Independent Scrutiny and Investigation into the care and treatment of

Ms PG

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.

Ms PG was considered as not having capacity to understand and consent to the scrutiny. Therefore the Trust's Caldicott Guardian authorised access to her notes. The scrutiny team wish to thank the Trust for providing the notes in a timely manner.

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

Executive Summary

Introduction

Ms PG, whilst at a money lender's house with another man, had gone into the home owner's kitchen, obtained a knife and stabbed the man in the neck. She then left the premises unaware that the money lender had died of his wound. The incident happened around midnight on 22nd August 2006. At the time of the incident Ms PG was in receipt of mental health services from South London and Maudsley NHS Foundation Trust (the Trust).

An Internal Structured Investigation was commissioned by the Trust to examine Ms PG's care and treatment. A multi-agency panel undertook the review which was completed on 19th February 2007.

A Board Level Inquiry took place on 22nd February 2007 to review the Internal Structured Investigation Report and draw up further recommendations if necessary.

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 expert knowledge. 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 Structured Investigation report, the Board Level Inquiry report and the case notes relating to Ms PG's care and treatment.

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

Outline of the Case

Ms PG was born on 11th November 1968 in the borough of Lambeth. She has two siblings and reports having had a strict upbringing, feeling under pressure to meet her father's high expectations.

She left school aged 16 years and enrolled in a one year typing course following which she worked for a telesales company for two years. Ms PG reported that at the age of eighteen she was asked to leave the family home by her father as he

was disappointed in her academic ability. She obtained council accommodation and had two live-in partners, the second relationship lasting three years. During this period she lost her job and could only find casual temporary employment. After the relationship ended Ms PG visited relatives overseas for two months, and it is during this period her mental ill health appears to have developed.

Ms PG was known to abuse drugs and had a criminal record, mainly for assaults, thefts, prostitution and drug related incidents. She was known to use knives. A forensic history can be found in Appendix Three.

Contact with local Psychiatric Services

Ms PG was initially referred to the local mental health services via the South West Case Management team (SW team) from the local Substance Misuse Services in 1993. Her diagnosis was schizophrenia and at that time she was being treated with anti-psychotic depot medication.

In January 1998 a Probation report (following a conviction for assault) noted that Ms PG's mental health had deteriorated, she was hearing voices and not taking her medication. The report recommended that the Court issued an order containing a condition that Ms PG had to attend the mental health services for treatment.

In July 1998 Ms PG's care was transferred to the South East Case Management Team (SE Team) as she had moved into their area. In June 1999 it was noted that Ms PG was not attending appointments and as a consequence her consultant psychiatrist requested a joint visit with her community psychiatric nurse (CPN).

In March 2000 Ms PG is reported as being "stable and happy". She continued on depot medication, Flupentixol Decanoate 75mgs intramuscularly three weekly.

Two months later in May 2000, Ms PG was arrested and accused of an assault and stabbing. She remained in custody, although when assessed by a Specialist Registrar from the Community Forensic Team she was found to be clearly psychotic and in need of hospital treatment.

On 26th July 2000 Ms PG, living with her mother following her release from prison, was reported as being intermittently irritable and aggressive, regularly using cannabis and showed evidence of tangential thinking and disjointed talk. At that time she was being prescribed the depot anti-psychotic medication Flupentixol Decanoate 80 mgs intramuscularly two weekly.

On 8th November 2000 at a CPA review arranged because Ms PG was pregnant, her mother stated that she was willing to support her daughter during her

pregnancy. A plan was also agreed for Ms PG to continue taking her depot medication as she would be a high risk of relapse if she didn't.

In January 2001 Ms PG had a miscarriage. She continued on her depot medication until 21st September 2001 when her mother reported concerns about her daughter's behaviour.

Ms PG remained on depot medication over the next few months. She reported having auditory hallucinations and paranoid beliefs. It was noted that when she was unwell voices would tell her to injure people by stabbing them with a knife.

In May 2002 she was arrested for robbery and an assault on a policeman. In June a Probation report concluded "she was deemed to present a significant risk of harm to the public should she stop taking her medication."

In July 2002 Ms PG was sentenced to 18 months imprisonment for cutting a man in the eye and arm. During 2003 after her release from prison Ms PG was compliant with her medication, remained mentally stable although still using street drugs. She applied for a place with a Housing Association but was unsuccessful.

In February 2004 Ms PG's care was referred back to the South West Case Management Team (SW team) as she had been living in their area for six months. In November 2004 the transfer had still not taken place and the consultant psychiatrist wrote to his colleague in the SW team expressing his dissatisfaction.

At the end of 2004 Ms PG was admitted to hospital and detained under Section 3 of the Mental Health Act 1983 (MHA). In January 2005 she absconded from hospital and was seen at her home on 6th January 2005 by her care coordinator. It was planned to take Ms PG to see her consultant psychiatrist the next day, to give her the prescribed depot injection and discharge her from the Section 3 MHA.

For the remainder of January 2005 she was difficult to engage, not attending for her depot medication, CPA reviews or court appearances. Her care was finally transferred to the SW team on 4th April 2005.

During the rest of 2005 Ms PG's engagement with services fluctuated, between being completely compliant with medication and appointments and then disengaging for several weeks.

On 17th January 2006 Ms PG attended the team base to report that her mother was moving out of the family home. (It had been indicated that her father, separated from her mother, was travelling between Jamaica and the UK trying to sell the family home).

Between 7th February and 28th April 2006 Ms PG was seen on 30 occasions, failing to attend appointments twice and not at her home on two other occasions. A CPA review took place on 28th March 2006 and in the period 9th May to 15th August a further 14 contacts were made with Ms PG.

On 15th August 2006 when attending the Team base she was seen by another team member, not her care coordinator, and behaved inappropriately towards him. She was told to return to the team base in one week for her depot medication.

On 23rd August 2006 Ms PG was arrested for murder.

Scrutiny Team Findings and Recommendations

The scrutiny team found that generally both the reports were a well balanced review of the care and treatment provided to Ms PG. They address the majority of issues that the scrutiny team identified through its overview. The findings and recommendations including the additional ones identified by the Board Level Inquiry were appropriate.

In particular the scrutiny team wish to commend the areas of good practice identified in both reports and confirmed by examination of the case notes.

Positive Factors

The following areas of good practice were found: -

- recognition that the Trust Board were aware that an independent investigation under HSG (94) 27 might be commissioned.
- the process whereby detailed minutes of the serious Incident Evaluation Meeting were taken.
- the number of contacts made with Ms PG's mother during the course of her contact with services. This was also demonstrated in the continued contact after the incident and notes taken with regard to Ms PG's mother's concern about how her daughter's difficulties would be presented.
- the team's flexibility in accommodating Ms PG's unscheduled attendance at their team base.
- the team's actions in maintaining contact despite the difficulties.
- the level of contact the team had with the Housing team.

Scrutiny Team Independent Findings

The scrutiny team found further areas that were not considered by either of the two reports.

Both internal reports evaluated in detail what was a relatively short period in the Trust's care of Ms PG. This limited timeframe potentially restricted the usefulness of the Internal Structured Investigation and subsequent Board Level Inquiry. It would have been more instructive to commence a detailed investigation from the initial contact with services but failing that to begin in more detail when Ms PG's transfer of care was first requested between the SE and SW team. This would have provided a better basis for examining the contrast of styles of care and would also have highlighted some of the issues regarding the transfer.

It was unclear as to the degree to which the medical staff were aware of Ms PG's history of violence associated with psychosis when they were making changes to her medication with the potential for precipitating a psychotic relapse. The Internal Structured Investigation did not identify risk assessment as an area of concern. The initial Case Management Team caring for Ms PG (SW team) were explicit about the relationship between insufficient medication and deterioration in Ms PG's mental state and subsequent onset of more violent impulses. The psychotic phenomena had included command hallucinations instructing her to harm people with knives.

The scrutiny team are concerned that the Internal Structured Investigation did not adequately explore the "belief system" of the team working with her. It appeared that the SW team consultant psychiatrist saw that Ms PG was not psychotic and that the focus of her presentation was her non prescribed drug use.

The Mental Health Act code of practice was not discussed by either report. The scrutiny team found that this was relevant in terms of Ms PG's discharge from hospital and Section 3 MHA on 7th January 2005 after she absconded and had returned to her mother's home. There was no discussion of Section 117 MHA and whether the requirements were fulfilled.

An exploration of the local operational policies in regard to the transfer of patients between teams and care coordinators would have been useful in order to understand the difficulties that occurred during these processes.

The scrutiny team found some issues with regard to CPA confusing. It would have been helpful if the reports had set out the Trust's CPA process in relation to transfer of care and changes in assessing responsibility for Ms PG's welfare. There does not appear to have been a discharge CPA in January 2005 and neither report referred to this omission.

The scrutiny team does have concerns in regard to comments recorded in the Serious Incident Evaluation Meeting that appeared to question whether the psychiatric team should be thought to have the responsibility for Ms PG given her damaged personality, chaotic lifestyle and mental illness. 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 Ms PG. There are aspects of her chaotic lifestyle and behaviour which were out of their responsibility and the scrutiny team would not wish to suggest that the team should have been able to remove the risk associated with these, but the link between psychosis and violence was something they did have a responsibility to try to manage.

The Internal Structured Investigation team were aware of a forensic report that had been prepared following the homicide. Although the scrutiny team are aware that using such information post incident carries with it difficulties they do consider that it should have been considered by the Internal Structured Investigation team to better understand the issues relating to Ms PG's care and treatment.

The scrutiny team found that the extremely lengthy period during which the SE team were attempting to transfer Ms PG's care to their SW team colleagues was not acceptable.

Issues addressed at the Trust Workshop with the Scrutiny Team

The following issues discussed at the workshop include those identified by the scrutiny team together with others that arose as a direct result of the detailed discussion with the Trust. The Trust provided detailed supporting evidence.

<u>Progress made against the Trust Action Plans</u>

The Trust provided a detailed report on the progress made against their Action plan. All have been completed with the exception of the second recommendation made by the Board Level Inquiry panel.

This relates to mental health state assessments and a requirement that this is completed in the relevant section on the ePJS system.

It was explained that the Trust are setting up specific "tabs" on the electronic system and undertaking a running tally of assessments being undertaken which include:

- annual audit of clinical records
- performance management reviews
- staff supervision
- nursing assurance visits
- productive services in the community
- publishing the results of the audits

Substance Misuse Services

In all areas the number of patients in treatment for addiction problems has increased and therefore ranges of treatment broadened. The Trust is working in partnership with other agencies to improve patient engagement and access. Inpatient services provide medical detoxification and stabilisation for drugs and alcohol clients.

In 2008 the Stockwell and Camberwell community drug teams moved together into a centre base in Brixton. The service deals specifically with the needs of stimulant users and in partnership with an agency working with crack cocaine users.

Other boroughs within the Trust are not so advanced with their Substance Misuse Services as Lambeth but work is in progress.

Dual Diagnosis

The Trust has developed a Policy for the Care and Treatment of Service Users with Dual Diagnosis (Co-morbid mental health and substance misuse problems). This was ratified by the Trust on 13th August 2008 and to be reviewed in 2011.

A great deal of work has been undertaken by the Trust in recruiting and training staff in Dual Diagnosis. A consultant nurse lead in Dual Diagnosis is in post.

Transfer of Patients between services

The Trust's CPA, November 2008 policy, outlines the processes in place to enable a smooth timely transfer of patients between services. Additional policies which also refer to safe and effective transfer include:

- Clinical risk assessment and management of harm framework (November 2008).
- Transfer of care criteria to Mental Health of Older Adult Services (September 2006)
- Transition of young people to adult services (April 2007)

The Trust is also in the process of preparing Guidelines into transfer procedures.

CPA Audit

The use of and quality of CPA is monitored and audited by the Trust.

- Annual CPA audit including the use of CPA.

- Regular review and monitoring of care coordinator caseloads and compliance with CPA by Community Team Managers.
- Electronic data is available to review CPA in relation to individual service users. This also provides information on: -

    - CPA reviews past their due date
    - Completion of risk assessments
    - Completion of child need and risk screen completion

Access to Forensic Services

Lambeth Adult Services access forensic services via a referrals meeting/central referral point. This is primarily in relation to service users within the criminal system. Lambeth and forensic services have recently introduced liaison meetings which consider individual patient care pathways and thresholds for referral. The Trust's staff are finding this an effective process. It was confirmed that the general adult consultants considered they had access to a quick forensic assessment and rapid move to an appropriate pathway depending on need.

Forensic community teams are now part of borough teams.

Visiting Consultant Role

Clarity in regard to a term used in the Internal Structured Investigation report regarding a "visiting consultant" was sought by the scrutiny team. This was an anomaly used by an interviewee of the Internal Structured Investigation and is not a term used by the Trust. Each community team has one whole time equivalent consultant psychiatrist who is fully involved in clinical leadership as part of the multi-disciplinary team.

Safeguarding Policies

The Trust has in place Safeguarding Children Policies and Procedures. A Trust intranet site is dedicated to child protection and a Safeguarding Children Committee is chaired by the Director of Nursing and Education.

There is a named lead for Child Safeguarding and a help line is place for staff to access.

Completion of the Child Need and Risk Screen is mandatory on the ePJS system for all service users.

Scrutiny Team Recommendations

The Scrutiny team commend the Trust on the progress made since these events in 2006 and would only make the following recommendations.

Terms of Reference

The Terms of Reference did not direct the internal structured investigation to examine a particular period in Ms PG's contact with the Trust's services.

Recommendation One

It is recommended that Terms of Reference direct the investigation to complete a detailed chronology/timeline or events to enable the investigation to consider an appropriate length of time to capture key elements of the person's care.

Carers Assessment

Ms PG was supported by her mother throughout her period of contact with mental health services. The scrutiny team have commended the level of contact made by the services with the mother. However it was unclear whether a Carer's Assessment had been offered and undertaken.

Recommendation Two

It is recommended that a Carers Assessment should be offered to all informal carers such as Ms PG's mother and recorded in the individual notes whether this has been undertaken or refused.

Information Sharing

The scrutiny team found evidence that Ms PG's past history was not shared between those involved in her care particularly when transferring between teams. It is understood that the Trust's electronic records (ePJS) contain information regarding individuals which is easily accessible to all clinical staff.

Recommendation Three - Summary Sheet

It is recommended that a transfer procedure is developed to be included in the ePJS system and kept up to date in line with policy. 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

1. Introduction

Ms PG, whilst at a money lender's house with another man, had gone into the home owner's kitchen, obtained a knife and stabbed the money lender in the neck. She then left the premises unaware that the man had died of his wound. The incident happened around midnight on 22nd August 2006. At the time of the incident Ms PG was in receipt of mental health services from South London and Maudsley NHS Foundation Trust (the Trust).

The Trust commissioned an Internal Structured Investigation Report of the incident which was completed in February 2007. The Internal Structured Investigation was completed by a Nurse Advisor, Clinical Director and Investigation Facilitator, all internal to the Trust. The Board Level Inquiry was undertaken by one of the Trust's Non-Executive Directors, their Director of Nursing and Medical Director.

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 expert knowledge. The scrutiny team were asked to assess the Trust's internal reviews and findings and make further recommendations if deemed necessary.

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

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 Ms PG by examination of the clinical information available from the Trust.

To compile a chronology of events.

Part Two

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

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

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

3. Purpose of the Scrutiny and Investigation

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

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

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

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

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

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

4. Methodology

It was agreed at the start of the scrutiny that the team would examine the internal review undertaken by the Trust. The scrutiny team would set out its findings in regard to the process undertaken and the Trust's progress against their internal review's recommendations. In addition the scrutiny team was to undertake a detailed analysis of Ms PG's case records held by the Trust prior to the death of the victim. Ms PG did authorise access to these records, however it was deemed by her consultant psychiatrist that she did not have the capacity to do so. The Trust's Caldicott Guardian did authorise the scrutiny team's access to the records.

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

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

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

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

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

5. Scrutiny Team Members

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

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

6. Outline of the Case

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

6.1 Background

Ms PG was born on 11th November 1968 in the borough of Lambeth. She has two siblings and reports having had a strict upbringing, feeling under pressure to meet her father's high expectations.

She left school aged 16 years and enrolled in a one year typing course following which she worked for a telesales company for two years. Ms PG reported that at the age of eighteen she was asked to leave the family home by her father as he was disappointed in her academic ability. She obtained council accommodation and had two live-in partners, the second relationship lasting three years. During this period she lost her job and could only find casual temporary employment. After the relationship ended Ms PG visited relatives overseas for two months and it is during this period her mental ill health appears to have developed.

Ms PG was known to abuse drugs and had a criminal record, mainly for assaults, thefts, prostitution and drug related incidents. She was known to use knives. A forensic history can be found in Appendix Three.

6.2 Contact with local Psychiatric Services

Ms PG was initially referred to the local mental health services via the South West Case Management team (SW team) from the local Substance Misuse Services in 1993. Her diagnosis was schizophrenia and at that time, she was being treated with anti-psychotic depot medication.

In January 1998 a Probation report (following a conviction for assault) noted that Ms PG's mental health had deteriorated, she was hearing voices and not taking her medication. The report recommended that the Court issued an order containing a condition that Ms PG had to attend the mental health services for treatment.

In July 1998 Ms PG's care was transferred to the South East Case Management Team (SE Team) as she had moved into their area. A Care Programme Approach (CPA) document detailed the transfer. The team's consultant psychiatrist sent a letter to the team in regard to Ms PG's treatment.

In June 1999 it was noted that Ms PG was not attending appointments and as a consequence her consultant a joint visit with her community psychiatric nurse (CPN).

In March 2000 Ms PG is reported as being “stable and happy”. She continued on depot medication, Flupentixol Decanoate 75mgs intramuscularly three weekly.

Two months later in May 2000, Lambeth Mental Health Team were asked to provide an appropriate adult as Ms PG had been arrested and accused of an assault and stabbing. She remained in custody, although when assessed by a Specialist Registrar (SpR) from the Community Forensic Team she was found to be clearly psychotic and in need of hospital treatment.

On 26th July 2000 Ms PG, living with her mother following her release from prison, was reported as being intermittently irritable and aggressive, was regularly using cannabis and showed evidence of tangential thinking and disjointed talk. At that time she was being prescribed the depot anti-psychotic medication Flupentixol Decanoate 80 mgs intramuscularly two weekly.

On 8th November 2000 at a CPA review arranged because Ms PG was pregnant, her mother stated that she was willing to support her daughter during her pregnancy. A plan was also agreed for Ms PG to continue taking her depot medication as she would be a high risk of relapse if she didn’t.

In January 2001 Ms PG had a miscarriage. She continued on her depot medication until 21st September 2001 when her mother reported concerns about her daughter’s behaviour. The CPN arranged a joint visit with Ms PG’s consultant psychiatrist. She was given her depot medication as it was due.

On 9th October 2001 a CPA review took place which noted that Ms PG still had some residual psychotic symptoms but appeared to be not distressed by them. Her depot medication had been increased to 80 mgs two weekly and it was advised that she should not be driving.

Ms PG continued on her depot medication over the next few months. She reported having auditory hallucinations and paranoid beliefs. It was noted that when she was unwell voices would tell her to injure people by stabbing them with a knife.

In May 2002 she was arrested for robbery and an assault on a policeman. In June a Probation report concluded “she was deemed to present a

significant risk of harm to the public should she stop taking her medication."

In July 2002 Ms PG was sentenced to 18 months imprisonment for cutting a man in the eye and arm. She was discharged from prison on 7th August 2003. Whilst in prison it had been reported that she did have evidence of thought disorder and delusions. She was to remain on Probation for seven months and she moved in with her mother.

Ms PG's mother contacted her care-coordinator on 21st August 2003 complaining that Ms PG sold her brother's television and stereo to pay drug dealers. She wanted Ms PG to leave but later agreed to her staying.

For the remainder of 2003 Ms PG was compliant with her medication and remained mentally stable although still using street drugs. She applied for a place with a Housing Association but was unsuccessful.

In February 2004 Ms PG's care was referred back to the SW team (CMHT) as she had been living in their area for six months. In November 2004 the transfer had still not taken place and the consultant psychiatrist wrote to his colleague in the SW team expressing his dissatisfaction.

At the end of 2004 Ms PG was admitted to hospital and detained under Section 3 of the Mental Health Act 1983 (MHA). In January 2005 she absconded from hospital and was seen at her home on 6th January 2005 by her care coordinator. It was planned to take Ms PG to see her consultant psychiatrist the next day, to give her the prescribed depot injection and discharge her from the Section 3 MHA.

For the remainder of January 2005 she was difficult to engage, not attending for her depot medication, CPA reviews or court appearances. Her care was finally transferred to the SW team on 4th April 2005.

During the rest of 2005 Ms PG's engagement with services fluctuated, between being completely compliant with medication and appointments and then disengaging for several weeks. In November she was seen by her new consultant psychiatrist. She had stopped taking her oral medication and the consultant increased her depot medication dosage. It was decided that she did not need ongoing outpatient reviews and that he would see her at her six monthly CPA review meetings.

On 17th January 2006 Ms PG attended the team base to report that her mother was moving out of the family home. (It had been indicated that her father, separated from her mother, was travelling between Jamaica and the UK trying to sell the family home).

Between 7th February and 28th April 2006 Ms PG was seen on 30 occasions, failing to attend appointments twice and not at her home on two other occasions. A CPA review took place on 28th March 2006 and in the period 9th May to 15th August a further 14 contacts were made with Ms PG.

On 15th August 2006 when attending the Team base she was seen by another team member, not her care coordinator, and behaved inappropriately towards him. She was told to return to the team base in one week for her depot medication.

On 23rd August 2006 Ms PG was arrested for murder.

7. Consideration of the Internal Structured Investigation Report

The following comments relate to the Internal Structured Investigation report and the subsequent Trust's Board Level Inquiry Report. The section has been sent out in accordance with the first part of the scrutiny team's Terms of Reference.

7.1 Internal Structured Investigation Report – Process Comments

Overall the scrutiny team found that both the Internal Structured Investigation and subsequent Board Level Inquiry were robust, well written and showed adherence to the Terms of Reference by both reports. These were appropriate for the case under consideration. The Trust did produce an initial "fact finding report" within the 72 hours regulatory requirement.

A detailed methodology was set out in the Internal Structured Investigation's introduction to the report which included reference to the Root Cause Analysis process that the investigation team would follow. The team were internal to the Trust although from a different sector and comprised of a consultant psychiatrist, senior nurse and an investigation facilitator. There were no external representatives on the team or from the Local Authority. It is accepted good practice to have an external investigator on homicide internal investigations.

A chronology and tabular timeline were produced but it was unclear whether the Internal Structured Investigation team reviewed the notes themselves or only the time line. It was unclear whether compiling these were part of the role of the investigation facilitator. The chronology only covered Ms PG's care from 6th January 2005 up until the date of the homicide. The scrutiny team were not aware of the details of individual staff interviews although there were extensive minutes of the Serious Incident Evaluation Meeting which was facilitated by a Deputy Director of the Trust and attended by eight members of Ms PG's care team plus the Internal Structured Investigation team members.

The decision to begin the detailed chronology in January 2005 presumably meant that the SE team consultant and Ms PG's previous care coordinator were not interviewed. This resulted in the Internal Structured Investigation team not having an opportunity to hear their assessment of Ms PG for the period she was under the care of that team.

The 72 hour management and the Internal Structured Investigation reports indicate that Ms PG's mother was contacted by the local services and the Internal Structured Investigation team. How this was undertaken is

unclear and there are no details of meetings with Ms PG's mother if they did occur.

The report did not comment specifically on adherence to local policies and procedures, therefore the scrutiny team has to assume that there was no breach in compliance with these by Ms PG's care team.

7.2 Board Level Inquiry – Process Comments

The Internal Structured Investigation report was reviewed by a panel of three Board members. The inquiry met with representatives from the Lambeth Recovery and Support Team, the Internal Structured Investigation team and senior management team responsible for the Lambeth mental health services. The Board Level Inquiry set out a clear statement of its purpose.

The Board Level Inquiry added two additional recommendations to the original Internal Structured Investigation report which centre around audit of care plans and medicine changes and updating mental state information on the electronic patient record system.

It is not clear whether the report or a summary of the progress made against the action plan was presented to the Trust Board.

7.3 General Comments

The scrutiny team considered how well the Internal Structured Investigation team examined and commented on the evidence provided to them. In view of Ms PG's lifestyle, her use of knives, drug misuse and the actions she took when the victim died, one of the main considerations should have been an assessment of the risks she presented to herself and others.

The scrutiny team were unclear as to whether Ms PG's case records were immediately secured by the Trust as there was a note that her consultant psychiatrist was having difficulty accessing these after the incident in order for him to check through these prior to them being forwarded to a solicitor.

The Internal Structured Investigation report did refer to Ms PG's medication regime but the changes to this were not highlighted as a potential issue in that it is recognised that medication changes can be associated with destabilising mental state.

Ms PG's forensic history was referred to in the body of the report but there was no evidence of how the information was used within Ms PG's care plans.

The Care Programme Approach was mentioned in the Internal Structured Investigation report but it appears that an in-depth discussion of its application and how it was applied in regard to Ms PG's care was not undertaken. This also relates to the difficulties discussed in the Internal Structured Investigation report in regard to maintaining a consistent treatment plan for Ms PG. The further issue of adequate support with Ms PG's drug related problems were highlighted but no details were provided as to how this could have been dealt with.

The scrutiny team wish to endorse the commendation made by the Internal Structured Investigation in regard to the amount of contact the teams had with Ms PG's mother during her contact with the mental health services. It is unclear however, whether Ms PG's mother had been offered a carer's assessment as part of the CPA process.

8. Scrutiny Team Findings and Recommendations

The scrutiny team found that generally both the reports were a well balanced review of the care and treatment provided to Ms PG. They address the majority of issues that the scrutiny team identified through its overview. The findings and recommendations including the additional ones identified by the Board Level Inquiry were appropriate.

In particular the scrutiny team wish to commend the areas of good practice identified in both reports and confirmed by examination of the case notes.

8.1 Positive Factors

The following areas of good practice were found: -

- recognition that the Trust Board were aware that an independent investigation under HSG (94) 27 might be commissioned.
- the process whereby detailed minutes of the serious Incident Evaluation Meeting were taken.
- the number of contacts made with Ms PG's mother during the course of her contact with services. This was also demonstrated in the continued contact after the incident and notes taken with regard to Ms PG's mother's concern about how her daughter's difficulties would be presented.
- the team's flexibility in accommodating Ms PG's unscheduled attendance at their team base.
- the team's actions in maintaining contact despite the difficulties.
- the level of contact the team had with the Housing team.

8.2 Scrutiny Team Independent Findings

The scrutiny team found further areas that were not considered by either of the two reports.

Both internal reports evaluated in detail what was a relatively short period in the Trust's care of Ms PG. This limited timeframe potentially restricted the usefulness of the Internal Structured Investigation and subsequent Board Level Inquiry. It would have been more instructive to commence a detailed investigation from the initial contact with services but failing that to begin in more detail when Ms PG's transfer of care was first requested between the SE and SW team. This would have provided a better basis for examining the contrast of styles of care and would also have highlighted some of the issues regarding the transfer.

It was unclear as to the degree to which the medical staff were aware of Ms PG's history of violence associated with psychosis when they were making changes to her medication with the potential for precipitation. The Internal Structured Investigation did not identify risk assessment as an area of concern. The initial Case Management Team caring for Ms PG (SW team) were explicit about the relationship between insufficient medication and deterioration in Ms PG's mental state and subsequent onset of more violent impulses. The psychotic phenomena had included command hallucinations instructing her to harm people with knives.

The scrutiny team are concerned that the Internal Structured Investigation did not adequately explore the "belief system" of the team working with her. It appeared that the SW team consultant psychiatrist saw that Ms PG was not psychotic and that the focus of her presentation was her non prescribed drug use.

The Mental Health Act code of practice was not discussed by either report. The scrutiny team found that this was relevant in terms of Ms PG's discharge from hospital and Section 3 MHA and on 7th January 2005 after she absconded and had returned to her mother's home. There was no discussion of Section 117 MHA and whether the requirements were fulfilled.

An exploration of the local operational policies in regard to the transfer of patients between teams and care coordinators would have been useful in order to understand the difficulties that occurred during these processes.

The scrutiny team found some issues with regard to CPA confusing. It would have been helpful if the reports had set out the Trust's CPA process in relation to transfer of care and changes in assessing responsibility for Ms PG's welfare. There does not appear to have been a discharge CPA in January 2005 and neither report referred to this omission.

The scrutiny team does have concerns in regard to comments recorded in the Serious Incident Evaluation Meeting that appeared to question whether the psychiatrist team should be thought to have the responsibility for Ms PG given her damaged personality, chaotic lifestyle and mental illness. 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 Ms PG. There are aspects of her chaotic lifestyle and behaviour which were out of their responsibility and the scrutiny team would not wish to suggest that the team should have been able to remove the associated with these, but the link between psychosis and violence was something they did have a responsibility to try to manage.

The Internal Structured Investigation team were aware of a forensic report that had been prepared following the homicide. Although the scrutiny team are aware that using such information post incident carries with it difficulties they do consider that it should have been considered by the Internal Structured Investigation team to better understand the issues relating to Ms PG's care and treatment.

The scrutiny team found that the extremely lengthy period during which the SE team were attempting to transfer Ms PG's care to their SW team colleagues was not acceptable.

8.2.1 Issues addressed at the Trust Workshop with the Scrutiny Team

The following issues discussed at the workshop include those identified by the scrutiny team together with others that arose as a direct result of the detailed discussion with the Trust. The Trust provided detailed supporting evidence.

<u>Progress made against the Trust Action Plans</u>

The Trust provided a detailed report on the progress made against their Action plan. All have been completed with the exception of the second recommendation made by the Board Level Inquiry panel.

This relates to mental health state assessments and a requirement that this is completed in the relevant section on the ePJS system.

It was explained that the Trust are setting up specific "tags" on the electronic system and undertaking a running tally of assessments being undertaken which include:

- annual audit of clinical records
- performance management reviews
- staff supervision
- nursing assurance visits
- productive services in the community
- publishing the results of the audits

<u>Substance Misuse Services</u>

In all areas the number of patients in treatment for addiction problems has increased and therefore ranges of treatment broadened. The Trust is working in partnership with other agencies to improve patient engagement and access. Inpatient services provide medical detoxification and stabilisation for drugs and alcohol clients.

In 2008 the Stockwell and Camberwell community drug teams moved together into a centre base in Brixton. The service deals specifically with the needs of stimulant users and in partnership with an agency working with crack cocaine users.

Other boroughs within the Trust are so not advanced with their Substance Misuse Services as Lambeth but work is in progress.

Dual Diagnosis

The Trust has developed a Policy for the Care and Treatment of Service Users with Dual Diagnosis (Co-morbid mental health and substance misuse problems). This was ratified by the Trust on 13th August 2008 and to be reviewed in 2011.

A great deal of work has been undertaken by the Trust in recruiting and training staff in Dual Diagnosis. A consultant nurse lead in Dual Diagnosis is in post.

Transfer of Patients between services

The Trust's CPA, November 2008 policy, outlines the processes in place to enable a smooth timely transfer of patients between services. Additional policies which also refer to safe and effective transfer include:

- Clinical risk assessment and management of harm framework (November 2008).
- Transfer of care criteria to Mental Health of Older Adult Services (September 2006)
- Transition of young people to adult services (April 2007)

The Trust is also in the process of preparing Guidelines into transfer procedures.

CPA Audit

The use of and quality of CPA is monitored and audited by the Trust.

- Annual CPA audit including the use of CPA.
- Regular review and monitoring of care coordinator caseloads and compliance with CPA by Community Team Managers.
- Electronic data is available to review CPA in relation to individual service users. This also provides information on: -

    - CPA reviews past their due date
    - Completion of risk assessments

- Completion of child need and risk screen completion

Access to Forensic Services

Lambeth Adult Services access forensic services via a referrals meeting/central referral point. This is primarily in relation to service users within the criminal system. Lambeth and forensic services have recently introduced liaison meetings which consider individual patient care pathways and thresholds for referral. The Trust's staff are finding this an effective process. It was confirmed that the general adult consultants considered they had access to a quick forensic assessment and rapid move to an appropriate pathway depending on need.

Forensic community teams are now part of borough teams.

Visiting Consultant Role

Clarity in regard to a term used in the Internal Structured Investigation report regarding a "visiting consultant" was sought by the scrutiny team. This was an anomaly used by an interviewee of the Internal Structured Investigation and is not a term used by the Trust. Each community team has one whole time equivalent consultant psychiatrist who is fully involved in clinical leadership as part of the multi-disciplinary team.

Safeguarding Policies

The Trust has in place Safeguarding Children Policies and Procedures. A Trust intranet site is dedicated to child protection and a Safeguarding Children Committee is chaired by the Director of Nursing and Education.

There is a named lead for Child Safeguarding and a help line is place for staff to access.

Completion of the Child Need and Risk Screen is mandatory on the ePJS system for all service users.

8.3 Scrutiny Team Recommendations

The Scrutiny team commend the Trust on the progress made since these events in 2006 and would only make the following recommendations in relation to their investigation process.

Terms of Reference

The Terms of Reference did not direct the internal structured investigation to examine a particular period in Ms PG's contact with the Trust's services.

Recommendation One

It is recommended that Terms of Reference direct the investigation to complete a detailed chronology/timeline or events to enable the investigation to consider an appropriate length of time to capture key elements of the person's care.

Carers Assessment

Ms PG was supported by her mother throughout her period of contact with mental health services. The scrutiny team have commended the level of contact made by the services with the mother. However it was unclear whether a Carer's Assessment had been offered and undertaken.

Recommendation Two

It is recommended that a Carers Assessment should be offered to all informal carers such as Ms PG's mother and recorded in the individual notes whether this has been undertaken or refused.

Information Sharing

The scrutiny team found evidence that Ms PG's past history was not shared between those involved in her care particularly when transferring between teams. It is understood that the Trust's electronic records (ePJS) contain information regarding individuals which is easily accessible to all clinical staff.

Recommendation Three - Summary Sheet

It is recommended that a transfer procedure is developed to be included in the ePJS system and kept up to date in line with policy. 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

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

11.11.68	Ms PG born - from date of birth contained in discharge summary.
1992	Ms PG experienced her first sign of breakdown in prison in Jamaica for drug smuggling.
1993	Ms PG referred to South West Case Management Team from the substance misuse services.
21/01.98	A probation report completed following conviction for ABH. Offence appeared to be related to a deterioration in Ms PG's mental health (she was hearing voices) having not been taking medication. Recommended probation order with condition of attending for treatment.
02.07.98	Transferred to South East Team because Ms PG moved into their area. CPA document, relating to transfer completed.
18.08.98	A letter from the Consultant of the South East Team to a probation officer outlining plans for Ms PG.
17.06.99	Third letter to CPN about Ms PG missing appointments asking to set up a joint visit sent by her consultant.
08.03.00	Letter from consultant having seen Ms PG, noted she was stable and happy to continue depot medication, Flupentixol Decanoate 75mg IM every 3 weeks.
04.05.00	Enquiry form from Lambeth Social Services Mental Health Team regarding a request from the police for an appropriate adult following Ms PG having been arrested accused of assault / stabbing.
12.05.00	Letter from SpR in Community Forensic Psychiatry, to the consultant in the SE Team, having assessed Ms PG as part of a Court Diversion Scheme. Found her to be clearly psychotic and in need of hospital treatment.
04.07.00	Letter from Consultant South East Team to the Magistrate Court in relation to Ms PG appearing on two counts of ABH.
26.07.00	CPA review - Ms PG now living with her mother following release from prison. Letter notes Ms PG is intermittently irritable and aggressive, regularly using cannabis, and showed evidence of tangential thinking and disjointed talk. She was taking Flupentixol Decanoate 80mg IM every 2 weeks.
08.11.00	Letter from consultant to CPN regarding CPA review that day.

Meeting prompted by news that Ms PG was pregnant. Mental state stable, mother willing to support her in the pregnancy and agreed plan to continue medication because of history of high risk of relapse if not taking medication.

09.01.01 Entry in handwritten notes confirming that Ms PG had a miscarriage.

21.09.01 Entry in notes describing Ms PG's mother's concerns about her daughter's behaviour. CPN arranged a joint visit with the consultant the same day. Given depot medication, which was due.

09.10.01 Letter from consultant to CPN following CPA review, confirming Ms PG still has some residual psychotic symptoms, but not distressed by them. Also confirming medication Flupentixol Decanoate 100mg every 2 weeks and that Ms PG should not be driving.

24.10.01 Report from consultant of the SE Team at request of Ms PG's solicitors in relation to charges of wounding and ABH following an incident on 29.04.2000.

13.11.01 Referral from SE Sector CPN to Southside Rehabilitation Association Ltd. Gives diagnosis as Schizophrenia since 1993. Auditory hallucinations and paranoid beliefs, mental state generally stable. Gives some history of violence and a risk screening form completed.

19.11.01 Entry in case notes giving account of breakdown in prison, and giving personal and forensic history. Also describing how Ms PG experiences voices telling her to injure people by stabbing with a knife when unwell.

14.05.02 Risk assessment tool completed. This included some details of assaults in 1985 and 1998 and possession of knife in April 2002. Case formulation of risk and care plan not filled in.

16.05.02 Referral form to children's' services, from SE Sector CMHT, following arrest for robbery and assault on police. In this referral is noted that baby died two years before.

20.06.02 Report from Probation service giving personal history along with some history of offending.

In discussing her risk the probation officer concludes that there is an emerging pattern in relation to offences of a violent nature. Her last offences are related specifically to her mental health at the time, and she was deemed to present a significant risk of harm to the public should she stop taking her medication.

23.07.02	Sentence notification describing an incident in which Ms PG cut a man in the eye and on his arm. Sentenced to 18 months imprisonment.
12.08.02	Memo from Mental Health/Probation Liaison Worker reporting that at an interview with Ms PG there was evidence of thought disorder, hearing voices and speaking to an unseen person.
20.08.02	Probation Service pre sentence report regarding the above incident. In the report the probation officer describes concerns about Ms PG's mental state and her description of being influenced by evil forces. In the accompanying fax the probation officer describes Ms PG complaining of hearing voices and being guided by evil spirits, he concludes that she can present a significant risk of harm to the community.
Undated	Hard written letter from Ms PG to consultant and CPN at CMHT asking them to collect her from prison as she is due her medication.
23.01.03	Note of phone contact with CPN from HMP High Point who was reporting what appeared to be evidence of thought disorder and delusions when he assessed Ms PG.
23.07.03	Notification of CPA review held in prison attended by the CPN from SE Team.
07.08.03	Discharge notification from HMP Downview. Ms PG on Flupentixol depot and Procyclidine.
15.08.03	Note from Care Co-ordinator saying Ms PG had not attended her appointment, he telephoned her mother and arranged to visit on the 18th.
21.08.03	Note from Care Co-ordinator following phone call from Ms PG's mother who was wanting to throw Ms PG out of the house after she had used her brother's TV and Stereo to pay drug dealers. (Entries in later notes seem to suggest that Ms PG's mother later relented, and allowed her to stay)
02.09.03	Note from Care Co-ordinator - Ms PG seemed generally well, discussed her use of street drugs and how they increase her vulnerability.
05.09.03	Letter from consultant SE Team to the Care Co-ordinator, having seen Ms PG that morning. Describes her as mentally well but in need of appropriately supported hostel accommodation.
September 2003	Monthly feedback from MACA Forensic Mental Health Practitioner saying she had liaised with Ms PG's Care Co-ordinator and her

Probation officer and did not think there was any need for her to be involved at this time. Care Co-ordinator was seeing her at least once per week, she was still with her mother who was reluctantly allowing her to stay, and was engaging with services. She had agreed to see a counsellor at the CMHT with regard to her drug problem.

07.10.03 Summary prepared for the Placement Panel giving information about her diagnosis, drug use, social difficulties, and includes risk history of violence and use of knives.

07.10.03 Letter from consultant SE Team to Care Co-ordinator. He noted Ms PG was mentally stable, still using street drugs but no obvious effect on mental state at that time. Taking Flupentixol Decanoate 100mg every 2 weeks and procyclidine 5mg daily.

04.11.03 Ms PG and Care Co-ordinator attended a meeting at St Mungo's Housing Association. Following the interview a letter said they were unable to offer Ms PG a place because they felt Ms PG was "insufficiently motivated with regards to her own personal development".

28.11.03 Record of a CPA meeting on the 21.11.2003 attended by Ms PG, her mother, Care Co-ordinator, consultant for SE Team. Plan for her to be seen every 2 weeks by care co-ordinator and by the consultant at 6 monthly CPAs or earlier if required. Contingency plan if mental health deteriorates includes increasing frequency of contact with professionals and liaison with mother. Should Ms PG miss a depot to be invited to attend next day or visit within 2 days.

28.11.2003 Summary by Care Co-ordinator, which indicates that Ms PG's mental health is settled at the moment, is on Flupentixol Decanoate 100mg every 2 weeks and is still using street drugs. History of verbal and physical aggression is noted in risk section, as is the fact that she is on probation until March 2004.

05.12.03 Handwritten application for Ms PG to become a member of Mosaic Clubhouse. Does not have a GP at this point. Her submission says "I get schizophrenia, I hear voices, I get dizzy spells." I want to get computer experience." The Care Co-ordinator encloses risk assessment and some further details.

17.02.04 Letter from Care Co-ordinator SE Team to SW CMHT requesting transfer of care to SW Team because Ms PG has been living in that area for approximately 6 months. Enclosed were summary documents including risk assessment (from 01.12.03), risk factors and summary of forensic history.

02.04 .04 Report from consultant SE Team to Camberwell Magistrates Court regarding two charges of theft. Gives brief past psychiatric history and forensic history. Recommends that if a probation order

is being considered then an attached condition of treatment should be considered.

02.04.04 Copy of an email from housing department in Lambeth to South East Team Care Co-ordinator about the difficulty in placing MS PG because of her not wishing to reduce her drug intake. Recommends that she be referred to the advisory panel in social services.

27.08.04 to 22 .11.04 Series of letters between the two Teams about taking over or not taking over the care of Ms PG in the short term.

22.11.04 Letter from consultant SE Team to locum consultant SW Team expressing his dissatisfaction at the suggestion that the transfer of Ms PG's care will not take place until 3 months after an initial meeting.

15.12.04 Letter from consultant South East team to a Firm of solicitors confirming Ms PG is currently an inpatient under his care and subject to Section 3 of the MHA.

06.01.05 Entry in electronic record by the Care Co-ordinator. Made home visit because Ms PG had absconded from hospital. Plan was to take her to Team Base the following day to see consultant with a view to discharging Section 3 and for Ms PG to have the depot injection.

07.01.05 Entry in electronic record. Ms PG saw the consultant and was presumably discharged from Section 3, although this was not mentioned in the entry. Plans for a transfer CPA with SW Team.

25.01.05 Ms PG overdue her depot injection, she spoke on the phone with her Care Co-ordinator who asked her to come to Team Base. CPA handover meeting arranged for 31.01.05.

26.01.05 Home visit by Care Co-ordinator to take Ms PG to court but not in. Court case postponed until 20.02.05.

28.01.05 Ms PG attended Team Base requesting Depot and tablet medication, which was provided.

31.01.05 Ms PG did not attend for her CPA rearranged for 22.02.05 at her home.

21.01.05 Phone calls from Ms PG's solicitor. She did not turn up for her court case and a warrant has been issued but the CPS are interested in dropping charges.

23.01.05 No mention of CPA on 22.02.05, but home visit from SE Team's Care Co-ordinator with member of SW Team. Ms PG not in, mother very apologetic. Professional's and mother went ahead

	with Transfer CPA.
31.03.05	Email from SW Team worker saying she will take over care from 04.04.05.
06.04.05	Telephone call between new Care-Co-ordinator SW Team and Ms PG's mother.
05.09.05	Home visit by Care Co-ordinator SW Team. Ms PG in low mood has been using Crack again and asking for help to stop.
12.10.05	Attended one hour early for her CPA Review and her first meeting with her new consultant, but left after 45 minutes without seeing him.
24.10.05	Attended Centre for depot injection. Asked when she can be seen by the new RMO.
04.11.05	Ms PG has stopped taking oral antipsychotic Flupentixol Decanoate and Care Co-ordinator stopped prescription. Should be seeing new consultant on 21.11.05.
21.11.05	Ms PG seen by new consultant for first time. In view of stopping oral medication, depot dose was increased. Consultant decided Ms PG did not need ongoing outpatient reviews and he would see her at 6 monthly CPA meetings.
17.01.06	Ms PG attended Centre without an appointment to say that her mother was moving out. Told to go back to HPU and Care Co-ordinator offered to accompany her.
18.01.06	Entry in the electronic record suggests change of Care Co-ordinator, no indication as to whether Ms PG had been aware of this before.
Between 07.02.06 and 28.04.06	Ms PG was seen on 30 occasions. Of these she attended the Base 20 times. She failed to attend twice and was not in on 2 visits.
28.04.06	Attended CPA with mother, seen by one of the non-consultant doctors on the team. The Depot medication was probably reduced again at this meeting because of side effects but not mentioned in the electronic record.
Between 09.05.06 And 15.08.06	Ms PG was seen on 14 occasions, 12 of them at the Base. She was late on one occasion and did fail to attend an appointment with another organisation, but did not miss appointments with her Care Co-ordinator.
15.08.06	Attended Team Base requesting her medication and was seen by a member of the team but not her Care Co-ordinator. She was not

due the depot for another week but was talking of going to live in Florida. She also was behaving in a somewhat inappropriate way towards the male worker. She was told this was not acceptable and to come back on the 22.08.06.

23.08.05 Entry in the electronic record to say Ms PG has been implicated in a murder.

Forensic Chronology Appendix Three

List of offences from notes:

1985	Assaulted a schoolgirl she knew.
1992	Convicted of possessing Cocaine in Jamaica.
1994	Charged with deception.
1998	Assaulted a woman, hitting her with a 12 inch piece of wood. Also hit the arresting officer.
2000	Waved a knife in a dangerous way. Cut a man on his arm in the evening.
2002	Bit a police officer on the arm while being arrested on suspicion of stealing a mobile phone.
2002	In possession of a knife while soliciting.
2004	Charges of mobile phone theft and soliciting.