Hospital, Whipps Cross, police report, [North Middlesex] Hospital and GP*" as well as a physical examination by an SHO *and "orthopaedic team requirements".*

7.90 Dr N explained to us that although Dr E, in her admission summary, had recorded that MO had stabbed Mr A, the discharge letter from Dr D the locum liaison psychiatric consultant at North Middlesex Hospital recorded MO as saying that he had not had a weapon in the fight with Mr A and had only been trying to defend himself. Dr N said he had therefore wanted a report from the police to establish exactly what had happened. Dr N also told us that when he had asked MO where precisely in Newham he had seen a psychiatrist, MO had named East Ham Hospital, hence the mention of that hospital in his plan.

7.91 In response to Dr N's request for further information, Nurse 2 contacted the surgery of GP3, MO's GP, who faxed to St Ann's the discharge letters sent to the GP on the occasions that MO attended at the A&E department of North Middlesex Hospital on 29 May 2006 and 23 June 2006 and on the occasion that he attended at the A&E department of Whipps Cross Hospital on 6 April 2006. For reasons the GP could not explain the staff did not fax the SE CMHT's discharge summary of 3 April 2006 that had been addressed to GP2, another GP who shared premises with GP3's practice. Nurse 2 also contacted the police involved in investigating the fight between MO and Mr A but there was no response. Nurse 2 left a

message on the police answer machine. There is no record of the police responding to it.

7.92 Later on 14 July 2006 MO was seen for a physical examination by an SHO, Dr Y. His notes show that he found MO looking well and walking on crutches and that his stab wounds were healing well. Dr Y suggested an x-ray be taken of MO's skull to confirm the presence of metal plates. MO refused to have an x-ray and would not explain why. Dr Y recorded:

> "*Physically well other than [reduced] power in left leg. Orthopaedics will do MRI scan once presence of metal plate in head.*[sic]*"*

7.93 Nurse 1, MO's named nurse, recorded in the multidisciplinary clinical notes that during the night shift of 15 July 2006 MO had continued to entertain paranoid ideas and had tried to barricade himself in his room. He had been compliant with medication. During that night shift Nurse 1 also completed further care plans for MO, a mental health unit assessment form and a brief risk assessment form. Nurse 1 left much of the mental health unit assessment form blank but in the section headed 'overall nursing impression and recommendations', he entered:

> *"Paranoid and suspicious, deluded that everyone is against him. Makes allegations against others. Can become aggressive towards others. Requires admission for assessment and to ensure his safety and the safety of others."*

7.94 Nurse 1 told us that this assessment of MO was based in part on his understanding of paranoia and in part on his own experience of MO. He told us:

> *"…paranoia, when you feel that somebody's against you and they are trying to attack you, means that that you have to defend yourself. Therefore you are also alert for an attack, so you would be ready to defend yourself. In being ready to defend yourself against an imaginary foe you end up being an aggressor."*

7.95 He also explained that:

> "*…somewhere along the line [MO] had an altercation with me where he accused me of being rude to him. So straightaway, I would know that this person has this kind of feeling that could be set off, maybe a word, or maybe by something that I did in all*

good meaning, that he would interpret that way."

7.96 In the brief risk assessment form, Nurse 1 marked MO as high risk for aggression/violence to others and for non compliance with treatment. He included the following narrative:

"*No previous history of psychiatric treatment. Was recently involved in a fight with neighbour in which knives were used. He stabbed neighbour and neighbour also stabbed him. Police are interested in interviewing [MO] regarding the fight. [MO] refused physical examination (scan) of his head. He says he has a metal plate in there. Appears paranoid about other patients on ward. Appears guarded with information about past and current history. Appears to need an interpreter, but is clear in allegations of sexual abuse etc."*

7.97 When we interviewed Nurse 1 he was uncertain whether he had learned that MO had stabbed Mr A on 23 June 2006 from Dr E's note when MO was admitted to St Ann's Hospital or from what MO had said to him. He told us:

"*I think it was common knowledge on the ward…That they had mutually stabbed each other…I think we all knew and were sharing that in handovers and things like that."*

7.98 The other members of the nursing staff we interviewed confirmed that it was commonly understood on the ward that MO was capable of violence and had inflicted injuries on Mr A.

7.99 On 16 July 2006 one of the nursing staff recorded in the multidisciplinary clinical notes:

"[MO] remains paranoid and suspicious. He complained that fellow patients have been spraying some noxious gas into his room when passing by. It took staff time to explain to him that this was not true and in fact his carpet was washed yesterday and has not fully dried yet. He however kept peeping at others when they pass by."

7.100 Dr V told us that he and Dr N found out only on the afternoon of Friday 14 July 2006

that MO's MHRT hearing had been arranged for 2.30pm on the afternoon of the following Tuesday 18 July 2006, the latest date possible under the Mental Health Review Tribunal rules 1983. Dr V was unable to attend the hearing and Dr N was asked to go on his behalf. Dr N wrote his report for the MHRT on the afternoon of Monday 17 July 2006. Shortly before the hearing Dr V and Dr N went through the report. There were certain matters missing from it, but Dr V advised Dr N that he could present additional evidence orally.

7.101 In the morning before the MHRT on Tuesday 18 July, Dr A, the medical member of the MHRT followed the usual procedure of going to Northumberland ward to view the file for MO and to conduct an interview with him. Dr A saw MO with a French interpreter though he told the panel that he is "*fluent in French to know whether the interpreter was right or not".* Dr A spoke with MO both in English and French.

7.102 MO was later seen by Dr V in his ward round together with Dr Nand a French speaking nurse. MO said that BB was trying to harm him. He said he was suffering from pain in his anus as a result of sexual abuse. When asked what he would do if taken off section he said he would go home straight away. He agreed to a skull x-ray. His prescription of Quetiapine was increased.

7.103 The notes of the MHRT proceedings on 18 July 2006 prepared by MO, the chair of the MHRT, state under the heading 'pre-hearing discussion':

> *"Dr [A] told us that he had examined the patient this morning for 30-40 minutes. He had found nothing untoward. The patient had been co-operative, and had smiled and behaved rationally. He gave a good account of himself. There was no evidence of any symptoms of mental illness."*

7.104 The MHRT received written reports from Dr N, ASWB, the ASW involved in sectioning MO, and the discharge letter from Dr D, the liaison psychiatric consultant at North Middlesex Hospital. The MHRT heard oral evidence from Dr N, ASWB, Nurse 3, a charge nurse on Northumberland ward, and MO. At the end of the hearing the MHRT ordered the lifting of MO's section. This was not to come into effect until Friday 21 July 2006, to allow for arrangements to be made to ensure that Mr A was not in a position to attack MO again.

7.105 The MHRT had concluded that there was no evidence that MO was suffering from mental disorder, although he may have previously suffered from a psychotic episode induced by taking khat.

7.106 Nurse 3 spoke with the delayed discharge team after the MHRT hearing about finding MO alternative accommodation. ASWB also contacted the HPU to discuss arrangements for housing MO on his discharge from hospital. ASWB arranged for Dr N to write to the HPU to explain why MO could not continue to be housed at Howard Road.

7.107 The St Ann's Hospital file for MO shows that at some time after the MHRT on 18 July 2006, Nurse 1, MO's named nurse, filled out a CMHT referral form, also called a discharge assessment of needs notice. Nurse 1 did not mark MO as presenting any of the risks set out in the section headed 'assessment checklist'. He explained to us that he had understood that the discharge by the MHRT meant it had to be acknowledged that there was nothing wrong with MO and it would not be right to describe MO as having any of the stated risks. In the form, Nurse 1 gave the reason for the referral as: "*Might need help in the community since he lives alone"*. He described MO's current mental state as:

> *"1. Paranoid about people wanting to attack and hurt him*
> *2. Possible non-compliance with medication."*

7.108 On 19 July 2006, Nurse 3 contacted the police involved in investigating the stabbing incident on 23 June 2006, to warn them that MO would shortly be discharged from section and was planning to go back to his former accommodation at Howard Road. DC RO told Nurse 3 that he was surprised by the verdict of the MHRT and that he would come to the ward to see MO and discuss his plans with him. Nurse 3's entries in the clinical notes for 19 July show that Dr V saw MO that day in a ward 'review'. MO told Dr V "*that once his section expires on Friday he will discharge himself from the ward. However he did agree to take any prescribed medications".*

7.109 When DC RO went to Northumberland ward on 20 July, as well as speaking briefly with MO, he spoke with staff about the outcome of the MHRT and asked to be given a copy of the MHRT decision. DC RO explained to us that he had thought the CPS might be interested in what it said about MO's mental state and capacity. He had asked ward staff to tell him if MO

was discharged the next day.

7.110 On 20 July 2006, Nurse 3, the charge nurse, completed a further CMHT referral form. He told us he could not recall whether he had seen the earlier referral form completed by Nurse 1. He had not discussed the earlier form with Nurse 1, and he had completed his form because he thought MO needed to be referred and to have a care coordinator appointed as quickly as possible. In his version of the referral form, which was faxed to MM, the manager of BEH NHS trust's Tottenham area CMHT at Tynemouth Road, Nurse 3 marked MO as being at risk of "*self neglect*", "*abuse/exploitation by others*", "*serious violence/harm to others*" and "*non compliance with medication*". He said the history of risk was "*not known*". Nurse 3 also wrote:

> *"[MO] is alleged to have been stabbed by neighbour (chest wound) nearly 2 weeks ago. Is also said to have threatened neighbour first before being stabbed…"*

Under the section headed 'current mental state', Nurse 3 wrote:

> *"Following the assault and stabbing incident, he was admitted to North Middlesex Hospital, wherein he received treatment for wound on the abdomen. Displayed paranoid and persecutory delusion while on the ward. Thereafter assessed and placed on section 2 MHA."*

Under the heading 'indication of urgency', Nurse 3 wrote:

> *"Extremely urgent as he wants to take his discharge once his section is lifted on Friday noon (25-7-06)."*

Under the heading 'housing situation' Nurse 3 entered:

> *"Has got flat which is funded by Newham Borough council. Given the stabbing incident, Police and the MDT do not believe that is advisable for him to go back to his flat. Hence the urgency of this case."*

7.111 Nurse 3 told us that it was his experience that it usually took a "*good two weeks*" for

the CMHT to appoint a care coordinator to a case, although there were times when one was appointed within ten days.

7.112 The files supplied to us by BEH NHS trust contain a CPA that was evidently completed for MO at some time after the MHRT on 18 July 2006. It is signed by Nurse 1, MO's named nurse. However Nurse 1 told us that it had been completed by another member of the nursing staff and then presented to him for signature. He told us that he could not remember who the other member of staff was and we have not been able to identify him or her. The CPA names BA, the manager of the HPU as the care coordinator and gives her address as the Plaistow offices of the HPU. In answer to the question, "*Has the Risk Assessment been completed*" reference is made to the brief risk assessment completed by Nurse 1 on 15 July 2006. Against the entry 'mental health needs', the only action put down is "*Discharged by the Mental Health Tribunal*". The sections headed 'unmet need', 'relapse indicators', 'contingency/crisis plan' are left blank. The form is not signed by MO. There is no evidence to suggest that a CPA meeting or any other formal meeting was held to discuss CPA and/or aftercare for MO.

7.113 On 21 July 2006 nursing staff on Northumberland ward were still trying to get in contact with the HPU to arrange for MO to be rehoused. They also tried to contact the police to find out who had MO's key to Howard Road. While ward staff were waiting for a response from the police, MO left the ward for a walk in the corridors but then left the hospital. The ward later received a call from St Ann's police station to say that MO was there. According to the clinical notes, the police were asked to send MO back to the ward "*so that proper arrangements could be made for him to go to the homeless persons unit in Plaistow".* While still at the police station, MO complained of chest pains and was taken to the A&E department at North Middlesex Hospital. According to the notes made by the Northumberland ward staff, MO was seen by a doctor who diagnosed a musculo-skeletal pain. MO refused an x-ray and blood test but had an ECG. MO returned form North Middlesex Hospital to Northumberland ward early on Saturday 22 July 2006. He told staff that he would stay in hospital over the weekend and contact the HPU for alternative housing on the following Monday.

7.114 An entry in the clinical notes for Sunday 23 July 2006 states:

> *"[MO] was confronted about his lack of compliance with medication. He admitted not*

taking them except his diabetic tablets. Upon investigation …tablets of metformin were found in his bin, at which point he apologised and promised to take them from now on."

7.115 On Monday 24 July 2006, MO's solicitors spoke to Newham council's accommodation team about the need to find him somewhere else to live. The accommodation team file note shows that the member of staff who spoke with the solicitors:

"*…expressed…concerns…about the information gathered from the managing agents (Veni Properties) that they suspect [MO] could be suffering from a mental health problem and he is not altogether himself…suspects people are watching him…*"

7.116 The solicitors were told to ask MO to attend at the offices of the HPU where he would be booked into emergency bed and breakfast accommodation, pending nomination for suitable alternative temporary accommodation. By the time his solicitors phoned the ward, MO had already left for the HPU. Later that day, the HPU telephoned the ward to tell staff that MO was being offered emergency accommodation. Nursing staff noted that at this stage they considered MO to be on leave until they had a contact address for him and were able to ask him to collect his discharge medication.

7.117 MM, the team manager of the Tottenham area CMHT, told us that she recollected a discussion in a CMHT team meeting, probably on Monday 24 July 2006, about whether the team should allocate MO a care coordinator, but there had been uncertainty about where MO would be housed and whether he was in fact eligible for treatment in the community by the BEH NHS trust. We have seen no record of any such discussion. MM believed that she had contacted Northumberland ward to ask the staff to let her know where MO was eventually housed. It appears, however, that Northumberland ward did not respond to the CMHT and no arrangements were made for MO to be allocated a care coordinator or to be seen on discharge either by the Tottenham area CMHT or by any other CMHT.

7.118 Dr N's note of Dr V's ward round on Tuesday 25 July states:

"..On Monday [MO] got B and B from Newham
TTA's [to take away medication] not collected

Discussed in team-Discharge from inpatient status as of today".

7.119 Dr V told us he thought there had been discussions either on the ward or in the CMHT's meeting on Monday 24 July 2006 about what could or should be done about MO and the risks he might pose. Dr V told us:

> "*We agreed to discharge him…because he disappeared from our antennae by that time, not completely but we had taken into account that we could have may be traced him wherever Newham had placed him. The reason our approach might not have been as assertive is that it was very clear he didn't want contact, he had been given, in his own words, a clean bill of health and therefore didn't need to have contact, there was no question in his mind that he needed contact, so it was very difficult to see how we could move forward, because none of the teams we have can assertively make contact with a patient who doesn't want to or doesn't need to."*

7.120 We have seen no record of the discussions involving medical staff about MO's discharge and the management of the continuing risks he posed. Dr V said he had no written evidence.

7.121 DC RO, who had not been told about MO's discharge from St Ann's Hospital, rang Northumberland ward on 26 July 2006 to find out where he was. He was given contact details for the HPU.

7.122 On 3 August 2006 Dr N wrote to MO's GP giving him a discharge summary. That summary was in the same form as the report he prepared for the MHRT with an additional paragraph outlining events since the MHRT. It did not contain a clear statement of diagnosis or prognosis nor did it expressly set out the risks MO presented or a plan for managing them. It set out MO's medication as follows:

> *"Metformin 500mg tds*
> *Quetiapine 350mg bd*
> *TTAs not collected by patient"*

25 July 2006 to 7 September 2006

7.123 When MO left St Ann's Hospital on 24 July 2006, the HPU gave him bed and breakfast accommodation at Banks Hotel in Park Avenue, Ilford.

7.124 On 25 July 2006 AC, the mental health coordinator at the HPU called CPN 1 at the SE CMHT to ask her to assess MO. CPN 1's note of that conversation states:

> "*…Call from [AC] at the HPU to inform that MO was in an incident with a neighbour in which he was stabbed needing hospital treatment. It appears that this is the 3rd incident, the two previous also involved knives and MO was the perpetrator then-it seems that he did not actually harm anybody but threatened with knife. [AC] is planning to bring [MO] back to Newham to access. services…[AC] is concerned about his mental state and requests for an assessment as soon as possible".*

7.125 The HPU rang MO the same day and advised him to attend for an assessment at the SE CMHT. AC and NB, the leader of the HPU team responsible for assessing MO's housing needs, told us that there was no written policy but the HPU usually sought a new assessment of the mental health needs of a client who had been out of contact with the HPU for a while or when something suggested a change in the client's mental health.

7.126 On 31 July 2006, MO went to the office of the HPU and complained to staff that some people had been *"spraying something"* on his door. MO moved that day to bed and breakfast accommodation at Luke House Hotel, Canton St E14 outside the borough of Newham.

7.127 MO attended for an appointment at the SE CMHT offices on 7 August 2006. CPN 1's note in the SE CMHT's record states:

> "*MO…seen by [CPN 1] and [Dr F, the consultant with the SE CMHT]. [MO] asked why he had come to see us and how could he be sure that CMHT office was not some other body operating from the address."*

7.128 After setting out MO's account of the incident that led to his being in St Ann's Hospital, the note continues:

"*…discharged 2 weeks ago…no follow up arrangements. He is in constant pain, wearing a body brace and using crutches-states he cannot stand up for very long and cannot do anything because of the discomfort."*

"[MO] denied using Khat for the past year, denied hearing voices and did not appear to be responding to any psychotic symptoms other than exhibiting suspiciousness and being guarded."

"[MO] does not wish to engage with CMHT and does not believe he needs treatment-has not registered with a GP…"

"In view of case being closed to South East team, not registered with a GP and living outside catchment area referral forwarded to [No Fixed Abode] rota team."

7.129 CPN 1 told us that she believed that MO's comment about not being sure that he was at the offices of the CMHT, rather than "*some other body*" was prompted by the fact that he had been seen by Dr F rather than Dr G, whom he had seen on all previous occasions. Dr G had gone on annual leave on 31 July 2006. CPN 1 also told us that she had been:

"*…taken aback by [MO's] vulnerability in the way he presented, it was quite vivid. When I saw him I saw a man who was extremely thin and he was on crutches and had a body brace…I felt he was much more vulnerable, and I wasn't sure about his mental health"*

7.130 As Dr F and CPN 1 had decided to refer MO to the south west CMHT which was doing the rota duty for patients referred with no fixed abode. On 1 August CPN 1 filled out a referral form. Among other things it stated:

"Currently some evidence of suspicious and guarded behaviour, but denied any psychotic symptomlogy, does not wish to engage with treatment…At present not enough collateral information about stabbing incident…Requires French interpreter to assess fully."

7.131 Under the heading 'risk factors', CPN 1 wrote "*More information required about stabbing".*

7.132 Later on Monday 7 August 2006, MO reported to the HPU that a resident at Luke House Hotel had assaulted him on 3 August after an argument in a corridor. The HPU contacted the manager of the hotel who said that MO had rung the police on 3 August to say that someone was trying to kill him. The police attended but could find no evidence of any assault on the CCTV cameras that covered the corridors. The manager told the HPU that he was cancelling MO's booking at the hotel. The HPU moved MO to accommodation at Harrow Road, London E6.

7.133 NB rang CPN 1 at the SE CMHT the same day and told her about the alleged assault at Luke House Hotel and the termination of MO's tenancy. NB wanted to know who would assess MO. CPN 1 told NB about the referral to the South West CMHT. She consulted Dr F and it was decided that the SE CMHT would assess MO after all because he had moved into the catchment area. CPN 1 told NB that she would arrange an appointment for MO. She completed a further referral form. In it she referred to the fact that *"MO had threatened people with a knife on at least two occasions and in June 06 he was assaulted and stabbed"*. CPN 1 also wrote about MO having been punched by a hotel resident the previous weekend. In the section headed 'risk factors' CPN 1 entered:

> "*Further deterioration in mental health*
> *Paranoia*
> *Increased vulnerability-at risk of harm from others."*

7.134 DC RO visited MO at his accommodation at Harrow Road on 8 August 2006 and arranged to interview him the next day about the fight on 23 June 2006 in which MO had been stabbed. DC RO told us that the interview took place on 9 August at the Royal London Hospital under the police's "*achieving best evidence*" policy. It was videotaped and an interpreter was present. DC RO gave us the following description of how MO appeared at the time of the interview:

> "*He seemed quite lucid. He hasn't got a speech impediment but he talks a bit quickly. It was quite confusing because he understood English quite well and he could speak it quite well, but we had an interpreter there, so one minute he would talk through the*

interpreter and at other times he'd try to explain it in English. He seemed quite okay with us, apart from the fact that we were fairly confident that he had a knife on him [at the time of the altercation], and any question relating to that he stonewalled it, nothing to do with him, that sort of thing…He did often sidetrack and go off at tangents about various things that he'd previously been an alleged victim for…"

7.135 On 23 August 2006 the agents managing the property at Harrow Road E6 rang the HPU to complain that MO had twice broken the water pipe to the washing machine and to say that they were terminating his licence to occupy the property. MO was moved to Barking Park Hotel that day. On 24 August he was asked to leave the Barking Park Hotel. He had been told he could not be moved to another room and set fire to the curtains. MO was moved to Hartley Hotel, Romford Road E7.

7.136 CPN 1 wrote to MO at Harrow Road E6 on 23 August 2006 to offer him an appointment on 29 August with her and Dr G, who had returned from holiday on 18 August. Dr G told us that he had not seen MO but that what he was told about him at that time, including about the stabbing incident on 23 June 2006, led him to think that MO was becoming unwell again and a risk to himself and others and might have to be sectioned again. Dr G gave his reason for believing MO might be sectionable as follows:

"We have an established diagnosis, there is a psychotic illness, he was stabbed, so he's at risk and he's so vulnerable. St Ann's hospital, perhaps they don't know much about his history, but we are aware of his history."

7.137 On 24 August 2006 Newham council's temporary allocations team wrote to MO at Banks Hotel Ilford, the property that MO had left on 31 July, to offer him temporary accommodation under its private leasing scheme.

7.138 MO failed to attend for the appointment with the SE CMHT on 29 August, so CPN 1 telephoned the HPU and spoke to MT, who had recently taken over the role of the HPU's mental health coordinator. MT told her that MO had left his accommodation at Hartley Hotel the day before and had not been seen since. CPN 1's notes in the contact record show that she asked the HPU to inform the CMHT if they were in touch with MO again and to:

"*…obtain detailed information from him about his reason for moving frequently in order to get some sort of picture about his presentation."*

7.139 MT did not record this request. CPN 1 also noted that MO's case was to be *"discussed at team meeting and closed for now".*

7.140 On 6 September 2006 CA, the manager of the SE CMHT sent an email to PC EB of the Jigsaw unit at Plaistow police station. The Jigsaw unit is the local police unit responsible for managing offenders in the community. The email alerted the Jigsaw unit that MO was missing and that the CMHT had concerns about him. CA's email said "*it appears [MO] is unwell and potentially very risky-it may be that he comes to your attention sooner rather than later"*.

7.141 CA explained in the email about MO's history of stabbing or punching fellow residents in his bed and breakfast accommodation and of his having been stabbed. CA added: "*he is still very paranoid as far as we know so is potentially still dangerous. We will keep in touch with HPU in case he turns up there at any time. If he is picked up could you let us know as we will be happy to come straight out and see him"*. PC EB pasted the email onto a report for the Newham borough police intelligence system.

7.142 On 7 September 2006 the members of the SE CMHT agreed to close MO's case. CA told us she thought that decision had been taken at a SE CMHT team meeting. CPN 1 suggested that it was taken in informal discussions involving Dr G, Dr F, CPN 1 and CA. Whatever discussions took place and whatever the reasons for the decision to close MO's case, they were not documented other than by a note in the contact record which said simply: "*Agreed to close case to the team as per information [about MO being missing]".*

7.143 CA told us that the reason that the case had been closed was that SE CMHT did not know where MO was, and could not keep a slot in their caseload open indefinitely. Dr G told us he did not think he had been present at the meeting which decided to close MO's case but he explained that decision as follows:

"*You talk about someone who we didn't have an idea where he was, and then we flagged up the name with the police, 'if anything comes up we'll do an assessment'. What else could we have done?"*

7 September 2006 - 20 December 2006

7.144 The HPU files suggest that MO was last seen at his accommodation at Hartley Road on 28 August 2006. Thereafter the services that dealt with MO in England had no further involvement with MO until 20 September 2006. On that day ASWB the ASW with BEH NHS trust received a phone call from AD, a clinical nurse specialist at a clinic in a refugee hostel in Dublin, who told ASWB that MO was living there. ASWB's note of her conversation with AD states:

> *"[The clinic] are trying to get [MO] to the GP. [AD] had seen a decision letter from the [MHRT] which MO showed him and wants background information. I said I will contact the doctor to see if we can send a report."*

7.145 ASWB told us that she sent the summary prepared for MO's discharge from St Ann's Hospital to the clinic in Dublin, having obtained Dr N's and Dr V's permission to do so.

7.146 We wrote to the staff at the clinic in Dublin in May 2008 asking them for the details of their involvement with MO. It was not until late June 2009, after we had completed our investigation and while this report was being quality assured, that the Health Service Executive in Dublin sent us a file containing their records relating to MO.

7.147 The Health Service Executive's file shows that MO arrived at the Balseskin refugee reception centre in Dublin on 6 September 2006. AD, the clinical nurse specialist in the reception centre's clinic, saw MO the same day. MO was displaying signs of paranoia. He showed AD his copy of the MHRT's decision of 18 July 2006.

7.148 AD arranged for MO to see the clinic's medical officer the following day. During his interview with the medical officer, MO complained that he had been sexually assaulted by other residents at the reception centre. MO would not agree to see a psychiatrist but he did agree to see a GP.

7.149 The GP whom MO saw on 8 September 2006 was concerned about MO's mental state. He prescribed Zyprexia 10 mgs daily. He wanted to refer MO for psychiatric assessment but MO refused.

7.150 Over the following few days MO told staff at the reception centre that other residents were trying to kill him by spraying fumes into his bedroom and he also repeated the allegations that he was being sexually assaulted by other residents. He admitted that he had thrown away the medication prescribed by the GP.

7.151 On 29 September 2006, after AD had received the discharge summary prepared for MO's discharge from St Ann's Hospital, he again referred MO to the GP. MO saw the GP on 29 September 2006 but the Health Service Executive's file contains no evidence of what happened at the consultation.

7.152 On 10 October 2006 MO assaulted a fellow resident of the reception centre by punching him in the mouth and threatening him with a large kitchen knife. In the early hours of 11 October 2006 MO was admitted, under police escort, to St Brendan's Hospital, Dublin on a Temporary Order under the Irish 1945 Mental Treatment Act. The psychiatric case notes and nursing notes contained in the Health Service Executive's file show that while he was in hospital MO appeared guarded and suspicious. At his own insistence he slept in a side room and barricaded the door with a chair. He was reluctant to take medication.

7.153 MO was discharged by St Brendan's Hospital on 31 October 2006. A hand written discharge letter written by an SHO, Dr R, to the GP who had previously seen MO states: "*[MO] is found to be suffering from a non specific psychotic illness? He made good progress and is discharged on Quietapine 200mg mane and 400 mg nocte".*

7.154 The letter also states that MO was given a week's medication and was to attend for an outpatient appointment on 8 November 2006. The Health Service Executive's file contains no further documents evidencing the reasons for the decision to discharge MO from St Brendan's Hospital.

7.155 On discharge from St Brendan's Hospital MO returned to the Balseskin refugee reception centre. AD's file notes show that MO continued to be verbally aggressive to staff and residents. They also show that MO saw the GP again on 3 November 2006 but we have not seen a record of what happened at that meeting. There is no evidence of MO attending an out patients appointment on 8 November 2006.

7.156 According to AD's file note, on 13 November 2006 MO was "noted by accommodation staff as 'missing'".

7.157 The medical and clinical staff who had contact with MO in Dublin are not subject to Department of Health guidance HSG (94)27 and their care and treatment of MO does not strictly fall within our terms of reference. For these reasons we have not persisted in trying to obtain more evidence and information from them.

7.158 On 18 October 2006, DC RO, who was trying to contact MO to make further inquiries in connection with the stabbing on 23 June 2006, contacted CPN 1 and asked her to provide a statement about MO's medical history. He explained to us that he thought that the team prosecuting SC would need this to decide what part MO should play in the case. CPN 1 sent DC RO an email outlining what she knew of MO's contact with services.

7.159 On 20 October DC RO placed an entry on the police national computer, known as a 'locate trace', under which any police officer who encountered MO and made a search of the police national computer against MO's name should pass to DC RO details of MO's whereabouts. He told us that his concern was to find an address for MO so that he could contact him and explain the need for him to return to London as a witness at Mr A's trial.

7.160 On 24 October 2006, Newham council gave notice, by means of a file note, of the discharge of its duty to house MO because of his refusal of the offer of suitable accommodation made on 24 August 2006.

7.161 According to DC RO, the first response to his locate trace entry on the police national computer was from the immigration offices in Dublin. And on 8 November 2006 DC RO's colleagues received a call to say that MO had been detained in Belfast for slapping a woman on a train from Dublin to Belfast. MO alleged that she had sprayed him with CS gas. DS TS, who investigated the killing of Camille Remy, said the court in Belfast had bound MO over to keep the peace. He thought MO had been seen by a doctor while he was in custody. We have not been supplied with police records relating to this incident and we do not know when any entries about it were made on the police national computer.

7.162 So far as we are aware, the next contact that MO had with public services was on Saturday 11 November 2006 when he went to Stranraer police station and told officers he wanted to return to Somalia. After investigating MO's immigration status, the police contacted DC RO in response to his locate trace. DC RO told them that MO was needed as a witness at the trial of Mr A. The police in Stranraer also contacted the local duty social worker, RU, because MO was thought to be in distress and in need of emergency accommodation. RU worked as part of the local long term children and families team. According to RU, the police in Stranraer told her that MO had been examined by a doctor, that he had no injuries and that he could communicate in English.

7.163 RU arranged emergency bed and breakfast accommodation for MO for 11 and 12 November 2006. She brought him food and gave him money. She also gave him directions to the social services office in Stranraer and told him to come to the office when it was open on Monday 13 November. RU said in her statement to police investigating Camille Remy's killing that she found MO *"very calm, very placid, very amenable. He understood everything I said and he spoke to me in English".* RU told us that MO had shown no sign of mental illness.

7.164 On Monday 13 November 2006, MO was seen at the social services offices in Stranraer by TY, the duty social worker. She was newly qualified and worked with the physical disabilities team. She said nothing in MO's behaviour suggested to her that he was mentally unwell. She told us "*He wasn't agitated, he wasn't distressed…He didn't give you cause for concern that he was going to get angry or he was going to be really distraught or anything like that*". She told us that MO had decided during the morning that he did not want to return to Somalia after all, but wanted instead to return to London. RU, who was also in the social services office that morning, told us she had agreed to contact the Metropolitan Police to find out whether, given their concern that MO should appear as a witness at the trial of Mr A, they would be prepared to pay his fare to London. They declined but told RU about MO's involvement with the SE CMHT.

7.165 TY phoned the SE CMHT and spoke to Dr G. According to both Dr G and TY, Dr G had made clear his view that the social services in Stranraer should seek to have MO sectioned. Dr G did not make a record of this conversation, but his recollection of it was:

> *"…I said to her, 'I know the guy. He's got a psychotic illness and if he is travelling*

around the country, it's an indication that the paranoia is getting worse and I would highly recommend placing him on section2, transferring him to our hospital'."

7.166 TY recollected Dr G having said "*quite clearly that [MO] needed to be sectioned*".

7.167 TY wrote in her file note that she had advised Dr G that MO *"was not presenting in a way that would cause concern, he was reacting to all I said in a reasonable and justified way. His behaviour was only as expected".* She also noted that she had asked Dr G how he felt MO would be affected by travelling to London by bus. Dr G said it would be unacceptable because he would need to move around and not feel trapped.

7.168 On advice from her duty manager CB, TY phoned the Crichton Hospital in Dumfries and asked to speak with a psychiatrist about MO. No one was available. She also contacted the duty mental health manager and duty mental health officer who arranged to send RK, a social worker and mental health officer, to assess MO. He was adamant when we interviewed him that he had made clear to managers who asked him to attend at the Stranraer social services that it was not his role or function to assess and diagnose MO's general mental state and that he would attend only to assess whether MO was fit to travel. RK told us that social services in Stranraer had also been aware that he was able only to assess MO's fitness to travel. He told us:

"I wasn't there in terms of operating this case. I was 'bussed' in for the sake of helping the duty worker assess whether it was reasonable for MO to travel. They knew this was the limit of my involvement".

7.169 TY, however, was equally clear in her interview with us that she had needed a mental health assessment of MO and that that was why she thought RK was there. She told us :

"*…I was not aware that RK thought he was just allowing [MO] to travel, because I wouldn't have asked for a mental assessment for him to travel. I was totally clear of what Dr G said and I told the managers what he'd said…I was clear that I spoke to the managers that Dr G said [MO] needs sectioning so I was expecting my managers to send somebody that was able to do that."*

TY recorded in her file note:

> *"[RK] was satisfied that [MO] did not meet the criteria to be the subject of a section order."*

7.170 The legal representative of Dumfries and Galloway council in his written comments on the draft of this report has told us:

> *"The assessment of whether someone has a mental disorder requiring treatment under the Mental Health (Care and Treatment) (Scotland)Act 2003 is carried out by a doctor who is recognised by the Act as being suitably qualified to make such an assessment. Mental Health Officers are neither qualified nor empowered by law to make this assessment…Only if [RK] had concerns about MO's mental health as a result of his interview with MO would he have arranged for him to be assessed by a psychiatrist, which is the procedure prescribed by law."*

7.171 RK told us that nothing in MO's behaviour or demeanour gave him concern about MO's mental state:

> *"I can't recollect his command of English, but I do recall that [TY] was able to communicate with him. His appearance and manner were unremarkable."*

> *"I did have a duty as a social worker and mental health officer to MO and to society at large and if anything had come to my attention about his demeanour, behaviour or if I had any other concerns, I would have alerted the health authorities about that".*

7.172 Later on 13 November a travel warrant was organised for MO and TY took him to Stranraer station where he boarded a train to London via Glasgow. RU then telephoned and emailed DC RO to tell him that MO had left Stranraer for London. TY told us she telephoned the SE CMHT to say that MO had been put on the train back to London. Dr G had no recollection of that call.

7.173 It seems that MO did not complete his journey to London on 13 November 2006, because police files disclose that on the night of 14 November he assaulted a deaf young man

on a train travelling from Leeds to Sheffield. Witness statements say the young man was communicating in sign language with his girlfriend. MO verbally abused the young man and later lunged at him and grabbed him round the throat with one hand. A fellow passenger pulled MO off the young man. The guard alerted the British Transport Police (BTP) at Sheffield and MO was detained and questioned on arrival at Sheffield. The young man did not want to pursue the matter. Police warned MO about his behaviour and he was eventually escorted from the station.

7.174 PC DO, of the British Transport Police told us he had checked the police national computer to see if MO was wanted or if there were any warning markers against his name. He said he would have seen the locate trace on the computer but he would not have responded until the following day because it was late.

7.175 PC DO recollected that MO had seemed anxious and evasive. He had thought that MO might have some mental health problem but, he said, not "*to the extreme where I would consider him to be a risk to either himself or anybody else".* PC DO did not think he had needed to take MO to hospital for a mental health assessment.

7.176 PC DO said MO returned to Sheffield station next day and asked another police officer about how he could get to London because he had no money. He was advised that he could get a friend or relative to pay for a ticket at another station and the ticket would be issued at Sheffield. That was the last the BTP at Sheffield saw of MO.

7.177 MO evidently managed to get to London because late on 15 November 2006 he was arrested in Islington for punching in the face a passenger on a number 38 bus. He was detained at Islington police station. Sergeant (now Inspector) GE, custody officer on duty when MO was first taken to Islington police station, told us that he had no recollection of MO and the matters relating to his detention but referred to the custody record which shows that he had detected no sign of mental illness.

7.178 The only risks he had identified concerned various medical conditions that MO himself spoke of, namely problems with his pancreas, kidneys and legs. GE had found no warning markers on the police national computer to indicate that MO had mental health issues or was at risk of being violent. GE called the FME to examine MO because of the health issues he had

identified.

7.179 The FME Dr H saw MO at about 1am on 16 November 2006. The examination form he completed said MO had complained of leg pains since his arrest, and that he had told the doctor that he was diabetic and on insulin and had had his last dose of insulin at 5pm the previous day. He had refused a blood sugar check. The doctor also noted that on examination, MO had been "*coherent and orientated*". The doctor marked the form so as to show that he found MO fit to be detained and fit to be interviewed.

7.180 MO had given a history of diabetes but had refused to allow his blood sugar levels to be checked, so Dr H recommended that he be checked half hourly. Dr H told us his notes of his examination of MO showed that he had found MO calm and with normal speech. Dr H told us there had been nothing alarming about MO's demeanour and no obvious signs of any mental disturbance.

7.181 According to GE, the custody records show that MO saw a solicitor on the morning of 16 November 2006 and at 1.40pm he was charged with the offence of common assault. He was kept in custody to appear at Highbury Corner Magistrates Court the next morning.

7.182 A different FME, Dr S, saw MO at 9pm on 16 November 2006. His examination form states that MO had refused to come out of his cell, that he had a swollen right foot and that he had run out of insulin and not had it for two days. Dr S told us that the swollen foot had resulted from kicking the cell door. Dr S recommended on the form that MO should be taken to hospital for an x-ray to exclude the possibility of a fracture and for a diabetic assessment. Dr S also noted that he had found MO unfit to be detained or interviewed.

7.183 According to GE, the custody record shows that MO was taken by police car to the A&E department at Whittington Hospital. An x-ray of MO's foot showed that it was not broken and his blood sugar levels were normal. MO was seen again by Dr S at Islington police station at about 2.15 am on 17 November 2006. The examination form completed on this occasion states that MO was fit to detain and interview. Dr S told us that "*if MO had presented with any kind of mental illness I would seek more information, but he came across as relaxed, oriented and cooperative".*

7.184 MO appeared at Highbury Corner Magistrates Court on 17 November 2006 and was bailed to an address at Monega Road E12 until 7 December 2006.

7.185 GE told us that he would have expected the officers investigating the case against MO to have seen the locate trace marker on the police national computer when they first conducted a search. GE did not respond to the locate trace. He told us it would not necessarily have been brought to his attention because it was "*unlikely to hold any relevance to the subject's actual detention or eventual case disposal".* GE was unable to explain why no one had contacted DC RO to tell him of the arrest in Islington until after MO had been released.

7.186 The witness statement DC RO prepared in connection with the investigation into the killing of Camille Remy said he received reports that on 21 November 2006 MO had attended at Whittington Hospital, in Highgate north London claiming he had been raped and was suffering injuries from an assault. MO went to Paddington police station on 22 November and alleged that he had been anally raped after being sprayed with a noxious substance.

7.187 MO went to the Great Chapel Street medical centre in Soho, London on 23 November 2006. The centre is a GP practice providing a service to homeless people. It employs a clinical nurse specialist, IE, who provides a mental health service. MO was seen by Dr L who told us that MO had requested help particularly in relation to finding accommodation. Dr L gave him a letter for housing purposes. He also asked IE to see MO because he had complained of symptoms that suggested depression. Dr L told us that he had not noticed anything to suggest MO was psychotic.

7.188 IE told us that MO had complained of problems with sleep and also with concentration and irritability. He had described fleeting suicidal thoughts but he had had no current active plans to act on them. IE had no recollection of MO telling him about his previous mental health problems. He said MO had "*wanted treatment for depression and those were the symptoms he was describing".* As a result, Dr L prescribed MO with the anti depressant Citalopram for two weeks. Dr L hoped that MO would return to the practice after that time, and that he would have received MO's medical notes by that time.

7.189 MO did not return to the Great Chapel Street medical centre. IE suggested they had

not tried to contact anyone else about MO because there seemed to be no risk and they did not know who else was involved with him.

7.190 Police records show that MO visited the housing options centre in Lewisham in the afternoon of 30 November 2006 and asked for accommodation. He became irate when his request was refused. He then appeared to calm down and started to leave the building. However he then picked up a chair and smashed a window with it. He was detained and taken to Lewisham police station.

7.191 One of the officers who arrested MO wrote in his investigation record that MO "*Didn't seem all there in the head when speaking with him".* He also recorded that he had seen the locate trace entry and as a result had communicated with DC RO who had "*made police aware that a mental health assessment needed to be done*". DC RO received no further information about MO's whereabouts. He found later that his locate trace had been removed from the computer some time after MO's arrest in Lewisham.

7.192 MO was seen by an FME, Dr O, at about 8pm on 30 November. The doctor's examination form says MO "*claimed to have diabetes but his blood sugars were normal"* even though he had had no medication for 10 days. The doctor also recorded that MO had been stabbed four months earlier but his scars were healing; he had had depression for a year and had been treated with Citalopram; he had said he had had suicidal thoughts but had not tried to kill himself and had no plans to do so. The doctor recorded that he had found no sign of overt mental illness and thought MO was fit to be detained and fit to be interviewed with an appropriate adult.

7.193 Dr O told us that his own handwritten notes of his interview with MO showed among other things that MO's behaviour had been *"within normal limits. There was no paranoia, nor other mental problems".* We asked Dr O why he had suggested that MO needed an appropriate adult present at interview. He replied:

> *"…there is a note on the corner of my record which indicates that the police had queried his mental state. I had no access to any previous medical notes but he gave a history of depression. I couldn't pick up any symptoms but it is possible that he might have been on his guard and not telling me something. Depression would indicate a*

poor concentration and it would put him at a disadvantage when being questioned".

7.194 OY, officer in charge of the investigation into the incident at the housing options centre, told us that police had been unable to get the local council to send a volunteer appropriate adult to the police station. On the morning of 2 December 2006, in view of the time MO had been in custody, he was bailed to attend at Lewisham police station again on 14 December 2006. It seems that MO refused to leave the police station, saying he wanted to be brought before the court. OY, who helped to escort MO from the police station, told us he had thought it "*odd*" that MO refused to leave but he indicated that there had been no other matters to give him doubts about MO's mental state.

7.195 In the evening of 2 December 2006, MO went to the A&E department at Whipps Cross Hospital. He complained of feeling depressed and suicidal. He was seen by the psychiatric liaison duty SHO Dr W. Dr W completed an initial assessment form in which he noted that MO had tried to kill himself the day before, could not manage his problems and had been sleeping rough for the past week. Dr W also recorded the following:

> "*[MO] says that BB sent about 50 men to kill him. MO says that his neighbours started to harass him and bully him…It came to a point that it was unsafe for him to stay at home, and he moved away from his home. He went to Sheffield to his sister to find accommodation…He was sleeping rough on the street. Then he thought there is no point in living and tried to jump from a bridge in Ealing yesterday at about 10pm."*

7.196 Dr W's record of his mental state examination of MO says he was *"dishevelled, unshaven with unkempt hair and a body odour".* Dr W noted MO's thought content as:

> *"Persecutory delusions, Delusions of reference, people referring to him as a 'bad man'. Passivity phenomena…No auditory hallucinations.*"

7.197 Dr W gave a diagnosis of *"?Delusional disorder? Schizophrenia with depressive features"* Dr W's initial management plan was:

> *"Needs admission to an acute psychiatric unit due to high suicidal risk and has prominent psychotic features.*

Patient has agreed to get admitted as an informal patient.
Level 3 observations
Risperidone 2 at night
Loranzepam 2 at night, if needed."

7.198 Dr W undertook a risk assessment for MO in which he indicated a number of risk factors.

7.199 Dr W no longer works in the UK and we have not been able to interview him.

7.200 MO was transferred by ambulance to Naseberry court early on 3 December 2006. Naseberry court is an acute psychiatric unit that forms part of the North East London Mental Health NHS Trust.

7.201 On arrival at Naseberry court, MO was seen by Dr M the unit's duty SHO and a nurse, whom Dr M and the North East London Mental Health Trust have been unable to identify.

7.202 The admission summary the nurse prepared for the most part repeats what was set out in Dr W's assessments of MO. Dr M told us it did not reflect how he had found MO. In his own note of his first interview with MO, Dr M recorded:

"*There were no elements of psychomotor agitation nor retardation. Nor were there any evident psychotic /depressive symptoms. No evidence of paranoid delusions. He denied any suicidal/homicidal thoughts. He stated that he was not happy with his room. He stated that he would have preferred an individual room with ensuite…he therefore wanted to self-discharge. He was non-sectionable and was advised to wait til morning and then the situation and his mental state would be re assessed*."

Dr M recorded a plan of:

"1 Monitor mental state…
2 Reassure patient that staff are doing their best to help him…"

7.203 At 6am on 3 December 2006 the nurse who had prepared the admission summary

recorded the following in the clinical notes:

> "*MO has been demanding to go home saying that he is a voluntary patient. Staff tried to explain to him that the doctor would have to see him first. He became restless pacing up and down the unit. He then picked up a chair threatening to break the door. He was offered medication to help him settle but he refused, remains restless.*"

7.204 Dr M saw MO again at 7am on 3 December 2006. MO told him he did not want to stay in hospital. In his note of the interview Dr M recorded:

> *"There was no evidence of psychiatric/depressive symptoms. No evidence of any delusional ideas. No evidence of any suicidal/homicidal ideation…When asked for the reasons of his complaints at the A&E, he replied that he did not have anywhere to go and wanted a place to go to."*

7.205 Dr M again noted that MO was "*non-sectionable".* MO insisted on leaving the ward but before he did so Dr M made him sign a form acknowledging that he was discharging himself against medical advice. Dr M also asked MO to return to A&E or Naseberry court if he felt unwell.

7.206 On 4 December 2006 MO went to the HPU offices. He said that he had had to go to Ireland to visit his sister who had been ill. He said he had phoned Newham council when he left in August. The HPU offered MO emergency bed and breakfast at the Metropolitan hostel in Hackney until 8 December 2006. The accommodation comprised a separate bedroom and shared cooking and washing facilities. NB, the HPU team leader involved in the decision to re-house MO on 4 December, told us he had intended to have MO re-assessed by the SE CMHT. He said:

> *"I did not want to book him into B&B in the first instance, but there were no annexes available, so I had no choice. So I only booked him in for a short period so that we could get him in for that interview, to determine where he had been, why he had not been in contact and where his recent contacts with the community mental health teams were."*

7.207 MO failed to attend for an appointment with HPU staff on Friday 8 December 2006. The assessment officer dealing with MO's case discussed it with CH, then acting principal homeless manager, and they agreed to extend the B&B booking at the Metropolitan hostel over the weekend in view of MO's mental health needs.

7.208 An assessment officer and CH agreed on Monday 11 December 2006 that MO would not need to make a new application for housing by the HPU and they extended his B&B booking at the Metropolitan hostel indefinitely. CH explained to us that she had not been aware of NB's concern that MO's contact with the SE CMHT needed to be investigated and a further assessment provided by them. She said the decision to extend the booking "*indefinitely*" had been taken to avoid MO having to return to the HPU to have the booking extended. She had expected the accommodation team to re-house MO when an annexe became available.

7.209 Late at night on 12 December 2006 MO was arrested for possessing a knife in the Kingsland Road, Hackney. MO told the police the knife was for opening cans of tuna. The police record states that MO had been "*evasive towards police questioning and appeared to be nervous".* It also shows that when asked if he was ill or suffering from mental health conditions MO replied "*yes, sick of this f***ing country".* PC MB, the arresting officer said she had thought that MO was possibly under the influence of drugs. She had thought his reasoning was strange.

7.210 MO was detained at Shoreditch police station where he was seen by an FME, Dr Z, at about 11.30pm. Dr Z completed a forensic medical examination form in which he recommended that MO was fit to be detained but not fit to be interviewed. He also noted on the form that MO had been "*angry/swearing/offensive*" and he queried whether MO was suffering from mental health problems, stimulant drugs or temper. Dr Z noted a care plan of videoing MO's cell and careful observations, rousing MO every half hour and self-harm precautions. Dr Z recommended that MO should be seen again by an FME in seven hours' time. Dr Z said in written evidence that he had checked MO's entries on the police national computer and had noticed that it did not show any previous mental health problems. He also wrote:

> "*I believed that [MO] may be under the influence of drugs or alcohol and that this may potentially be influencing his presentation and that it would be sensible to allow*

a period of rest and a further assessment of his affect and mental state prior to any decision being made about the need for a formal mental health assessment."

7.211 We have seen no evidence to suggest that MO was ever seen again by a doctor at Shoreditch police station and re-assessed for his fitness for interview. Nevertheless, the police record shows that PC MB interviewed MO at 2.55am on 13 December. When we asked her how this had come about she replied "*I guess the sergeant must have said to take him for interview". S*ergeant VA, the custody sergeant, told us that he did not recollect the events of 13 December 2006 but police records he had referred to show that MO had had legal representation. Sergeant VA told us that if MO had wanted to be interviewed and had said he was fit for interview, and his solicitor agreed, there would have been no reason to delay the interview.

7.212 MO appeared before Thames Magistrates later in the morning. The case was adjourned for trial and MO was released.

7.213 In a police computer entry dated 15 December 2006, PC OY, the officer investigating the incident at the housing options centre at Lewisham on 30 November 2006, recorded that MO's police bail granted at Lewisham police station had been extended until 30 January 2007.

7.214 The chronology compiled by the police investigating the killing of Camille Remy shows that on 17 December 2006 MO called the police and reported that his neighbour had sprayed something on his door and had assaulted him two weeks earlier. A police officer went to the Metropolitan hostel to investigate but it appears that the police concluded that MO was deluded and that no assault had taken place.

7.215 On 19 December 2006 MO went to the HPU's offices. The manager of the Metropolitan hostel had advised him to go there after he had complained about being refused another room. The HPU staff member who saw MO noted in the HPU file that MO:

"…said that he has been having trouble with his neighbour. When asked what kind of problems applicant said that his neighbour had been spying on him and attacked him. I asked [MO] for proof of this but he failed to provide any details."

7.216 After a conversation between the HPU staff member and the manager of the Metropolitan hostel, MO was again told that he would not be given another room. He became abusive and stormed out of the HPU's offices.

7.217 On the same day DC RO sent an email to PC EB of the Jigsaw unit at Plaistow police station in response to the report that she had placed on the local intelligence system. In his email DC RO offered to speak to PC EB and update her about what he knew of MO's movements in November 2006. PC EB told DC RO she had been in touch with the SE CMHT and they did not know where MO was. DC RO told us that he had not tried to contact PC EB earlier because he had assumed that he was the only person with any real interest in MO's whereabouts.

7.218 At about 11.30am on 20 December 2006 MO fatally stabbed Camille Remy on the fourth floor of the Metropolitan hostel where both had a room. Camille Remy had recently travelled to England from France hoping to find work.

7.219 LE, the general manager employed by the property company that owns the Metropolitan hostel, told us that Camille Remy's room at the hostel had been booked via a company trading under the name of Meeting Point. It specialises in finding accommodation for foreign students. LE explained that neither Meeting Point nor Newham council had expressed any requirements about where in the building their clients were to be housed. LE told us that she had made it a rule that students would have their own floor because she thought it was "*better for all the young ones to be together"*.

7.220 LE did not explain why MO had been given a room on the same floor as Camille Remy. She said the property company that owned the Metropolitan hostel no longer ran hostels for both students and homeless people.

7.221 US, a friend of Camille Remy who was also staying at the Metropolitan hostel in December 2006, told us that MO's behaviour in the weeks before he killed Camille Remy had been "*strange"* and the subject of discussion among the students at the hostel. On one occasion MO had followed two female students from the street into the building and right to the door of their room. US said that when he and some others told the hostel manager of their concerns about MO the response had been "*that they were going to see how it goes".*

The representatives of the company that owns the Metropolitan hostel told us that the managers to whom US and others probably spoke were no longer with the company and might have gone abroad. We were not able to interview them.

Part 2 - analysis and comment

In this part of our report we analyse and comment first on the issues which arise from our investigation and relate to the management, practice and procedure of the services with which MO had contact. Then we deal with matters relating more closely to the care and management of MO.

8. The management of services, practice and procedure issues

The south east CMHT

Caseload

8.1 Paragraph 4.2 of the ELC NHS trust's operational policy for community mental health teams states:

> *"The CMHT will have a clear and explicit responsibility to provide mental health care for a local population according to specified GPs; the maximum caseload will be 250 service users."*

8.2 Dr G, the associate specialist with the SE CMHT who saw MO on a number of occasions in late 2005 and early 2006, told us that he had nearly 100 allocated CMHT patients and saw a further 120 outpatients. He also said that on occasions he had had to cover for the other associate specialist with the SE CMHT. This evidence suggests that the CMHT's caseload overall was within the limits set by the operational policy, but it also shows that the workload of individual members of the CMHT was demanding.

8.3 CPN 1, the CPN who dealt with MO, told us that she could not recollect precisely how many allocated cases she had responsibility for while she was seeing MO. However, she said her workload as a care coordinator had always been the highest in the SE CMHT and was usually about 26 or 27 cases. At the time of her interview with us she had a caseload of 29. This is in excess of the caseload suggested by the operational policy which states at paragraph 16.1:

"*It is anticipated that full time care coordinators will have a caseload of 25 service users (most of them on enhanced level CPA) and part time staff will have their caseload reduced pro-rata.*"

8.4 It is clear from the evidence that we have received that CPN 1 has always had a challenging workload. CA, the SE CMHT team manager, agreed with the suggestion that CPN 1's workload might have been a struggle and told us:

"We're working in a very high pressure environment in that we have an awful lot of deprivation, a very high level of need. To be allocated in our team things have to be fairly serious to be an allocated case, so you have 25 people with a very high level of need, and you have to get the paperwork right, you have to see people on a regular basis, it is very high pressure."

8.5 CPN 1 agreed that her workload meant that she had time only to undertake the most critical tasks and told us:

"We are meant to record absolutely everything that happens - it's virtually impossible. Important information may get lost."

8.6 Nevertheless, the members of the SE CMHT that we spoke to were complimentary about CPN 1's work as a CPN. They spoke of her competence and considerable experience, and commended the effort that she put in to caring for her patients.

8.7 Dr G suggested that the pressure of work meant that he too was not always able to give enough attention to completing paperwork. We discovered a number of instances, which we discuss elsewhere, where the SE CMHT staff did not adequately record important discussions and events relating to the care and treatment of MO.

8.8 The demands of the caseload of the SE CMHT also appear to have had some influence on the decision on 7 September 2006 to discharge MO and close his case to the SE CMHT. CA explained to us, that the reason behind that decision was "*That we didn't know where [MO] was and we couldn't carry on keeping a slot…We're constantly under pressure to close cases because we have to have some kind of throughput".* As we consider in chapter 9 below, we

believe that that decision was flawed and we are concerned that it appears to have been influenced at least in part by the needs of casework management.

8.9 We have been told that the pressures on the staff of the SE CMHT have increased in the past year as a result of a significant number of resignations from what has previously been a stable team with low turnover of staff, and the fact that it has proved difficult to recruit to the vacant posts.

Comment

We find that the workload of the SE CMHT and of individual staff members may adversely affect the way the SE CMHT manages patients and the way individual staff members fulfil their duties.

Recommendation

R1 The ELC NHS trust should keep the staffing levels of the SE CMHT under review to ensure that casework pressures do not adversely influence the way patients are managed, to ensure that individual caseloads are manageable and allow staff to fulfil all their professional obligations, including record-keeping, satisfactorily.

Case review

8.10 The SE CMHT's staff told us that they had two team meetings a week. On Mondays they had a business meeting when they considered issues relating to the management of the team, its working practices and policies. On Thursdays they had a multidisciplinary clinical meeting. The clinical meeting considered only the cases under assessment and issues relating to the allocation of care coordinators. We asked about the opportunities for members of SE CMHT to consider and reflect with colleagues on issues relating to the care of particular patients. We were told that there was no opportunity for SE CMHT as a whole, on a regular basis, to discuss and offer each other peer review of their case handling. We asked CA about the opportunities for staff to discuss difficulties managing particular patients. She told us these "*would be discussed in a CPA and medical reviews, and also, to be fair, the consultants we have are very good when they're there. If you're having a problem with someone they'll*

go and talk to them. That's more an informal thing but it happens a lot".

8.11 Members of the SE CMHT acknowledged to us that there would be advantage in discussing cases with colleagues, who might have a different perspective to offer, on a regular and more reflective basis. The need for a formalised opportunity for SE CMHT staff to meet as a multidisciplinary team to discuss case handling is also acknowledged in the ELC's operational policy for community mental health teams which states, at paragraph 17.1:

> *"Each catchment area team will meet twice every week: 1 for allocation meeting…minutes will be taken with clear action plans for distribution to team members; 2 for clinical meeting (i.e. case discussion with 2 cases each 30 minutes, discussion re clinical strategies, treatment plans, etc.)."*

8.12 CPN 1 and Dr G explained to us that whenever they saw MO they thought he was always subject to continuing assessment and no final decision was ever taken about his diagnosis or his treatment needs. They told us that his case would have been discussed in the SE CMHT's Thursday clinical meeting. So the lack of any arrangements for reviewing allocated cases at a clinical team meeting appears to have had no bearing on MO's case.

Comment

The SE CMHT team approach to managing complex cases should be more formalised.

Recommendation

R2 The SE CMHT should consider holding regular team meetings as a team to discuss and review individual case handling and any issues and lessons arising.

Staff supervision and development

8.13 Paragraph 20.4 of the operational policy for community mental health teams states:

> *"All staff will have regular management and clinical supervision of their work and appraisal of their professional development, in accordance with the supervision and*

performance development policies of the employing authority. The team manager will regularly monitor supervision performance against given criteria for all non-medical staff; the Consultant will have overall responsibility for supervision arrangements for Associate Specialists/SPRs and SHOs."

8.14 Dr G told us that while Dr F was a consultant with the SE CMHT he was Dr G's educational supervisor. They communicated about patient matters but no time had been set aside specifically for Dr F to provide supervision to Dr G. Further, Dr F had not undertaken an appraisal of Dr G. We have not been able to interview Dr F, so we have not heard his account of the extent to which he fulfilled his obligations to supervise and appraise Dr G.

Comment

We have no reason to doubt Dr G's assertions about these matters and we believe that they indicate the need for the ELC NHS trust to examine its arrangements for ensuring that consultants fulfil their obligations to supervise and appraise other medical staff.

Recommendation

R3 ELC NHS trust should review the effectiveness of its arrangements for ensuring and verifying that consultants appropriately fulfil their responsibilities for supervising and appraising other medical staff.

8.15 CPN 1 and CA told us that when the SE CMHT saw MO its staff had not received routine training on risk assessment and risk management. CPN 1 had received no training on risk assessment and management. The only risk assessment document the SE CMHT completed for MO was the risk checklist CPN 1 completed on 1 March 2006. As we describe in paragraph 7.43 CPN 1 made a number of errors in completing that checklist. She explained to us that although by March 2006 the form in question had been in use for sometime, she and her colleagues had received no training in how to use it. They had found it confusing.

8.16 CA told us that in the aftermath of the killing of Camille Remy by MO, the ELC NHS trust had commissioned a two-day course in risk assessment and management. CA was expecting staff to attend as part of their personal development planning. CPN 1 told us she

had now undertaken that training. ELC NHS trust has stated in its response to the internal inquiry report and recommendations updated in December 2008 that "*Risk assessment and management training is incorporated in the trust training programme. In addition regular forensic and general adult psychiatry update workshops are planned in 2009".*

8.17 As we discuss elsewhere, we believe that the SE CMHT lacked commonly understood and firmly embedded risk assessment and risk management processes. We think this had an adverse impact on the care and management of MO. In order to ensure that all staff have a real understanding of risk assessment and management and that all patients are at all times subject to robust and effective risk assessment and risk management, the ELC NHS trust needs to ensure that there is systematic and continuing staff training.

Comment

We welcome the fact that risk assessment and management training are now available to the staff of ELC NHS trust, but what CA told us and the trust's response to the internal inquiry report referred to in paragraph 8.19 above suggest that the training could still be undertaken as one-off courses attended on a voluntary basis. We believe it should be compulsory for all new and existing staff responsible for caring for patients with mental health problems, and should be the subject of continuing regular training. We believe that ELC NHS trust's clinical risk assessment and management policy, which makes no mention of staff training, should be amended to make it a requirement that staff receive training of the kind we suggest.

Recommendations

R4 ELC NHS trust should ensure that all staff with responsibility for the care of patients are subject to compulsory and continuing training in risk assessment and risk management.

R5 ELC NHS trust should amend its clinical risk assessment and management policy to set out the requirement for training of the kind recommended at recommendation 4 above.

Northumberland ward, St Ann's Hospital

Caseload and occupancy levels

8.18 Dr V, MO's RMO while he was treated at St Ann's Hospital, told us that he had inherited thirty or so inpatients on one day in early June 2006 after agreeing to take on the Tottenham area caseload from Dr L. These inpatients were in addition to his own inpatient caseload from Hornsey and Highgate, which at that time was down to 10 – 15 because he had been abroad for a while. Dr V told us:

> "*I must have inherited 25 or 30 on one day, which is a lot of cases to take on. I would have gone through what I thought were the most pressing ones early on, and worked long days until I became on top of them, so by the third week or the fourth week, which was when [MO was being discharged] I would have known most cases. But [MO] was new…so there was no history to catch up on as such, he was new to us.*"

8.19 Dr V told us he believed that his combined inpatient workload may have reached fifty at one point. His patients were on six different wards at St Ann's Hospital. In addition to his inpatients, Dr V had had responsibility for Tottenham area community patients, and had continued to do a couple of sessions dealing with community patients from his own Hornsey and Highgate patch.

8.20 When Dr V agreed to take on responsibility for Dr L's patients he had been told by hospital managers the arrangement would last for a few months. In the event, it went on for nearly a year.

8.21 Dr N, the SHO who worked with Dr V in caring for patients from the Tottenham area, including MO, was complimentary about the way Dr V had managed his workload. He told us that Dr V had regularly visited the wards to see his patients and confirmed what Dr V had told us about his practice of ringing the ward every morning at about 8am to discuss any problems or issues that might have arisen. Nevertheless, Dr V made it clear to us that his workload at this time was a challenge. He told us:

> *"There is no disguising the fact that 40-plus patients is very busy by any standards. In*

those days I was probably on the ward four or five times a week, most days. I had taken over this incredibly busy job and it was full-time."

8.22 In addition to the pressures placed on Dr V, as an individual, he and the rest of the staff on Northumberland ward had had to contend with the pressures of the high occupancy rate on that unit. Nurse 3, one of the charge nurses on Northumberland ward when it opened in about May 2005, told us that it had had 21 beds, but after about eight months or so the number had been reduced to 19 in order to create space for a staff room and a manager's office. Staff told us that between 28 to 30 patients were usually treated on the ward. They explained to us that some of the excess patients might have been found beds elsewhere at St Ann's Hospital, but most would have been given leave to sleep away from the hospital. We were told that on one occasion the number of patients being treated on the ward had risen to 38 or 40.

8.23 In its 2008 review of NHS acute inpatient mental health services entitled "*Pathway to recovery*", the Healthcare Commission (now the Care Quality Commission) referred to the Royal Society of Psychiatrists as suggesting that ideal average bed occupancy should be about 85% if a safe environment is to be provided. We have not been given the precise figures for the bed occupancy rates on Northumberland ward, but even disregarding those patients who were given leave to sleep out, the bed occupancy levels on that ward appear to have been well in excess of those recommended. We heard from staff on the ward that a lot of their time had been taken up in managing the high ward-occupancy levels and this had had a detrimental effect on patient care and the patient experience. Nurse 3, the charge nurse, told us:

"People like me spend our time, of seven and a half hours we spend five and a half hours doing things which are not clinical things you are supposed to do with patients. This is the enormity and gravity of the problems that exist at the moment at St Ann's Hospital, and probably everywhere, I don't know. Finding which bed, patients are not resting properly, they are on heavy medication. By the time that you deal with all these issues the shift is almost gone."

8.24 Northumberland ward has recently been re-established in newly refurbished accommodation elsewhere in St Ann's Hospital. Our interviews with staff took place while the

ward was being relocated and we do not know the occupancy rates in the new premises.

Impact of workload pressures on information sharing

8.25 We believe that the workload pressures on the staff on Northumberland ward while MO was an inpatient also contributed to the fact that important information which suggested that MO had a capacity for violence towards others was not shared with Dr V, his RMO.

8.26 When MO was admitted to St Ann's Hospital, the on-call SHO recorded the fact that MO's neighbour Mr A had also been stabbed in the fight on 23 June 2006. Nursing staff on Northumberland ward noted several times that MO had acted aggressively and presented a risk of violence to others. For instance, Nurse 1, MO's named nurse, wrote in the mental health unit assessment form on 15 July 2006:

> *"[MO] makes allegations against others. Can become aggressive towards others. Requires admission for assessment and to ensure his safety and the safety of others."*

8.27 In the brief risk assessment form completed on the same day Nurse 1 entered:

> *"Was recently stabbed in a fight in which knives were used. He stabbed neighbour and neighbour also stabbed him."*

8.28 On 20 July 2006 Nurse 3, the charge nurse, completed a CMHT referral form/discharge assessment of needs notice in which he marked MO as being a risk of "*serious violence/harm to others"* and also wrote:

> *"MO is alleged to have been stabbed by neighbour (chest wound) nearly two weeks ago. Is also said to have threatened neighbour first before being stabbed."*

8.29 The nursing staff we interviewed told us that the view that MO was capable of being violent and aggressive and had used a knife against another person was based on what he had told them about his fight with Mr A, on their own observations of MO, and on an occasion when he had acted aggressively on the ward towards Nurse 1. The staff told us that this view of MO was well understood and shared by all the nursing staff on Northumberland ward and

that they had discussed it at their handover meetings. They also said that these matters were recorded in documents that Dr N, the SHO, would have seen, and that they would have briefed Dr N about them.

8.30 Dr N said he knew that Mr A had been injured in the fight with MO. He believed too that he had pointed out to Dr V the entry in the clinical notes by Dr E, the on-call SHO, which said that Mr A had been stabbed in that fight. However, he felt that there was uncertainty about exactly how Mr A had been injured and about the extent of his injuries so he had sought further information about the altercation between MO and Mr A from the police. The request for information was made on 14 June 2006. Dr N said his work pattern would have prevented him from seeing the assessments of MO completed by Nurse 1 on 15 July before the MHRT hearing on 18 July 2006. He has also told us that because he was working in the community on the day before the hearing and on a female ward on the morning before the MHRT he had had little opportunity to obtain an up to date briefing from nursing staff before the hearing.

8.31 The written reports to the MHRT made the MHRT aware of the fact that MO had been involved in a fight with Mr A and that Mr A had been injured in that fight. Dr N's evidence was that he told the MHRT that he had asked the police for further information about the fight and he believed he had told the MHRT that MO posed a risk to others. But there is no evidence that Dr N specifically referred the MHRT to the facts that MO had been an aggressor in the fight with Mr A and that he had displayed aggression and acted upon paranoid thoughts on the ward. We believe these were significant matters that the MHRT should have been told about and might have altered the outcome of the proceedings before the MHRT.

8.32 Dr V told us he thought there was "*a reasonably good culture of communication"* on the ward but he could not remember seeing any documents that referred to MO having stabbed Mr A or being aggressive or a threat to others and he did not recollect anyone bringing these matters to his attention. He also told us that if he had been told that MO had been aggressive in the past: *"It would certainly have changed what we might have presented to the [Mental Health Review Tribunal]."*

Comment

We accept that it is more than likely that a consultant of Dr V's experience, would have

seen the significance of any evidence that MO had been aggressive or violent towards others and would have sought to have it put before the Mental Health Tribunal. The fact that that did not happen leads us to find that Dr V did not know about these matters. We believe that the fact that the staff on Northumberland ward were working under great pressure and had to deal with and share information about many patients must have played some part in their failure to pass on to Dr V important information about MO.

8.33 We asked Dr V about the extent to which information was fed back to him from the wards:

> *"These are wards with 18/19 beds, but in fact 25/26 patients sleeping out…They didn't all have key workers. We are looking at a strained system, which has improved, but it was a strained system at the time…"*

Recommendations

R6 BEH NHS trust should keep the patient numbers of individual medical staff under review to ensure that they are at all times manageable and allow staff to fulfil their professional obligations, including allowing them to have an appropriate grasp of the issues relating to their patients.

R7 BEH NHS trust should keep the occupancy rates of its wards to the levels recommended by the Royal College of Psychiatrists and other professional bodies in order to provide a safe environment.

Nursing care review

8.34 The nursing staff we interviewed said the regular handover meeting at the end of each shift was their main forum for discussing issues relating to their patients. They told us that they would talk about all the patients on the ward. They maintained a handover record book and would refer to a patient's written notes or, since its introduction in about October 2007, the RiO computerised record system. Dr N thought the handover arrangements were good:

"I don't know exactly what they say in there, but I can reassure you that in the morning the night staff are there and they go through all the patients, and what has happened in the night, what are the problems, what are the issues, and they discuss it…that's my observation."

8.35 Nurse 3, the charge nurse, said nursing staff used the ward handover meetings as an opportunity to discuss long-term aspects of a patient's care and not just the immediate issues arising from shift to shift. However, there have never been arrangements in place for regular meetings of the nursing staff as a whole at which they can consider and review in a more reflective way cases presenting particular difficulties or challenges. Nor do they appear to have a regular opportunity to consider as a group more general issues relating to nursing care and practice on the ward. Staff said there had been plans in the past to hold staff meetings but they had often not taken place.

Comment

We do not suggest that the care and treatment offered to MO while he was on Northumberland ward suffered because of the lack of an opportunity for the staff to meet for the purposes we have described. We do however believe that, as a matter of good practice, and for the benefit of patient care in the future, the staff should have that opportunity.

Recommendation

R8 BEH NHS trust should ensure that staff have regular planned opportunities for in depth consideration of and reflection on issues and challenges relating to their professional practices and the care of individual patients.

Named nurse arrangements

8.36 Named nurses are expected to devote time to getting to know a particular patient, to take a special interest in their progress and to take some responsibility for the documentation and nursing care of the patient. Nurse 3, the charge nurse, explained that the nursing staff on Northumberland ward were divided into teams and they allocate named nurses to the patients

from the group that worked with their particular consultant. On occasions however, in order to ensure a fair distribution of work, nurses from another consultant's team might have to be allocated to a particular patient.

8.37 When MO was admitted to Northumberland ward he was allocated Nurse 1 as his named nurse. Nurse 1 told us that he was on night duty throughout the time that MO was a patient on the ward. Nursing staff told us they believed that any information or insights that Nurse 1 had gathered about MO would have been passed on to other staff via the handover meetings. They also explained that work that had needed to be done in respect of MO that could be done only during the day, such as pursuing inquiries of other agencies, would have been discussed at handovers and dealt with by other members of the nursing team. Nurse 3 suggested that the nursing staff on the ward understood the need to work as a team and, in the absence of a patient's named nurse, those in charge on the ward would re-allocate to another nurse any work to be done.

Comment

We find that the fact that MO's named nurse was on night duty throughout his time as an inpatient had some adverse effects on the way that his case was managed.

8.38 Nurse 1 highlighted the limits on his opportunities to gain a better insight into MO's state of health and problems when he told us:

> *"I was on night duty so I didn't have that daily during the day contact with [MO]. It's only when I came on nights from a quarter-to-nine until whenever he went to bed that I would see him."*

8.39 Further, it is clear that there were a number of instances when it would have been of benefit if Nurse 1 as the named nurse had been available during the day to work on behalf of MO rather than another less involved member of staff. For example, Nurse 1 had formed views about the risks that MO might pose to others, he had recorded these in ward records as we set out at paragraphs 8.30 and 8.31 above and he provided a full handover to the day nursing staff, but he had not been available to brief either Dr N or Dr V in person about what he knew and the views he had formed of MO.

Comment

We cannot say with certainty that if Nurse 1 had briefed Dr N in person or had been on the ward at the time of Dr V's ward rounds, Dr V would have been made aware of the possible risks that MO posed to others but it is a possibility.

8.40 Further, as we explain at paragraph 7.112 the only CPA form hospital staff ever completed for MO was filled in by an unidentified member of staff; it was incomplete; it failed to identify an appropriately qualified person, (i.e. a mental health worker) as the care coordinator; and it failed to identify a plan of care. Nurse 1 explained what he recalled of how that CPA document came to be drawn up as follows:

> *"Because I was on nights somebody has done it [during the day], so they have come to me and said" We've done you a favour, done this for you, now will you sign it".*

Comment

There is no evidence of any CPA meeting or other formal meeting to discuss CPA or MO's aftercare or discharge from St Ann's Hospital. It is not possible to say that there would necessarily have been better arrangements in place to plan for MO's aftercare if Nurse 1 as his named nurse had been more available to oversee that process, but again it is a possibility.

We find that there is a need for more robust arrangements to ensure comprehensive and continuous input into a patient's care by a nurse or nurses with particular responsibility for that patient.

Recommendations

R9 BEH NHS trust should devise a system for ensuring that each patient has a named nurse who is available to:

- provide comprehensive nurse assessment

- share and communicate that assessment appropriately
- ensure appropriate nursing care planning and management.

R10 Where the named nurse is not available for a significant time or is unable to fulfil the requirements referred to at recommendation 9 above, another named or associate nurse should be appointed.

Staff development

8.41 SA was the ward's temporary acting manager while MO was a patient on Northumberland ward. He held the post between July 2005 and October 2006. He said that he had not undertaken staff appraisal nor held performance management meetings with the nursing staff during his time as ward manager, but he had supervised nurses on an informal basis. Staff also explained they had no regular supervision at that time. And training, apart from mandatory training courses, had been undertaken on the basis of staff subscribing for courses they wanted to take when places were available.

8.42 Nurse 3 said that since the appointment of a new ward manager staff had received regular supervision sessions and an annual appraisal. He also said that in addition to BEH NHS trust requiring staff to undertake more mandatory training, other training needs were now identified via the supervision and appraisal process.

8.43 The internal investigation into the care and treatment of MO recommended that BEH NHS trust should put in place a rolling programme of risk assessment and management if it had not already done so. The trust's action plan in response to the internal investigation demonstrates that mandatory trust-wide risk training has been developed and that the trust has set itself the task of ensuring that all professional staff "*receive regular update*".

Comment

We welcome these responses by the BEH NHS trust. In view of our finding that the assessment and management of risk in relation to MO was a crucial weakness in the care offered to him by mental health services, we wish to endorse the recommendation of the internal investigation in respect of risk training and recommend that its implementation

is the subject of continued monitoring.

Recommendation

R11 The BEH NHS trust should continue to monitor the implementation of the internal inquiry recommendation with regard to the need for compulsory and continuing training in risk assessment and risk management.

Newham council's homeless persons unit

8.44 In considering the service the HPU offered to MO, both in terms of providing accommodation and in the way that it related to the other agencies involved with him, we had to bear in mind the demands on Newham council's housing services. UC, Newham's strategic manager for housing needs, told us there were 28,000 people on Newham council's housing waiting list and 5,497 in temporary accommodation, making the demand for local authority accommodation the highest in London. Newham council's difficulties in providing accommodation are compounded by the fact that it has to compete for available housing in Newham with local authorities from elsewhere in London seeking to take advantage of the borough's relatively lower property prices. Newham council too has had to resort to placing people in accommodation outside its borders in order to meet its housing needs.

Out of borough accommodation

8.45 As the history of MO's contact with services, set out at chapter 7, shows, Newham council re-housed MO on many occasions. All the properties that Newham council provided for MO, (apart from the one at Harrow Road E6, which MO occupied from 7 August to 23 August 2006 and the Hartley Hotel, at Romford Road E7, which MO occupied from 24 August to 29 August 2006) were outside the borough of Newham. This was contrary to the advice the HPU received about MO from the SE CMHT and from its own medical assessment officer. CPN 1 wrote in the recommendation section of her vulnerability report to the HPU in October 2005 when MO first applied to Newham council for accommodation:

> "*A local accommodation would be preferable given that [MO] has some connections in the area, as well as permitting continuation with education.*"

8.46 Elsewhere in the form she wrote:

> *"Although he is not an allocated case to this team, his mental state is being monitored and he is required to attend this office."*

8.47 The medical assessment officer who considered MO's appeal against being accommodated at 20 Howard Road, N15, recommended in his report dated 30 June 2006 that given MO's mental health history it would be best if he were placed "*where appropriate supervision can be given*" and that "*N15 might not be the best place for him given the nature of his previously established support".*

8.48 One outcome of MO being accommodated outside Newham was that when he was admitted to hospital in June 2006, it was to a hospital that did not have links to the community services that treated him at other times. This appears to have undermined coherent care planning and the sharing of information.

8.49 At the time of MO's admission to St Ann's Hospital, staff had difficulty obtaining information about his mental health history because they had no firm idea about where he had been seen and treated in the past. MO told ASWB, the ASW, that he had had a "*small depression*" in Newham, but staff at the hospital explained that in order to obtain information about MO they would have had to ring round all the CMHT's in Newham to identify which one had seen him. They did not in fact make contact with the SE CMHT and as a result important information about MO's mental health history, including the occasion on which he was cautioned for threatening someone with a knife in October 2005, was not made available to staff at St Ann's Hospital.

8.50 Dr V and other staff of the BEH NHS trust, including the team manager of the South Tottenham area CMHT, told us that when MO was discharged from St Ann's Hospital staff had been uncertain about where he was to be accommodated. As a result, they were uncertain about the arrangements that could be made for MO to receive aftercare from their CMHT or any other community mental health services. It was clear from what Dr V told us that not knowing where MO would live had influenced the planning of the staff of the BEH NHS trust. He said:

"We could have found out where he was being housed, we could have contacted Newham Hospital…but it wouldn't necessarily have produced any result. If I knew where he was being housed I would have known which sector he had fallen in, I could have spoken to them and they may have sent somebody out to see him, but he would have told them 'I don't want to know', because that is what he was telling us."

8.51 We believe that if staff at St Ann's Hospital had known where MO was to be accommodated they would have taken a more robust approach to planning his aftercare, even though there were doubts about his willingness to engage with mental health services. We believe that at the least staff would have shared with the relevant community services their concerns about MO's mental state and their records giving clues to the potential risks that MO posed.

8.52 In the event however, there was no contact between BEH NHS trust and the SE CMHT and it was AC and NB of Newham's HPU who contacted the SE CMHT to ask them to assess MO. And it was they who passed on the information they had gleaned from St Ann's Hospital and elsewhere about MO having threatened people with knives on at least two previous occasions and having been stabbed in the fight with Mr A on 23 June 2006.

Comment

We find that the fact that MO was housed mostly outside the borough of Newham undermined care planning and information sharing about him. We have no doubt that in most cases the task of trying to engage and treat a mental health patient is more difficult if the patient is housed away from the services they need to access and away from their family and community networks.

We welcome the fact that in response to the events involving MO Newham council has adopted a policy of housing all clients with mental health problems in the borough.

The type of accommodation offered by the HPU

8.53 Staff of the HPU said the HPU and Newham council's accommodation team did not

undertake formal risk or other assessment to determine the suitability of properties for housing clients with mental health problems. The HPU usually tried to ensure that clients with mental health problems were not placed in shared accommodation or accommodation with shared facilities.

8.54 When the HPU first agreed to provide MO with emergency accommodation on 13 October 2005, the duty manager responsible recorded on the HPU computer file for MO:

> *"B and B authorised for 7 nights pending our obtaining [more in depth psychiatric report] and carrying out an assessment of the client's mental health/vulnerability. Advised that the client should be placed in an annex for his/others safety."*

8.55 Some of the properties where MO lived, even when classified as emergency bed and breakfast accommodation, were in fact self-contained annexes or bedsits. However, when MO reappeared on 4 December 2006 to ask Newham to house him again after an absence of about three months, no self-contained property was immediately available. MO was given a room with shared washing and cooking facilities at the Metropolitan hostel in Hackney until 8 December 2006. NB who dealt with MO's case on 4 December 2006 said:

> *"I did not want to book him into B and B in the first instance, but there were no annexes available, so I had no choice. So I only booked him in for that short period so that we could get him in for…interview, to determine where he had been, why he had not been in contact and what his recent contacts with the community mental health teams were."*

8.56 NB made no record of his decision-making or his view that MO's contact with the CMHT needed to be considered.

8.57 On 8 December 2006 other HPU staff extended MO's B&B booking at the Metropolitan hostel until 11 December. On that day the decision was taken to extend the booking indefinitely, although CH, the HPU's acting principal homelessness officer who was involved in the decision, said she had expected MO to be transferred to an annex when one became available. The HPU staff did not make contact with the SE CMHT at this time. They did not obtain an up-to-date assessment of MO's mental state or the risks related to accommodating

him.

Comment

We have given careful consideration to the question of the extent to which the HPU were at fault in December 2006 in placing MO, a man known to be capable of being aggressive and violent towards others, in accommodation that was not self-contained and which necessarily gave him more contact with the other residents of the building. However, although the Metropolitan hostel provided the setting in which MO was able to attack and kill Camille Remy, it must be borne in mind that the circumstances in which he had attacked or threatened others in the past had varied widely. And the fight on 23 June 2006 in which MO is believed to have attacked Mr A happened when MO was housed in a separate self-contained flat.

In our view it is possible that MO might have carried out a fatal attack wherever he had been housed.

Further, it cannot be said that the HPU acting by itself would or should have known that placing MO at the Metropolitan hostel significantly increased the likelihood of him attacking a fellow resident.

The root of the problem posed by MO was his mental illness. As we discuss elsewhere, fundamental to minimising and containing the risks associated with having a person such as MO living in the community is the need for thorough risk assessment and management and robust CPA and information sharing arrangements. All agencies relevant to a person's care, including housing, need to take an active part in these processes, but they are the responsibility above all of mental health services. And it is the responsibility of mental health services to ensure that knowledge of any risks a patient poses are shared with other agencies, and that appropriate care plans, including housing arrangements, are devised to mitigate those risks. We believe it would be perverse to expect that Newham council's housing services, in providing MO with accommodation, would necessarily have taken responsibility for ensuring that they protected the rest of the world from the risks resulting from MO's mental state.

8.58 Furthermore, as a number of HPU staff have pointed out, it would be unrealistic to expect the housing services in Newham always to have suitable self-contained accommodation available for emergency housing for a client such as MO. NB put the point as follows:

> *"There are a certain percentage of clients like that, usually single men, and obviously in an ideal world we would be housing them in annexes or self-contained properties all the time and within the borough, so that they could access any services that they need to. But the reality is that we do not always have the B&B available in the borough and we do not always have annexes. So if the person is there, and we legally owe them a duty to provide them with some sort of accommodation, then we may have to accommodate them in the short term in somewhere which is out of the borough or which is a B&B…"*

> *"You can only plan if you have the resources, and as I say, in an ideal world, but the reality is that the resources were not there, to always have maybe three or four or five annexes sitting empty waiting for people like this to turn up and then you could put them into. That is not the reality of the situation…"*

Comment

We do not believe that there should be an absolute requirement on Newham council's housing services to ensure the suitability or match in all respects of any particular property to the needs of an individual client. Given the demand for emergency and temporary accommodation and the limits on the resources available to meet that demand, any such requirement would be unduly restrictive and unrealistic.

In relation to housing clients with mental illness it would also place an onus on housing services to contain risks and other problems arising from matters about which they will not always have an adequate understanding or adequate information.

Nevertheless, as we consider below, as a matter of good practice, in respect of clients with mental health problems, there should be a risk assessment that focuses on housing needs when they first seek accommodation and at any stage thereafter when there is a change in their circumstances. This assessment should be done to ensure that where

possible, obvious risks are avoided in providing accommodation for a client with mental health problems. Above all, it is needed to ensure informed discussion with mental health services about the appropriateness of available accommodation and that appropriate support is given to the mental health services' care plans for the client.

It was unsatisfactory and not good practice that HPU staff failed to contact the SE CMHT in December 2006 for an up-to-date assessment of MO's mental state and the risks associated with it. But even if MO had been referred for assessment and the HPU had as a result been alerted to a need for MO to have self-contained accommodation, it is not certain that any such accommodation was available at any time between 4 and 20 December 2006. Even if MO had been placed in self-contained accommodation, he might nevertheless have attacked someone else other than Camille Remy.

It is also worth pointing out that while it was not good practice that HPU staff did not refer MO to the SE CMHT in December 2006, we cannot be certain that the SE CMHT would have been able to detect MO's mental state at that time or take effective action to contain any risks that he posed. For, as we discuss elsewhere, MO was capable of masking his symptoms, and it is unlikely that the SE CMHT would have been able to gather a full history of his movements and behaviour.

Information sharing

8.59 HPU staff demonstrated on a number of occasions an admirable willingness to liaise with other agencies and to gather information necessary to ensure they dealt with MO appropriately. For instance, in October 2005 when MO first sought accommodation from the HPU, the duty worker spoke on the phone with the manager of Anchor House, the hostel where MO had been living, and learned about the incident in which MO had chased a fellow resident of Anchor House with a knife. On MO's discharge from St Ann's Hospital the staff of the HPU contacted the SE CMHT to ask for an up-to-date assessment of MO and told the SE CMHT what they had found out about MO threatening people with knives.

8.60 On other occasions the staff of the HPU or Newham council's accommodation team failed to share information or liaise with other bodies. We have already discussed the instance in December 2006 when the HPU failed to inform the SE CMHT that MO had

reappeared in London to seek an up-to-date assessment of his mental state. We also refer to the period in late July and August 2006 when the accommodation team frequently re-housed MO, after complaints by or against other residents, and on one occasion because he had set fire to his curtains. Newham council's housing services did not tell the SE CMHT about these matters but that information could have given the SE CMHT a better insight into MO's mental state. The failure to keep the SE CMHT abreast of MO's movements also meant that the SE CMHT wrote to the wrong address to invite MO to an appointment on 29 August 2006.

8.61 HPU staff said they and Newham council's accommodation team did not give landlords information about the risks posed by clients with mental health problems who are placed in their properties. Reasons given for this included a reluctance to stigmatise clients and anxiety about breaching their confidentiality. Some staff suggested that informing landlords of risks posed by clients might result in landlords refusing to offer accommodation. Other staff, however, justified the failure to be explicit with landlords because landlords were generally aware that mental illness was one reason why people were offered local authority accommodation and accepted the risks involved. As one staff member put it:

> *"…people in the hotel business, you don't really have to tell them much because if you are in that business, if you are housing a single man that isn't physically impaired, you would know that the only reason that we would house him is that he has mental health [problems], because there is no other reason that we would accept a single man to go into bed and breakfast."*

Another member of staff said:

> *"The industry is well aware of the group it's dealing with; there's no hidden agenda here at all, no secret. They know what they let themselves in for and they take commercial decisions around that."*

8.62 The evidence we received demonstrates no clear and commonly understood rationale for the fact that Newham council's housing services' staff do not disclose to their landlords information about clients.

8.63 We have seen an email dated 15 June 2006 in which a member of Newham council's

accommodation team asked the managing agents, Veni properties, to visit the property that MO was occupying at Howard Road to assess the extent of damage he was thought to have caused. The email ended "*Please note that two officers must visit this tenant at all times, for confidential reasons I cannot disclose".* This raises the question of why it was thought appropriate to inform the managing agents that MO was deemed a risk to others, necessitating two members of the agent's staff to attend a visit, but not thought appropriate to alert the landlord of the property to that fact.

Comment

Whatever implicit understanding a landlord might have of why a person was offered local authority housing, we believe that if specific and significant matters had a bearing on the safety of the landlord, the landlord's employees or the other tenants of a property, the landlord should be told about those matters and should be given the opportunity to form a view about whether he or she chooses to accept the risks involved.

In addition to our concerns about Newham council's housing services' arrangements for sharing information about the risks associated with clients with mental health problems, we have some concerns too about its internal information sharing system.

8.64 The housing department's computerised record system contains an easily accessible running record of a client's contact with the HPU and the accommodation team, including risk assessments. Nevertheless, it appears that staff do not always notice important information contained in those records. CH explained that the documents in a clients' computer files are arranged in the order in which they are scanned in. CH said it could be difficult to find specific information without reading a whole file. She said "*what tends to happen in fairness is you would go back over the most recent stuff".* She conceded that when she considered MO's need for emergency housing in December 2006 she was not aware of the advice recorded on the system on 13 October 2005 that MO should be housed in an annex for his own safety and that of other people.

8.65 OL, formerly the interim service head for Newham council's homelessness service who later provided cover during a period of leave by the head of the Housing Options service, said

there was now a system known as 'Cautionary Contacts' under which concerns about how to deal with particular clients can be marked on the housing department's computer records. But OL also pointed out that the Cautionary Contacts system was undermined by anxieties about data protection. Clients must be told before their data are included in the system and are often amended because of their objections.

8.66 We understand that team meetings take place in the HPU but we received conflicting evidence about the extent to which such meetings were used as an opportunity to pass on information about problems that might arise or matters that need to be borne in mind in relation to particular clients.

8.67 MO's case demonstrated a number of times the limitations on the flow of information within Newham council's housing department. For example, CH's ignorance in December 2006 of the advice about the need for MO to be housed in an annexe and the fact that MO's frequent moves to different accommodation in July and August 2006 and the reasons for them were not discussed between the HPU and the accommodation department and were not drawn to the attention of MT, the HPU's mental health coordinator. MT, who took over as the HPU's mental health coordinator during the first half of 2006 said of MO:

> *"[He] was never brought to my attention, the simple reason being that he was an existing case, an existing application that has been dealt with whereby we have already accepted the full housing duty towards him."*

8.68 This implies that the HPU and its present mental health coordinator do not necessarily expect to be kept abreast of the progress of accepted clients, even where they exhibit problems that might relate to their mental health needs.

Comment

It is central to the planning and management of the care of mental health patients who pose a risk to themselves or to others that there are systems in place for sharing relevant information about those patients between and in the agencies and bodies with whom they have contact. We found a number of deficiencies in the way information was shared by and within Newham's housing services which ought to be addressed.

8.69 The internal investigation into the care and treatment of MO identified a need for greater communication between mental health and housing services in the borough of Newham. It recommended that those services should develop a protocol for working with homeless people with mental illness. It recommended that the protocol should encompass the management of risk and information sharing and the role of a lead on mental health within Newham's housing service particularly in relation to the CPA process. The recommendation referred to the need for clarity of lines of communication when clients move. The ELC NHS trust states in its response to the internal investigation that a protocol that addresses the recommendation has been agreed with Newham's housing service and a twice-yearly meeting cycle has been established.

8.70 This is a welcome development in ensuring better working between mental health and housing services and in particular in ensuring robust CPA processes.

Comment

We believe however that there is still a need for an even wider agreement on information-sharing between all agencies, including the police and landlords, who could play a part in the management of homeless people with mental health problems in the borough of Newham. We also see a need to ensure that Newham council's housing services have a robust system for ensuring that all information about clients with mental health issues is captured and disseminated among housing staff as appropriate.

Recommendations

R12 Newham council's housing services should develop a multi-agency memorandum of understanding setting out the terms on which they can share information about clients thought to pose a risk to themselves or others with other relevant agencies and bodies, (including landlords), so that appropriate CPA and risk management plans for such clients can be devised and delivered.

R13 The HPU should develop a process under which a pivotal person or persons within the HPU ensures on an ongoing basis that relevant information about clients' mental health needs

is gathered and reported back (in accordance with the suggested memorandum of understanding) to CMHTs, and any other relevant agency, as well as to Newham's accommodation team and other staff in Newham council's housing services.

Risk assessment

8.71 The only assessment document mental health services provided to the HPU about MO was the vulnerability assessment/report CPN 1 undertook on 13 October 2005. The homelessness assessment officer who received that assessment discussed its content with the duty senior officer who made a note in MO's file:

> *"[Telephone call] to psychiatric nurse of CMHT CPN 1 to get more in-depth psychiatric info on the client's current mental health condition, and risk assessment that clearly states whether or not the client will pose a risk to himself and others. (Client has been issued with a [notice to quit] by Anchor house because he chased another resident with a knife)."*
>
> *"CPN 1 was unavailable and a call back message was left…"*
>
> *"B and B authorised for 7 nights pending the above info from CPN 1, and carrying out an assessment of the client's mental health/vulnerability. Advised that the client should be placed in an annex for his/others safety."*

8.72 We found no evidence that a further risk assessment was supplied, despite several attempts to contact CPN 1. On 2 December 2005 AC, the mental health coordinator assessed MO as vulnerable and on 5 December he was formally accepted for housing.

8.73 The HPU sought a further assessment of MO when he was discharged from St Ann's Hospital on 24 July 2006 but as we describe under chapter 7, the SE CMHT sent the appointment letter to the wrong address. In any event, MO had left London by the appointment date. NB said that when he granted MO emergency accommodation on 4 December 2006 he had intended that the SE CMHT should give a further assessment of MO but it did not take place.

8.74 The HPU's standard form vulnerability report for people with mental health support needs seeking housing has a number of sections. Most relate to whether the applicant for housing meets the eligibility requirements set out in the Housing Act 1996. In one section, however, the mental health practitioner completing the report is asked: "*Has there been a history of violent behaviour?*" The report form then asks the following supplementary questions:

> *"If yes, please describe the behaviour, including whether it is directed towards self, staff, family, neighbours or others in the community.*
> *What are the likely triggers for the violent behaviour?*
> *Is it advisable that housing workers should visit in pairs?*
> *Should housing workers only visit accompanied by a mental health worker?"*

8.75 Another section of the report form headed 'Other issues of concern' gives the following prompt:

> *"An example of an issue of concern might be a history of sexual offences or sexually inappropriate behaviour, arson, noise nuisance, or seriously antisocial behaviour."*

8.76 Under the section for the mental health practitioner to make recommendations is:

> *"Any other requirements. Where there are concerns around suicidal intent-you will normally recommend that the subject is placed in low rise accommodation"*

8.77 The vulnerability report form asks the practitioner completing it to address certain matters relating to the risks associated with accommodating the person for whom housing is sought. However, it is heavily focused on risks to housing workers rather than to any others, including other residents. It does not specifically ask the practitioner to comment on what sort of accommodation might be suitable for the client. It does not specifically address the question of whether it is appropriate for the client to share accommodation or other facilities. It does not ask the practitioner to outline the care plan in place for the client and the contribution that housing services might be able to make to it, including the information sharing that might be expected and might assist in delivering the care plan.

8.78 MT, the HPU's mental health coordinator said it had been the practice since she took over that role in the first part of 2006 to require a separate psychiatric risk assessment for all clients seeking to be housed on the grounds of mental health needs. The HPU's document entitled '*Procedure for Mental Health Clients*', introduced in October 2006 includes the following:

> *"All clients who approach as homeless following discharge from hospital have to provide the following:*
>
> *1 Risk Assessment/Care Plan*
>
> *2 Vulnerability Assessment*
>
> *When a client approaches the homeless persons unit following discharge from Newham Centre for Mental Health and presents as being homeless the same day no accommodation will be provided until the above documentation has been received by this office, such as a vulnerability assessment/care plan/risk assessment."*
>
> *"It is imperative that a risk assessment is provided so we can determine whether client is a risk to others i.e. in terms of violence, aggression or at risk to themselves i.e. self harm, suicidal tendencies. We need to be satisfied that our other clients will not be at risk from mental health clients placed into bed and breakfast accommodation."*
>
> *"The same applies if applicant has been referred by local service centre/community mental health teams"*

Comment

The 'procedure for mental health clients*' gives HPU staff more specific guidance than before about the purpose and type of information and assessment required for clients with mental health needs. However psychiatrists and other mental health professionals providing the information and assessments will not necessarily focus adequately on the specific risks we refer to above and the other matters associated with accommodating a client. For this reason we consider that the HPU needs to devise a risk assessment form that specifically addresses the issues relevant to housing clients.*

As we discuss in paragraphs 8.74 to 8.75 we do not see it as appropriate or practical for housing services to have to bear the burden of ensuring that properties provide an absolute match with the needs of an individual client with mental health needs. Nevertheless, for the sake of other tenants, housing workers, landlords and their employees, as well as for the sake of the client, housing services must be well informed about obvious risks that could influence decisions about the accommodation offered to a client. And although the duty to plan and deliver a client's care plan rests with mental health services, housing services should be given the information they need to be able to support as far as possible the care planning and delivery processes.

We believe that, in discussion with the community mental health teams, the vulnerability report form should be reviewed to ensure that it answers the needs and issues that we have referred to.

Recommendation

R14 In discussion with the CMHTs, Newham's housing department should review the risk documentation it receives in respect of clients with mental health needs to ensure that it encompasses and focuses on relevant housing issues, including:

- the suitability of certain types of accommodation
- risks that the client might pose to housing workers, landlord's, their employees and other tenants
- the oversight, or other input to the client's care plan, that is required from housing workers
- the need to share information.

Comment

Bearing in mind the failure of HPU staff to seek to have MO reassessed at the time that he reappeared in December 2006, we believe that the HPU should amend its 'procedure for mental health clients' *document to require that the risks relating to housing a client are reassessed in the event of any significant change in the client's circumstances, such as a period in hospital, or a lengthy unexplained absence.*

Recommendation

R15 The HPU should amend its 'procedure for mental health clients' document to require that the risks relating to housing a client are reassessed in the event of a significant change in the client's circumstances, such as a period in hospital, or a lengthy unexplained absence.

9. The care and management of MO

Introduction

9.1 We have borne in mind in trying to evaluate the care and treatment MO received from the services with which he had contact that his case presented those services with a number of difficulties. First, the matter of communication. MO is not a fluent English speaker. In addition, his psychotic thinking could cause him to offer jumbled accounts of his history and experiences. Nevertheless, most of the mental health staff we interviewed suggested it was possible for him to communicate and while it may have required effort by both parties they felt that they had an accurate understanding of what he told them. Dr D the psychiatric liaison consultant who saw MO at North Middlesex Hospital said:

> "*I don't at any time remember having any particular problem communicating with him, nor him having a problem expressing himself. As you can see he told me quite a lot about his background. The way he described it was jumbled up chronologically, so I had to establish what he told me was going on and then put it in the right order, and sometimes go backwards and forwards and say 'was it like this?'. After a while we were able to get an account that he agreed upon. I remember that being a bit difficult, but I felt that was largely due to his psychotic thinking rather than a language problem. He was having trouble making sense of his experiences rather than having trouble expressing them in English…There were some things that he was guarded about and didn't want to reveal, and there were some things that he wasn't particularly interested in."*

9.2 Nurse 1, MO's named nurse while he was a patient at St Ann's Hospital, told us that MO was *"able to make what he wants clear".*

9.3 The way MO presented was another complication in his care and management. On occasions he was guarded, suspicious and uncooperative. It is evident that he did not always show signs of mental illness. Of the many FME's who examined MO shortly after incidents in which he had been highly aggressive or violent, only Dr T, who saw MO on 3 October 2005, and Dr Z who saw him on 13 December 2006, appear to have noticed possible signs of mental illness. The social worker and mental health officer who saw MO in Stranraer on 13 November

2006 also told us that he showed no signs of mental illness. The panel members of the MHRT were clear in their evidence that MO was calm and behaved appropriately during the MHRT hearing and displayed no signs of mental illness.

9.4 MO may have had periods of lucidity. For instance, when MO saw ASWB the ASW on 13 July 2006, he told her it was a "*stupid idea*" that people were trying to harm him. ASWB also recorded MO as having said then: *"…all the things about the man in Somalia were rubbish. He doesn't think the brother put anyone up to harassing him".* However, in her report to the MHRT, ASWB also raised the possibility that MO may have been masking his symptoms. Other staff who treated MO raised this possibility too. Dr G, the associate specialist with the SE CMHT, said:

> *"It's my recollection of him he is a very bright man, and he used to work as a teacher, he does have a university degree. I believe that because of his high IQ the paranoia was masked; he was able to do it quite intelligently."*

9.5 The RMO currently treating MO in Broadmoor agreed that MO was capable of masking his symptoms for a certain period.

9.6 After the fight on 23 June 2006 in which MO suffered multiple stab wounds he had to use crutches and was physically debilitated. This, along with masking symptoms and the linguistic barriers referred to above, appears to have led some of the clinicians who examined MO to perceive him as vulnerable and a potential victim, rather than a perpetrator of violence and aggression. This seems to have been particularly the view in the SE CMHT. CPN 1, the CPN with the SE CMHT, said that when she and Dr F saw MO on 7 August 2006 after his discharge from St Ann's Hospital she felt there had been:

> *"…a change in the way he presented…I felt he was much more vulnerable, and I wasn't sure about his mental health…I didn't make the link with him being attacked because he was provoking somebody else."*

9.7 Dr V, MO's RMO while he was a patient at St Ann's, said:

> *"…he was a relatively mild mannered gentleman, educated, university graduate.*

Tottenham is a rough area with rough patients who are very socially and economically deprived and emotionally deprived. He spoke three languages…he spoke them in a relatively cultured educated fashion, so he wasn't presenting us with those kinds of issues."

9.8 Those who had to assess and manage MO were hampered above all by the limited and inconsistent nature of his engagement with them. He appears to have seen members of the SE CMHT about eight times between 5 October 2005 and 22 March 2006 but the SE CMHT then closed his case because he was not psychotic and had made plain that he did not want to engage with mental health services.

9.9 MO's stay in hospital under section, beginning in late June 2006, came to an abrupt end one month later when the MHRT unexpectedly lifted his section and he chose to discharge himself. Thereafter, SE CMHT staff saw him only once more, on 7 August 2006, after the HPU had asked him to attend at the SE CMHT offices. MO did not receive a formal assessment on that occasion. An appointment for such an assessment was offered for 29 August 2006 but the appointment letter was mis-addressed and anyway he had left London by then and had started to travel around the British Isles.

9.10 During MO's travels he appears to have been seen briefly by mental health services in Dublin as well as by a social worker and mental health officer with a CMHT in Scotland. On his return to London on 15 November MO was arrested three times in three different parts of London. During those arrests MO was seen briefly by four different FMEs, but only once recorded as displaying possible mental health symptoms.

9.11 MO went to a GP practice in Soho on 23 November 2006. On 2 December 2006 he went to A&E at Whipps Cross. He was transferred to Naseberry court psychiatric unit where he stayed the night of 2 December 2006 before discharging himself the next day against the advice of a doctor.

9.12 In addition to the fact that their contact with MO was usually brief, most of the health services who encountered him had no direct contact with each other so they had only an incomplete picture of his mental health history. They were unable to establish a pattern to his behaviour and a firm and accurate picture of the risks he posed. MO was homeless and had

no family or other networks who could offer mental health services additional information or clues about his mental state.

Care planning; risk assessment and risk management

9.13 The staff of the SE CMHT and of Northumberland ward at St Ann's Hospital who had responsibility for the care and treatment of MO for the most significant periods did not effectively implement the care programme approach nor did they undertake proper assessment and management of risk in relation to him. This led to a number of missed opportunities to overcome some of the difficulties we refer to in paragraphs 9.1 to 9.12 and to ensure that MO's care was better planned and the risks that he presented were better understood and contained.

The care programme approach

9.14 The care programme approach (CPA) describes the continuing process by which a mental health service will:

- assess the needs of a mental health patient
- plan and coordinate the ways in which those needs are to be met
- monitor and review the progress of those plans and the way that the needs of the patient are being met.

9.15 It is designed to be the principle vehicle and cornerstone for managing the care of a mental health patient. It is a 'whole systems approach' aimed at promoting care across all aspects of a patient's life, including housing, employment, leisure and education.

9.16 Mental health patients used to be categorised for the purposes of CPA and the degree of support they received as being on either "standard" or "enhanced". However, from October 2008, CPA ceased to be the term used to describe the provision of mental health services to those with more straightforward needs. It now applies only to more complicated, formerly "enhanced" needs, cases. Formal CPA planning and paperwork no longer need to be undertaken in straightforward cases.

9.17 Risk assessment is an essential and continuing component of properly managed mental health care and is therefore an integral part of CPA.

CPA, risk management and risk planning in respect of MO - within the ELC NHS trust

Relevant policy

9.18 ELC NHS trust's revised care programme approach policy dated January 2006 states at paragraph 2.1, in the section headed 'guiding principles':

> *"Particular attention should also be paid to people who have no permanent address and lead a transient lifestyle. It is recognised that homeless people who experience mental illness present with a variety of complex needs and have a greater need for a framework to help maintain necessary links between User and services"*

9.19 Under the heading 'enhanced CPA' the policy gives the following criteria for enhanced CPA:

> *"A diagnosis of a severe and persistent major mental illness."*

And:

> *"A requirement for multiagency involvement and co-ordination."*

9.20 Paragraph 12.7 sets out the roles of the patient's care coordinator under CPA. It includes the following:

> *"Maintaining regular contact with the service user and developing a therapeutic relationship*
>
> *Providing a link with services for the service user and carers and providing support in the community*
>
> *Continuing assessment of need and risk*

Monitoring mental state and responding appropriately to signs of deterioration

Monitoring the implementation of the CPA care plan and liaising with others as appropriate

Ensuring regular reviews of the CPA care plan are taking place and appropriate documentation is completed and up-to-date…"

Paragraph 4.4 of the policy states:

"A care coordinator, selected from the most appropriate professional group will be allocated in all cases accepted for the [services of the ELC NHS trust]. This will occur as promptly as possible"

9.21 Paragraphs 20.2 and 20.3 of the policy state:

"In the event of a service user not being located they should not be removed from Enhanced CPA, but designated 'Out of Contact'. The Mental Health Act Office should be informed in order for a central record to be kept…"

"If the service user has been out of contact for more than one year, then in these exceptional circumstances they can be discharged from enhanced CPA…"

9.22 ELC NHS trust's clinical risk assessment and management policy dated January 2006 states at paragraph 3, under the heading 'principles and values'*:*

"3.1 The assessment and management of risk is the responsibility of all the clinical staff working within [ELC NHS trust] and of the service user themselves. It is not a one off activity but is a continuing responsibility."

"3.2 Risk assessment is a process informing the management of risk, and enables services to meet their responsibility to protect the public, and the client's safety…"

"3.7 Multi-agency collaboration at all levels is essential to ensure effective risk assessment and management."

Under the heading 'communication' the policy states:

"7.1 On-going risk management of individuals requires frequent reviews, sound information and first class communication. Effective risk management will often involve several workers sometimes from a variety of agencies."

"7.2 When conducting risk assessments practitioners need to be curious and actively seek information that they do not have rather than waiting for others to provide this information…"

Paragraph 8 headed 'process' includes the following:

"8.1 The risk assessment/management process is initiated when a person becomes subject to CPA and/or when they receive specialist mental health care."

"8.2 Risk assessment and management should be viewed as an integral part of the CPA process."

The use of CPA and risk assessment and management

9.23 By late October 2005 Dr G and CPN 1 had seen and assessed MO twice and CPN 1 had seen him alone once. Dr G and CPN 1 said they had difficulty deciding whether he was suffering from psychotic illness or was depressed. Dr G concluded that he was not at that time psychotic and that the paranoid symptoms he had experienced were khat-related. He and CPN 1 decided not to allocate MO to the SE CMHT but to arrange instead for him to be seen as an outpatient at the Shrewsbury Road clinic.

9.24 The circumstances in which MO had first approached the SE CMHT for help particularly confused Dr G and CPN 1. MO had brought with him a referral letter from the police who had cautioned him for threatening a fellow resident at Anchor House with a 12-inch knife, but, according to Dr G, that letter, which we have not seen, told them little if anything about that

incident. Most of what they knew about it came from MO himself.

9.25 Dr G had found MO's account of his dealings with the police "*puzzling…our initial impression was he is making up this in order to get accommodation and he is someone who knows that system very well, so we were a bit dubious about it.*" Dr G told us that he thought he had asked CA, the SE CMHT team manager, to check if MO had a forensic history or was known to the police. He said:

> *"We were trying to get some collateral information. We didn't have much."*

9.26 CA made no reference in evidence to anyone asking her to contact the police about MO. She said she did not know why the police had not been contacted:

> *"It would be something that I would have thought would happen, and I don't know why it wasn't done on this occasion."*

She went on:

> "*To all intents and purposes the [the police] are the referrer and we would normally contact the referrer for more information to fill in the whole context."*

9.27 Before the SE CMHT closed MO's case, CPN 1 filled out a standard form full needs assessment for MO. It was dated 26 October 2005. According to CA there had been no need for CPN 1 to complete such an assessment at this stage because it is only required for cases that have been allocated and placed under CPA following assessment.

9.28 Under the section in the full needs assessment headed 'thought content', CPN 1 wrote:

> *"Thinks he talks to himself when sitting alone, hence people are running away from him because of his mental problem. The Somali community have no respect for him."*

> *"When outdoors thinks he is hearing voices talking to him when no-body is around. Believes that problems are due to stress and being away from his country."*

9.29 Under the section headed 'contact with police' CPN 1 referred to the incident at Anchor House. Under the section headed 'alcohol and drugs', she wrote:

> "*Admits to chewing khat on a daily basis for 4 years and for past 1.5 month only uses it sporadically."*

9.30 CPN 1 did not indicate on the form that any needs had been identified or that MO needed any further assessments. She recorded the plan for him as:

> *"1 To start commence citalopram 20 mg mane*
> *2 To follow up at the Out Patient clinic*
> *3 Case closed to the CMHT"*

9.31 Apart from the full needs assessment form, no other CPA documentation was completed for MO at this stage. There is no record of a risk assessment having been undertaken when the SE CMHT decided that MO would be seen as an outpatient. Dr G was emphatic that he would have undertaken his own risk assessment. He said:

> *"I do it in my own practice. I do it with every patient I see. I have to make sure before they leave the door that they are safe."*

And CA said:

> "*At that point, I was not expecting the team to do a formal risk assessment when people were under assessment. Yes, they would be processing the risk assessment in their own mind but filling in the paperwork, I don't think I was expecting that at that point."*

9.32 Dr G wrote a discharge letter to the GP Dr B on 28 October 2005, setting out what was known of MO's history and background, including the Anchor House incident. It reported on the findings of the SE CMHT about MO's mental state. It did not comment specifically on the question of risk.

9.33 The police referred MO to the SE CMHT again on 21 November 2005, as described in chapter 7. Over the next four months Dr G and CPN 1 saw him four more times and CPN 1 saw him twice, before the SE CMHT discharged him on 22 March 2006.

9.34 According to Dr G, when he saw MO with CPN 1 on 21 November 2005:

> "*…we confronted him with this piece of information [that MO had given to police] about allegations of being sexually interfered with, and then he started talking about it and then he talked about having what you call first-rank symptoms of schizophrenia: cameras and the police monitoring his movements and all these things…He denied experiencing suicidal or homicidal thoughts…And always with him I had hospital admission at the back of my mind, it was always there…But at this stage he was engaging with us, he was compliant with the medication and I didn't have enough grounds to section him.*"

9.35 We asked Dr G whether he thought at that time that MO might have to be sectioned he replied:

> *"Of course yes. If he stopped the medication at this stage I would have sectioned him, or I would have organised a Mental Health Act assessment."*

9.36 CPN 1 recorded in her note of the meeting on 21 November 2005 that the assessment had "*revealed a range of psychotic symptoms"* and that MO had been started on anti-psychotic medication (Aripiprazole 10mg to be increased to 20mg daily in seven days' time).

9.37 When MO saw CPN 1 and Dr G again on 5 December 2005, he admitted that he had chewed khat since the last meeting. There was no significant change in his mental state. Dr G increased the prescription of Aripiprazole to 30mg daily.

9.38 When Dr G and CPN 1 met with MO in the presence of a French interpreter on 19 December 2005, Dr G noted that he was preoccupied with paranoid delusions and police investigations of his allegations but his paranoia appeared to be lessening. Dr G prescribed the same medication as before.

Comment

It seems plain that by early December 2005 the SE CMHT had taken on responsibility for the care of MO but he was not placed on CPA and no care coordinator was formally allocated to him under CPA.

9.39 It was not until 21 February 2006 that CPN 1 completed a CPA registration form for MO naming herself as his care coordinator. We asked CPN 1 why MO had not been put on CPA earlier. She suggested it was because he was still being assessed to determine if he was *"a case for CMHT follow-up".* She told us that MO was allocated at this time only in order to comply with a requirement that anyone seen as a patient should be allocated and placed under CPA within three months. However, Dr G told us that he did not think that MO was still being assessed in February 2006. He said that when he saw MO on 19 December 2005, the plan had been that MO *"would stay with us for a while".*

Comment

Given the nature of MO's presentation, and the level of care and treatment the SE CMHT offered him in early December 2005, we accept what Dr G told us and find that MO had been taken on as a patient and should have been allocated and placed on CPA at that time. We note that CA, the team manager of the SE CMHT readily agreed with this suggestion.

9.40 When CPN 1 completed the CPA registration form she marked MO as being on standard level CPA. He had not at that stage been diagnosed with "*severe and persistent major mental illness*" and so did not strictly fulfil the criteria for enhanced CPA as set out in the trust's ELC NHS trust's CPA policy and referred to in paragraph 9.19 above.

Comment

We believe that MO should have been on enhanced CPA, bearing in mind the guiding principles section of the CPA policy about paying particular attention to the needs of homeless people and their need for a greater framework to help maintain links with services and the fact that he was known to have threatened someone with a knife.

9.41 Dr G said he believed that MO had fulfilled the criteria for an enhanced level in the CPA framework.

9.42 CPN 1 said that when she arranged to meet MO on 28 February 2006 she had planned to complete some more CPA documentation with him but he had told her at that meeting that he did not want *"further input"* from the SE CMHT. He told CPN 1 that he believed that he was well. He also said he had stopped taking medication a month earlier because he had mistakenly taken an excessive dosage. CPN 1 asked MO if he would attend one more appointment with Dr G and he agreed.

9.43 On 1 March CPN 1 completed a standard risk checklist form for MO. She told us that although the risk checklist form had been in use for sometime, she and her colleagues had not received training on how to use it and they had found it confusing. The form that CPN 1 completed for MO contained a number of errors and omissions She made entries under the headings 'aggression/violence to others', 'substance misuse' and 'poor nutrition' but did not indicate whether these were current risks. She did, however, identify 'non-compliance with medication' and 'disengagement from mental health services' as current risks. Further, she indicated on the form that she was "lacking *appropriate information or unable to fully assess for other reasons"* but she answered "*no*" to the question "*Is a detailed risk assessment indicated?"* This was the only formal risk assessment document the SE CMHT prepared for MO.

9.44 When MO met with Dr G and CPN 1 on 22 March 2006 he said he was fine. According to CPN 1's notes, he denied hearing voices or having paranoid thoughts and claimed that he had learned to distinguish between his ideas about other people and reality. MO told her and Dr G he needed to "*get on with his life and does not wish to engage with the CMHT".* He refused an outpatient appointment and said he did not intend to continue taking medication. CPN 1 noted the plan for MO as "*Close case to CMHT. Letter to GP and consultant".* Dr G said the rationale for the decision to discharge MO was that:

> "*…he explicitly expressed his desire to be discharged from the team. We did our objective assessment, he wasn't acutely psychotic; there wasn't much I could do as a mental health service…and I didn't feel he was detainable under the Mental Health Act."*

9.45 CPN 1 wrote on 3 April 2006 to GP2, the GP who shared premises with GP3, enclosing a copy of the discharge letter that Dr G had written on 28 October 2005. She also gave a brief update on MO's contact with the SE CMHT. She concluded:

> *"In view of [MO] voicing that he will not engage with the services his case will now be closed to this team. He is aware of the self-referral procedure and has been advised to contact you in the event of needing CMHT help, since he is out of our catchment area."*

9.46 The letter did not address the issue of the risks that MO might pose.

9.47 Dr G, CPN 1 and CA all said the decision to discharge MO would have been taken after an informal discussion with Dr F, the consultant with the SE CMHT. No formal CPA meeting took place at which MO's discharge was discussed and planned. Apart from CPN 1's notes in the SE CMHT's contact record referred to above and the comments in her letter of 3 April to GP2, there was no formal documentation of the decision to discharge or the thinking behind it. There was no further formal risk assessment of MO. The letter of 3 April addressed to GP2 was placed on GP3's file for MO.

9.48 After the referral by the HPU, the SE CMHT next saw MO on 1 August 2006. CPN 1's notes show that the HPU had informed the SE CMHT about his fight with Mr A and his use of knives on that and previous occasions. During the interview on 1 August, at which both CPN 1 and the consultant Dr F were present, MO said he had been the victim and had been stabbed after he had asked his neighbour Mr A to turn his music down. CPN 1 recorded that MO did not appear to be responding to psychotic symptoms during the interview other than exhibiting suspiciousness and being guarded. However, she also recorded MO as asking "*why had he come to see us and how could he be sure that CMHT office was not some other body operating from the address".* CPN 1 noted that MO denied having taken khat for the past year.

9.49 We have not had the opportunity to interview Dr F. However, CPN 1 made plain that at the meeting on 1 August she had formed the overwhelming impression that MO was vulnerable. She told us:

"This time I was quite taken aback by his vulnerability the way he presented, it was quite vivid. When I saw him I saw a man who was extremely thin and he was on crutches and had a body brace."

9.50 Nevertheless, when CPN 1 wrote out the form to refer MO to the south west CMHT who held the rota duty for patients of no fixed address, she stated under the heading 'healthcare needs':

"*At present not enough collateral information about stabbing incident (police or hospital). Requires French interpreter to assess fully."*

Under the heading 'risk factors' she entered:

"More information required about stabbing."

9.51 When NB contacted CPN 1 again on 7 August 2006 to inquire about MO's assessment he told her that MO had been in a fight at his accommodation over the previous weekend and that he was being moved back to Newham. CPN 1 and Dr F therefore agreed that MO would not be referred to the south west CMHT, but that the SE CMHT would after all see him again. The further referral letter that CPN 1 then addressed to the SE CMHT gave MO's healthcare needs as:

"*Currently on crutches and having difficulties with mobilising freely. Also wearing a body brace.*
In pain
Needs medical follow up"

MO's risk factors were given as:

"Further deterioration in mental health
? paranoia
Increased vulnerability-at risk of harm from others."

9.52 In this second referral CPN 1 did not specify the further inquiries that she had suggested in the earlier referral. She did not acknowledge that MO might pose a risk to others. She said she had not made further inquiries of the police or St Ann's Hospital about the stabbing incidents in which MO had been involved because she had not felt that MO "*was so critical".*

9.53 When Dr G returned from his holiday and was told about the meeting with MO, he asked why Dr F had not sectioned MO. He also asked CPN 1 and Dr F whether they had contacted St Ann's Hospital. Dr G said Dr F had referred to having seen the MHRT's decision report giving reasons for lifting MO's section. According to Dr G this led him to assume that there had been contact with the hospital.

9.54 The SE CMHT did not draw up further CPA documentation and did not undertake any formal risk assessment of MO at this stage. CPN 1 told us that because MO had been discharged previously from the CPA register he was "*taken on as an assessment once again".* Dr G agreed that he would see MO with CPN 1 for an assessment that was arranged for 29 August 2006.

9.55 MO failed to appear for the appointment on 29 August. The HPU told the SE CMHT that he had left his accommodation and the SE CMHT decided to discharge him. According to CA, the team manager, they did so because they could not keep a slot in their case load open indefinitely. No risk assessment was undertaken and no risk management plan was drawn up at the time. However, CA in consultation with Dr F contacted the Jigsaw team at Plaistow police station to tell them that MO was missing and to ask to be informed if he was picked up. The email CA sent to the Jigsaw team gave a brief history of MO and described him as being "*quite unwell and potentially very risky"* and also *"potentially still dangerous".*

Comment

We believe that these events relating to MO's two periods of care and treatment by the SE CMHT demonstrate that CPA was not properly embedded as the fundamental basis on which the SE CMHT assessed, planned and managed the care of its patients. These events also show that the SE CMHT did not approach the assessment and management of risk in relation to MO in the systematic, rigorous and continuous way expected under

CPA and under the ELC NHS trust's own clinical risk assessment and risk management policy.

MO was taken on as a patient in early December 2005 and should have been made subject to CPA then. But he was not in fact registered for CPA until 21 February 2006, two months later. CPN 1 said when she eventually registered MO for CPA she did so only because he had been seen by the SE CMHT for three months and the policy was that patients should be registered within that time. She thereby indicated that she, and possibly others in the SE CMHT, had not seen CPA as the fundamental tool for assessment and management of patients that it is meant to be, but rather as a matter of process and procedure.

We have also found that when she completed the CPA registration, CPN 1 mistakenly marked MO as being on standard CPA, an assessment that Dr G did not agree with. This demonstrated a lack of shared understanding about MO's position and status with regard to CPA.

MO was referred to the SE CMHT again at the end of July 2006. He had previously been registered for CPA and subsequent events had indicated further psychotic illness and MO's risk to himself and others but the SE CMHT did not re-register him for CPA. Nor did they undertake a proper risk assessment or agree a risk management plan. We believe they should have done all these things.

9.56 The only formal SE CMHT documents that dealt in any specific way with risk in relation to MO were the full needs assessment dated 26 October 2005, the risk checklist dated 1 March 2006, and the referral dated 7 August 2006. As we have shown, all these documents were either inadequately or incorrectly completed and/or based on insufficient information.

Comment

We believe that it was because of the lack of embedded CPA and risk management processes that the SE CMHT failed to develop, agree and document a reliable understanding of the risks that MO presented and robust plans for managing those risks.

We also believe that this lack of a reliable shared understanding of risk in relation to MO would have made clinicians more prone to rely on MO's immediate presentation rather than taking a more accurate, longitudinal view based on his longer-term history and presentations.

9.57 CPN 1 and Dr F appear to have been overwhelmingly influenced by MO's frailty and apparent vulnerability when they saw him on 1 August 2006. As CPN 1 put it: "*at that minute I didn't think he could harm a fly".*

9.58 As we now show, the lack of rigorous CPA assessment and planning processes and the resulting inadequate understanding and management of risk clearly had an impact on how the SE CMHT managed MO's case.

9.59 Dr G said that when the decision was taken to discharge MO from the SE CMHT in April 2006, he thought "*risk had lessened because he was compliant with the medication; there wasn't any incident of violence during this period of time. He was engaging with us, he was very open".* A more rigorous and collective recording by the SE CMHT of MO's risks in the period leading up to this discharge would have shown that his reporting of substance misuse (in the form of chewing khat) had varied over time and was unreliable, indicating that this was probably still a significant risk. It would have highlighted MO's reluctance to comply with medication and to engage with mental health services. And it should also have indicated the need for further information about MO, his history and his reactions to others from independent sources including the HPU, the police, and others who dealt with the incident at Anchor House.

Comment

We believe better assessment of risk in relation to MO would have indicated the need for some continuing effort on the part of the SE CMHT to try to engage with him after 3 April 2006. Even if this could not be managed on a consistent basis, or directly with MO, there was a case for maintaining some contact via the HPU and for investigating if any other means of contact with MO was available.

We cannot say if a plan by the SE CMHT to manage MO beyond 3 April 2006 would

significantly have altered the pattern of events in this case. But we find that the fact that no plan was put in place was a missed opportunity.

9.60 CPN 1 and Dr F saw MO when he was referred back to the SE CMHT after being discharged from St Ann's Hospital. They appear to have thought he did not need to be sectioned. However, Dr G said when he later returned from his holiday and was told about MO's presentation, he was extremely concerned about his mental state and thought he might meet the criteria for being detained under the Mental Health Act. Dr G said he took this view because:

> *"We have an established diagnosis, there is a psychotic illness, he was stabbed, so he's at risk and he's vulnerable. St Ann's Hospital, perhaps they don't know much about his history but we are aware of his history".*

9.61 Dr G also questioned whether there had been contact with St Ann's Hospital. He said that Dr F had referred in their conversations to seeing the MHRT decision so he had assumed that contact had been made. In fact, no member of the SE CMHT had contacted either St Ann's Hospital or the police to get better information about what had happened to MO since the SE CMHT last saw him. This shows a lack of a shared, reliable understanding of risk in the SE CMHT. It resulted from the collective failure by the SE CMHT to undertake a proper review of risk in a forum such as a CPA meeting, based on all relevant information.

Comment

A better review of MO's case and the risks he posed at this stage might have resulted in the SE CMHT seeking to have him re-sectioned. If he had been re-sectioned when he was in contact with the SE CMHT after his discharge from St Ann's Hospital, it could have had a significant impact on the course of events. For these reasons we believe that the failure to undertake a proper assessment and review of MO's case at this time was a significant missed opportunity. However this refers to a period well before December 2006 and, even if MO did meet the criteria for re-sectioning, it cannot be known whether he would have been fully treated or continued to be detained at the time of the killing of Camille Remy.

9.62 If MO had been subject to CPA in August 2006 (as we believe he should have been), then under paragraph 20 of the ELC NHS trust's revised CPA policy the SE CMHT should have kept his case open after he disappeared at the end of that month. However, if MO had been subject to CPA and proper risk assessment, then whether they formally discharged him or not, the staff of the SE CMHT should have been alert to the need for some formal plan to ensure that the police, the HPU and the SE CMHT continued to share any information they received about MO and agreed a joint response to it.

9.63 Dr G might then have sought to involve other agencies when Dumfries and Galloway social services contacted him on 13 November 2006, when he was told they were returning MO to London by train. Equally, there might have been a better chance of the HPU informing the SE CMHT about MO reappearing at their offices on 4 December 2006.

Comment

Accordingly, it is a possibility, but only a possibility, that if the anxieties that were felt by SE CMHT staff at the time of MO's discharge on 7 September, and which CA communicated to the Jigsaw team, had been properly discussed under CPA in a joint forum with the other agencies, and had been the subject of a properly recorded joint planning process, then the SE CMHT might have become involved with MO again in the critical period immediately before 20 December 2006. However given MO's ability to mask his symptoms, and the difficulty of establishing a full picture of his movements and behaviour, we cannot say what the outcome of the SE CMHT's involvement would have been or whether it would have avoided the death of Camille Remy.

For the reasons that we have given, we find the SE CMHT did not effectively implement CPA nor undertake proper assessment and management of risk in relation to MO and this had an impact on his care and treatment.

We were pleased to learn that as a consequence of MO's case, it is now the practice of the SE CMHT to undertake a risk assessment of all patients the moment that they are first seen for assessment.

And Dr G told us that although the completion of formal risk assessment forms is the

responsibility of the care coordinators he will now usually sit down and agree the risk assessments with them.

9.64 The internal investigation into the care and treatment of MO also identified the need for more rigorous risk assessment processes in ELC NHS trust and the BEH NHS trust. The internal investigation panel made the following recommendation:

> *"Consideration of available assessments must be an integral part of every CPA review and every meeting about a patient's care and treatment, including discharge planning. This must be explicitly recorded for all such meetings and must be incorporated into the policies of both trusts. Adherence to this must be monitored through regular audits."*

The internal investigation panel also recommended:

> *"That an audit be carried out periodically of the quality of a sample of risk assessments and risk plans within the CMHTs."*

9.65 ELC NHS trust's updated response to the internal inquiry states that as at October 2008 the CPA policy and documentation include specific requirements to ensure that risk assessment is integral to CPA reviews. The response also shows that CPA and risk audits (other than in the community setting) have been carried out and will continue to form part of the audit timetable. A further update has been received from the trust advising that a risk assessment audit has now also been completed for community services.

Comment

We welcome ELC NHS trust's response to the internal investigation recommendations made in respect of risk assessment. Nevertheless our investigations have identified a need for a better understanding of the role and purpose of the CPA framework as a whole, which includes risk assessment and management, as well as a need for a greater commitment by all clinical staff, including medical staff, to adhere to and use the framework as the cornerstone of every patient's care and treatment.

Recommendations

R16 The ELC NHS trust should ensure that all staff caring for patients undertake robust care planning in line with current policy and best practice in relation to the care programme approach, which includes risk assessment and risk management, and that they understand where responsibility for such assessments and plans lies.

R17 The ELC NHS trust should amend its clinical risk assessment and risk management policy to reflect the fact that the risk assessment and management process begins the moment a person is first assessed and not merely when they are registered for CPA or are deemed to be receiving specialist mental health care.

R18 Adherence to the requirement for proper CPA planning (see recommendation 16 above) and the need to begin risk assessment and risk management from the time a person is first assessed by services (see recommendation 17 above) should be monitored through regular audits undertaken as indicated in the ELC NHS trust's response to the internal investigation.

9.66 We deal with staff training in respect of risk assessment and risk management in paragraphs 8.18 to 8.21. We reiterate the need for the recommendations that we have made in respect of that issue.

Discharge and discharge planning by the SE CMHT

9.67 It appears that the decisions to discharge MO from the SE CMHT took place in October 2005 and in April and September 2006 were not taken in formal meetings, were not formally documented and did not involve other agencies. Above all, they were not based on a robust and shared assessment of the risks MO posed and the means by which those risks might best be managed, including the roles other agencies might usefully play in any continuing management plans.

Comment

As we have already discussed, these failings in relation to discharge planning resulted in

what we consider to have been inappropriate decisions to discharge and inadequate plans for managing MO after discharge.

9.68 The internal investigation panel made a number of recommendations in respect of discharge by the ELC NHS trust. The recommendations of the internal investigation panel and the steps to implement them, as set out in a letter to us dated 30 January 2009, are given below.

Internal investigation recommendation:

> *"The decision to discharge a patient from a service must always be taken in the context of a formal discharge planning meeting. The reasons must be recorded. There must be a clear record that relevant risk factors have been considered. A formal plan must always be drawn up and should clarify the role of any other agencies who might be involved and what action they are expected to take. Such expectations should be communicated to these agencies and documented. Regular audit of notes of patients discharged from the service should be carried out to ensure compliance with this policy."*

ELC NHS trust response:

> *"The trust admission and discharge policy update in August 2008, specifies requirements for risk assessment prior to discharge (section 8) and for CPA which itself specifies and provides documentation for risk management. The discharge check list includes completion of risk assessment and CPA. A discharge audit has been completed and Newham is now in its re-audit stage."*

Internal investigation recommendation:

> *"Audit sampling of case files of specific types/groups of clients to be carried out to identify common themes and difficulties as a basis to improve practice. The panel would recommend that a sample be looked at of recently discharged clients focussing on homeless clients and 'difficult to engage' clients."*

ELC NHS trust's response:

> *"A discharge audit for homeless/difficult to engage service users has been carried out on 20 cases however data is not readily available, and a further audit and joint working is needed with [HPU] and will be carried forward with [HPU]."*

Internal investigation recommendation:

> *"That the trusts' policies on discharge be reviewed in the light of findings of [internal investigation] report and the above audits."*

ELC NHS trust's response:

> *"The trust policy has been reviewed and implemented in August 2008."*

Recommendation

R19 The ELC NHS trust should continue to monitor the implementation of the internal investigation recommendations in relation to patient discharge.

CPA, risk management and risk planning in respect of MO - within the BEH NHS trust

Relevant policy

9.69 The BEH NHS trust's care programme approach policy dated November 2005 sets out the following under the heading 'working together in the inpatient setting':

> *"4.1 All new patients admitted directly to hospital must be assessed for eligibility under CPA and a care coordinator allocated soon after admission*
> *a) patients who are not known to services and therefore are not receiving care under the CPA will need to be assessed as soon as possible. In such cases the following would apply.*
>
> - *The ward named nurse will make all the necessary arrangements for a first CPA to*

take place in the ward round within the first two weeks of admission.

…

- *From there on the care coordinator and the named nurse will work together with the patient during their stay on the ward, identifying needs, drawing up a care plan and planning for the discharge of the patient*

This process will ensure that the patient can be discharged when they are fit to do so with the required package of aftercare already in place, thus ensuring a seamless service."

9.70 Under the heading 'transfer of care', the care programme approach policy states:

"*Where a service user moves to a new area or between services such as CAMHS to adult mental health services, it is essential that the programme of care is handed over and continues by the mental health services in that area…"*

9.71 Paragraph 11 of the care programme approach policy deals with risk assessment. It states:

"11.1 All service users subject to the CPA must have at least a Brief Risk Assessment and Risk Management Form completed…Where there is high risk, an Extended Risk Assessment Risk Management Plan must be drawn up…The risk assessment should always be discussed with the clinical team leader and the multidisciplinary team where there are serious concerns and, where possible, should be completed jointly with the service user. Within this setting it is important that all of the professionals involved in the decision making process have access to all the relevant information. Where this is not possible, individual professionals should assure themselves that the information on which they base their decisions is up to date, accurate and as complete as possible. Any and all decisions must be clearly identified in the service user's clinical notes.

11.5 The brief risk assessment aims to identify a history of past risk behaviour. It focuses on recent risk behaviour. All inpatients should have a brief risk assessment completed as part of their assessment. In patient staff must complete the brief risk

assessment for all new admissions to hospital within 5 days.

11.6…It is important that a thorough risk assessment is undertaken and a clear reasoned plan of care is developed and documented, demonstrating the best possible practice has been followed…"

9.72 The provisions of the care programme approach policy set out above are also contained in the latest version of the policy dated March 2007.

9.73 Paragraph 3.3 of the BEH NHS trust's clinical risk and management policy dated September 2005 provides:

"…a risk assessment must always take place and evidence reasoning for this judgement recorded in the case notes and on the Risk Assessment form. Appropriate action and communication should then take place on the basis of that assessment."

And paragraph 3.4 provides:

"…People with longer term, severe difficulties and particularly those known to have a propensity for dangerous or risk taking behaviour, need special consideration both at the time of discharge and during follow up in the community.
In such cases:

1 Before discharge from hospital, a risk assessment must be done and a risk management plan agreed by all concerned…"

Risk assessment and risk management in relation to MO

9.74 In considering whether the staff on Northumberland ward at St Ann's Hospital followed good practice in assessing MO and drawing up care and risk management plans for him, we note that he was in their care only briefly. He was sectioned at North Middlesex Hospital on Friday 7 July 2006 but was not transferred to St Ann's Hospital until Monday 10 July 2006. His section was lifted at the MHRT on Tuesday 18 July, the order becoming effective on Friday 21 July. MO left St Ann's Hospital for good on the morning of Monday 24 July 2006.

9.75 Given the timescale of MO's admission to St Ann's Hospital, it is not surprising that staff did not arrange to allocate a care coordinator for MO and organise a formal CPA meeting while he was an inpatient. CPA policy on allocating a care coordinator and holding the first CPA meeting clearly did not apply in MO's case.

9.76 A number of doctors saw MO while he was briefly on Northumberland ward before the MHRT and began appropriate treatment.

9.77 Dr V, the RMO, and his SHO Dr N, also identified a number of sources that needed to be contacted in order to establish a firmer picture of MO's mental history and the nature of the risks he posed. However, they already had some history and an early assessment of MO from the discharge summary prepared by Dr D the psychiatric liaison consultant at North Middlesex Hospital. He had concluded that *"…there is considerable risk associated with [MO's] illness"* but he did not specify whether the risk was principally to MO himself or to others.

9.78 On 15 July 2006 Nurse 1, MO's named nurse, completed a brief risk assessment and risk management form in which he identified MO as a high risk in respect of "*Aggression/Violence to others*" and in respect of "*Non-Compliance with treatment".* He also noted in the narrative section that MO had stabbed his neighbour Mr A during the fight on 23 June 2006. The mental health unit assessment Nurse 1 completed on 15 July 2006, referred to MO's capacity to "*become aggressive towards others".* Nursing staff witnessed several times behaviour by MO which suggested he was both liable to be aggressive and at risk of acting on his paranoid delusions. For instance, Nurse 1 told us of an occasion when MO had been aggressive during a conversation, and on 15 July 2006 he wrote in the clinical notes that MO had tried to barricade himself in his room. The following day it was noted by a nurse that MO kept peering at others as they passed his room and complained that they had been spraying his room with noxious gas. Nursing staff told us it was commonly understood on the ward that MO was capable of being violent with others and that he had inflicted injuries on Mr A.

9.79 After the MHRT, Nurse 3, the charge nurse on Northumberland ward completed a referral form (also called a discharge assessment of needs notice) addressed to the Tottenham area CMHT on 20 July 2006. He marked MO as at risk of "*self neglect",*

"abuse/exploitation by others", "serious violence/harm to others" and *"non compliance with medication*". He said history of risk was "*not known"*. He also wrote:

> *"[MO] is alleged to have been stabbed by neighbour (chest wound) nearly 2 weeks ago. Is also said to have threatened neighbour first before being stabbed…"*

9.80 Although Dr V was aware that MO had been stabbed he had no recollection of having seen the risk assessment and risk management form in which Nurse 1 referred to MO as having stabbed Mr A. Neither did he recall seeing the referral form completed by Nurse 3 on 20 July 2006. He did not recollect anyone bringing to his attention evidence to show that MO had stabbed Mr A or had been aggressive in the past and posed a threat to others. He had not seen MO as a threat to others. Dr N said he had been aware of the suggestions that Mr A had sustained injuries at the hands of MO but he had felt that there was still uncertainty about exactly how. Nevertheless, he considered MO posed a "*moderate to severe"* risk to others. He believed he had shown Dr V the entry in the clinical notes of the on-call SHO who admitted MO which recorded that Mr A was also stabbed in the fight with MO.

9.81 It is clear from the evidence of Drs V and N and the nursing staff on Northumberland ward that there was a lack of information sharing and a lack of shared understanding in the team that treated MO about his mental health history and the risks he posed. We have already shown in chapter 8 that this lack of shared information and understanding at the time of the MHRT hearing had the effect that certain significant matters relating to MO's risk to others were not put to the MHRT and that this may have altered the outcome of that hearing. And as we explain below, we also find that it continued throughout MO's time as a patient on Northumberland ward and had an unsatisfactory impact on the arrangements that were made for MO's discharge.

Comment

Accordingly, we find that risk assessment and risk management in relation to MO was not undertaken in a systematic way, based on all relevant information, and agreed and understood by all staff responsible for his care. As a result, information known to staff and relevant to the assessment and treatment of MO was not communicated to his RMO and the assessment of risk in relation to MO was not as robust as it should have been.

Discharge of MO by the BEH NHS trust

9.82 Dr V said he believed that MO's discharge would have been discussed either in the CMHT meeting on Monday 24 July 2006 or during Dr V's ward round on Tuesday 25 July 2006. Dr N believed that MO had been discussed at the CMHT meeting. Dr N said the CMHT's discussion about MO's discharge focused on appointing a *"care coordinator who would take the leading role, who would be responsible in the community, try to see him, try to follow him up, and pass on the message to the concerned authorities, there Newham or wherever".*

9.83 MM, the Tottenham area CMHT manager, told us that the discussion about MO at the CMHT meeting on 24 July 2006 related only to the request from the ward for the allocation of a care coordinator. An issue arose about whether MO would be housed outside Tottenham and would therefore be ineligible for care by the CMHT. MM told us that she subsequently discussed this issue with SA the ward manager and she believed that she had asked that the ward staff let her know where MO was eventually housed. MM told us that these were the only discussions that she had regarding MO.

9.84 There is no record of any discussion or consideration, by the ward or the Tottenham area CMHT, of risks in respect of MO's discharge and aftercare arrangements.

9.85 In the end no care coordinator was appointed and no other aftercare arrangements were made for MO.

9.86 Dr N sent a copy of the discharge summary dated 3 August to the surgery of MO's GP. The summary set out what Dr N knew of MO's history and referred to matters and events that indicated risk in relation to MO, although it did not specifically identify those risks under a separate heading nor did it set out a specific aftercare plan.

9.87 Dr V said:

> "*It would appear that on the 25th we agreed to discharge him in his absence and that we did have some discussion in the community as to what we could or should do, because he disappeared from our antennae by that time, not completely but we had*

certainly not taken in to account that we could have may be traced him wherever Newham placed him. The reason our approach might not have been as assertive is that it was very clear he didn't want contact, he had been given, in his own words, a clean bill of health therefore didn't need to have contact, there was no question in his mind that he needed contact, so it was very difficult to see how we could move forward, because none of the teams we have can make contact with a patient who doesn't want to or doesn't need to."

Comment

We believe that events leading to MO's discharge and the thoughts of various of the mental health team, including Dr V, about how the discharge would be managed, suggest significant confusion and ambivalence.

9.88 We know that both Dr V and Dr N and all other staff who cared for MO were keen that he should continue to remain in hospital under section and were surprised and disappointed by the outcome of the MHRT. We know too that ward staff made a number of requests for the CMHT to allocate a care coordinator to MO. Notwithstanding this evident anxiety to ensure that MO should continue to be subject to some form of supervision and care, in the end they allowed MO to leave hospital without any one having responsibility for trying to engage with him and no other plans for continuing support.

Comment

We believe that if the BEH NHS trust staff who cared for MO had undertaken a more rigorous and collective assessment of the risks relating to him and his discharge into the community, they would have been alerted to the need at least to try to put some form of after care plan in place. In particular, staff on Northumberland ward knew that MO was to be re-housed by Newham council and, as Dr V appears to have conceded, it should have been possible to identify and make contact with the mental health services in the area where MO was going to be re-housed so that they could try to establish contact and engage with him. CMHT staff are often charged with the difficult task of trying to engage reluctant patients where the risks are perceived as high, and are sometimes successful. Equally, it might have been appropriate to have had direct discussions with

housing staff and police to consider what if any information sharing might have been appropriate for ensuring that MO had support in the community.

The HPU referred MO to the SE CMHT after his discharge but there was no direct contact between the SE CMHT and the ELC NHS trust. This appears to have resulted in the SE CMHT having only a partial picture of MO's mental state. The SE CMHT might have taken a different path in its care of MO in July and August 2006 if the BEH NHS trust had planned the transfer of his care to the SE CMHT.

We believe the BEH NHS trust's inadequate assessment of MO at the time of his discharge and its aftercare planning was a missed opportunity.

9.89 We have already set out the recommendations made by the internal investigation in relation to CPA and discharge processes and procedure. We endorse those recommendations. In response to the internal investigation recommendations, the BEH NHS trust said it would update CPA procedures for all clinical staff. A new CPA policy has been developed by BEH NHS trust which incorporates practise guidance on risk assessment and management and the trust's quality and professional leads sub committee considers regular risk management audit reports. The trust's revised CPA and discharge policies now include clarification of roles and responsibilities in relation to discharge, including informing external agencies about expectations of them. The trust also stated that discharge procedures were audited in June 2008 and it was undertaking an audit of the discharge of patients who are homeless and using inpatient services with a view to identifying common themes and difficulties as a basis for improving practice and reviewing relevant policies.

Comment

We believe that the BEH NHS trust's responses to the internal investigation recommendations should ensure that the procedural framework for CPA, risk assessment and appropriate discharge planning is in place. Nevertheless, it was a particular weakness in the care of MO that significant information and assessments about him were not always shared among all relevant members of staff. It is important that staff fulfilling CPA and risk assessment and discharge processes can take into account all the information available about a patient.

Recommendation

R20 The BEH NHS trust should ensure that risk assessments and risk management plans are discussed in multidisciplinary team meetings so that all professions can contribute relevant information and understand any plans devised.

The care that MO received at North East London Mental Health NHS Trust

9.90 The notes and records that were prepared by Dr W the liaison psychiatric SHO who saw MO at Whipps Cross Hospital on 2 December 2006, set out the matters and incidents MO referred to which led Dr W to conclude that MO was a suicide risk and exhibiting "*prominent psychotic features*". These included MO's tale of BB sending 50 men to kill him and of trying the day before to jump off a bridge in Ealing. Dr M, the duty SHO at Naseberry court acute psychiatric unit, confirmed that he would have seen those notes and records when he interviewed MO on his admission to Naseberry court early on 3 December 2006.

9.91 However, Dr M said he would have conducted a fairly long interview with MO when he was admitted and had a further interview later that morning but he had found no evidence of any persecutory delusions or any psychotic or depressive symptoms. Dr M accounted for the differences between how MO presented at the two hospitals by saying he had accepted what MO had told him about having behaved as he did at Whipps Cross Hospital because he wanted a place to stay.

9.92 Dr M also suggested that the nursing notes from Whipps Cross Hospital supported this explanation, showing that MO was calm and cooperative while he was there and had twice accepted tea and biscuits or sandwiches. As Dr M put it:

> *"The patient came with suicidal ideation. The patient is paranoid. The patient is sitting calmly, having tea and a sandwich and is very cooperative. Most of our paranoid patients that I see they are guarded and not that cooperative. They are anxious and scared."*

9.93 Dr M also said the nursing staff at Naseberry court had told him about the incident

recorded in the nursing notes in which MO was told he could not leave the ward without seeing the doctor, had become restless, picked up a chair and threatened to break the door lock with it. Dr M said he thought that was an expression of MO's frustration at not being able to leave the ward. He said "*Not everybody who lifts a chair is [psychotic] sick".*

9.94 Dr M said he saw nothing to raise concerns that MO might harm either himself or others and if he had he would have sought to have MO sectioned under section 5(2) Mental Health Act 1983. Nevertheless, he said he could not have been certain about MO's mental state, which was why he wanted him to stay in hospital "*so that we could observe him more and come to a conclusion as to what was happening".*

9.95 Dr M said MO would have been physically examined at Whipps Cross Hospital and that the staff there would have alerted him to any relevant matters arising. The records show, however, that no physical examination was undertaken at Whipps Cross Hospital. Later, in his response to the draft of this report, Dr M said that as a rule he does undertake his own physical examination of his psychiatric patients but it may not happen until they are settled. In any event, Dr M did not physically examine MO before he left Naseberry court.

Comment

We accept what Dr M said about MO not having presented with psychiatric symptoms when he examined him. However, not to have undertaken a physical examination of MO at either Whipps Cross Hospital or at Naseberry court was not good practice. Given that no physical examination had been undertaken at Whipps Cross Hospital and given that, according to Dr M, MO was calm and cooperative when admitted to Naseberry court, we believe that Dr M should have undertaken a physical examination at that time. Such an examination would have revealed the scars of the injuries that MO suffered in the fight with Mr A and that might have led to a discussion of those events and provided Dr M with greater insight into MO's mental state.

Recommendation

R21 North East London Mental Health Foundation Trust should ensure that medical staff carry out a physical examination of patients as part of the admission procedure.

The care MO received in Dublin

9.96 We wrote to the staff at the clinic at the Balseskin refugee reception centre in Dublin in May 2008 asking them for the details of their involvement with MO. It was not until late June 2009, after we had completed our investigation and while this report was being quality assured, that the Health Service Executive in Dublin sent us a file containing their records relating to MO. These records give rise to a number of questions. These include the circumstances in which MO was discharged from St Brendan's Hospital on 31 October 2006 and the assessment of the risks that he posed at that time, and why no one communicated with health services in London at the time that MO was discharged or when he went missing from the Balseskin refugee reception centre.

9.97 The services that had contact with MO in Dublin are however not subject to Health Service Guidance (94)27 and their care and treatment of MO does not fall strictly within our terms of reference. For these reasons we have not persisted in trying to obtain more evidence and information from them.

The care MO received from Dumfries and Galloway social services

9.98 An issue arose for us about the appropriateness of the arrangements that were put in place by the social services staff of Dumfries and Galloway council for having MO assessed on 13 November 2006. We received evidence, set out under chapter 7 above, to show that there were differing expectations of the role that RK, the mental health officer sent to see MO, would play and of the extent of any assessment that he gave of MO. TY, the duty social worker who was dealing with MO on 13 November made it plain that she had asked her managers to send someone to Stranraer who could give a mental health assessment of MO. That was what she had understood RK would do. RK on the other hand was adamant that he had only seen MO for the purpose of assessing whether he was fit to travel.

9.99 We wanted to find out how the misunderstanding arose with a view to making recommendations designed to avoid a recurrence. We tried to interview the manager who decided to send RK to Stranraer; however she was not available for interview within the timescale of our interview process. The services in question are not subject to Health Service

Guidance (94)27 and in the circumstances we did not consider it appropriate to pursue this matter further.

Conclusion on the care and management of MO

In this report we refer to certain acts or omissions in MO's care as amounting to missed opportunities, where, if practitioners had taken a different course, they might have been able to alter the course of events. However, given the difficulties presented by MO's case, in particular his ability to mask his symptoms, the difficulties that practitioners had in building up a picture of his behaviour and his mental state, and MO's reluctance to engage with services, we cannot say that, on any of the particular occasions referred to, the killing of Camille Remy in December 2006 was predictable, or that MO necessarily met the criteria for detention and treatment under section for a significant period so that the death of Camille Remy could and should have been avoided.

10. Record-keeping

10.1 The documents supplied to us by ELC NHS trust, BEH NHS trust, and Newham council's housing services show that most members of staff followed good practice by making a clear written record of any contact with MO or with other professionals dealing with him.

10.2 But we found some instances where staff failed to make a written record where they should have. Among these was the interview that MO seems to have had with CPN 1 and Dr G on 24 October 2005, at which MO was prescribed an antidepressant. Dr G also failed to record that staff from Dumfries and Galloway social services had contacted him about MO on 13 November 2006. MT, the HPU's mental health coordinator failed to record that CPN 1 had asked the HPU on 29 August 2006 to tell the SE CMHT if they had any further contact with MO.

Comment

This last omission was particularly significant because if other HPU staff had been aware of the SE CMHT's wish to know of further contacts with MO, it might have prompted an assessment of MO by mental health services in December 2006.

10.3 We found a number of instances of what we consider inadequate records. The staff of the SE CMHT did not record in detail the discussions that they had on the three occasions that they decided to discharge MO. And the BEH NHS trust staff did not record their discussions relating to arrangements for MO's discharge from St Ann's Hospital. We believe this was another facet of the failure by both SE CMHT and the staff of BEH NHS trust to undertake and demonstrate robust collective risk assessment and risk management.

10.4 We believe it would be appropriate for the trusts and the HPU to remind staff of the need to make a full record of all contacts that they have with a patient or of all significant discussions that they have in relation to a patient.

Recommendation

R22 ELC NHS trust, BEH NHS trust and the HPU should remind all staff of the need to keep a full record of the contacts that they have with a patient and all significant discussions that they have in relation to a patient.

11. The Mental Health Review Tribunal

11.1 MO applied to the MHRT on 11 July 2006 for a review of his detention under section 2 Mental Health Act 1983. On the same day BEH NHS trust's Mental Health Act office sent a fax to ASWB, the ASW who had been involved in sectioning MO, asking her to prepare a report for the MHRT hearing. We have not seen the request to the Northumberland ward staff asking them to prepare their reports but we assume that they too were sent by fax on 11 July 2006.

11.2 The Mental Health Act office wrote to ASWB and the staff on Northumberland ward on Thursday 13 July to tell them that MO's MHRT hearing would be held on the following Tuesday, 18 July 2006, the latest a hearing could be held. BEH NHS trust's Mental Health Act manager said the letter would have been followed up with a phone call because time was short. However, Dr V said he had not known the date of the MHRT until late in the afternoon of Friday 14 July 2006. Dr V had not been able to attend the MHRT on Tuesday 18 July so Dr N had been asked to go on his behalf. We assume therefore that Dr N did not realise that he would be attending the MHRT until late in the afternoon of Friday 14 July at the earliest.

11.3 Dr V said Dr N wrote his report for the MHRT in the afternoon of Monday 17 July 2006 and it was typed up at the trust's Tottenham locality office. Dr N collected the typed report on the morning of the MHRT and Dr V discussed it with him in his ward round later that morning. Dr V recollected that he had raised the fact that some things were missing from the report. There was not time before the hearing for Dr N to have the report re-typed so Dr V told Dr N that he should present additional evidence orally.

11.4 However Dr N said he had only received the typed report about half an hour before the hearing and, realising that it did not address all the matters it should have, he phoned Dr V who told him he could give further evidence orally.

11.5 Dr N's report began by setting out the history of MO's presentation and admission to North Middlesex Hospital and on transfer to St Ann's Hospital. It referred to MO's assertion that his neighbour Mr A had attacked him because he did not want Mr A's dog to sit in front of his door. The report made plain that MO's psychiatric history was uncertain and Dr N gave the "impression on admission" as "*Psychosis? Schizophrenic*". Most of the report was set out under the heading "progress and treatment on the ward". Dr N gave a jumbled report of what

MO had told staff while on the ward, including his allegations that other patients had been trying to kill and sexually abuse him, the fact that he had reported having previously seen a psychiatrist "*in Newham hospital*", and that he had had a metal plate inserted in his head after being injured in a car crash. Dr N also said "*it was planned to obtain more information from France, family, East Ham Hospital and Whipps Cross Hospital. A report was requested by the police and North Middlesex Hospital and GP".*

11.6 The report was incorrectly headed 'Part 1 Summary' and did not make clear that it was prepared to provide medical evidence to the MHRT. It failed to address directly the criteria for MO's continued detention under section 2 Mental Health Act 1983, namely the nature or degree of the mental disorder that MO was believed to be suffering from and the risks that he was thought to pose to himself or others. The report also failed to make plain the doctors' plans for further assessment and treatment of MO. Dr N said of the deficiencies in his report:

> *"I've seen previous reports submitted. I haven't got training for that report, but I have seen and I have observed that there should be diagnosis and there should be conclusion and other things as well."*

11.7 Dr V explained what he understood of Dr N's experience of presenting evidence at MHRT hearings: "*He'd done a dozen. I think" and "I'd been in tribunals with him for some reason, so either he was watching me or I was watching him. He will have watched me on one occasion, I am sure. How he was I don't know".* Later Dr V said *"I thought he was up to it".* Dr N said he had been to at least 10 MHRT hearings before and had presented evidence at some of them. But Dr N said he had not received dedicated training or other education in relation to tribunals.

11.8 No transcript was made of the proceedings of the MHRT. We have however seen the brief notes the chairman of the MHRT made at the time as well as his written reasons for the tribunal's decision to lift MO's section. We have interviewed all members of the tribunal. As we show below, we have concerns about the MHRT's approach in considering the evidence in MO's case and in their questioning of individual witnesses. Nevertheless, the evidence suggests that Dr N did not put the case for MO's continuing detention clearly and struggled with the process of the MHRT. Dr A, the medical member of the MHRT, in his written

comments on the draft of this report told us the MHRT *"had been of the unanimous opinion that the detaining authority had failed to make the case required by law; and that the Tribunal was then told that in such a case there was no alternative in law but to discharge the patient".*

11.9 In his evidence to us, Dr A gave the following account of Dr N's role in the proceedings:

> *"To the best of my knowledge [Dr N] said he didn't have a diagnosis yet, he suspected he was suffering from schizophrenia. I don't remember he'd reached a diagnosis, and it was one of the many bones of contention. What followed from that was if he didn't have a diagnosis how could we say it was nature. There was also something to do with degree where he went wrong. I don't remember exactly how he went wrong, but I think it was almost it wasn't degree now but it had been or it could be again, something like that. It was very vague. The evidence was catastrophic."*

11.10 The chairman of the tribunal made plain in his written reasons for lifting MO's section that members of the MHRT did not think Dr N had put forward a coherent or consistent case for detaining. The written reasons say Dr N had at first maintained that MO's detention was in the interests of his own health and safety and for the protection of others but later in the proceedings he had changed his position about the protection of others. The written reasons also refer to Dr N having put forward broad assertions he could not support with examples. The chairman's contemporaneous notes of the evidence support the accounts given by him and Dr A of Dr N's performance at the MHRT in that they show that Dr N answered the question "W*hat are your objective findings",* by saying "*On present, not anything identifiable".* And in answer to the question "*Is the section necessary for the protection of others"*, Dr N answered "*No, but maybe, because no report".*

11.11 Dr V believed at the time of the MHRT that MO needed to be detained under section and he was confident that the MHRT would not lift the section. He said:

> *"I thought he would not be discharged. I thought it was quite clear that he was still unwell, he had a history of being unwell, that he would put himself at risk. I was therefore quite shocked that he was discharged."*

11.12 He said that after the MHRT hearing he spoke with Dr N about it on a number of occasions and Dr N had been upset by the way that the tribunal had gone. Dr V told us that Dr N "*felt he had not been able to get the points across that he wanted to*".

Comment

In all the circumstances, we find that Dr N was not adequately prepared for his role as medical witness at MO's MHRT hearing.

11.13 He had received no specific training or educational supervision in relation to tribunals, and he had limited experience of presenting evidence to a MHRT. As a result the report he prepared for the MHRT was deficient in a number of significant respects and he did not have time to amend it before the hearing. It seems too that he did not have the confidence or experience to ensure that whatever the deficiencies in his written evidence he was still able to make a coherent oral case for the continuing detention of a man whom he and Dr V considered in obvious need of assessment and treatment under section.

Recommendations

R23 BEH NHS trust should ensure that staff required to prepare reports or give evidence before a MHRT are informed immediately of any application to the MHRT and of any date fixed for a MHRT hearing so they can prepare for the hearing.

Comment

The internal investigation report recommended that all staff responsible for producing reports for the MHRT fully understand their duties and that regular audits of the reports should take place. We endorse this recommendation, but believe that the matters in this case demonstrated a need for a wider training and development of people attending tribunals and therefore make the following recommendation.

R24 BEH NHS trust should ensure that trust staff required to prepare reports, or give evidence to a MHRT are adequately:

- trained
- supervised
- supported
- updated on new developments

in relation to the practice and procedure of the MHRT, report-writing for the MHRT and presenting evidence and argument to the MHRT.

The MHRT's decision

11.14 Without a full transcript we do not have a complete account of the proceedings before the MHRT. However we have seen the chairman's notes, which he has described as a record of the evidence. He has told us that he "*left out nothing beyond trivia or repetition". W*e have also seen the written reasons for the tribunal's decision which were drafted by the chairman and approved by the other members of the tribunal. In addition, we have had the opportunity to interview the members of the tribunal as well as all those who appeared before the tribunal, namely, Nurse 3, the charge nurse on Northumberland ward, ASWB, the ASW, and Dr N. These sources have given us a consistent account of what occurred and we make a number of observations.

11.15 Dr A, the medical member, had examined MO in the morning before the hearing. A French translator was present but Dr A said he had spoken with MO in both English and French. He said "*I'm fluent in French to know whether the interpreter was right or not".* Dr A reported in the pre-hearing discussions with the other tribunal members that he had found no symptoms of mental illness in MO and had found him, "*cooperative*". He said MO had smiled and behaved rationally.

11.16 Dr A went on to tell his colleagues on the tribunal that the meaning of MO's evidence was different in French from its English translation. He said MO had said things that hospital staff could have taken as evidence of psychotic thoughts but whose meaning or emphasis in French would not indicate symptoms of psychosis. One example given was that when MO said his food was being "*poisoned*", he had in fact meant simply that it was not good.

11.17 The chairman of the MHRT made clear that he and the lay member of the MHRT had

been influenced by what Dr A had told them about the possibility that on previous occasions MO's meaning had been lost in translation. The chairman said "*We were impressed by Dr A's command of French".* The outcome appears to have been that the MHRT was not prepared to rely on evidence based on what MO had told doctors and other staff because he had not been communicating through an independent interpreter. The chairman said:

> "Where *we found that [MO's] version of a number of things conflicted with what the professionals were saying, in the absence of an interpreter we found in his favour, and on some good evidence from our doctor, assuming our doctor was as fluent as he said."*

11.18 The chairman wrote:

> *"We had to judge this [the evidence of MO's claims that* BB *was trying to harm him] in the context of one of the central facts of this case to which we have already alluded, namely that today appears to have been the first time when an independent French-speaking interpreter was available. We felt that the reports of psychiatric symptoms were in all the circumstances unreliable, though we did accept that there might have been a short period of psychosis, perhaps as a result of previous use of khat and cannabis…"*

11.19 The fact that the MHRT doubted the reliability of evidence based on reports of what MO had said had a major impact on the outcome of the proceedings. The chairman said: "*In this case. If we had been satisfied of the reliability of the reports, I am quite sure we would not have discharged."*

Comment

We believe that the MHRT was wrong both to have relied so heavily on the point about MO not being seen with an independent interpreter and to have been so sceptical about evidence based on reports given by MO indicating psychiatric symptoms.

It was plain from the hospital notes, which Dr A would have seen, that MO had been interviewed by Dr N with a French-speaking nurse present to act as interpreter. Above

all, it was clear that MO had displayed symptoms of paranoid psychosis, on many occasions, and to many different teams of psychiatric practitioners.

11.20 There was significant consistency and correspondence between the reports of MO's symptoms given by separate staff at St Ann's Hospital and also from the report the MHRT saw from the locum liaison psychiatric consultant at North Middlesex Hospital. The MHRT had evidence, referred to in the written decision, that MO had gone to Whipps Cross Hospital on two occasions, once claiming the Somalian man BB had been poisoning his food and once claiming he had been sexually abused.

Comment

We believe that the accounts that were given of MO's symptoms were of such number and consistency as to undermine the suggestion that they were all based on misinterpretation.

11.21 Dr A had also raised with the tribunal in their pre-hearing discussions the issue of the hospital staff's reliance on the fact that MO had refused an MRI scan, claiming to have a metal plate in his head. Dr A pointed out that if there was a metal plate in MO's head, an MRI scan would not be appropriate and his response had been rational and not attributable to mental illness. Dr N was also criticised in the written decision of the tribunal for referring the tribunal to MO's refusal to have an x-ray, aimed at establishing whether there was in fact a metal plate. The criticism appears to have been based on the fact that Dr N had admitted that he could find and feel no scar on MO's head and therefore, the MHRT suggested, no x-ray was necessary. The point being made in this respect in Dr N's report to the tribunal was that MO's refusal to have an MRI scan on the grounds that he had a metal plate in his head probably indicated delusion: it was possible MO did indeed have a plate in his head but a physical examination suggested otherwise, and MO's refusal to have an x-ray also appeared to suggest that there was in fact no metal plate.

Comment

The tribunal's criticism of the hospital for having sought an x-ray they felt was unnecessary was missing the point. We believe that MO's behaviour in this respect was

open to interpretation as resulting from delusion and the hospital staff's approach to it was logical. They were right to refer the MHRT to it.

11.22 Two other matters had an obvious bearing on the tribunal's decision. One was the fact that, as we have shown, Dr N's medical evidence to the MHRT was not as specific or as consistent as it might have been. Any doubts the MHRT had about that evidence were compounded by the fact that MO did not display any symptoms and behaved appropriately during the examination by the medical member and during the hearing. The medical member of the tribunal, Dr A, said that his examination of MO had found nothing untoward in his mental state. The lay member of the tribunal said he had "*seemed very calm, there were no symptoms at the time*".

Comment

For the reasons we have given above we have some concerns about the approach of the MHRT. Nevertheless, it is clear that the MHRT was not presented with all the evidence that was available to support the hospital's case, even if that evidence was in the clinical records and available to the medical member. Furthermore, the evidence that was presented to it was unclear, and at times inconsistent, and it did not specifically address the MHA criteria for detention. Given that the burden of proof is on the detaining authority to prove its case on each of the criteria for detention, that the MHRT have to judge whether the patient meets the criteria at the time of the hearing having regard to all the circumstances, and that MO presented as well both when interviewed by the medical member and during the course of the hearing, it is perhaps unsurprising that the MHRT decided to lift MO's detention.

Even if MO's detention had not been lifted, it is not certain that MO would still have been detained or otherwise unable to pose a risk to others some five months later in December 2006 when the killing of Camille Remy occurred.

12. Contact and support from trusts to families

12.1 We were asked to review the actions of the ELC NHS trust and the BEH NHS trust in response to the death of Camille Remy and to comment on the way the trusts managed this incident, including the quality of any contact they had with the families of Camille Remy and MO.

12.2 MO appears to have no family in England. The trusts have therefore been unable to contact them to provide information and support.

12.3 After the killing of Camille Remy, LO, a Metropolitan Police family liaison officer, acted as the link between her family and the police. When we asked the trusts they said that they too relied on LO to support Camille Remy's mother, Mireille Cluzeaud, and her family. The trusts did not appoint anyone to be the family's dedicated point of contact with health services.

12.4 A meeting took place in June 2007 between Camille Remy's family and members of the trusts' internal investigation team to discuss the internal investigation procedure.

12.5 A further meeting took place in October 2007 to share the findings of the internal investigation and explain to Camille Remy's family about the commissioning of the independent investigation.

12.6 Madame Cluzeaud told us in a letter dated 20 May 2008:

> "*…although the help from the police was immediate, warm and invaluable that once the first days passed the help turned out to be less apparent with the necessity for us to repeat our demands over and over again."*

She also wrote:

> *"Due to translation, differences in culture and personality there have been it seems to me a lot of incomprehension (replies that don't answer the question)."*

12.7 Correspondence that we have seen and LO's own comments to us suggest that she devoted a lot of time to supporting Camille Remy's family and answering queries raised by them. However her role was complicated by the fact that Camille Remy's family is in France and English is not their first language, and by the fact that she had to deal with queries that often related to how MO's case had been dealt with by health services.

12.8 We recognise that assessing the appropriate level of support to offer the family of the victim of a killing is difficult. But it is clear from what Madame Cluzeaud has said that she did not feel as supported as she would have liked. And we believe that it would have been easier for Camille Remy's family and more appropriate in this case if the trusts themselves had given the family a point of contact with them rather than relying on a police family liaison officer to provide support to Camille Remy's family.

13. Police and criminal justice issues

13.1 During the course of our investigation issues arose in relation to the handling of MO's case by the police and the criminal justice system. We determined that these issues either did not fall strictly within our terms of reference, or they had only a marginal impact on MO's care and treatment. Nevertheless we met with Detective Chief Inspector AI, the officer with responsibility within the Metropolitan Police for MO's case, and raised with him the issues which we believe merit further consideration by the Metropolitan Police. Those issues are:

- The decision by the Crown Prosecution Service not to charge MO in respect of the fight with Mr A on 23 June 2006.

- The fact that MO was interviewed by police at Shoreditch police station on 13 December 2006 even though the FME had determined only a few hours earlier that MO was not fit for interview and should be seen again by an FME.

- Whether adequate information is made available to an FME examining a detainee at a police station about that detainee's previous record of involvement with the police, and any known medical and mental health history.

Appendix A

Recommendations and progress by East London NHS Foundation Trust

Update December 2008
Recommendations from Internal Investigation Re: MO

The Trust developed and implemented an action plan in response to these recommendations and progress monitored through the Trust SUI Sub Committee. This report presents an update on the Trust's progress towards implementing the recommendations presented by the panel.

''Unless otherwise stated the Panel recommendations apply to both mental health trusts. However even where a recommendation only applies directly to one of the two Trusts, the Panel would suggest that both Trusts consider the recommendations as best practice. Although the Panel considered the involvement of Housing Services and the Police it is outside the remit of the Panel to make recommendations to these agencies other than in so far as they may relate directly to mental health'' Panel members October 2007.

Risk Assessment and Management

1. Consideration of available risk assessments must be an integral part of every CPA review and every meeting held about a patient's care and treatment, including discharge planning. This must be explicitly recorded for all such meetings and must be incorporated into the policies of both Trusts. Adherence to this must be monitored through regular audits.

   The CPA policy and CPA documentation as at October 2008 includes specific requirements and templates to ensure that risk assessment is integral to CPA reviews. Trust-wide CPA and risk assessment audits have been completed during 2008, and will continue to form part of the annual audit timetable.

2. If not already in place that a rolling ongoing programme of risk assessment and management training be put in place based around real patient case studies. That the current training in the Newham Services be extended to cover all staff and that its effectiveness be reviewed.

   Risk Assessment and Management training is incorporated in the Trust Training Programme. In addition, regular forensic and general adult psychiatry update workshops are planned for 2009.

3. That an audit be carried out periodically of the quality of a sample of risk assessments and risk plans within the CMHTs.

   Risk assessment audits in the community have not yet been carried out. However an audit tool has been developed and will be introduced in early 2009.

Lone Working Policy

4. Strict compliance with the Lone Working Policy in the Newham Community Services must be enforced.

The CMHT Operational Policy has been reviewed to incorporate compliance with the Lone Working Policy and reinforced where necessary as part of local induction procedures and clinical supervision.

Discharge Procedures

5. The decision to discharge a patient from a service must always be taken in the context of a formal discharge planning meeting. The reasons must be recorded. There must be a clear record that relevant risk factors have been considered. A formal plan must always be drawn up which should clarify the role of any other agencies who might be involved and what action they are expected to take. Such expectations should be communicated to these agencies and documented. Regular audit of notes of patients discharged from the service should be carried out to ensure compliance with this policy.

   The Trust Admission & Discharge policy updated in August 2008, specifies requirements for risk assessment prior to discharge (section 8) and for CPA which itself specifies and provides documentation for risk management. The discharge checklist includes completion of risk assessment and CPA.

   A discharge audit has been completed in Newham and is now in its re-audit stage.

6. Audit sampling of the case files of specific types/groups of clients to be carried out to identify common themes and difficulties as a basis to improve practice. The Panel would recommend that a sample be looked at of recently discharged clients, focussing on homeless clients, and "difficult to engage" clients.

   A discharge audit for homeless/difficult to engage service users has been carried out on 20 cases however data is not readily available, and further and joint working is needed with Homeless Person Unit, and will be carried forward with the Housing Options Team.

7. That the Trusts' policies on discharge be reviewed in the light of findings of this report and the above audits.

   The Trust Policy has been reviewed and implemented in August 2008.

Role and responsibilities of the "Responsible Medical Officer" (RMO) under the Mental Health Act

8. That the Associate Medical Director for Haringey review the performance of the consultant psychiatrist, Dr GI, with respect to his clinical supervision of juniors, discharge-planning and carrying out his duties as Responsible Medical Officer for patients detained under the Mental Health Act. The Associate Medical Director should review Dr GI's job plan and workload to ensure that he has time to provide adequate input to patients under his care.

   Whilst this recommendation refers to a specific individual employed by BEH NHS Trust, we have reviewed the supervision systems in place in the Trust. Appraisals are held annually, supervision arrangements are in place and include discussions on carrying out RMO duties. A clinical performance indicator template developed in Newham and has

been endorsed as a standard for the Trust by the Medical Director.

Mental Health Review Tribunals

9. The BEHMHT Medical Director and Mental Health Act Manager take steps to ensure that all staff responsible for producing reports for tribunals fully understand their duties to provide within their reports all evidence relevant to supporting the case for the patient's continuing detention.

10. Regular audit of the quality of reports submitted to tribunals be carried out.

11. BEHMHT implements a policy expressing the expectation that the RMO will in general attend tribunals, especially those in which the decision may be difficult or there are serious risk issues. If they cannot, they must review the report (which is written in their name) before it is submitted to the tribunal and they must ensure that the doctor who does attend is sufficiently trained and experienced. In all but the most exceptional circumstances the doctor presenting the medical evidence should be approved under Section 12 of the Mental Health Act. It is the responsibility of BEHMHT to ensure that doctors are supported in being able to attend tribunals. This policy should be kept under review in the light of any forthcoming changes in the Mental Health Act.

12. The MHA office at St Ann's should work with clinical staff to ensure that there is sufficient time to put as full a set of reports before the Tribunal as soon as possible even if this means requesting delays in the Tribunal to the extent to which this is reasonable and within Tribunal rules.

The above recommendations have been considered by the Trust. The Mental Health Review Tribunal Policy states who is responsible for monitoring quality of reports (page 12). The Mental Health Act Team monitor and collect figures on how many reports are sent back to the trust due to poor quality.
A total of 46 random files (2007) from across services have been audited during 2008. Tribunals are generally (37 out of 46) attended by a consultant (RMO). Policy requires the – RMO or substitute deputy with knowledge and experience of patient and psychiatry to complete reports. Following the above audit, the Medical Director has sent a letter to all Clinical Directors requesting that they ensure that all HRT reports are checked and countersigned by RMO.

Record Keeping

13. The Clinical Director for Newham should use the job-planning process to ensure that consultant psychiatrists comply with the standards of record-keeping expected by the GMC and that notes meet standards demanded by CNST. Through supervision, the consultants must see that junior medical staff also comply with this process. These points should be included as "Personal objectives" in the job plans of Newham psychiatrists.

Record keeping standards have been audited via regular mandatory Trust wide audit programme and results reviewed in supervision.

14. Instances of poor record keeping highlighted in this report should be taken up with the

individuals responsible through the supervision process.

A structured supervision arrangement is in place for MDT staff. An independent re audit of supervisory records and sample case files, including those of patients on Section 37/41 was carried out during 2007.

Communication between Newham Mental Health and Newham Housing Services

15. There should be a protocol between Newham MH and Newham HPU regarding working with those who are homeless and have mental illness. This should include management of risk, information sharing, the newly created role of a lead on mental health in Housing, particularly with respect to the CPA process. Most importantly there must be clarity of lines of communication when clients move. This should have endorsement at the highest levels with training through to all relevant front-line staff. Joint working on this recommendation would improve the interface and understanding of roles.

    A protocol has been agreed with Housing – of which Housing Options Team/HPU is a part which addresses these requirements, and twice yearly meeting cycle established. The Borough Director and Deputy Borough Director attend this meeting.

16. That ELCMHT develop and provide training in mental health awareness that could be offered to those most likely to work with homeless people with mental illness.

    The development of the protocol and improved joint working has enabled training needs to be identified with Housing providers and the Mental Health Development Manager will deliver the training package in April 2009, as requested by Housing.

17. The Panel strongly supports the progress being made by Newham Housing Services to return individuals to housing within the borough. The Panel welcomes the intention that in future those people with evident vulnerabilities will be housed within the borough in order to assist in maintaining continuity of care and support from other agencies who may be working with these individuals.

18. The Haringey Services to review their joint working arrangements with Haringey HPU to ensure that equally appropriate systems are in place.

Operation of MAPPA and the MDO Group

19. That the terms of reference of the Newham MDO group and its relation to the MAPPA be reviewed and refreshed with renewed sign up from all members of the group.

    The Newham MDO group have agreed new terms of reference which include confidentiality and information sharing. The Trust will make these revised Terms of Reference available to the other two boroughs to inform developments for non-MAPPA MDO arrangements in those boroughs, The Trust is undertaking a review of formal MAPPA arrangements and is expected to report on these (Associate Clinical Director Forensic to Associate Medical Director) by February 09.

Confidentiality

20. The Caldicott guardians of both trusts take steps to see that all staff fully understand their duties with respect to clinical confidentiality according to the GMC's "Duties of a doctor" and other guidance. Staff need to be aware of the process which must be followed if information is to be shared with outside agencies and need to understand the exceptional circumstances which can justify sharing such information without the patient's consent.

    The issue of information sharing and clinical confidentiality is emphasised as part of the Information Governance presentation delivered at the monthly corporate induction and the induction programme for doctors in training. Information leaflets have been produced which are also available on the Trust Intranet. Further advice is available to staff via the Trust Information Governance Lead.

21. The current functioning of the Newham MDO should be reviewed urgently to ensure that there are no breaches of the rules around confidentiality.

    MDO arrangements specifically discuss the standards for confidential disclosure.

22. Special attention should be given to doctors who have trained abroad and who may hence have a different understanding of their ethical obligations than those demanded by the GMC. Both Trusts should implement mandatory training on induction for medical staff trained abroad regarding the expectations of the GMC and regarding legal issues which may be specific to Britain, for example around the Mental Health Act, common law treatment and the Mental Capacity Act.

23. That guidelines be issued by ELCMHT to staff on information disclosure to the MAPPA and any other related groups.

    The Medical Director circulated 3 accepted guidelines regarding confidentiality to all consultants during 2008.

    1 RCPsych
    2 DoH
    3 GMC

Attendance at Investigatory Panels

24. That it be made clear to all those called to give evidence to investigating Panels that there is an expectation that they would have read the notes before attending the Panel to be able to provide as much help as possible to the Panel in understanding past events.

This is now routine practice.

Appendix B

Action plan for Barnet, Enfield and Haringey NHS Trust

Recommendations	Action Required	Lead Officer	Date for Completion	Audit at 6 months Date	Findings
Risk Assessment and Management. 1 (273) Consideration of available risk assessments must be an integral part of every CPA review and every meeting held about a patient's care and treatment, including discharge planning. This must be explicitly recorded for all such meeting and must be incorporated into the policies of both Trust. Adherence to this must be monitored through regular audits.	Update on CPA procedures for all clinical staff to include refresher on skills base for care co-ordination.	Jeremy Walsh / Alun Baylis Assistant Directors Community and Inpatient Services	March 2008	September 2008	Completed. A new CPA Policy has been developed (Issued Jan 09). The Policy incorporates practise guidance for care co-ordinators and includes guidance on risk assessment and risk management
(274) If not already in place that a rolling on-going programme of risk assessment and management training be put in place based around real patient case studies. That the current training in the Newham Services be extended to cover all staff and that its effectiveness be reviewed.	Roll out of RIO	Ian Clift / Jeremy Walsh/ Alun Baylis/Delia McMillan – Head of Training	Ongoing	April 2008 Peter Maris Audit Lead for Trust	All risk assessments are now completed on RiO: roll out commenced: 2006 (version 4.5). All BEH services now have RiO –version 5 to be implemented: June 2009.
(275) That an audit be carried out periodically of the quality of a sample of risk assessment and risk plans within the CMHTs.	Risk training is mandatory for all staff in BEH. Ensure all staff receive update and a register is kept in all teams. Planned audit of notes to take place on a monthly basis in the community teams and recorded where the staff member is local authority on the SAP/FW-I	Support and Recovery Team Managers	Ongoing	On-going	15 Minute Audit commenced Oct 2006. A risk assessment audit was completed: 26th November 2008

Recommendations	Action Required	Lead Officer	Date for Completion	Audit at 6 months Date	Findings
	system				
(279) That the Trusts' policies on discharge be reviewed in the light of finding of this report and the above audits.	Review Trust Policies as per findings of relevant audits	Ian Clift Deputy Director of Nursing and Clinical Governance and Veronica Flood Policy Officer	April 2008	Completed September 2008	

Recommendations	Action Required	Lead Officer	Date for Completion	Audit at 6 months Date	Findings
Role and responsibilities of the "Responsible Medical Officer" (RMO) Under the Mental Health Act. 3 (280) That the Associate Medical Director for Haringey review the performance of the consultant psychiatrist, Dr GI with respect to his clinical supervision of juniors, discharge-planning and carrying out his duties as Responsible Medical Officer for patients detained under the Mental Health Act.	Associate Medical Director to meet with Consultant Psychiatrist and develop agreed supervision plan with him The Associate Medical Director to review Dr GI's job plan and workload to ensure that he has time to provide adequate input to patients under his care.	Dr J Seargeant and Dr L Rosewicz	January 2008	July 2008	Completed

Recommendations	Action Required	Lead Officer	Date for Completion	Audit at 6 months Date	Findings
Mental Health Review Tribunals 4(281) The BEHMNT Medical Director and Mental Health Act Manager take steps to ensure that all staff responsible for producing reports for tribunals fully understand their duties to provide within their reports all evidence relevant to supporting the case for the patient's continuing detention. (282) Regular audit of the quality of reports submitted to tribunals be carried out.	Policy for producing reports for Tribunals to be reviewed in the light of the findings of this report	Oliver Treacy Director of Enfield MHS/ Andrew Smith Lead MHA Officer	April 2008	September 2008	Draft Policy completed to go to Policy Group June 2009
(283) BEHMNT implements a policy expressing the expectations that the RMO will in general attend tribunals, especially those in which decision may be difficult or there are serious risk issues, if they cannot, they must review the report (which is written in their name) before it is submitted to the tribunal and they must ensure that the doctor who does attend is sufficiently trained and experienced. In all but most exceptional circumstances the doctor presenting the medical evidence should be approved under section 12 of the Mental Health Act. It is the responsibilities of BEHMHT	Mental Health Act Officers within Borough services to undertake regular audits of quality of reports	Andrew Smith Lead MHA Officer	April 2008	September 2008	Mental Health Act Audit completed Dec 2008.
	Policy to be developed regarding attendance of RMOs at Tribunals	Oliver Treacy Director Enfield MHS/Andrew Smith Lead MHA Officer	April 2008	September 2008	Draft Policy completed to go to Policy Group June 2009
To ensure that doctors are supported in being able to attend tribunals. This policy should be kept under review in the light of any forthcoming changes in the Mental Health Act.	Lead Mental Health Act office to work with Mental Health Act administrator regarding timescales for reports of Tribunals	Andrew Smith Lead Mental Health Act Officer	April 2008	September 2008	Draft Policy completed to go to Policy Group June 2009
(284) The MHA office at St Ann's should work with clinical staff to ensure that there is sufficient time to put as full a set of reports before tribunals as soon as possible even if this means requesting delays in the Tribunal to extent to which this is reasonable and within tribunal rules.					

Recommendations	Action Required	Lead Officer	Date for Completion	Audit at 6 months Date	Findings
Confidentiality. 6(292) The Caldicott guardians of both Trusts take steps to see that all staff fully understand their duties with respect to clinical confidentiality according to GMC's "Duties of a Doctor" and other guidance. Staff need to be aware of the process which must be followed if information is to be shared with outside agencies and needs to understand the exceptional circumstances, which can justify sharing such information without the patient's consent. (294) Special attention should be given to doctors who have trained abroad and who may hence a different understanding of their ethical obligations then those demanded by the GMC. Both Trusts should implement mandatory training on induction for medical staff trained abroad regarding the expectations of the GMC and regarding legal issues which may be specific to Britain, for example around the Mental Health Act common law treatment and Mental Capacity Act.	GMC requirements incorporated in mandatory training programme for all doctors	Dr. Hagen Rampes / Dr. Ros Furlong	April 2008	September 2008	
Attendance at Investigating Panels 7 (296) That it be made clear to all those called to give evidence to Investigating Panels that there is an expectation that they would have to read the notes before attending the Panel to be able to provide as much help as possible to the panel in understanding past events.	SUI Policy to be updated to include guidance for staff when attending Panels.	Beryl Stroll Patient Experience Manager Quality	January 2009	July 2009	SUI Policy reviewed (January 2009). Revised Policy to be updated to include additional information for staff when attending Panels.

Appendix C

List of interviewees

Name	Role	Organisation
MT	Homeless assessment officer	Newham council
Ms A	-	Mental Health Review Tribunal
Dr G	Associate specialist	East London NHS Foundation Trust
Inspector Al	Detective chief inspector	Lewisham police station
UC	Strategic manager for housing needs	Newham council
CA	Manager, south east CMHT	East London NHS Foundation Trust
SA	Temporary ward manager	Northumberland ward
James Boag	Assessment case worker	Newham council
LO	Detective constable	Lewisham police station
VA	Sergeant	Stoke Newington police station
CH	Principal homeless manager	Newham council
Dr S	Forensic medical officer	-
DS J	Detective sergeant	Lewisham police station
EB	Police constable	Plaistow police station
Nurse 3	Deputy manager	Northumberland ward
ASWB	Approved social worker	Haringey council
DS TS	Detective sergeant, Homicide and Serious Crime Unit	Lewisham police station
PC DO	Police constable	British Transport Police
Dr V	Psychiatrist	Barnet, Enfield and Haringey Mental Health Trust
AC	Team leader, prevention and visiting	Newham council
PC MB	Police constable	Shoreditch police station
RO	Detective constable	Tottenham police station
Dr M	Senior house officer in psychiatry	North East London Mental Health Trust
OL	Scrutiny and projects manager	Newham council
TY	Social worker	Dumfries and Galloway council
LE	General manager	Top Class Investments
NB	Homeless assessment officer	Newham council
Nurse 1	Staff nurse	St Ann's Hospital
Mr O	Chair	Mental Health Review Tribunal
OY	Police constable	Lewisham police station

MO	Perpetrator	-
Dr X	Consultant psychiatrist	Broadmoor Hospital
Dr A	Medical member	Mental Health Review Tribunal
MM	Manager of mental health services	Haringey council
GP3	General practitioner	Langthorne health centre
IE	Clinical nurse specialist	Great Chapel Street health centre
Dr L	General practitioner	Great Chapel Street health centre
Dr H	Forensic medical examiner	-
PLNA	Psychiatric liaison nurse	Whipps Cross Hospital
Dr N	Senior house officer	St Ann's Hospital
Dr D	Liaison psychiatrist	North Middlesex Hospital
Mr Y	Manager, Mental Health Act office	Chase Farm Mental Health Trust
RU	Social worker	Dumfries and Galloway council
Dr O	Forensic medical examiner	-
Dr R	Forensic medical examiner	-
Ms U	Intelligence analyst	Lewisham police station
CPN 1	CPN and care coordinator, south east CMHT,	East London NHS Foundation Trust
RK	Social worker and mental health officer	Community mental health team, Wigtonshire
GE	Inspector	Islington police station

In addition to the above, the investigation team met twice with the family and friends of Camille Remy.