Independent Scrutiny and Investigation into the care and treatment of

Mr CH

Commissioned by NHS London

NHS London

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Acknowledgements

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

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

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

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Executive Summary

Introduction

On 12th May 2004 Mr CH was arrested and charged with the murder of a male who had been stabbed and died as a result of his injuries sustained the previous day. Mr CH had been previously in receipt of mental health services being provided by East London NHS Foundation Trust (the Trust).

The internal investigation was commissioned in 2004 but never completed and in late 2006 the case, with two others, was erroneously taken off the Trust's tracking system for Serious Untoward Incidents. This was discovered in February 2008 and the report was completed in April 2008, four years after the Trust first commissioned the investigation.

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

Methodology

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

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

No details of Mr CH's victim were known to the scrutiny team nor of the relationship between the two men.

Outline of the Case

Mr CH was born on 23rd March 1965. He has two surviving siblings, an older sister and younger brother. His father was from Jamaica and his mother of Irish descent. Both parents are still alive, although now separated.

At the age of 13 years he was reported to have become troublesome, truanting from school and he received his first conviction for burglary. From age 14 years he spent most of his time in care because of his criminal behaviour. It was

reported that he started sniffing glue and later became a user and dealer of crack cocaine. He was also known to abuse alcohol and use heroin.

He was reported to have left school aged 16 years, with no qualifications. He has had various occupations including a delivery driver, courier, cleaning and other basic manual work.

He has been known to use several aliases and has an extensive criminal record which includes carrying a firearm with intent and grievous bodily assault. In 1981, (aged 16 years), he was first detained in Borstal and has been detained in prison at least four times since, with sentences of four months to three years.

Contact with Psychiatric Services

Mr CH's first contact with psychiatric services was in 1982 whilst in Borstal for theft and grievous bodily harm. He was diagnosed as suffering from Paranoid Schizophrenia and treated with anti-psychotic medication.

In March 1985, whilst on remand in Chelmsford prison Mr CH was assessed by the psychiatric services and admitted to Hackney hospital. This was the first of three admissions this year, the second in April on a Section 37 of the Mental Health Act 1983 (MHA), a Court disposal under the Mental Health Act, with the third admission, also under Section 37 MHA between July and September. He was reported as displaying clear symptoms of schizophrenia.

A fourth admission took place in December 1986 under Section 47 MHA, (transfer from prison under the MHA). He was discharged in July 1987.

In 1992 Mr CH was admitted to the Interim Secure Unit at Hackney hospital. It is unclear as to how long he was an inpatient as subsequent reports differ. One suggests that he remained in hospital for 18 months whist another states that he was discharged after a few months in August 1992.

Further admissions took place in:

- November 1995 under Section 3 MHA.
- February 1996 to a Medium Secure Unit under Section 3 MHA
- June 2003 under a Section of the MHA

In the intervening times between hospital admissions Mr CH also spent some time either on remand in prison or completing his sentences there. His care and treatment (depot injections) was continued whilst in prison although there were several occasions when his local Community Mental Health Team (CMHT) made strenuous attempts to contact him only to find that he was in prison again.

On 11th February 1998 Mr CH attended an Emergency Clinic following his release from Prison. He reported that he was still taking Carbamazepine 500mgs daily and Zuclopenthixol 200mgs every two weeks.

There is no further contact reported until early 2001 when the mental health services were contacted by Brixton Prison healthcare team in regard to his potential release from prison and his homelessness. He was released from prison during January 2001.

In September 2001, a worker from the Southside Partnership who had been working with Mr CH since his release from prison in January, contacted the CMHT and reported that Mr CH was be homeless, sleeping in a car in Camden but the local Homeless team (Focus) would not accept responsibility for him as he was still officially under the Hackney CMHT. On 8th October 2001 Mr CH was allocated a care coordinator from the Hackney CMHT.

A transfer to another locality team, (the North West Locality Team), was arranged as Mr CH had moved out of the current team's area but this was delayed.

Mr CH remained under the care of the CMHT with no further issues arising until January 2004 when he presented with threatening and violent behaviour at the Drug Dependency Unit where a junior doctor prescribed him Methadone. The consultant later stopped the Methadone as he wanted a full assessment undertaken prior to medication treatment.

Mr CH did not attend a follow up appointment on 8th March 2004 but did attend a CPA review on 12th March. It was noted that he reported that he was no longer using heroin, had reduced his crack cocaine and cannabis usage. He also reported that he intended to visit Jamaica for five months. His medication was changed to oral medication, Olanzapine from depot injection. His case was closed until his return.

On 29th June 2004 the CMHT were informed that Mr CH had been arrested and charged with murder. No contact had been made by him with the team since his case closed in March 2004.

Scrutiny Team Findings and Recommendations

The scrutiny team found that the internal review report was not a well balanced review of Mr CH's care and treatment. It appeared that assumptions had been made about the issues raised in the three cases before any proper examination of the cases had taken place. Their decision to follow a themed approach hampered a thorough review process. The Trust set up an external inquiry to examine the process failures that led to the case being lost to the system.

Positive Factors

The Hackney Community Mental Health Team provided an assertive attempt to maintain contact with Mr CH particularly with the contact and liaison with other agencies such as prisons. They also were mindful of the need to re-establish contact with Mr CH once he was released from prison following his frequent detentions.

The internal review report contained notes of the interviews with staff. This is not accepted practice for investigations. From the notes it appears that conflicting evidence was not challenged or followed up by the internal review. The scrutiny team would also comment that no external people to the Trust were interviewed, for example Mr CH's GP.

The findings and recommendations were general and tailored to the common themes of the report as a whole. The Trust have progressed and implemented their action plan with the exception of the Ward practice which was being currently reviewed at the time of the workshop and it was indicated that this would be completed at the end of May 2010.

The scrutiny team found that the clinical notes demonstrated that numerous individual professionals made strenuous attempts to manage the risks posed by Mr CH recognising him as a man with a significant and disabling mental illness as well as the proclivity for criminal acts prior to 2002. They showed considerable effort in their attempts to maintain a therapeutic contact with him, despite his chaotic lifestyle using the CPA process. This did not follow through with his care from October 2002 when it appeared that those involved with his care during this period took a more compartmentalised approach. The details of the handover process between the teams was not clear from the notes and this may have disadvantaged the second team on understanding how Mr CH presented when he was ill.

The internal review did not comment on the application of the proposed plan in October 2001 to discharge Mr CH from Section 117 after two months of being held on duty. The scrutiny team would have been concerned if this plan had been carried through. This would have been inappropriate given the nature of his illness and need for ongoing support as identified by forensic opinion and the previous treating team. It is unclear from the notes as to what happened with the plan to discharge Mr CH but he appeared to continue on CPA.

There was little analysis of the complex interplay between Mr CH's psychotic mental illness, personality factors and social factors.

The general comment in the internal review report that "*Mental health care professionals are expert at addressing risks arising from mental illness*" may have been an attempt to be supportive to staff. It did not characterise the reality

that mental health professionals in all parts of the country frequently find it very difficult to address risks associated with mental illness complicated by other factors. The internal review panel seemed to suggest that the risks posed by the individuals were not the responsibility of the mental health professionals. There should have been no doubt that the team had a responsibility to do what was possible to try to minimise the risks to and posed by Mr CH. There are aspects of his chaotic lifestyle and behaviour which were outside of their responsibility and the scrutiny team would not wish to suggest that the team should have been able to remove the risks associated with these, however the link between psychosis and violence was something they did have a responsibility to try and manage.

The scrutiny team found it significant that the views expressed in the following comment "No clear relationship between Forensic history Episodes of Psychotic illness (Opinion of medical staff in the past)" were repeated throughout the notes so readily. The original entry was written by an SHO during as assessment in December 1995. The scrutiny team were unable to find entries from 'medical staff in the past' expressing that opinion, indeed two days prior to the entry, a consultant forensic psychiatrist, who knew him previously had assessed Mr CH and written that when unwell Mr CH poses a significant risk of serious violence and in the community needs close supervision. It is particularly concerning that the SHO's entry appears to have been quoted by another SHO in a report made after the homicide, demonstrating how powerful such a comment can be.

The scrutiny team found that the situation in March 2004 when Mr CH stated that he was travelling to Jamaica for a long visit and his case closed to the team was not best practice. The intention to refer his care to his GP during this period without any further plan, agreement or follow up or any account of a detailed discussion with Mr CH of his plans or access to medication was unsatisfactory.

The scrutiny team assume that the medication change from depot to oral was part of this plan. In view of the length and severity of his mental illness a more detailed management plan of his mental health needs should have been a priority.

It is impossible to know the consequences of changing the depot injection to oral medication but in normal circumstances it would be appropriate to monitor the individual's mental state given the well recognised risk of relapse following such a change.

From the notes there appears to have been little discussion with Mr CH in regard to his illness and potential risk particularly as he had never visited Jamaica before.

The scrutiny team found that the internal review's recommendations were hard to connect with their findings, which were not measurable against implementation nor was it possible to evaluate the impact on the Trust's services.

Issues addressed at the Trust Workshop with the Scrutiny Team

The following section provides details of the issues discussed with the Trust at the Workshop and their responses to that discussion.

Progress against the Internal Review Action Plan

The scrutiny team were informed that with the exception of one recommendation, that of ward practice initiative, these were all completed. (At the time of writing this report it is understood that all actions have been completed).

Access to Forensic Services

The Trust assured the scrutiny team that forensic services had improved since the time of the incident. They have increased their own forensic consultants and also provide a Forensic Outreach service for patients in the community as part of the Sector Forensic teams who support individuals in the community. Access to the Medium Secure Unit's process has been reviewed and improvements put into place to enable patients to be admitted quickly and also move through the unit more efficiently.

Drug Screening and prevention of drugs in inpatient areas

The Trust provides drug screening kits which are available on the inpatient areas and they have established good relationships with the local liaison police in order to jointly tackle this issue.

A dedicated Dual Diagnosis Specialist team is now provided and the Trust have an ambition to provide a Alcohol Specialist Consultant to work within the team

A substance misuse zero tolerance policy is in place across the Trust.

Housing requirements

A Community Rehabilitation team is now provided by the Trust and their role would be to deal with patients' issues such as housing and potential homelessness.

Prison liaison

The Trust provide an in-reach prison consultant psychiatrist service to the local prisons.

Scrutiny Team Recommendations

The scrutiny team have been critical of the internal review process undertaken in this case. The team have had the opportunity to discuss this with the Trust who has helped clarify the situation as it was then and now. The normal process that serious untoward incidents are investigated and are scrutinised and considered by the Trust Board did not occur in Mr CH's case.

The scrutiny team make the following recommendations to East London NHS Foundation Trust.

Investigations of Serious Untoward Incidents

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

Recommendation One

It is recommended in accordance with best practice and to ensure that staff have the opportunity to check that the evidence they have given to internal reviews is accurate and reflects the issues that they wish to raise that all interviews undertaken for internal reviews are recorded and transcribed verbatim. These transcriptions are for the purpose of ensuring the investigation team can also check and validate their findings and not for inclusion in reports.

Care Programme Approach

It was found that the CPA process did not allow for a detailed plan for Mr CH's visit to Jamaica.

Recommendation Two

It is recommended that the CPA process includes plans and contingency for individuals who are deciding or planning on being away from their normal residence for a lengthy period.

Transfer of patients between teams

The scrutiny team could find no clear evidence of a good handover of Mr CH's care.

Recommendation Three - Summary Sheet

It is recommended that a summary sheet is developed to be sited at the front of patients' records and updated on a regular basis. This should include:

- Current and Diagnostic History
- Risk History with a detailed list of all violent incidents and any link to abnormal mental state
- Risk Management Plan
- Changing diagnosis if relevant
- What medication worked well and problems with medication including allergic reactions
- Admission history
- Markers for relapse
- Signs of relapse
- Contingency plans to manage relapse
- Current care team and contact details

Alcohol Services

Recommendation Four - Alcohol Services

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

1. Introduction

On 12th May 2004 Mr CH was arrested and charged with the murder of a male who had been stabbed and died as a result of his injuries sustained the previous day. Mr CH had been previously in receipt of mental health services being provided by East London NHS Foundation Trust (the Trust).

The internal investigation was commissioned in 2004, but in late 2006 the case, with two others, was erroneously taken off the Trust's tracking system for Serious Untoward Incidents. This was discovered in February 2008 and the report was completed in April 2008, four years after the Trust first commissioned the investigation.

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

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

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

2. Terms of Reference

Part One - Internal Review

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

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

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

To compile a chronology of events.

Part Two

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

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

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

3. Purpose of the Scrutiny Investigation

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

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

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

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

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

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

4. Methodology

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

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

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

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

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

This report has been drafted to include an analysis of the Trust's internal review, a brief history of Mr CH and a detailed consideration of the care and treatment provided to him by the Trust. It includes the scrutiny team's findings and recommendations of the areas that may need further exploration to ensure processes are put into place to reduce the likelihood of similar incidents to state that incidents like this will never happen again. We can nevertheless, all learn from incidents to ensure that the services provided to people with a mental illness are safer and as comprehensive as possible; that the lessons learnt are understood and appropriate actions are taken to inform those commissioning and delivering the services.

5. Scrutiny Team Members

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

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

6. Outline of the case

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

6.1 Background

Mr CH was born on 23rd March 1965. His father was from Jamaica and his mother of Irish descent. He has two surviving siblings, an older sister and younger brother. Both parents are still alive, although now separated, his father has returned to live in Jamaica (1990) and his mother is living in Hackney.

At 11 years old Mr CH fell from a balcony fracturing his arm and sustaining head injuries. At the age of 13 years he was reported to have become troublesome, truanting from school and he received his first conviction for burglary. From age 14 years he spent most of his time in care because of his criminal behaviour. It was reported that he started sniffing glue and later became a user and dealer of crack cocaine. He was also known to abuse alcohol and use heroin.

He was reported to have left school aged 16 years, with no qualifications. He has had various occupations including a delivery driver, courier, cleaning and other basic manual work.

He has been known to use several aliases and has an extensive criminal record which includes carrying a firearm with intent and grievous bodily assault. In 1981, (aged 16 years), he was first detained in Borstal and has been detained in prison at least four times since, with sentences of four months to three years. A full forensic history can be found in Appendix Three.

6.2 Contact with the Psychiatric Services

Mr CH's first contact with psychiatric services was in 1982 whilst in Borstal for theft and grievous bodily harm. He was diagnosed as suffering from Paranoid Schizophrenia and treated with anti-psychotic medication.

In March 1985, whilst on remand in Chelmsford prison Mr CH was assessed by the psychiatric services and admitted to Hackney hospital. This was the first of three admissions this year, the second in April on a Section 37 of the Mental Health Act 1983 (MHA), a Court disposal under the Mental Health Act, with the third admission, also under Section 37 MHA between July and September. He was reported as displaying clear symptoms of schizophrenia.

A fourth admission took place in December 1986 under Section 47 MHA, (transfer from prison under the MHA). He was discharged in July 1987.

In 1992 Mr CH was admitted to the Interim Secure Unit at Hackney hospital. It is unclear as to how long he was an inpatient as subsequent reports differ. One suggests that he remained in hospital for 18 months whilst another states that he was discharged after a few months in August 1992.

A further admission took place in November 1995 under Section 3 MHA. It is reported that Mr CH was highly disturbed and violent requiring treatment on the Intensive Care Unit (ICU) at Homerton hospital. Following an attempted serious assault on a male nurse, Mr CH was assessed by a Consultant Forensic Psychiatrist, on 22nd December 1995. His opinion was that when unwell Mr CH posed a significant risk of serious violence and required close supervision in the community. A summary written in February 1996 by an SHO states that the Forensic Consultant revised the decision that Mr CH required Medium Secure Treatment. This was later written in a letter to Mr CH's consultant psychiatrist from the forensic consultant.

Two days later Mr CH was assessed for admission to the Interim Secure Unit (ICU) at Hackney hospital under Section 3 MHA. It was reported that he was thought disordered and paranoid and prescribed depot medication, Zuclopenthixol Decanoate 600mgs intramuscularly weekly, and oral medication Carbamazepine 200mgs twice daily and Procylidine 5mgs daily.

On 8th January 1996, the ward staff noted that Mr CH was settling, less thought disordered but still paranoid. (The forensic consultant had changed his view that Mr CH required a Medium Secure placement. His general consultant psychiatrist noted his disappointment regarding this). In February 1996 Mr CH was transferred from ICU to a general adult psychiatric ward where he was given permission to commence weekend leave.

An initial a Care Programme Approach (CPA) meeting took place on the ward on 15th February 1996. Four days later (19th February) a Mental Health Review Tribunal upheld Mr CH's Section 3 MHA. Whilst still an inpatient ward staff from a neighbouring ward complained that Mr CH was threatening both staff and patients on that ward and in the community. He was discharged on 20th May 1996 and was reported as living with his mother. His depot medication was reduced to 500mgs two weekly, (not weekly). The Community Mental Health Team (CMHT) monitored his care whilst he was in the community.

A CPA review was arranged for 24th January 1997, his consultant psychiatrist did send apologies as he was unable to attend the meeting but it is not clear from the case notes as to whether this then occurred. A further CPA review on 1st April 1997 noted that Mr CH was reluctant to keep CMHT office follow up appointments and home visits had not been successful. He did however attend the outpatient appointments with his consultant psychiatrist.

As he had recently moved and was living out of the original team's catchment area his care was to be transferred to another consultant. The transfer was delayed as he was being held on remand in Pentonville Prison which the team were only informed of after Mr CH had missed several appointments and depot injections. The team were eventually informed that whilst he was at the Prison he would be receiving treatment there.

On 11th February 1998 Mr CH attended an Emergency Clinic following his release from Prison. He reported that he was still taking Carbamazepine 500mgs daily and Zuclopenthixol 200mgs every two weeks.

In 2000 he was again on remand in Pentonville prison.

There is no further contact reported until early 2001 when the mental health services were contacted by Brixton Prison healthcare team in regard to his release from prison and his homelessness. Several phone contacts were made between the services in regard to his future care. He was released from prison during January 2001.

In September 2001, a worker from the Southside Partnership who had been working with Mr CH since his release from prison in January, contacted the CMHT and reported that Mr CH was homeless, sleeping in a car in Camden but the local Homeless team (Focus) would not accept responsibility for him as he was still officially under the Hackney CMHT.

On 8th October 2001 Mr CH was allocated a care coordinator from the Hackney CMHT. In November it is alleged that he stole his care coordinator's mobile phone from her bag whilst visiting the CMHT offices. Around this time it was also reported that he had received facial injuries including a broken jaw which required surgery.

A case review took place in July 2002. Mr CH had recently served another prison sentence and on his release was allocated temporary accommodation. He told his care coordinator that he was uncertain as to whether he should remain on depot medication. It was reported that he continued to misuse heroin. A transfer to another locality team, (the North West Locality Team), was arranged as Mr CH had moved out of the current team's area.

On 16th June 2003 Mr CH was admitted to Homerton hospital and formally detained under a Section of the MHA on 11th July 2003. There was a lack of clarity in the case notes as to how Mr CH was detained as one set of notes stated that he had been detained under Section 136 MHA by the police and Social Services records state that he was admitted under Section 37 MHA. It is considered by the scrutiny team that it is most likely that he was detained initially under a Section 136, then Section 2 which was converted to Section 3 MHA. He

had originally been arrested for attempted burglary at a local school. On admission he was found to be thought disordered with erratic behaviour.

In July Mr CH was reported as remaining paranoid and thought disordered and a CPA review took place on the ward on 15th July 2003. This was attended by the CMHT. It was agreed to allocate a care coordinator, to continue aftercare under Section 117 MHA and for Mr CH to remain on his depot medication.

On 11th October 2003 he was transferred to the Middlesex hospital for two days for treatment to an infected jaw. It was planned to discharge Mr CH the following week. It appears that he left the ward on 14th October 2003 with an appointment with a Housing Association in regard to accommodation. There was no evidence of a discharge plan, CPA review or patient summary in the records.

Mr CH remained under the care of the CMHT with no further issues arising until January 2004 when he presented with threatening and violent behaviour at the Drug Dependency Unit where a junior doctor prescribed him Methadone. The consultant later stopped the Methadone as he wanted a full assessment undertaken prior to medication treatment.

Mr CH did not attend a follow up appointment on 8th March 2004 but did attend a CPA review on 12th March. It was noted that he reported that he was no longer using heroin, had reduced his crack cocaine and cannabis usage. He also reported that he intended to visit Jamaica for five months. His medication was changed to oral medication, Olanzapine from depot injection. His case was closed until his return.

On 29th June 2004 the CMHT were informed that Mr CH had been arrested and charged with murder. No contact had been made by him with the team since his case closed in March 2004.

7. Consideration of the Internal Review Report

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

7.1 Internal Review – Process Comments

Overall the scrutiny team consider that the internal review was not structured in a way which enabled a balanced analysis of Mr CH's care and that this was compounded by the fact that the internal review attempted to deal with three cases in one report. There was no demonstrable analysis of the evidence that facilitated links between findings and recommendations. The scrutiny team found no evidence that a 72 hour management report had been completed.

As indicated there was not a specific internal review report into Mr CH's case. A report dealing with three cases, including Mr CH, was commissioned by the Trust in 2004 but despite several queries from both the Trust and Strategic Health Authority the investigation team did not complete their report until 2008. The Trust did commission a further external inquiry into why the three cases, and an additional case, had not been investigated according to their standard procedure and also why the Trust were not aware that the three cases had not been reported to their Trust Board. This scrutiny and investigation has found assessment of the internal review complicated by the decision of the Trust to examine the three cases within the same process particularly as one case was not a homicide.

The composition of the review panel, whilst independent of the Trust, did not include anyone who was not a health professional. In view of Mr CH's social needs and criminal background it would have been more appropriate to have had a panel member with a social services background.

The internal review panel interviewed a number of Trust staff, notes of these meetings were taken and checked with those interviewed. One person requested the tone of their response to be modified. The interview notes were not verbatim and were included in the report. This is not accepted practice for investigations.

The Terms of Reference for the internal review specifically refers to the suitability of care for the victim's family. However there is no evidence that the Trust or the investigation team had contact with the families of the victim or Mr CH. It is noted that the investigation team did request that the Trust contact the family to seek their involvement but the scrutiny team could find no evidence that this had occurred.

It is clear from both the internal review and subsequent external inquiry that the Trust had not considered informing the Strategic Health Authority or had considered the possibility of an independent investigation under the auspices of HSG (97) 27.

The internal review did include information regarding Mr CH's background and childhood history but only examined events in more detail for a period of 12 months prior to the incident.

7.2 Internal Review Report – General Comments

The scrutiny team considered the effects of examining the three cases as a group and how this combination impacted on the final report. Although the three cases were dealt with separately in the first part of the report any analysis and resulting conclusions based on that individual were not separated out. Without individual findings on each case, it was impossible to link any issues identified with their respective recommendations. A further consequence of considering three cases together was the focus on similarities of the three cases and in the view of the scrutiny team this led to an overemphasis on substance misuse. This further led to a failure to properly examine Mr CH's clinical and social needs as identified in the case records.

In the opinion of the scrutiny team it was considered that the four year delay to complete the internal review of four years was unacceptable. The scrutiny team had the opportunity, at their workshop with the Trust, to discuss how this and the other cases were lost within the Trust system. The external inquiry which was commissioned to identify the problem which led to the failure in the Trust's systems, and the inquiry's report, is welcomed. The scrutiny team were satisfied that the systems in place within the Trust now should prevent similar problems arising again.

The internal report focussed on criminality and substance misuse and possibly tended to minimise Mr CH's serious psychiatric disorder. There appeared to be an over emphasis on separating out criminal behaviour and associated risk connected to lifestyle as opposed to mental illness. The implication appeared to be that "*risk associated with lifestyle is not the business of mental health professionals".* Without very clear evidence from subsequent forensic reports post homicide it is not justified for the internal review to assume that Mr CH's mental illness did not potentially play a significant part in him committing the homicide.

Mr CH's contact with mental health services spanned a period of 22 years. The internal review panel only identified in detail the last year of contact between Mr CH and the mental heath services. It was not possible to determine why they had decided to concentrate on this short period and this meant that it was impossible to make a contrast between the services provided by the two main

community teams involved in his care. The scrutiny team found such a comparison helpful as detailed elsewhere in this report.

Mr CH was reported several times as being potentially violent to others. The report appeared to dismiss risk as largely arising out of his substance misuse. This was unhelpful and misleading in a person who suffered from schizophrenia and had acted violently in relation to disordered thinking during periods of inpatient observation and treatment. Mr CH had had several forensic assessments undertaken in the years prior to the homicide which identified significant risks associated with his psychotic symptoms. The scrutiny team found that although risk assessment was mentioned in the substance of the internal review report it was not examined or analysed.

Mr CH's concordance with prescribed medication and the appropriateness of changes of dose and type are explored by the internal review. However it was difficult to separate their thinking specifically in regard to Mr CH's care rather than overall consideration of the three cases.

8. Scrutiny Team Findings and Recommendations

The scrutiny team found that the internal review report was not a well balanced review of Mr CH's care and treatment. It appeared that assumptions had been made about the issues raised in the three cases before any proper examination of the cases had taken place. Their decision to follow a themed approach hampered a thorough review process. The Trust set up an external inquiry to examine the process failures that led to the case being lost to the system.

8.1 Positive Factors

The Hackney Community Mental Health Team provided an assertive attempt to maintain contact with Mr CH particularly with the contact and liaison with other agencies such as prisons. They also were mindful of the need to re-establish contact with Mr CH once he was released from prison following his frequent detentions.

8.2 Scrutiny Team Independent Findings

The internal review report contained notes of the interviews with staff. This is not accepted practice for investigations. From the notes it appears that conflicting evidence was not challenged or followed up by the internal review. The scrutiny team would also comment that no external people to the Trust were interviewed, for example Mr CH's GP.

The findings and recommendations were general and tailored to the common themes of the report as a whole. The Trust have progressed and implemented their action plan with the exception of the Ward practice which was being currently reviewed at the time of the workshop and it was indicated that this would be completed at the end of May 2010.

The scrutiny team found that the clinical notes prior to 2002 demonstrated that numerous individual professionals made strenuous attempts to manage the risks posed by Mr CH recognising him as a man with a significant and disabling mental illness as well as the proclivity for criminal acts. They showed considerable effort in their attempts to maintain a therapeutic contact with him, despite his chaotic lifestyle using the CPA process. This did not follow through with his care from October 2002 when it appeared that those involved with his care during this period took a more compartmentalised approach. The details of the handover process between the teams was not clear from the notes and this may have disadvantaged the second team on understanding how Mr CH presented when he was ill.

The internal review did not comment on the application of the proposed plan in October 2001 to discharge Mr CH from Section 117 after two months of being

held on duty. The scrutiny team would have been concerned if this plan had been carried through. This would have been inappropriate given the nature of his illness and need for ongoing support as identified by forensic opinion and the previous treating team. It is unclear from the notes as to what happened with the plan to discharge Mr CH but he appeared to continue on CPA.

There was little analysis of the complex interplay between Mr CH's psychotic mental illness, personality factors and social factors.

The general comment in the internal review report that "*Mental health care professionals are expert at addressing risks arising from mental illness*" may have been an attempt to be supportive to staff. It did not characterise the reality that mental health professionals in all parts of the country frequently find it very difficult to address risks associated with mental illness complicated by other factors. The internal review panel seemed to suggest that the risks posed by the individuals were not the responsibility of the mental health professionals. There should have been no doubt that the team had a responsibility to do what was possible to try to minimise the risks to and posed by Mr CH. There are aspects of his chaotic lifestyle and behaviour which were outside of their responsibility and the scrutiny team would not wish to suggest that the team should have been able to remove the risks associated with these, however the link between psychosis and violence was something they did have a responsibility to try and manage.

The scrutiny team found it significant that the views expressed in the following comment "No clear relationship between Forensic history Episodes of Psychotic illness (Opinion of medical staff in the past)" were repeated throughout the notes so readily. The original entry was written by an SHO during as assessment in December 1995. The scrutiny team were unable to find entries from 'medical staff in the past' expressing that opinion, indeed two days prior to the entry, a consultant forensic psychiatrist, who knew him previously had assessed Mr CH and written that when unwell Mr CH poses a significant risk of serious violence and in the community needs close supervision. It is particularly concerning that the SHO's entry appears to have been quoted by another SHO in a report made after the homicide, demonstrating how powerful such a comment can be.

The scrutiny team found that the situation in March 2004 when Mr CH stated that he was travelling to Jamaica for a long visit and his case closed to the team was not best practice. The intention to refer his care to his GP during this period without any further plan, agreement or follow up or any account of a detailed discussion with Mr CH of his plans or access to medication was unsatisfactory.

The scrutiny team assume that the medication change from depot to oral was part of this plan. In view of the length and severity of his mental illness a more detailed management plan of his mental health needs should have been a priority.

It is impossible to know the consequences of changing the depot injection to oral medication but in normal circumstances it would be appropriate to monitor the individual's mental state given the well recognised risk of relapse following such a change.

From the notes there appears to have been little discussion with Mr CH in regard to his illness and potential risk particularly as he had never visited Jamaica before.

The scrutiny team found that the internal review's recommendations were hard to connect with their findings, which were not measurable against their implementation nor was it possible to evaluate the impact on the Trust's services.

8.2.1 Issues addressed at the Trust Workshop with the Scrutiny Team

The following section provides details of the issues discussed with the Trust at the Workshop and their responses to that discussion.

Progress against the Internal Review Action Plan

The scrutiny team were informed that with the exception of one recommendation, that of ward practice, these were all completed. (At the time of writing this report it is understood that all actions have been completed).

Access to Forensic Services

The Trust assured the scrutiny team that forensic services had improved since the time of the incident. They have increased their own forensic consultants and also provide a Forensic Outreach service for patients in the community as part of the Sector Forensic teams who support individuals in the community. Access to the Medium Secure Unit's process has been reviewed and improvements put into place to enable patients to be admitted quickly and also move through the unit more efficiently.

Drug Screening and prevention of drugs in inpatient areas

The Trust provides drug screening kits which are available on the inpatient areas and they have established good relationships with the local liaison police in order to jointly tackle this issue.

A dedicated Dual Diagnosis Specialist team is now provided and the Trust have an ambition to provide a Alcohol Specialist Consultant to work within the team

A substance misuse zero tolerance policy is in place across the Trust.

Housing requirements

A Community Rehabilitation team is now provided by the Trust and their role would be to deal with patients' issues such as housing and potential homelessness.

Prison liaison

The Trust provide an in-reach prison consultant psychiatrist service to the local prisons.

8.3 Scrutiny Team Recommendations

The scrutiny team have been critical of the internal review process undertaken in this case. The team have had the opportunity to discuss this with the Trust who has helped clarify the situation as it was then and now. The normal process that serious untoward incidents are investigated and are scrutinised and considered by the Trust Board did not occur in Mr CH's case.

The scrutiny team make the following recommendations to East London NHS Foundation Trust.

8.3.1 Investigations of Serious Untoward Incidents

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

Recommendation One

It is recommended in accordance with best practice and to ensure that staff have the opportunity to check that the evidence they have given to internal reviews is accurate and reflects the issues that they wish to raise that all interviews undertaken for internal reviews are recorded and transcribed verbatim. These transcriptions are for the purpose of ensuring the investigation team can also check and validate their findings and not for inclusion in reports.

8.3.2 Care Programme Approach

It was found that the CPA process did not allow for a detailed plan for Mr CH's visit to Jamaica.

Recommendation Two

It is recommended that the CPA process includes plans and contingency for individuals who are deciding or planning on being away from their normal residence for a lengthy period.

8.3.3 Transfer of patients between teams

The scrutiny team could find no clear evidence of a good handover of Mr CH's care.

Recommendation Three - Summary Sheet

It is recommended that a summary sheet is developed to be sited at the front of patients' records and updated on a regular basis. This should include:

- Current and Diagnostic History
- Risk History with a detailed list of violent incidents and any link to abnormal mental state
- Risk Management Plan
- Changing diagnosis if relevant
- What medication worked well and problems with medication including allergic reactions
- Admission history
- Markers for relapse
- Signs of relapse
- Contingency plans to manage relapse
- Current care team and contact details

8.3.4 Alcohol Services

Recommendation Four - Alcohol Services

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

Scrutiny Template

Appendix One

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

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

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

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

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

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

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

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

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

Chronology of Events Appendix Two

Date	Event
23.03.1965	Mr CH was born in Hackney. He had a normal birth and milestones.
1972	His brother died, aged 9 years, when Mr CH was aged 7years old.
1976	Mr CH aged 11 years, fell from a balcony, fracturing his arm and sustaining a head injury. He was reported as being an average student with no disciplinary problems at this time.
1978	At age 13 Mr CH worked on a milk round early in the mornings, At this time he began truanting from school and received his first conviction for burglary.
1979	From age 14 he spent most of his time in care because of his criminal behaviour.
1981	Left school at 16 years and attended Hackney Technical College for a few months.
1982	Mr CH spent some time in Borstal for theft and grievous bodily harm. He was diagnosed as suffering from Paranoid Schizophrenia and treated with anti-psychotic medication.
1983	Mr Ch was noted to be psychotic while in Ashford prison on remand.
1984	Mr CH in prison for armed robbery.
1985	Mr CH was seen in Chelmsford prison whilst on remand. He had three admissions during this year. Fist admission March then in April transferred to Hackney hospital on a Section 37 MHA. Third admission between July and September again under Section 37 MHA. Clear symptoms of schizophrenia reported.
1986	Mr CH's fourth admission was in December 1986 under Section 47 MHA. He was discharged July in 1987.
1990	His father moved back to Jamaica. Mother who is of Irish origin remained in UK. Mr CH's parents separated in 1986, he has two surviving siblings an older sister and younger brother.
1992	Admitted to Interim Secure Unit at Hackney hospital. The length of

admission is in doubt because subsequent reports suggest 18 months but a letter from the psychiatrist treating him at the time says he was discharged in August 1992 not August 1993.

November 1995 — Admitted to Homerton hospital under Section 3 MHA. Subsequent letter suggests Mr CH was highly disturbed and violent, requiring treatment on the Intensive Care Ward.

22.12.1995 — Seen by consultant in forensic psychiatry following an attempted serious assault on a male nurse. His opinion was that when unwell CH poses a significant risk of serious violence and in the community needs close supervision. (N.B. in the Part I Summary written in February 2006 the SHO says the Forensic Consultant revised his decision about needing Medium Secure Treatment.)

24.12.1995 — Assessed for admission to Hackney Hospital Interim Secure Unit under Section 3 of the MHA. Index Offences – GBH, Burglary, Unlawful wounding, ABH, Possession of Firearms, Taking and Driving Away. (more likely this is a list of past offences as well as current ones.) Presented thought disordered and paranoid. On maximum doses of depot - Zuclopenthixol Decanoate 600mg IM weekly, Carbamazepine 200mg BD, Procylidine 5mg Daily.

Assessment states “No clear relationship between Forensic history Episodes of Psychotic illness (Opinion of medical staff in the Past)”

08.01.1996 — Mr CH’s notes continue on Bevan ward, the impression is that there has been some settling of his behaviour, less thought disordered but still paranoid.

25.01.1996 — Letter from Forensic Consultant to Ward Consultant saying he had reassessed CH and no longer thought that he needed admission to the Regional Secure Unit.

30.01.1996 — Letter from Ward Consultant to Forensic Consultant expressing disappointment that he has changed his mind following Redford Lodge (presumably a private secure unit) not accepting him.

05.02.1996 — Transferred back from ICU to Conolly ward, settled and concordant with medication. Mr CH to start weekend leave.

06.02.1996 — A report was made to the Mental Health Review Tribunal recommending that Mr CH remain liable to detention and confirming that he will receive care under “a full tiered system of CPA.

15.02.96 — Note of initial CPA meeting on the ward. Date for next CPA set for

30.09.96.

19.02.96 Mental Health Review Tribunal upheld the Section 3 MHA.

22.02.96 Mr CH contacted the girlfriend of a patient who died on Bevan ward telling her that the staff on the ward had killed her boyfriend because he was black. She was seen by a member of staff but no apparent record of a discussion with Mr CH about the incident.

14.03.1996 Although apparently acting appropriately on his ward, staff from Bevan ward complained that Mr CH has been threatening staff and patients on their ward as well as staff outside the hospital in a local pub.

27.03.1996 Generally positive OT assessment of Mr CH's independent living skills.

02.04.1996 Ward round plan to arrange a CPA/Section 117 MHA meeting.

30.05.96 Ward round with Mr CH's consultant, Section 3 MHA has expired, he was living in Crystal Palace and with his mother. Plan to reduce depot to Zuclopenthixol 500mg every 2 weeks (from weekly), continue Carbamazepine 200mg + 300mg, needs to sort out accommodation and be seen in 4 weeks.

17.06.1996 Part II Discharge Summary giving account of admission and meeting with Consultant prior to discharge.

18.09.1996 Letter regarding CPA for Mr CH on the 30.09.96. His consultant unable to attend but he was emphasising the importance of Mr CH's medication.

27.09.1996 Letter from SHO following appointment with Mr CH. Calm and settled and happy to continue medication. Appeared sleepy on medication. After discussion with his consultant, agreed a reduction in depot to 500mg every three weeks.

23.01.1997 Letter from Ward Consultant apologising because he cannot attend the CPA on 24.01.97 but emphasising the need for regular medication and no further reduction at present.

14.02.97 Follow up appointment with consultant, Mr CH was feeling well, but a bit slowed down on medication. Plan to reduce Zuclopenthixol to 300mg from 400mg every two weeks.

01.04.1997 CPA meeting. Mr CH reluctant to keep office follow up appointments and home visits have not been successful but he has kept appointments with consultant. Next CPA booked for 03.06.97.

02.04.1997	Letter from Consultant to another consultant (for the area in which Mr CH was then living) suggesting a future transfer of care.
06.06.1997	DNA appointment with Senior Registrar.
15.08.1997	Seen for appointment by the Senior Registrar. No problems. Confirm continue Level 2 CPA.
10.10.1997	DNA'd appointments, subsequently a number of letters and memos letting consultant and GP know that Mr CH was not keeping appointments and missing depot injections were sent form the CMHT.
14.11.1997	Letter from Care Coordinator saying Mr CH had been on remand in prison and confirming that he was receiving medication from there.
11.02.1998	Attended emergency clinic following release from Pentonville Prison (in since September 1997). Still on Carbamazepine 500mg per day but Zuclopenthixol is now down to 200mg every two weeks.
12.10.2000	Mr
09.02.2001	Note of contact from Brixton Prison where CH has a further 3 months to serve, for burglary, but will then be homeless.
03.2001 to 09.2001	Records of various phone calls regarding Mr CH, staff in Hackney liaising with Brixton project, probation etc. It was reported that Mr CH has money and housing problems, not clear if he is receiving or taking medication.
20.09.2001	Record of phone call from worker in Southside Partnership who has been working with Mr CH since discharge from prison in January. Has now been made homeless, sleeping in a car in Camden but local homeless team (Focus) will not accept responsibility because he is under care of Hackney.
08.10.01	Case discussed with team manager and plan for Mr CH to be allocated ASAP which occurred later same day.
31.10.2001	Mr CH discussed in the team meeting – plan to discharge him from Section 117 MHA, to be held on the caseload for two months and then discuss with a view to transfer to other locality.
29.11.01	Mr CH visits office requesting assistance with Housing Benefit forms but is informed by Care Coordinator that they will not be involved in care and he must go via duty.

Later entry suggesting he stole a personal mobile phone from Care Coordinator's bag.

2001 In a statement dated 17.10.02 Mr CH reported that he had received facial injuries, a broken jaw which required an operation.

16.07.2002 Mr CH' s case review, recently released from prison living in temporary accommodation. Has a key worker but he is uncertain if he needs to be on depot. Reports still taking heroin. For transfer to North West locality team as no longer in area.

Referral to North West Locality Team by Specialist Registrar, Mr CH having moved into that area.

16.06.2003 Mr CH admitted to Homerton Hospital and detained under a section of the MHA. Entries in notes describe a variety of methods of detention:
- the discharge summary says detained at police station under Section 2 MHA
- assessment note says admitted under Section 136 MHA then converted to Section 2 MHA.
- Letter to Social Services says admitted under Section 37 MHA.

Most likely seems Section 136 followed by Section 2 followed by Section 3 MHA.

27.06.2003 ASW assessment report completed, Mr CH had been arrested for attempted burglary at a local school. Detained under Section 2 MHA. Assessed as being thought disordered with erratic behaviour.

11.07.2003 Section 2 MHA converted to Section 3. Mr CH still paranoid and thought disordered.

15.07.2003 CPA on ward attended by CMHT. Plan for Enhanced CPA

05.09.2003 Statement from Mr CH in regard to a charge of possession of bladed article, theft and Public Order Act.

09.09.2003 CPA planning record completed for Section 117 aftercare. For care coordinator allocation. To continue with depot treatment.

18.09.2003 Mr CH appealed against his detention. Psychiatric report completed. Team support further detention.

01.10.2003 Planned transfer to Middlesex Hospital for 2 days for treatment of infected jaw.

09.10.03 Ward round with Consultant, Mr CH showing no obvious signs of psychotic symptoms. Plan for discharge CPA following week.

14.10.2003 Mr CH appears to leave hospital taking his belongings and has an appointment with an Housing Association. For previous few days has been mostly off the ward. No discharge plan, No evidence of CPA, no Part II summary. (?missing notes).

31.10.2003 Mr CH to move to a smaller flat. Housing applying for a transfer.

19.12.2003 Application made by social worker for a community care grant. For the purchase of furniture for Mr CH's flat.

22.01.2004 Mr CH presented at the Drug Dependency Unit with threatening and demanding manner. Seen by a junior doctor who started him on methadone, consultant removed this as wished him to undergo an assessment prior to medication treatment.

08.03.2004 DNA.

12.03.2004 Care Programme Approach review. Notes that Mr CH no longer is using heroin, crack usage reduced, also cannabis. Discharged from Homerton Hospital, East Wing.

Medication changed from Clopixol to Olanzapine and Procycliden. Mr CH intends to travel to Jamaica, staying for 5 months from 21st March 2004. Case closed until his return.

29.06.2004 Telephone contact recorded regarding Mr CH being involved in a murder. No confirmation by police.

30.06.2004 SUI 24 hour form completed re CH being charged with murder having allegedly stabbed someone. Being held at Belmarsh prison. Charged on 12th May 2004.

Forensic History Appendix Three

	Event
31.01.1977	Burglary – conditional discharge
03.05.1978	Burglary – attendance centre.
18.05.1978	Burglary x 2 – fined and received a conditional discharge.
02.07.1981	Fined for being on enclosed premises.
21.08.1981	Theft and assault. Borstal training.
24.11.1981	Four offences, failing to surrender to bail, theft of motor vehicle. No insurance, no licence. Conditional discharge.
25.11.1981	Motoring offences x 5. Returned to Borstal.
08.04.1982	Theft of pedal cycle. Conditional discharge. Criminal damage, conditional discharge.
03.06.1983	Assault and burglary x 2. Custody.
04.12.1984	Carrying item for theft (carrying an instrument with the intention to break into property/car). Fined.
02.05.1985	Criminal damage. Hospital order.
16.07.1985	Criminal damage. Hospital order.
10.09.1986	Theft from person. 8 months prison.
19.09.1986	Burglary. Prison 4 months.
30.03.1989	Robbery and carrying a firearm with intent. 3 years – Robbery. 1 year – firearm. Concurrent. Did 18 months in prison.
25.01.1991	Theft and ABH (assault). 12 months prison sentence.
12.05.1995	Common assault. Probation Order.
30.05.1996	Possession of controlled drug (cannabis) cautioned.
13.12.1996	Possession of controlled drug (Class A). Cautioned.
28.07.1997	Burglary. Conditional discharge.
15.10.1997	Taking motor vehicle without consent. 4 weeks prison.

21.07.1998	Driving whilst disqualified. 6 weeks prison
25.05.2000	Burglary x 2. Conditional discharge.
21.03.2001	Burglary. Possession of offensive weapon. Probation order.
18.09.2001	Shop lifting. Common assault. Criminal damage. Community Rehabilitation order 18 months (took into account on 27.01.03 that didn't do this).
12.04.2002	Burglary, 6 months prison.
27.01.2003	Offensive weapon. Theft from motor vehicle. 3 months for each (prison). Threatening behaviour, offensive weapon. No insurance. 4 months for first 2 offences running concurrent with above.