Niche PATIENT SAFETY

NHS England

An independent investigation into the care and treatment of a mental health service user (Mr I) in London

Author: Naomi Ibbs, Independent Investigator

First published: November 2015

Niche Patient Safety is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

Niche Patient Safety

Emerson House

Albert Street

Eccles

MANCHESTER

M30 0BG

Telephone: 0161 785 1001

Email: enquiries@nicheconsult.co.uk

Website: www.nichepatientsafety.co.uk

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Prepared by: Niche Patient Safety

Contents

1 Executive summary

1.1 NHS England, London commissioned Niche Patient Safety (Niche) to carry out an independent investigation into the care and treatment of a mental health service user (Mr I). Niche is a consultancy company specialising in patient safety investigations and reviews. The terms of reference are at Appendix A.

1.2 The independent investigation follows guidance published by the Department of Health in HSG (94) 27, on the discharge of mentally disordered people, their continuing care in the community and the updated paragraphs 33-36 issued in June 2005.

1.3 The main purpose of an independent investigation is to identify whether there were any aspects of the care that could have altered or prevented the incident. The investigation process will also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

1.4 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.

1.5 It is common practice not to use the victim's name in reports such as this, however this is not always acceptable to victims' families. It was the family's express wish that we use Mr Hamilton's name throughout this report. We would like to express our sincere condolences to Mr Hamilton's family.

Mr I's mental health history

1.6 Mr I had a history of substance misuse, regularly using heroin, crack cocaine and intravenous drugs. Mr I was prescribed methadone prior to the offence and had been in contact with two substance misuse services in the preceding year.

1.7 Mr I had had little contact with mental health services prior to the index offence. He had been receiving treatment from Turning Point substance misuse services since July 2009. In September 2010 Mr I disclosed to his substance misuse worker Ms J that he had attempted suicide by cutting his wrist and confirmed that his intention was to end his life.

1.8 Ms J wrote to Mr I's GP, Dr H and asked that Mr I be referred for psychiatric assessment. Mr I was assessed by the Primary Care Liaison Nurse Ms B1 and was then referred to the Early Interventions Team at Central & North West London NHS Foundation Trust in October 2010. Clinical staff from the Early Interventions Team saw Mr I for assessment on seven occasions over a 21-month period. There were a significant number of attempts by staff to engage with him,

which were unsuccessful, as Mr I did not respond to telephone or text messages. He also told support staff at his hostels and at Turning Point that he didn't want further contact with the Early Interventions Team.

Accommodation

1.9 Mr I was homeless and had been living on the streets or in hostel accommodation for some time. In July 2009 Mr I was living at St George's Hostel, provided by Riverside ECHG and in August 2011 he moved into Shirland Road hostel, provided by Broadway where he met Mr Hamilton, who moved in to Shirland Road hostel in October 2011.

Relationship to the victim

1.10 As stated in above, Mr I and Mr Hamilton met one another when Mr Hamilton moved into the Shirland Road hostel in October 2011. Mr Hamilton was one of two other residents who shared a flat with Mr I. Mr I reported to the police that he and Mr Hamilton "*used to smoke drugs together*" and that as Mr Hamilton didn't know any local dealers, Mr I "*would get his drugs for him"*.

Offence

1.11 On 9 April 2012 Mr Hamilton was found dead in his flat in Shirland Road, Maida Vale, London. Mr Hamilton had suffered a number of wounds inflicted by a long bladed knife or sword.

1.12 The police report states that it is believed that Mr Hamilton was killed between 27 and 29 March 2012 and that it is further believed that Mr I tortured Mr Hamilton to obtain his PIN number. The last time Mr Hamilton was seen to leave the hostel where he lived was on 27 March 2012.

Sentence

1.13 In 2013 Mr I was sentenced to 30 years imprisonment after he was found guilty of the murder of Mr Hamilton. In sentencing the judge said:

"*You inflicted 17 wounds and the most serious was delivered specifically with the intent to sever the spinal cord to cause paralysis and death, exactly as you had seen on a DVD. Whether or not that was Saw 6, found by the police in your room, or another in the series does not matter. Plainly it was something specific you had seen and tried to imitate*." [1]

[1] *The Law Pages*

Internal Investigations

1.14 Central & North West London NHS Foundation Trust ('the Trust' – hereafter and Broadway (the hostel provider) undertook internal investigations that have been reviewed by the investigation team.

1.15 An experienced investigator, external to the Trust, led the internal investigation for the organisation, with input on the panel from senior Trust employees.

Independent investigation

1.16 This independent investigation has drawn upon the internal process and has studied clinical information, witness statements, interview transcripts and policies. The team has also interviewed clinical staff who had been in contact with Mr I or who had attempted to meet with him. We were unable to interview any staff from the hostel provider.

Conclusions

1.17 It is our view that this tragic homicide could not have been predicted or prevented. We do consider however, that hostel staff could have predicted a further assault by Mr I on one or more of the residents at Shirland Road.

Recommendations

1.18 The independent investigation supports the recommendations made by the Trust internal investigation team, and has not repeated them. The recommendations from our independent investigation focus on the improvements that we consider should be made across the system to ensure that the most vulnerable individuals in the homeless and hostel community are appropriately supported and kept safe.

1.19 There is compelling evidence that the hostel staff were aware of the concerns raised about the risk posed by Mr I in the fortnight prior to the homicide of Mr Hamilton, but no information was shared with mental health services until after Mr Hamilton's death. It is essential that all parts of the care and support system know how to escalate and share concerns when individuals are at risk.

Recommendation 1
Commissioners of care and support services must ensure that all providers are clear about their responsibilities for escalating concerns about the safety of vulnerable adults in institutional settings and for sharing appropriate information between agencies supporting individuals.

Recommendation 2
Commissioners of care and support services must ensure that when a serious incident occurs robust internal investigations are undertaken by providers and that learning is shared across all services.

Recommendation 3
The Trust must review the Early Intervention Team Operational Policy to clarify the meaning of 'red zone' and 'amber zone' clients, including how the zones are categorised.

Recommendation 4
When multiple agencies are involved in the care and support of an individual, a shared care plan must be in place that details the individual's history, risks, crisis interventions and escalation plans.

Recommendation 5
The Health and Wellbeing Board should receive this report to aid improvements in system integration and transformation.

Recommendation 6
The Trust must ensure that a systematic process is in place to monitor compliance with key policies and that regular audits are undertaken.

Recommendation 7
Commissioners of care and support services should ensure that service providers have an appropriate policy to record welfare checks. The policy should include clarity about the purpose, content and interval of those welfare checks, it should also be clear about the escalation process once the maximum interval has been reached.

Recommendation 8
Providers of substance misuse services should identify and agree a system of sharing risk information about clients who move between service providers, whilst adhering to patient confidentiality.

Good Practice

1.20 We found that there was evidence of notable good practice, which we wish to highlight in this report.

1.21 When Mr I reported his self harm to his substance misuse support worker Ms J she took his report seriously. Ms J wrote a comprehensive letter to Mr I's GP, Dr H and supported Mr I to access the appointments provided by the primary care liaison nurse and Early Intervention Team.

2 Offence

2.1 On 9 April 2012 Mr Hamilton was found dead in his flat in Shirland Road, Maida Vale, London by Mr I and other residents of the hostel. Mr Hamilton had suffered a number of wounds inflicted by a long bladed knife or sword. [2]

2.2 Police initially questioned Mr I and other residents of the hostel on 10 April 2012.

2.3 Investigations undertaken by the Metropolitan Police indicated that Mr Hamilton was killed between 27 March and 29 March 2012. Mr Hamilton was last seen entering the hostel on CCTV on 27 March having been out to collect his methadone and is not seen to leave the address again. Mr Hamilton failed to collect his methadone prescription left for him on 29 March; this was described as out of character for him.

2.4 CCTV showed Mr I moving around in the early hours on 29 March shortly after activity in Mr Hamilton's flat, which caused Mr Hamilton's net curtains to move for about 20 seconds. During the afternoon of 29 March Mr I is seen placing a number of items, including what is believed to be clothing, into the bins at the front of the hostel address.

2.5 CCTV at the bank showed Mr I using the cash machine on 8 April 2012 to withdraw money from Mr Hamilton's bank account after the period that the police believe Mr Hamilton was killed.

2.6 On 19 July the police re-interviewed Mr I and then charged him with the murder of Mr Hamilton.

Sentence

2.7 In 2013 Mr I was sentenced to 30 years imprisonment after he was found guilty of the murder of Mr Hamilton. In sentencing the judge said:

"*You inflicted 17 wounds and the most serious was delivered specifically with the intent to sever the spinal cord to cause paralysis and death, exactly as you had seen on a DVD. Whether or not that was Saw 6, found by the police in your room, or another in the series does not matter. Plainly it was something specific you had seen and tried to imitate.*"

[2] *Metropolitan Police Homicide and Serious Crime Command, Case Summary*

3 Independent investigation

Approach to the investigation

3.1 The independent investigation follows the Department of Health guidance (94) 27[3], on the discharge of mentally disordered people and their continuing care in the community, and updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in Appendix A.

3.2 The main purpose of an independent investigation is to discover whether there were any aspects of the care, which could have altered or prevented the incident. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

3.3 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning.

3.4 The investigation was carried out by Naomi Ibbs, Independent Investigator for Niche, with expert advice provided by Dr Ian Cumming. The investigation team will be referred to in the first person plural in the report.

3.5 The report was peer reviewed by Carol Rooney, Senior Investigations Manager, Niche.

3.6 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance[4].

3.7 We used information from Mr I's clinical records provided by the Trust, Turning Point, Westminster Drugs Project, Imperial College Healthcare NHS Trust, and the two GP surgeries where Mr I had been registered since 2010. We also used information from the two hostel providers, Broadway (now known as St Mungo's Broadway) and Riverside English Churches Housing Group (ECHG), and evidence gathered from the internal investigation reports conducted by the Trust and Broadway.

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[3] *Department of Health (1994) HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care, amended by Department of Health (2005) - Independent Investigation of Adverse Events in Mental Health Services*

[4] *National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

3.8 As part of our investigation we interviewed:

- the Trust Early Intervention Team consultant psychiatrist;
- the Trust Court Diversion Team manager.

3.9 These interviews were recorded and transcribed. The transcripts were returned to the interviewees for corrections and signature.

3.10 We were unable to interview Mr I's care co-ordinator as she had left the Trust and did not respond to our requests for interview. Another member of staff provided us with written responses to our questions.

3.11 It took considerable time to receive the information requested from St Mungo's Broadway (the new name for the hostel provider where the offence took place). We received an initial response within four weeks, however the remaining information was not received until twelve weeks after our request. We were unable to interview the only member of their staff who remains in post as we were advised this would have caused this person undue distress.

3.12 We wrote to Mr I at the start of the investigation, explained the purpose of the investigation and asked to meet him. Mr I gave written consent for us to access his medical and other records. We met with Mr I in prison and offered him the opportunity to meet with us again to discuss the report prior to publication. Mr I said that he did not want us to return prior to the report being published.

3.13 We asked Mr I if he would like us to make contact with any member of his family. He said he did not wish for us to do so.

3.14 The victim's sister was identified as the point of contact for the victim's family. We met with her at the start of the investigation, explained the purpose of the investigation and offered to meet with her to share the report prior to publication. It was her express wish that we refer to her brother as Mr Hamilton throughout our report.

3.15 A full list of all documents we referenced is at Appendix B.

3.16 The draft report was shared with the Trust, St Mungo's Broadway, Turning Point and NHS England prior to publication. This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed to review and comment upon the content.

Structure of the report

3.17 Section 4 provides background information about Mr I; childhood, training and employment and relationships.

3.18 Section 5 sets out the details of the care and treatment provided to Mr I. There are a number of clinical and support staff who were involved with Mr I during the period relevant to the investigation. We have provided a summary of the roles at Appendix C and have included a full chronology of his care at Appendix D in order to provide the context in which he was known to services in London.

3.19 Section 6 examines the issues arising from the care and treatment provided to Mr I and includes comment and analysis.

3.20 Section 7 provides a review of the internal investigations undertaken by the Trust and Broadway, and reports on the progress made in addressing the organisational and operational matters identified.

3.21 Section 8 sets out our overall analysis and recommendations.

4 The care and treatment of Mr I

Childhood and family background

4.1 Little is known about Mr I's childhood and family background. In an earlier letter from the Trust to Mr I's GP dated 9 January 2008 the doctor recorded that Mr I did not want to discuss his personal history. This letter followed an appointment at the Trust's substance misuse rapid access service in Soho where Mr I had attended after he had stopped collecting his methadone and attending appointments.

4.2 In a Trust assessment dated October 2010 it is reported that:

"*Mr I was born in Stanwell, Middlesex and that he had a difficult childhood. His parents separated when he was young and it is noted that previous reports suggest that his mother favoured his younger sister because she was more academic.*"

4.3 In the same assessment, it is also reported that:

"*Mr I had a difficult relationship with his mother and sister and consequently was brought up between his mother and grandmother. He lived with his father in his early teens however his father was physically abusive towards him and as such was removed by social services and returned to live with his mother.*"

"*Mr I was excluded from school when he was 15 years old and attended the GAP project at Kingston College. However he left without gaining any qualifications and described himself as never being academic.*"

4.4 When we met with Mr I in December 2014 we asked about his family background. Mr I told us that he had an "*okay childhood*" that he was never in care, there was no abuse and no family violence. Mr I also told us that he had no problems at school and was never suspended or expelled. We asked Mr I if he had any plans for his life when he was at school; he told us that he did not and that he started "*smoking weed*" aged 13 or 14.

Training and employment

4.5 Mr I told an Early Interventions Team worker in 2010 that he had had a few jobs including "*dustman, aquatics and in a supermarket*" totalling about 18 months of employment between the ages of 16 and 19. Mr I also reported that he was unemployed at the time (November 2010) but that he worked unofficially for the Big Issue. Mr I was in receipt of unemployment and support benefits at the time.

Relationships

4.6 Mr I had a girlfriend in November 2010 whom he had met the week prior to the assessment in which it was reported. At the time Mr I reported that he had no close friends, that his friends in the hostel were transient and that he wanted to have closer relationships.

4.7 No other relationships have been documented.

4.8 When we met with Mr I we asked him about relationships. He told us that he had no significant relationships although there were some people in prison he felt able to trust and that he had some contact with his family by letter.

Relationship with the victim and other hostel residents

4.9 Mr I and Mr Hamilton met one another when Mr Hamilton moved into the Shirland Road hostel in October 2011. Mr Hamilton was one of two other residents who shared a flat with Mr I.

4.10 Mr I reported to the police during his interview on 10 April 2012 that he and Mr Hamilton "*used to smoke drugs together*" and that as Mr Hamilton didn't know any local dealers, Mr I "*would get his drugs for him"*. Mr I also told the police that he hadn't seen Mr Hamilton for five weeks and that the last time he had seen Mr Hamilton was when they went to the post office to collect their benefits. Mr I reported that Mr Hamilton would often not leave his room but sometimes would use the communal kitchen to cook.

4.11 During this same interview Mr I told the police that Mr Hamilton had a lot of money and would give his bank card to people and ask them to withdraw money and "*score drugs*" for him. Mr I also said that Mr Hamilton would lend people money and that they would not repay him, which would lead to arguments.

4.12 Mr I told police that Mr Hamilton was 45 years old, suffered mental illness and was on a methadone prescription. Mr I said that Mr Hamilton was in receipt of disability living allowance, (£250 every four weeks) and had an army pension of £230 every week. Police enquiries found that Mr Hamilton was receiving £197.20 per month from disability living allowance and £272.48 every fortnight for income support allowance. This was notably more income that Mr I was receiving (£174.22 per fortnight).

4.13 During the police investigation Mr B (resident of Flat B) reported that the rumour circulating in the hostel was that Mr I was taking money from Mr Hamilton and bullying him. Mr B told police that he was so disturbed by the rumours that he told his key worker Ms B3 (the same key worker as for Mr I) what he had heard.

4.14 During the police investigation Mr C (resident of Flat C) reported that he had first met Mr I in a hostel in Victoria, at a time when Mr C described Mr I as a bully. Mr C had also met Mr Hamilton prior to moving into Shirland Road hostel and would occasionally go to Mr Hamilton's room for a chat. As Mr I's room was opposite Mr Hamilton's room, Mr C would also talk to Mr I. Mr C was aware that Mr I and Mr Hamilton had an arrangement that whenever one of them was paid they would take it in turns to buy each other drugs. Mr C recalled one occasion when he accompanied Mr I and Mr Hamilton to "*score some drugs*" when Mr I punched Mr Hamilton in the head. Mr Hamilton fell to the floor, hitting his head on a fence on the way. Mr C asked Mr I why he hit Mr Hamilton. Mr I replied that it was "*because he was sick of Mr Hamilton's attitude*".

4.15 Mr C also told police that the day after Mr I had punched Mr Hamilton, Mr I had punched Mr C in the back of the head, accusing him of stealing his SIM. Later that evening Mr I came to Mr C's room and banged on his door. Mr C opened the door to find Mr I holding a bag in one hand and a large meat knife in the other. Mr C said that he just shut the door. Mr C told police that after this he tried to stay out of Mr I's way and told staff at the hostel that he feared for his life. He also stopped visiting Mr Hamilton for fear of bumping into Mr I.

5 Chronology

Adolescence

5.1 The internal investigation report identified that Mr I was excluded from school for threatening a teacher. Mr I subsequently attended an assessment at Ashford Hospital where it was found that he had signs of self-harm and his mother was reported to have had concerns that he was taking illicit drugs.

5.2 We have not found this information in any records that have been made available to us. Therefore we are unable to ascertain what action was taken following this assessment, including whether Mr I was referred to mental health or substance misuse services for treatment.

2007/8

5.3 Mr I had been on a 40ml methadone prescription to be taken daily. Mr I reported to a psychiatrist working in the Soho substance misuse service that in December 2007 he had also been using crack cocaine and had been injecting almost daily. There are no details regarding what Mr I had been injecting.

5.4 Following this assessment appointment the doctor recorded that she found no evidence of formal thought disorder and recorded diagnoses of mental and behavioural disorders due to the use of opiates and cocaine.

2009

5.5 In December 2009 Mr I was seen by the hepatology clinical nurse specialist at Imperial College London. Mr I was diagnosed with hepatitis C and it was recorded that he required a course of anti-viral treatment lasting 48 weeks. It was noted by the hepatology clinical nurse specialist that the side effects of the treatment could result in patients not completing treatment. Therefore to maximise patients' chances of completing treatment it was recorded that the hepatology clinical nurse specialist would refer Mr I to the psychiatric team on the hepatology unit. The adverse effects of treatment were noted as

- irritability;
- emotional disturbances;
- mood swings;
- depression.

5.6 Mr I was offered an appointment with psychiatry on 28 February 2010. We have not been able to identify if Mr I attended that appointment or whether any treatment was provided.

2010

5.7 In March 2010 Mr I started anti-viral treatment for hepatitis C and reported side effects after treatment in weeks one and two. The side effects were noted as:

- raised temperature, headache and flu-like symptoms;
- apathy and lethargy.

5.8 On 19 March Mr I had an "*accidental overdose*" of methadone, he was admitted to St Thomas' Hospital, treated and was discharged two days later.

5.9 Mr I was subsequently seen by the hepatology clinical nurse specialist on 23 and 30 March to monitor his presentation and to check his bloods.

5.10 Mr I attended nine times up to week 20 for the effect of his treatment. He was often rude and argumentative and one female nurse recorded that she felt very uncomfortable seeing him and had kept her clinic door open during the consultation. Mr I stopped attending at week 24 (mid August 2010) and failed to attend appointments offered on 24 August, 25 August and 19 September.

5.11 Mr I eventually attended an appointment on 10 October but did not attend any further appointments.

5.12 In September 2010 Mr I reported to his Turning Point key worker, Ms J, that he had recently relapsed on both crack and heroin and that he was experiencing suicidal thoughts.

5.13 Mr I told Ms J that he had attempted suicide on 28 September 2010 by cutting his arm from the centre of his wrist down into his arm. Mr I told Ms J that he had cut himself with the intention of ending his life. He said that he had attended hospital to have the wound treated and that whilst he was there he had been offered a psychiatric assessment but had refused.

5.14 In October 2010 his GP, Dr H and his Turning Point key worker Ms J referred Mr I to the community mental health team. It was reported that he had presented with symptoms of depression "*since aged 16*" and that the depressive symptoms deteriorated in February 2009 when he stopped taking interferon. Mr I was assessed by Ms B1 a Primary Care Liaison Nurse, on 25 October 2010 with his Turning Point key worker present. Mr I reported that for the previous four months he had been guided by good spirits, but that latterly they had "*become derogatory*

and were misguiding him". Mr I was keen to point out that he was not mentally unwell but asked to see a psychiatrist and stated that he would be willing to try antipsychotic medication.

5.15 Mr I's case was subsequently discussed at the community mental health team meeting when it was recommended that he be referred to the early intervention team run by Central & North West London NHS Foundation Trust. Mr I was contacted and informed of the recommendation and agreed to the referral. The community mental health team concluded that the primary care liaison nurse Ms B1 should make the referral.

5.16 On 11 November 2010 primary care liaison nurse Ms B1 sent Mr I's referral to the early intervention team. Accompanying the referral was a letter from Turning Point to Mr I's GP, Dr H, in which there was a request for Dr H to make a referral for psychiatric assessment.

5.17 On 17 November 2010 Mr I, accompanied by his key worker Ms J from Turning Point, attended an appointment with primary care liaison nurse Ms B1. Mr I reported that things had improved and attributed the change to a new relationship with a girl he had met five days previously. Mr I admitted spending a lot of time with the girl in the previous week and consuming excessive amounts of alcohol. He also reported that consequently he had not been attending the drug project as regularly as he should have been. Mr I reported that he had cut his wrists two weeks prior to the appointment and that he was glad he had not fatally injured himself. The referral to the early intervention team was discussed with Mr I, and he said that he was happy to meet with them despite the fact that he didn't feel he was mentally unwell.

5.18 On 23 November 2010 Mr I attended an assessment with an occupational therapist Ms S from the early intervention team. Mr I described his mood as low but said that he didn't have a mental illness. Mr I was seen by the consultant psychiatrist Dr G who felt that there was some diagnostic uncertainty; it was noted that Mr I was anxious to avoid a diagnosis of mental illness.

5.19 On 29 November Ms S left a message for Mr I at the King George's hostel regarding his appointment that day. Mr I later failed to attend the appointment.

5.20 Mr I was originally supported by Ms J, but in November 2010 Ms B2 started taking over Mr I's care as Ms J was going on maternity leave. In December 2010 a referral was made for Mr I to be considered for Tier 4 detoxification and rehabilitation[5]. We can find no evidence of who received this referral or what the outcome was.

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[5] *The National Treatment Agency defined Tier 4 (inpatient and residential rehabilitation services) in the document Improving services for substance misuse: Joint Service Review published in January 2009. The relevant extract of the definition can be found at Appendix E.*

5.21 On 7 December Ms S left a message for Mr I at the King George's hostel regarding his appointment that day. Again Mr I later failed to attend the appointment.

5.22 Mr I eventually attended an appointment on 24 December 2010 with Dr G, accompanied by his new Turning Point key worker Ms B2. Dr G noted that the referral to the early interventions service was prompted by concerns about Mr I's spiritual belief system and his reports of hearing voices. It was recorded that Mr I explained that he was not suffering from mental illness and that his difficulties related to anger, depression and frustration. It was also recorded that he was "adamantly against' psychiatric medication but felt that psychological therapy may help him offload and develop mental techniques to cope with his difficulties. At this time the plan was to offer Mr I a three-month extended assessment during which time he would be allocated to a care co-ordinator and occasionally seen by a doctor.

5.23 When we interviewed Dr R from the Early Intervention Team, she told us that Dr G was a locum covering her maternity leave. Dr R told us that the decision to offer a three-month extended assessment was taken solely by Dr G and that no similar decisions were made prior to, or since, Dr R's maternity leave. We have also confirmed that the decision was not in line with Trust policy.

2011

5.24 On 24 January 2011 Mr I attended an appointment with his new care co-ordinator, an occupational therapist, Ms P. Mr I openly discussed his self-harm and suicide attempts, acknowledged that his spirit experiences were "*outside the norm*" and stated that he felt he had to prove that he wasn't psychotic. Mr I also declined any medication.

5.25 On 27 January Mr I's case was discussed in the clinical review meeting when it was noted that he was "*moved down into amber zone"*[6]. We were told that patients who are at high risk are managed as red zone clients, which means that they are discussed every day. Dr R told us that some teams across the Trust use the principle of zoning clients, but that each team uses zoning in a different way appropriate to the complexity of clients they work with. Dr R told us that there are zoning guidelines in place for her Early Intervention Team. The zoning guidelines state that clients in the amber zone may present with high levels of need but without major risk factors.

5.26 In January 2011 Ms B2 met with Mr I and his hostel support worker Mr R as Mr I wanted to move on from the King George hostel to a hostel

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[6] *Zoning and Handover Guidelines provided by the Trust indicate that the amber zone is used for clients who "may present with high levels of need, but without major risk factors. Examples could be clients who continue to present high levels of need without presenting with major risks or safety concerns, or clients who are unwell but engaged with care".*

where there was more emphasis on training and employment. Ms B2 also supported Mr I to complete his CV and recorded that Mr I felt happier now that he "*had some things to work towards*". Ms B2 also recorded that Mr I had told her that "*he was not sure about the mental health service now that he has other things to keep him busy*" and asked Ms B2 not to chase them [for follow up contact].

5.27 In February 2011 Mr I reported to Ms B2 that he had attended his appointment with the Early Interventions Team and that he felt attending the sessions was helpful. Ms B2 recorded that Mr I had not used [drugs] in 13 weeks and was feeling the benefit of it.

5.28 Also in February Mr I started attending Narcotics Anonymous and reported that he found them quite useful but wished that people were more positive. Mr I attended a few sessions before requesting a support session with Ms B2 when he reported that he had found the previous evening's Narcotics Anonymous session very annoying, as everyone had been very negative. Mr I said that he wanted to be around positive people and Ms B2 agreed that he should not attend if he was not finding it beneficial.

5.29 In February Mr I met with his care co-ordinator, Ms P, twice, once at the early intervention team base and once in a coffee shop. At the first meeting Mr I brought several spiritual/psychic books with him, as Ms P had suggested, so that Ms P could understand Mr I's experiences in greater detail. At the second meeting Mr I initially presented as warm and friendly but became irritated and suspicious when Ms P started "*covering old ground*" and accused Ms P of trying to "*trip him up*". Mr I said that he felt that the early intervention team were unable to offer him any input of value as he felt he did not have a psychotic illness.

5.30 Mr I told Ms B2 that he had attended his appointment with the Early Interventions Team and that he "*felt he was trying to convince them all the time that he was not mentally unstable anymore*". Ms B2 recorded that Mr I said that he "*felt that now he had stopped using substances for some time and had positive things in his life, he didn't need the support of mental health services as he had previously*".

5.31 In March Ms B2 had a discussion with the resettlement worker about Mr I's suitability for independent housing. Ms B2 recorded that he felt he was suitable as he was not using substances, was attending Fairbridge[7] daily, actively looking for employment and training in the future, more stable in his mental health and able to ask for support when he needed it.

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[7] *The Fairbridge Programme is an individually tailored personal development programme for young people aged between 13 and 25. It combines one-to-one support and group activities, delivered by a team in Prince's Trust Centres.*

5.32 In late March Ms B2 recorded that Mr I had been selected [from a group of volunteers at Fairbridge] to go on a boat trip around Scotland and was very pleased and excited about it. Mr I reported that he felt very positive about the future and asked Ms B2 to attend his graduation ceremony from Fairbridge.

5.33 In March Mr I said that he was not available for appointments with his care co-ordinator as he was busy with a college course. Ms P asked if he would be free for a brief meeting but Mr I said that she should call first. Ms P tried to make contact but Mr I either did not respond or said that he was not available. On 18 March a letter was sent to Mr I inviting him to a medication review on 29 March. On the same day a discussion was held with Ms B2, Mr I's project worker from Turning Point. Ms B2 said that she felt Mr I was stable and expressed uncertainty about whether Mr I had experienced psychotic symptoms and reported that Mr I had told her he did not need such a high level of support for his mental health.

5.34 On 29 March Mr I attended the medication review with Dr R. Mr I was initially reluctant to talk and said that he didn't want to see the team any more. Dr R had noted that Mr I's presentation was unkempt but that he had good eye contact and despite some "*tangential thinking*" he was clearly not thought disordered. Dr R felt that the diagnosis at that point was unclear and planned to meet again in one month.

5.35 Mr I also reported to his Turning Point support worker Ms B2 that he had a discharge appointment with the Early Intervention Team on 29 March and that he was not keen to go as he felt that he did not need to attend. Ms B2 encouraged Mr I to attend the appointment, as "*it would be good to get a proper discharge*".

5.36 In April Ms B2 called Mr I to see how he was getting on. Mr I reported that he had completed all the modules for his gardening course and was attending college three times a week. The same month Ms P recorded that she found it difficult to engage with Mr I and that it had been agreed that he would be referred for psychological assessment.

5.37 In May 2011 Ms P sent several texts and left several messages for Mr I, on five different days asking him to contact her to confirm a time for a Care Programme Approach[8] meeting. Calls were also placed to the hostel and messages left with hostel staff. On one occasion the member of staff from the hostel with whom Ms P spoke reported that "*there were no concerns about Mr I and that he was currently very stable*". On a later occasion the member of staff from the hostel with whom Ms P spoke reported that "*Mr I continued to attend college but that staff had noticed a drop in his mood and he had become less communicative with [hostel] staff*". In late May Ms P wrote to Mr I, as

[8] *Care Programme Approach is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. www.nhs.uk*

he had not returned her calls or text messages. Ms P invited Mr I to a meeting on 3 June and suggested that he choose the venue. There is no evidence that Ms P received a response to this letter.

5.38 In June Mr I was assessed by Turning Point when he presented saying that he had relapsed after four or five months of abstinence. Mr I reported that he was on 10mg methadone (recently increased from 6mg methadone) and he was reminded of the overdose risk of injecting heroin and inhaling solvents. The frequency of the methadone dose was not recorded by the worker.

5.39 Mr I expressed concern that he was "*going downhill again*" and the worker on duty discussed options with Mr I. It was agreed that a "*detox and rehab*" process would be the most suitable for Mr I. Mr I subsequently attended a preparatory sessions and decided that the detox and rehab process was not appropriate for him at that time as he didn't want to work in a group setting. Mr I discussed his desire to move to independent living with the support worker on duty who expressed concern about the potential for Mr I to lose his tenancy if he were to be found using substances. Mr I said that he felt he had issues that he wanted to discuss and said that he wanted to see the Turning Point psychologist. Mr I's support worker Ms B2 made the referral and the psychologist indicated that he would be able to see Mr I in mid July. Ms B2 made several attempts to contact Mr I but was unable to do so as his phone was switched off.

5.40 In June 2011 Ms P discussed Mr I with the consultant psychologist Dr R who advised that Ms P write to Mr I inviting him to attend a Care Programme Approach meeting and to inform him if he didn't attend, the meeting would continue in his absence. Ms P followed Dr R's advice and informed Mr I that a Care Programme Approach meeting would be held on 5 July. Ms P also copied the letter to Ms B2, Mr I's project worker from Turning Point, asking that support be provided to Mr I to encourage him to attend the meeting.

5.41 Ms P wrote to Mr I's GP, Dr H, and asked him to provide some physical health screening information to form part of the information for Mr I's Care Programme Approach meeting.

5.42 In July Ms B2 reminded Mr I of his appointment with the Early Intervention Team via text message. She received a response from Mr I stating that he was not going to attend. Ms B2 tried to speak to Mr I but was unable to get an answer so responded via text stating that the clinical team needed to see Mr I if they were going to discharge him. She did not receive a response.

5.43 Ms B2 attended the Care Programme Approach meeting in early July and then called Mr I to give him some feedback. Ms B2 recorded that she told Mr I that the Early Intervention Team were not going to discharge Mr I and that they wanted to continue to work with him. Mr I told Ms B2 that "*they still think I'm psychotic so I'm not giving them the*

time of day". Ms B2 agreed that she would meet Mr I at his hostel to discuss it with him. Mr I agreed to this but when Ms B2 arrived he stated he was "*busy with other stuff*" and that he would see her another day.

5.44 Ms B2 met with Mr I a couple of days later when she told him that the Early Intervention Team were unsure whether he had experienced an episode of psychosis but that the psychologist "*wanted to support him with the issues that were troubling him ie family etc*". Mr I agreed to meet with the Early Intervention Team and then make a decision about whether he wanted to engage with them.

5.45 In mid July Ms P contacted Ms B2 to arrange to meet with her and Mr I as agreed at the Care Programme Approach meeting. Ms B2 indicated that Mr I was focussed on moving into shared accommodation but that she would try to encourage him to work with Ms P. Around this time Mr I reported that his substance misuse was decreasing again and that he was excited about the prospect of moving.

5.46 Ms B2 accompanied Mr I to his meeting with the Early Intervention Team and recorded that he engaged well during the meeting although he was defensive about his psychosis and spirituality but that he was happy he had attended. Ms B2 also recorded that she spoke about needing to transfer Mr I to another substance misuse service as his new accommodation was in a different area.

5.47 In August 2011 Mr I moved into a room at Shirland Road Hostel, run by Broadway. His support worker was Ms M.

5.48 On 31 August 2011 Mr I's case was closed with Turning Point, he was referred to the Westminster Drug Project for substance misuse support and treatment to be provided. Mr I failed to attend his first appointment, which resulted in his GP, Dr H, being asked to continue prescribing for him until his support worker Ms B4 returned from holiday in mid September.

5.49 Mr I attended the induction meeting at Westminster Drug Project at the end of August, but appeared to be under the influence of stimulants so was refused access.

5.50 In mid September 2011, before his support worker Ms B4 returned from holiday, Mr I attended the clinic to advise that he was planning to register with a different GP practice and be prescribed for his opiate dependence by the new GP.

5.51 On 23 September 2011 Mr I did not attend his appointment with the doctor at Westminster Drug Project. Ms B4 contacted Mr I to find out why and Mr I reported that he had registered with a new GP, Dr M, who would be treating him. Ms B4 called Mr I's shared care worker, Mr J, at Dr M's surgery. Mr J reported that he had tried to persuade Mr I to engage with Westminster Drug Project so that his mental health needs

could be addressed, but that Mr I was clear that he wanted to be treated by Dr M's service. Ms B4 then informed Mr I and Mr J that Mr I's case would be closed.

5.52 On 31 October 2011 an attempt was made by Ms J2 at the Westminster Drug Project to contact Mr I to find out if he wanted to re-engage with the service. There was no response. On 7 December Ms J2 spoke to Mr I who said that he had stopped coming to the service as he had relapsed, but he now wanted to start again. An appointment was booked for 12 December 2011 and on 4 December Mr I's case was allocated to Ms Z. The Westminster Drug Project records end there and therefore we must presume that Mr I never attended the appointment on 12 December.

5.53 In November 2011 Mr I's housing support worker Ms M recorded that he had not been engaging with any service and that he needed a lot of prompting to attend key work sessions. Mr I told Ms M that he would not be able to stay clean whilst living at Shirland Road and that Mr Hamilton had been "sorting him out on payday with gear". Ms M contacted Ms B2, Mr I's previous substance misuse support worker to discuss her concerns. Ms B2 told Ms M that Mr I's mental health could deteriorate when he was using and that he could get frustrated very easily. We can find no evidence that Ms M made any contact with the substance misuse worker supporting Mr I at that time, nor can we find evidence that Ms M contacted anyone from the Early Intervention Team.

5.54 We can find no evidence of any substitute prescribing for the period December 2011 to April 2012.

2012

5.55 In January Ms P contacted Mr I's housing support worker Ms M, as she had been unable to make contact with Mr I. Ms M advised that there were no concerns about Mr I's mental health. Ms P sent Ms M a copy of Mr I's care plan. Later in the month Mr I reported to Ms M that he felt good and was continuing to reduce his use of drugs.

5.56 On 15 March an incident report was completed by staff at Broadway Housing after one of the residents reported that Mr I had been threatening other residents. This resident also reported that Mr I had assaulted a resident few weeks previously but that the victim had been too afraid to report it. The reporting resident said that he didn't want his name mentioned by said that Mr I was "*not right at the moment, and is dangerous*". The resident also said that "*someone in the house was going to get hurt, either someone will attack Mr I, or he will harm someone first*". The hostel records stated that the police were not called by staff at this point and that advice was given to the reporting resident to "*contact police* [himself] *if he was concerned for his or other residents' safety*".

5.57 The following week, staff did contact police. A later entry in the hostel records states that two residents who had been assaulted by Mr I were unwilling to speak to the police or "*go on records about the allegations*". The entry goes on to state that Mr S and Ms B4 "*have contacted the police and intend to speak with them and give statements based on what we have been told by residents*".

5.58 On 22 March police took a statement from Ms B4 regarding the forced entry of the front door of the hostel, suspected to have taken place on 15 March. The police advised that they would not be able to take action "*unless they receive a witness statement, CCTV evidence, or tenants contact the police calling 999 (should another incident occur).*"

5.59 On 29 March Ms P discussed Mr I during a supervision session with Dr R. Ms P and Dr R agreed that they would attempt an unannounced home visit and that Ms P would call Mr I's support worker to find out his daily movements. Ms P called the hostel the same day but received no reply and left a message on the answer machine.

5.60 On 5 April 2012 hostel support worker Ms B4 informed Ms P that there were concerns about Mr I being threatening and aggressive towards fellow residents. Ms P recorded that Ms B3 reported concerns about Mr I becoming threatening and aggressive towards fellow residents, that "*Mr I threatened to stab another tenant*" and that Mr I's drug use (particularly solvent abuse) had escalated. Ms B3 also told Ms P that she had entered Mr I's room to conduct a routine maintenance check and had seen a knife and hammer on the table. Ms B3 advised that she had not yet seen Mr I to discuss this with him. We know from the Broadway internal incident report that the discovery of the knife and hammer took place on 5 April. The same report states that "*Ms B3 is going on annual leave on Friday 6 April … all tenants have been informed and advised to call the police in the event of an emergency*". It is unclear from Broadway records how the all the tenants were informed, as we know that the homicide of Mr R had taken place by this time. We have since learned from the Executive Director at St Mungo's Broadway that "*it is common practice if a client is not in to slip a note under their door.*"

5.61 On 11 April Ms P called Ms B3 to arrange to visit Mr I and spoke with housing project manager Mr S. Mr S informed Ms P that there had been a "*serious incident*" over Easter, which resulted in Mr I being questioned by the police, and that Mr I was not allowed to return to the hostel. Ms P recorded that Mr S "*refused to provide further details*" other than he was in the process of sourcing alternative accommodation for Mr I who was at Holborn police station until an address could be found for him to be bailed to. We have since learned from the Director at St Mungo's Broadway that Mr S had been advised by the police not to provide further information at that point. However, it appears that at the time this reason was either not made clear to Ms P or not understood by Ms P.

5.62 Ms P then called Holborn police station to get more details and left a message for someone to call her. There is no indication that Ms P was able to establish why M was in Holborn police station.

5.63 On 12 April Mr I's case was discussed on the clinical review meeting and he was moved to the red zone. This meant that the team discussed Mr I's case on a daily basis as the risks had increased. A further call was placed to Holborn police station to ascertain Mr I's whereabouts but there was no response and Ms P left a further message for someone to call her.

5.64 On 16 April Ms P called the housing department who advised that Mr I had left the police station and that it was believed Mr I was in touch with Connections at St Martin's[9]. Ms A called Connections and spoke to Mr P who confirmed that he had seen Mr I several times over the weekend and that he had no concerns about his mental state. Mr P advised that he believed that Mr I was sleeping rough. Ms P advised Mr P to contact her if he had any concerns about Mr I.

5.65 On 17 April Ms P called the housing project manager Mr S who confirmed that Mr I had moved into Dean Street Hostel. Mr S reported that he had noticed no overt signs of mental ill health, but he had noted that Mr I's behaviour seemed odd (very calm) given the circumstances. Mr S said that Mr I had provided an explanation for having the knife (it was a kitchen knife) and the hammer (he was putting up pictures) in his room. Mr S reported that he had spoken with Mr I about the early interventions team and that Mr I was totally against any contact with the team, even by telephone. Ms P recorded that the plan was to discuss Mr I's case in the clinical review meeting and to attempt an unannounced home visit with Dr R.

5.66 On 27 April Turning Point records show that Mr I advised that he wanted to access substance misuse support from Turning Point again.

5.67 On 30 April Ms P recorded that she and Dr R would make an unannounced home visit to Mr I's new hostel in GCS on 2 May.

5.68 Dr R and Ms P continued to make numerous attempts to contact Mr I during the following weeks, including contacting a number of prison health services where they believed Mr I was being detained. None of their attempts resulted in successful contact with Mr I.

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[9] *The Connection at St Martin-in-the-Fields provides an integrated package of services which help people to cope with the physical crisis of being homeless, and address the underlying issues which may have caused the homelessness and/or arisen from it.*

Contact with criminal justice system

5.69 In addition to the conviction for the index offence, information provided by the Metropolitan Police shows that Mr I has 23 convictions relating to 33 offences committed between 2004 and 2013. Six of the offences were committed after the date range of the homicide prior to Mr I being charged with that offence.

5.70 Mr I had been given a custodial sentence on five occasions in addition to the custodial sentence for the index offence:

- 84 days in a young offenders' institution in 2005 for common assault;
- 16 weeks in a young offenders' institution in 2007 for supplying controlled drugs;
- 6 weeks' imprisonment in 2008 for handling stolen goods;
- 8 weeks' imprisonment in 2013 for common assault [offence committed in prison];
- 12 weeks' imprisonment in 2013 for battery [offence committed in prison].

5.71 Mr I had also been given a community drug treatment order[10] in May 2005.

[10] *A Community Drug Treatment Order is an order issued by the court that requires an individual to participate in a drug treatment programme.*

6 Arising issues, comment and analysis

6.1 There were a number of agencies involved in the care and treatment of Mr I during the period of time that his case was open to the Early Intervention Team (December 2010 to July 2012).

6.2 Communication between Mr I's substance misuse workers (Ms J and Ms B2) and his care co-ordinator Ms P was good. Mr I's disclosure to Ms J about his self harm in September 2010 was taken seriously and Ms J put her concerns in writing to Mr I's GP. Communication to Mr I's care co-ordinator from staff at the Shirland Road hostel was poor when there were concerns about Mr I's presentation.

6.3 The internal investigation found that the care co-ordinator who had been allocated to Mr I had little experience of working with clients with complex needs. We were not able to explore this with the care co-ordinator but it was a clear finding in the internal investigation.

Risk assessments

6.4 We can find only two Risk Screening Forms (RA1) completed by Central & North West London NHS Foundation Trust staff. Ms B, the primary care liaison nurse, completed the first Risk Screening Form in November 2010. Ms P completed the second Risk Screening Form in July 2011 at a time when she had not been able to contact Mr I for nearly five months. The document indicated that further assessments should have been completed for substance misuse and self-harm/suicide. We have not been able to find evidence that either of these were completed.

6.5 The risk assessment policy[11] in place at the time advises that for service users who have a history of substance misuse, full risk assessments are completed. The policy describes the relevance and importance of the additional risk assessments and specifically notes increased risk factors for self-harm/suicide at least two of which were relevant to Mr I.

6.6 The policy also states that a Risk Management Plan (RA3) should form part of the Care Programme Approach for the service user and that it must be directly informed by the preliminary and specific risk assessments. The document states: "*It* [Risk Management Plan] *must be completed for all service users*". We can find no evidence that a Risk Management Plan was ever completed for Mr I by Central & North West London NHS Foundation Trust staff.

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[11] *Central & North West London NHS Foundation Trust Clinical Risk Assessment and Management Policy and Adult Services Clinical Risk Assessment and Management Procedure, approved October 2008, reviewed December 2009.*

6.7 The policy further states that a Risk Event History (RA4) "*MUST* [sic] *be completed in all cases*". Again we can find no evidence that a Risk Event History was ever completed for Mr I by Central & North West London NHS Foundation Trust staff.

6.8 We have not seen any risk assessments completed by Turning Point. In the interview with the internal investigation team Ms B2 from Turning Point stated that she would see Mr I at his hostel rather than asking him to attend the Turning Point service so that she could see him more often. Ms B2 was asked about what consultant psychiatry input the Turning Point service could provide to Mr I. Ms B2 stated that as Mr I was "*linked in*" with the early interventions service it was felt that it would be better to keep the psychiatric link through that team, and that to provide the option for him to see a psychiatrist at Turning Point would provide him with too many options.

6.9 There is no evidence that this decision was reviewed when Ms B2 felt that Mr I became more unstable in October 2011 and was not engaging with the early intervention team. It was also at this time that the service providing Mr I's substance misuse support changed from Turning Point to Westminster Drugs Project as he had moved hostel.

6.10 On 15 March 2012, two weeks prior to the incident a resident at the hostel made a report to Broadway Housing staff that Mr I had been threatening residents, including the victim of the index offence, Mr Hamilton. The reporting resident had told hostel staff that Mr I was dangerous and expressed concern that someone in the property was going to get hurt. Hostel staff recorded that they were unable to speak to the alleged victim (Mr Hamilton) as he had not been at the property when they had visited. Hostel staff also recorded that Mr I's risk assessment would be reviewed if the alleged incidents were confirmed.

6.11 Mr S recorded that hostel staff were unable to take any action regarding the allegations as no resident would make a formal complaint to either Broadway staff or the police as the residents were fearful of the consequences. Mr S told the internal investigation team that residents said that even if Mr I was evicted from the hostel they would still feel vulnerable to him in the wider community.

6.12 We have seen no evidence that Mr I's risk assessment was reviewed, although the internal investigation undertaken by Broadway states that Mr I's risk was assessed as medium on 28 March 2012. The report conclusion indicates that this was considered to be inappropriate given the concerns raised and that Mr I's risk should have been updated to high.

6.13 Following the allegation made by a resident on 15 March Broadway staff were no longer able to visit to hostel alone and visits had to take place in pairs. This indicates that the organisation took the potential risk to staff seriously. However, this decision left the residents at

greater risk as, due to a short staffing issue, it became more difficult for staff to visit and support residents appropriately.

6.14 The internal investigation team was told by Mr S "*as soon as the reports from other residents had come in…we contacted the police, we endeavoured to contact the mental health services and did inform them of what was going on*".

6.15 We have found only one piece of evidence in the Trust records that Broadway staff shared concerns about Mr I's presentation with Ms P. This was on 5 April 2012, as a result of Ms B3 having seen a knife and hammer in Mr I's room, which in itself was three weeks after the resident's allegation of Mr I's threatening behaviour towards other residents. By the time the concerns about Mr I's behaviour were shared with Ms P the homicide of Mr Hamilton had already been committed.

6.16 Opportunities to review Mr I's risk were lost on two significant occasions:

- In June 2011 by Central & North West London NHS Foundation Trust staff at the point when Ms B2 told Ms P that Mr I had relapsed in June 2011;

- In March 2012 by Broadway Housing staff when a complaint was received about his behaviour towards other residents, which was not reported to mental health services for three weeks, by which time the homicide had been committed.

Care Programme Approach

6.17 An Adult Mental Health Core Assessment was completed by Ms S when Mr I was initially referred to the Early Intervention Team. Three copies of this document were provided to us by the Trust in Mr I's clinical records, all of which were dated 23 November 2010 and all were found to be identical. Section 1: Information Sharing was not completed and there was nothing entered in the section for Assessor's Summary and Immediate Action. This would have been the opportunity to identify any significant risks. The Outcomes section of the assessment was also not completed.

6.18 The Care Programme Approach Policy in place at the time identifies those professionals who should normally be invited to Care Programme Approach reviews and this includes the relevant GP. The policy indicates that invitations should be sent on the Trust template and should include a return form for those unable to attend to submit any information required.

6.19 Ms P wrote to Mr I's GP, Dr H on 13 June 2011 prior to the Care Programme Approach review meeting on 5 July. The letter is titled "*Request to share information*" and does not offer a specific invitation

for the GP to attend. It is not clear whether or not this was the Trust template in place at the time.

6.20 Given the lack of contact that Ms P and the rest of the early interventions team had had with Mr I, combined with the fact that Dr H was the prescriber for Mr I's methadone it would have been particularly useful for Dr H to have been specifically invited to the meeting. We can find no evidence in either Dr H's records or Central & North West London NHS Foundation Trust records of Dr H contributing any information to the meeting.

6.21 Ms P completed a Care and Support Plan on 5 July 2011 following the Care Programme Approach meeting. This was seven months after Mr I was first seen for assessment by the locum psychiatrist Dr G.

Lack of response and contact by Mr I

6.22 The Care Programme Approach Policy states that if contact with the service user has not been re-established, a Care Programme Approach review should be held to consider the options. This was done in July 2011.

6.23 The policy also states:

"*If contact with the service user cannot be re-established decisions should be based on the available evidence of need. They should not be discharged unless there is clear evidence they no longer need support from mental health services. This would normally require they have contact with another agency, such as a GP, who can assess their current levels of need. If there are continuing needs for secondary mental health service support they should be designated as out of contact and remain nominally linked with the care team to ensure there is some level of continuity if they are contacted successfully or re-referred*."

6.24 Ms P continued to make assertive efforts to contact Mr I after the Care Programme Approach meeting and subsequent meeting in the coffee shop with Ms J2 and Ms B2. We can find no evidence that this approach was discussed and agreed by the multi-disciplinary team.

Awareness of forensic history

6.25 There is no evidence in the records from Central & North West London NHS Foundation Trust or Turning Point records that staff were aware of Mr I's forensic history.

6.26 Broadway staff were aware of two prior offences: handling stolen goods; and offering to supply [drugs], however they had no knowledge of Mr I's conviction in 2008 for assault.

6.27 Had this information been shared with all agencies working with Mr I, and the information about concerns from other residents, been shared by hostel staff, a different opinion may have been reached about the level of risk that Mr I presented to others.

Follow up and transfer of care

6.28 We have seen no evidence of any handover documents between Turning Point and Westminster Drugs Project. The transfer took place at a time of heightened risk for Mr I as he had recently become unstable, had started injecting cocaine and inhaling solvents, and had moved hostel. A senior manager at Turning Point told us that Mr I's case with Turning Point was closed, rather than transferred, to Westminster Drugs Project. The same manager also told us that as Mr I's psychosocial support was voluntary, Mr I would have to have given consent for information to be passed to another agency. Mr I never engaged with Westminster Drugs Project and therefore the opportunity to seek his consent never arose.

6.29 We can find no evidence that Mr I accessed any substitute prescribing between December 2011 and April 2012. He had been discharged from the Turning Point prescribing caseload and had never engaged with Westminster Drugs Project. He was accessing substitute prescribing from his GP, Dr M, between September and December 2011. Mr I received his prescriptions through his Turning Point support worker who arranged for Dr M to sign the prescriptions. Mr I stopped attending for his prescription in December 2011 and we can find no evidence that this was followed up.

6.30 It also appears that no agency working with him was aware that he had stopped accessing substitute prescribing and therefore his risk assessment was not reviewed in light of the change in circumstances. We have addressed this issue in Recommendation 9.

Staffing

6.31 The Broadway internal investigation highlighted that lack of staffing "*was an issue which contributed to the difficulties of this case*". The housing support worker Ms B3 told the Broadway incident reviewer that it was her view that more could have been done to support the clients had there been the full complement of staffing. Ms B3 also said that providing support to clients was made more difficult when, after the allegations made by a resident on 15 March, staff were not able to visit the hostel alone.

Use of the term hostel

6.32 Throughout the report we have described the service provided by Broadway as a hostel. This is because all the records we have

reviewed have used the term. As part of the factual accuracy checking, St Mungo's Broadway (the new name for the provider of the service at Shirland Road) highlighted that the service provided at Shirland Road was actually a supported housing service.

6.33 The Executive Director at St Mungo's Broadway has highlighted that "*the term 'hostel' is commonly associated with a high staff to client ratio and twenty hour on site support*". He also stated that such a service is "*aimed at clients with medium to high needs and risk assessments*".

6.34 We have been told that the service at Shirland Road was a supported housing service for former rough sleepers with substance misuse needs, that there was no office on site and that visiting support was only available during office hours.

6.35 It appears from the records completed Central & North West London NHS Foundation Trust staff that they believed that they were liaising with a hostel, rather than a supported housing service. Dr R has confirmed to us that she and her colleagues thought that Mr I was living in a hostel, but that they knew it was not a high support hostel and that it did not have 24 hour support.

Welfare checks

6.36 The information provided by the Executive Director at St Mungo's Broadway states that if a resident is not in, it is common practice to slip a note under their door. The Executive Director also told us that two members of staff made daily welfare checks on clients. However, we have not seen any evidence to support this statement.

6.37 The Executive Director told us that because of the semi-independent nature of the service, it was quite common not to see clients for several days at a time. On Thursday 5 April 2013 notes were slipped under residents' doors. This was between 9 and 11 days after police believe that Mr Hamilton was killed. It is our opinion that during a period of increased risk, and at a point when staff needed to reassure residents, not having direct contact with a resident for more than a week is inappropriate.

7 Internal investigation and action plan

Trust internal investigation

7.1 We have reviewed the internal investigation report guided by the NPSA investigation evaluation checklist. The internal investigation was conducted by an independent investigator who was commissioned by the Trust.

7.2 A number of interviews were held with staff employed by the Trust and other agencies, including Broadway hostel provider, Turning Point, Riverside hostel provider, Camden and Islington (as provider of medical input to the South Westminster Drug and Alcohol Service). The interviews were all recorded and transcribed, and those transcriptions have been made available to us.

7.3 The internal investigation identified 11 recommendations, which are summarised in paragraph 7.5 below.

7.4 The care and service delivery problems identified were:

- Lack of awareness within the early intervention team of Mr I's forensic history, which led to partially informed risk assessment and management.

- Poor communication between the substance misuse worker (Mr J) who was supervising Mr I's methadone prescription via the shared care service at the GP surgery and the early intervention team. Mr J was unaware of the involvement of the early intervention team and the early intervention team were unaware that Mr I was not having his regular methadone prescription.

- The early intervention team was not aware that Mr I had been placed on a Drug Treatment Order

7.5 The recommendations made were:

- All information known about the service user and relevant to their future care, including substance misuse history, criminal record history and physical health, must be considered and included in all assessments completed by the EIT together with the following:

  a) the opinion of a prescribing substance misuse service should be obtained;

  b) the assessment should include the individual's forensic history and routine policy disclosure sought for anyone who is known to have a history of assault;

c) consideration of liaison and consultation with the Dual Diagnosis service and the agreement of set procedures to be followed if the service user refuses to engage with the service.

- Any discussion about the relationship between substance misuse, psychosis, aggression and violence should be address in the care plan and recorded in the individual's risk assessment records.

- A continuous record should be kept of the service user's care history to include a full risk assessment of matters such as substance misuse, psychosis and violence. Gaps in that record should be discussed and addressed prior to hand over of treatment responsibility.

- A review should be conducted to determine whether paper records stored prior to the implementation of Jade should be scanned onto a central system for ease of access. Following this review, if it is found not to be possible, a system for noting that a paper record exists, with a key to its access location should be created on Jade.

- Service users should only be allocated a key worker/care co-ordinator by the service providers if they have the relevant experience of working with service users with their particular care need presentations, for example substance misuse, psychosis.

- The transfer of individuals between the South and NW substance misuse services joint Transfer Policy should be reviewed by both partnerships and amended to include joint meetings for those individuals that have had extensive involvement in one part of the borough. Previous community care substance misuse notes should be transferred, to ensure engagement and continuity of care. The information transferred between the services should include details of all current professionals involved in their care.

- It is further recommended that the same principles are applied to all transfers of care between different service providers.

- There should be a review of the supervision of Drug Treatment Orders in Westminster and the systems currently in place taking into consideration how this information is disseminated across the agencies involved in an individual's care.

- The EIT and or Substance Misuse services when dealing with individuals who have a dual diagnosis and complex needs should consider how best to meet those needs. This should be clearly stipulated in a jointly agreed care plan and actioned appropriately in order for both mental health and substance misuse goals to be clarified and reviewed with all involved as part of the CPA process. The care plan should also include what actions will be taken if a service user voluntarily disengages from the services and how long the service user can continue being held on the caseload.

- The services work closely with the housing providers and the Local Authorities in its strategic development of "Supporting People Housing" that is aimed at supporting and sustaining people in their continuing need for support and engagement of substance misuse services as proposed in the recently published independent investigation into the treatment provided to "Mr Hamilton and Mr B".

- The assessment of individuals being placed in shared hostel accommodation must contain details about the medical and forensic histories of those requiring placements and shared with the hostel support staff.

7.6 We support these recommendations, and have not repeated them but consider that the Trust should also implement an assurance programme to provide information about how effectively the relevant Trust policies are being followed. This has been addressed in Recommendation 7.

Trust action plan

7.7 We have reviewed the action plan from the internal report that was updated in January 2014. The updates include supporting evidence to indicate that the action has been completed.

7.8 The plan addresses all the recommendations made by the internal investigation team.

Broadway internal investigation

7.9 The Broadway Incident Review Report identifies that "*short staffing contributed to the difficulties of this case*" but states, "*it could not prevent what had happened*". The report also states that "*staffing issues are common to all Broadway's services and whilst not desirable, is not something which can be avoided*".

7.10 It is our view that had there been appropriate levels of staff in place, additional support could have been provided to enable clients to report and record their concerns more formally. It would also have provided the opportunity for staff to have more time to consider what other actions could be taken to safeguard the clients at risk.

7.11 The issue of Mr I's risk assessment not being updated after the complaints from other residents in March 2012 is raised. The report identifies that when a client is alleged to have threatened or been violent towards other clients, "*high*" is an appropriate risk rating. The report states, "*Although this would not have made a difference in this case, strict adherence to the procedure in relation to risk assessment reviews will safeguard future clients*."

7.12 Again it is our view that had the risk rating been properly reviewed, and timely actions taken to alert other professionals involved in Mr I's care, it is possible that other residents would have been safer.

7.13 The report also states that although the risk assessment was not updated, appropriate action was taken "*following the incident report*" in involving the police and Safer Neighbourhood Team.

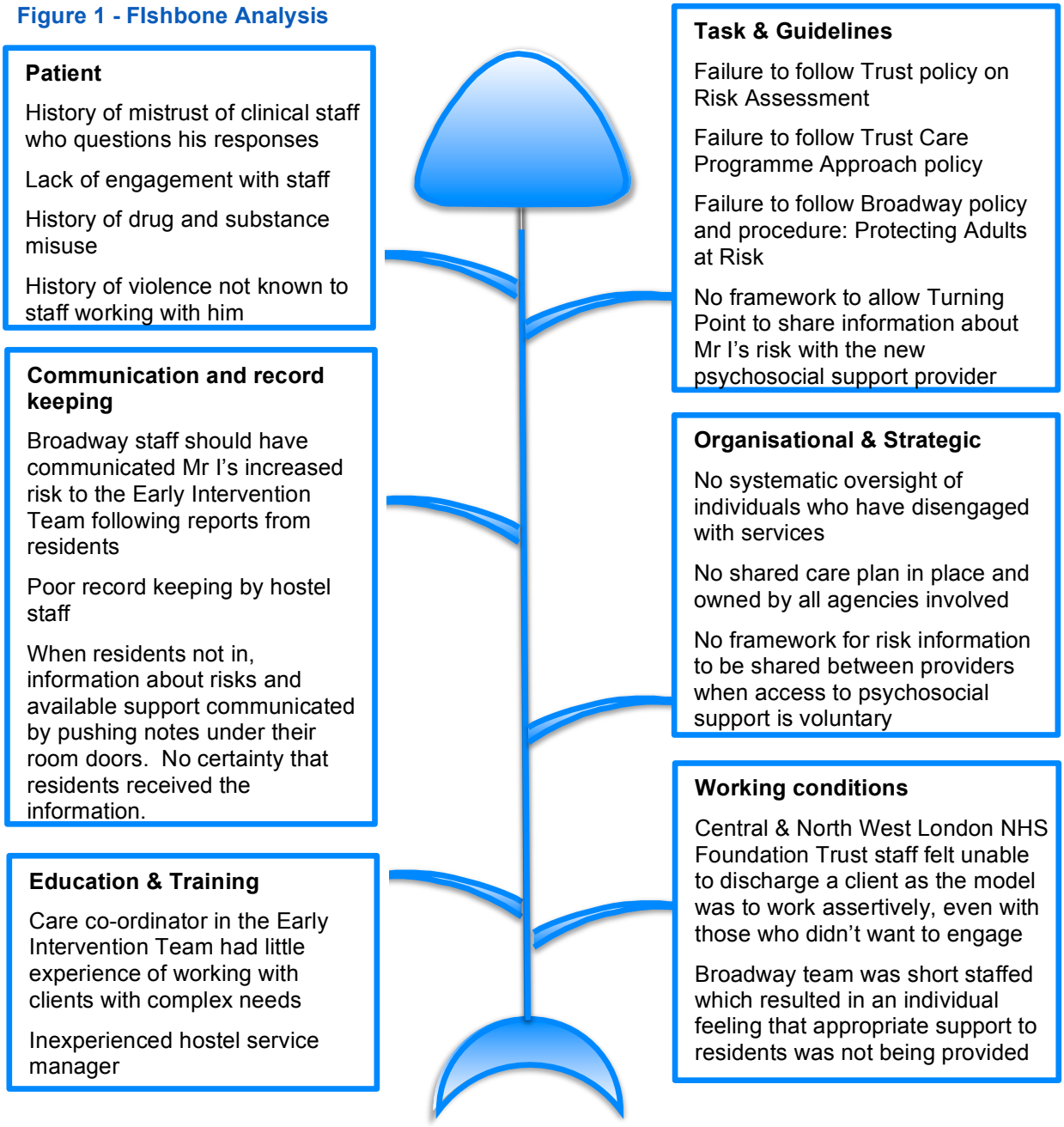
7.14 Whilst we would agree that involving the police and Safer Neighbourhood Team were appropriate actions, it is our view that further actions to inform the Early Intervention Team should have been taken.

8 Overall analysis and recommendations

8.1 The Central & North West London NHS Foundation Trust internal investigation identified a number of areas of learning, which we support and have not repeated here. We have however recommended that the Trust implements a systematic process to monitor compliance with key policies and that regular audits are undertaken (Recommendation 7).

8.2 The Fishbone Analysis in Figure 1 below sets out the key issues we have identified.

Figure 1 - FIshbone Analysis



Predictability and preventability

8.3 There was no information available to Central & North West London NHS Foundation Trust staff to indicate that Mr I was unstable or that he posed a risk to others. Ms P was told in January 2012 by Ms M, the housing support worker that Mr I was stable and there were no serious concerns about Mr I's mental health.

8.4 On 15 March 2012, two weeks prior to the index offence a resident at the hostel made a report to hostel staff that Mr I had been threatening residents, including the victim Mr Hamilton. The reporting resident had told hostel staff that Mr I was dangerous and expressed concern that someone in the property was going to get hurt. Hostel staff recorded that they were unable to speak to the alleged victim (Mr Hamilton), as he had not been at the property when they had visited. Hostel staff also recorded that Mr I's risk assessment would be reviewed if the alleged incidents were confirmed.

8.5 Following the allegation made by a resident on 15 March Broadway staff were no longer able to visit the hostel alone and visits had to take place in pairs. This indicates that the organisation took the potential risk to staff seriously. However, this decision left the residents at greater risk as, due to the short staffing issue, it became more difficult for staff to visit and support residents appropriately.

8.6 This information was not passed on to Central & North West London NHS Foundation Trust staff in a timely fashion. It is therefore our opinion that staff at Central & North West London NHS Foundation Trust took appropriate actions based on the information they had available to them.

8.7 During interview with the internal investigation team Mr S said that he had encouraged residents to make statements to the police about Mr I's threatening behaviour. Mr S told the internal investigation team that if residents had done this, it would have given him the evidence to terminate Mr I's tenancy agreement. Mr S said that at the time this was what he had wanted to do but was unable to do so as the residents were so fearful of Mr I that they felt they would still have been vulnerable to him, even if he no longer lived at the hostel.

8.8 It is our view that hostel staff had information to predict that Mr I would assault one or more residents again. However we acknowledge that staff would not have known how serious such an assault might be.

8.9 We therefore consider that the tragic homicide of Mr Hamilton could not have been predicted or prevented.

Recommendations

Recommendation 1
Commissioners of care and support services must ensure that all providers are clear about their responsibilities for escalating concerns about the safety of vulnerable adults in institutional settings and for sharing appropriate information between agencies supporting individuals.

Recommendation 2
Commissioners of care and support services must ensure that when a serious incident occurs robust internal investigations are undertaken by providers and that learning is shared across all services.

Recommendation 3
The Trust must review the Early Intervention Team Operational Policy to clarify the meaning of 'red zone' and 'amber zone' clients, including how the zones are categorised.

Recommendation 4
When multiple agencies are involved in the care and support of an individual, a shared care plan must be in place that details the individual's history, risks, crisis interventions and escalation plans.

Recommendation 5
The Health and Wellbeing Board should receive this report to aid improvements in system integration and transformation.

Recommendation 6
The Trust must ensure that a systematic process is in place to monitor compliance with key policies and that regular audits are undertaken.

Recommendation 7
Commissioners of care and support services should ensure that service providers have an appropriate policy to record welfare checks. The policy should include clarity about the purpose, content and interval of those welfare checks, it should also be clear about the escalation process once the maximum interval has been reached.

Recommendation 8
Providers of substance misuse services should identify and agree a system of sharing risk information about clients who move between service providers, whilst adhering to patient confidentiality.

Appendix A – Terms of reference

- Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the trust has made in implementing the action plan.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from Mr I's first contact with services to the time of his offence.
- Review the appropriateness of the treatment of Mr I in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of Mr I harming himself or others.
- Examine the effectiveness of the Mr I care plan including the involvement of the service user and the family.
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if this incident was either predictable or preventable.
- Provide a written report to the Investigation Team that includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a brief post investigation evaluation

Appendix B – Documents reviewed

Central & North West London NHS Foundation Trust Documents

- Clinical records for Mr I
- Trust Final Serious Incident Investigation Report dated 2 September 2013
- Trust Joint Action Plan dated January 2014
- Transcripts of interviews conducted during the internal investigation
- Witness statements provided as part of the initial root cause analysis investigation
- Kensington, Chelsea & Westminster Early Intervention in Psychosis Team Operational Procedures 2008 [advised by the Trust that this policy remains current]
- Clinical Risk Assessment and Management Policy and Adult Services Procedure 2009
- Clinical Risk Assessment Policy to November 2015
- Care Programme Approach Policy
- Admission, Transfer and Discharge Procedures Addictions – Community Services approved 8 June 2012
- Admission, Transfer and Discharge Procedures Community Recovery Services approved 8 June 2012
- Overarching Policy for the Discharge and Transfer of Patients in the Trust ratified 6 March 2012
- Community Outreach Rehabilitation Team Operational Policy
- Community Recovery Organisational Chart
- Westminster Dual Diagnosis Service February 2009
- Dual Diagnosis Policy ratified 19 March 2013

Broadway and St Mungo's Broadway Documents

- Client records for Mr I
- Broadway Incident Report Form dated 15 March 2012
- Shirland Road Incident Review Report dated April 2013
- Broadway Protecting Adults at Risk: Combined policy and procedure approved October 2011
- St Mungo's Broadway Safeguarding Adults Policy and Procedure dated 23 January 2015
- Supporting People Contract between the Lord Mayor and Citizens of the City of Westminster and Broadway for Supporting Housing Schemes for Single Homeless People dated 4 September 2006
- Supporting People Steady State Contract Variation Notices dated 29 May 2008, 10 July 2008
- Violence and Lone Working Combined Policy and Procedure approved January 2011
- Performance Standards for SHN Housing Support Workers

Other resources

- GP records from the two surgeries where Mr I was registered in the year prior to the offence
- Turning Point records
- Client records from King George's Hostel
- Patient records from Imperial College Healthcare NHS Trust

Appendix C – Clinical and Support Staff involved in the care and treatment of Mr I

Ref	Role	Organisation
Dr G	Locum Consultant Psychiatrist	Early Intervention Team, Central & North West London NHS Foundation Trust
Dr H	GP	Cardinal Hume Centre
Dr M	GP	Elgin Clinic
Dr R	Consultant Psychiatrist	Early Intervention Team, Central & North West London NHS Foundation Trust
Mr J	Shared Care Worker	Turning Point
Mr S	Housing Manager	Broadway
Ms A	Resettlement Worker	Riverside ECHG
Ms B1	Primary Care Liaison Nurse	Cardinal Hume Centre/Central & North West London NHS Foundation Trust
Ms B2	Support Worker	Turning Point (took over from Ms J)
Ms B3	Support Worker	Broadway
Ms B4	Keyworker	Westminster Drug Project
Ms H	Support Worker	Broadway
Ms J	Support Worker	Turning Point (maternity leave from December 2010)
Ms J2	Unknown	Westminster Drug Project
Ms M	Support Worker	Broadway
Ms P	Care Co-ordinator	Early Intervention Team, Central & North West London NHS Foundation Trust
Ms S	Occupational Therapist	Early Intervention Team, Central & North West London NHS Foundation Trust
Ms Z	Unknown	Westminster Drug Project

Appendix D – Chronology of Mr I's contacts with his GP, Substance Misuse Providers, Hostel Providers and the Trust, and events leading up to the homicide

Date	Source	Event	Information
09/12/09	GP records	Letter	From Dr B, Consultant Hepatologist, Imperial College. Advising that Mr I reported he had been clean from street drugs for 3 months and that he was still losing weight as his low income prevented him from buying nutritious food. **Plan:** review in 3 months
23/12/09	GP records	Letter	From Imperial College to Dr H advising that Mr I would be referred to psychiatric team on the unit prior to commencing treatment. Also advising that Mr I has vaccinations for hepatitis A and B.
12/03/10	GP records	Letter	From Imperial College to Dr H advising that Mr I was commenced on anti-viral treatment for hepatitis C on 2/3/10.
14/09/10	GP records	Letter	From Imperial College to Dr H providing an update on Mr I's response to anti-viral treatment for hepatitis C. Reported that Mr I had not been seen since week 20 [approximately mid July 2010] and that he had not attended three appointments offered to review his treatment.
25/10/10	Internal investigation report		Referred by Turning Point and GP for mental health assessment at the CMHT. Presented with symptoms of depressions since aged 16. Reported that depressive symptoms deteriorated in February 2009 when he stopped taking interferon (prescribed to treat hepatitis C).
25/10/10	Patient notes - CNWL	Progress note	Mr I attended for assessment with key worker Ms J. Presented with symptoms of depression since age 16 years. Previous 4 months Mr I stated he felt he had been guided by good spirits but lately they had become derogatory and were misguiding him. Mr I pointed out he was not mentally unwell but asked to see a psychiatrist and stated he would be willing to try antipsychotic medication. Follow up to be arranged in 4 weeks.
26/10/10	Patient notes - CNWL	Progress note	Discussion in CMHT team meeting concluded that Ms B refer Mr I to EIS team. Telephone contact with Mr I - he agreed to plan.

Date	Source	Event	Information
11/11/10	Patient notes - CNWL	Risk Screening Form RA1	Current/past misuse of illicit drugs Previous suicide attempts, history of self harm and suicidal thoughts Sense of hopelessness No to everything else. Three weeks previously Mr I had cut both wrists with a knife, required stitches. Reported that he was regretful the suicide attempt didn't work. Currently being prescribed 25 mls methadone but still using £10-£15 of crack and heroin fortnightly. Mr I keen to receive help but also keen to point out he was not mentally unwell - spirits were not voices. Asked to see a psychiatrist and stated would be willing to try antipsychotic medication.
17/11/10	Patient notes - CNWL	Progress note	Follow up at surgery. Mr I attended with key worker Ms B2. MT reported slight improvement and attributed it to a new relationship with a girl he met 5 days previously. Mr I admitted consuming excessive amounts of alcohol in the previous week with her and as a result he had not be attending the drug project as regularly as he should. Mr I reported that he had cut both wrists with a knife 2 weeks previously but stated he was glad he didn't fatally hurt himself. Discussed referral to EIS – Mr I said he was happy to meet with then despite the fact that he didn't feel he was mentally unwell.
19/11/10	Patient notes - CNWL	Progress note	Message left at hostel for Mr I to call occupational therapist Ms S.
23/11/10	Patient notes - CNWL	Progress note	Assessment conducted by occupational therapist Ms S. Contacted drug worker Ms B2, discussed with team and arranged further assessment with Dr G on 29/12.

Date	Source	Event	Information
23/11/10	Patient notes - CNWL	Mental Health Core Assessment	Completed by Ms S. Summary of Mr I's current circumstances and family/social history provided. Noted that Mr I reported he had a new girlfriend whom he met the previous week. Mr I had said that he found her supportive but that she also had some difficulties and was homeless at that time. No assessor's summary or immediate actions completed. No outcomes completed.
29/11/10	Patient notes - CNWL	Progress note	Message left at Hostel for Mr I to call occupational therapist Ms S re appointment that day.
29/11/10	Patient notes - CNWL	Failed appointment	DNA.
01/12/10	Patient notes - Turning Point	Note	Referral made within Turning Point for Mr I to be considered for Tier 4 treatment (detox and rehab).
07/12/10	Patient notes - CNWL	Progress note	Message left at hostel for Mr I to call occupational therapist Ms S re appointment that day.
07/12/10	Patient notes - CNWL	Failed appointment	DNA.
10/12/10	Patient notes - CNWL	Progress note	Call to hostel - Mr I not in.
13/12/10	Patient notes - CNWL	Progress note	Call to hostel – Mr I not able to come to the phone. Message left by social worker asking if M could attend appointment on 17/12/10 @ 2:00pm
15/12/10	Patient notes - CNWL	Progress note	Social worker called Mr I - he confirmed he could attend the appointment on 17/12.
24/12/10	Patient notes - CNWL	Progress note	Note of Dr G's letter to Dr H, written following assessment of Mr I.

Date	Source	Event	Information
24/12/10	Patient notes - CNWL	Letter	To Dr H from Dr G, following review held on 24/12/10 with Ms B2. Consultant noted that it was extremely difficult to draw a firm conclusion from the assessment and therefore it had been decided that an extended three month assessment would be undertaken. Dr G noted "*The presence of a psychotic illness is supported by his account of the spiritual voices which is consistent with definitions of true hallucinatory experiences, the temporal relationship with interferon therapy which is known to have possible neuropsychiatric sequelae. Against this however is the long-standing nature of his beliefs, the absence of bizarre content, and the preservation of his affect.*"
24/12/10	GP records	Letter	From Dr G, CNWL Early Intervention Team providing summary of a review that took place on 24/12/10. Difficulty in completing assessment due to non-attendance at appointments by Mr I. Mr I reported that his interest in spiritualism and psychic ability began at age 18 (he was then 23) and that he believed his contact with the spirit world would end at age 30. Mr I reported that his contact with the spirit world had changed about 4 months previously when he began hearing spirits communicating with him: a male mythological god Pan and a female nymph Cat. Mr I went on to say that the spirits help him deal with his emotions and generally have a benevolent influence although sometimes they expose him to negative emotions. Concern was raised about a recent episode of self harm which was reported to have stemmed from Mr I's belief systems. However Mr I said that he had become overwhelmed by the frustration of living with his experiences and had lacerated his arms. Noted that MT has a long history of self harm, primarily in the form of opiate overdoses and generally in response to his frustrations and inability to cope with stressful circumstances. Mr I explained that he did not feel he was suffering from mental illness, and that his difficulties relate to anger, depressions and frustration. He is adamantly against psychiatric medication but feels that psychological therapy may help him offload and develop mental techniques to cope with his difficulties. **Plan:** carry out a three month extended assessment, during which time Mr I will be allocated to a care co-ordinator and occasionally seen by a doctor.

Date	Source	Event	Information
10/01/11	Patient notes - CNWL	Progress note	Case allocated to occupational therapist Ms K for three month assessment.
21/01/11	Patient notes - CNWL	Progress note	Case transferred to occupational therapist Ms P, appointment made to see Mr I on 24/1/11.
24/01/11	Patient notes - CNWL	Progress note	Appointment with occupational therapist Ms P, Dr S and Ms S. Mr I was late but notified team beforehand. Mr I openly discussed DSH and suicide attempts. Mr I acknowledged that his spirit experiences "sounded outside the norm" and stated that he felt the need to prove he wasn't psychotic. Mr I declined medication.
28/01/11	Patient notes - CNWL	Progress note	Following discussion in clinical review meeting the previous day, M moved down into amber zone.
07/02/11	Patient notes - CNWL	Progress note	Meeting with occupational therapist Ms P at team base. Mr I brought several spiritual/psychic books at Ms P's suggestion, in a bid to understand Mr I's experiences in greater detail. Discussed history of self harm. Mr I concerned about physical scarring and the impact it might have on his future. Mr I denied any current drug use and mentioned he would like to reduce his methadone. Plan: read a loaned book, arrange a medication review, liaise with key worker Ms B2, next meeting 16/2 over coffee.
16/02/11	Patient notes - CNWL	Progress note	Meeting with occupational therapist Ms P at coffee shop. Discussed unusual experiences, which Mr I stated began about five years previously when he was sleeping rough. Presented as warm and friendly but became irritate and suspicious when covering 'old ground' and accused Ms P of trying to 'trip him up'. Mr I said he felt the EIS team were unable to offer him any input of value as he felt he did not have a psychotic illness. Observed to be restless and jumpy/edgy.

Date	Source	Event	Information
09/03/11	Patient notes - CNWL	Progress note	Occupational therapist Ms P called Mr I the previous week to ask if he was able to attend medication review. Mr I stated he was busy with his course and therefore unable to attend. Ms P asked if he could meet with her briefly that week, Mr I said she should call first. Ms P sent text on 8/2 - no reply Ms P called M on 9/3 to arrange meeting for that week or the following week. Mr I stated he would be unable to meet until his course finished the following week and told AP to call w/c 14/3.
18/03/11	Patient notes - CNWL	Progress note	Letter sent to Mr I inviting him to medication review on 29/3. Discussion with key worker Ms B2. Ms B2 stated she felt Mr I was stable, doing well, not using drugs and not self-harming. Ms B2 expressed uncertainty about whether Mr I had experienced psychotic symptoms and reported that Mr I had told her he did not feel he needed such a high level of support for his mental health.
18/03/11	Patient notes - CNWL	Letter	To Mr I from care co-ordinator Ms P to invite him to attend a review with the team consultant on 29/3/11 @ 2:30pm.
29/03/11	Patient notes - CNWL	Progress note	First meeting with Dr R, consultant. Mr I initially reluctant to talk and said he did not want to see the team anymore. Presentation slightly unkempt, talkative, pleasant with good eye contact. Despite some tangential thinking, clearly not thought disordered. Mr I stated he didn't want a battle with the team about what they might call psychosis. Mr I stated that he was drug free, that he had started two courses and was enjoying living in his hostel. Diagnosis remained unclear, to meet again in one month.
Apr-11	Patient notes - CNWL	Progress note	Text received from Mr I requesting letter for his college to confirm he was under the EIT in order for Mr I to access course funding. Call to Mr I to obtain details required for letter and to arrange next appointment on 20/4.
08/04/11	Patient notes - CNWL	Referral	Referral from care co-ordinator Ms P to psychology. Noted that Mr I was accepted for an extended assessment in December 2010, his presentation was ambiguous and it was unclear whether he had experienced a psychotic episode.

Date	Source	Event	Information
04/05/11	Patient notes - CNWL	Progress note	Several texts and messages left by Ms P for Mr I to contact her to confirm time for a Care Programme Approach meeting. Permission obtained to respond to email sent by course leader to support application for funding.
09/05/11	Patient notes - CNWL	Progress note	Attempts to contact Mr I on his mobile - no response. Call to hostel, Mr I had just left the building. Hostel support worker reported that there were no concerns about Mr I and that he was currently very stable. Ms P asked that Mr I contact her urgently.
10/05/11	Patient notes - CNWL	Progress note	Message left at hostel for Mr I to call Ms P.
18/05/11	Patient notes - CNWL	Progress note	Message left at hostel for Mr I to call Ms P. Ms P spoke with support worker to find out when Mr I would be most likely at home so that Ms P could visit. Support worker reported that Mr I continued to attend college but that staff had noticed a drop in his mood and he had become less communicative with staff. Query glue sniffing. Query affected by a friend moving on. Support worker reported that Mr I had been put forward for an independent flat with floating support. Plan: attempt home visit on Fri 20/5 if not heard from Mr I
23/05/11	Patient notes - CNWL	Letter	To Mr I from care co-ordinator Ms P as Mr I had not returned calls or texts. Meeting offered on 3/6/11, venue to be decided by Mr I.
06/06/11	Patient notes - CNWL	Progress note	Ms P discussed Mr I with consultant psychologist, advised that Ms P write to Mr I inviting him to Care Programme Approach meeting and that if he doesn't attend it would be held in his absence. Copy of letter sent to key worker Ms B2 asking that she support Mr I to attend.
06/06/11	Patient notes - CNWL	Letter	To Mr I from care co-ordinator Ms P stating that she was sorry that they hadn't been able to meet up but that she was pleased to hear from the staff at the hostel that he was doing well. Acknowledged that Mr I wasn't interested in engaging with the team but that the team wanted him to remain involved. Advised that a CPA review was going to be held on 5/7/11 at 2:30pm.

Date	Source	Event	Information
13/06/11	Patient notes - CNWL	Progress note	Physical health screening check sent to GP in preparation for Care Programme Approach. No contact from Mr I.
13/06/11	GP records	Letter	From CNWL Early Intervention Team requesting information to input to Care Programme Approach review on 5/7/11.
16/06/11	Patient notes - CNWL	Progress note	MDT meeting minutes: last 3 months completely disengaged, question about whether Mr I was psychotic or not, invited to Care Programme Approach with drug worker. Hostel report that Mr I was doing well.
20/06/11	Patient notes - CNWL	Form	Untitled document signed by care co-ordinator Ms P, but undated. Date stamped as "Received 20 Jun 2011". Document records that Mr I "appears to be stable in the hostel", that a blood test had been taken to check that Hepatitis C had cleared, and that he was struggling to stay off heroin and crack despite being prescribed methadone.
20/06/11	Patient notes - CNWL	MH Clustering Tool	4 severe to very severe problems in agitated mood 3 moderately severe problems in repeat self-harm (historical) 4 severe to very severe problems in safeguarding children vulnerable dependant adults (historical) 4 severe to very severe problems in engagement (historical)
05/07/11	Patient notes - CNWL	Progress note	Care Programme Approach meeting held in Mr I's absence. Drug worker Ms B2 attended, consultant Dr R and psychologist Ms J2 also present. Ms B reported that Mr I had relapsed in terms of drug use and was injecting heroin, and using crack and solvents daily. Mood has been low at disappointment at using again. Ms B2 stated she had a good relationship with Mr I and had started to see him more regularly as he had disengaged when he first relapsed. Ms B2 described a pattern of behaviour whereby Mr I tends to relapse during the summer. Range of strategies discussed for engaging Mr I and agreed that Ms P would attempt a low key meeting at the end of July in a community setting with Ms B2.

Date	Source	Event	Information
05/07/11	Patient notes - CNWL	Risk Screening Form RA1	Notes no current or past abuse or misuse of alcohol, alcohol usage not above safe drinking level. Yes to current or past abuse or misuse of illicit drugs, previous suicide attempts and history of, or evidence of, self harm. No risk of violence or sexual assault to others, including MH workers. Absence of positive social contact noted. Summary: Mr I has a long history of IV drug use, homelessness, deliberate self-harm and suicide attempts. Several episodes of DSH and suicide documented but Mr I vague about exact dates. [Mr I] reports attempting to OD using methadone and heroin, has slit wrists/chest in suicide attempts and also cut his arms to hurt but not kill himself. After a sustained period of abstinence he has recently recommenced using drugs and his keyworker reports he is using heroin (injecting), crack and solvents regularly. Not thought to be currently self-harming in any other way. Not currently expressing suicidal ideation. Mental state reported to be stable although not currently engaging with EIT so unable to assess. Engaged with drug services and living in supported accommodation.
05/07/11	Patient notes - CNWL	MH Clustering Tool	HoNOS: 23

Date	Source	Event	Information
05/07/11	Patient notes - CNWL	Care & Support Plan	Referred to EIS by key worker due to concerns that reports of voices were indicators of emerging mental illness. Initially engaged will but later disengaged after becoming disillusioned with what he felt the service could offer him. EIS hope to work with Mr I to identify what makes his benign and welcomed experiences become more challenging and frustrating. CPA held in Mr I's absence, reported by key worker Ms B2 that Mr I was low in mood and had begun using heroin again after a period of abstinence. EIS psychologist to work with Mr I. Needs areas identified as: **physical health:** completed course of interferon for Hepatitis C but Mr I failed to attend follow-up to confirm whether it has cleared **substance use:** recently started to use heroin again, cycle of relapse during summer months noted **accommodation:** Mr I keen to move on from supported hostel to more independent accommodation, explained during CPA that Mr I has to be actively working towards this [improvement in substance misuse issues] for the transfer to be facilitated. Mr I not responding to attempts to contact in order for staff to liaise with him to agree Care Plan. Copy of care plan sent to Mr I after repeated unsuccessful attempts. Care plan 'signed' and dated 26/9/11.
August 2011	St Mungo's Broadway records	Tenancy	Mr I signed a tenancy agreement and moved into the hostel at Shirland Road.
05/08/11	Patient notes - CNWL	Progress note	Meeting with Ms P, Ms B2 and Ms J2. Mr I admitted he had used heroin earlier in the day and stated that he was excited about moving into a flat on Monday. Mr I engaged reasonably well in a discussion about what psychology sessions might comprise but was combative when he didn't agree with things said. Mr I will be allocated a new substance misuse worker when he moves but Ms B2 stated she would remain involved during the transitional period.

Date	Source	Event	Information
13/08/11	Patient notes - CNWL	Referral to psychology - feedback	Document notes unclear presentation, possible psychotic episode in context of dysfunctional family, long history of polysubstance abuse and history of self harm. Mr I last seen on 5/8/11 in the coffee shop at Victoria Station with hostel key worker and Ms P. Noted he was in high state of arousal, a little hostile and not trusting. A number of options regarding psychology offered to Mr I. Psychologist noted it was very difficult to engage in busy coffee shop. Plan: offer Mr I an appointment on return from psychologist's leave if he is willing to take it up.
19/08/11	GP records	Letter	From North Westminster Drug and Alcohol Service advising that Mr I had been seen for assessment on 18/8/11. He had requested continued prescribing of methadone following relocation to the north of the borough.
30/08/11	Patient notes - WDP	Note	Call with Dr H, GP, current prescriber for Mr I. Dr H was informed that following the WDP clinical meeting WDP had decided that they would not take on Mr I's care at that time as Mr I had missed his medical assessment the previous Friday and his WDP worker would be on leave for two weeks. Dr H agreed to continue to manage Mr I's prescribing until a transfer date had been arranged.
16/09/11	Patient notes - CNWL	Progress note	Message left for Mr I to contact Ms P to arrange an appointment.
19/09/11	Patient notes - The Elgin Clinic	Consultation	Seen at GP surgery by Turning Point worker Mr J. Mr I advised that he no longer wanted to receive his methadone prescription from NWDAS and wants to receive it from the GP surgery. Mr J encouraged Mr I to attend NWDAS so that he could receive support for his mental health, but Mr I "*was having none of it*". Prescription issued for 15mls methadone for 21/9-19/10
26/09/11	Patient notes - CNWL	Letter	To Mr I from care co-ordinator Ms P enclosing copy of Mr I's care plan as Ms P had been unsuccessful in contacting Mr I on the phone. Ms P requested that Mr I let her know if he still wanted to meet with the psychologist.

Date	Source	Event	Information
27/09/11	Patient notes - CNWL	Progress note	Ms P contacted Mr I's resettlement worker at KGH, Ms A who provided M's new address. Ms A stated she last saw Mr I two weeks previously when he had presented as extremely hyper but that he had been doing well and regularly attended college until the previous week when he stopped going.
17/10/11	Patient notes - The Elgin Clinic	Consultation	Mr I seen in surgery by Dr M and given prescription for 20/10-17/11. Recorded that he was in a hurry and couldn't stay to talk.
11/11/11	St Mungo's Broadway records	Action note	Asked Mr I to come to office to do new support plan and risk assessment. He has not been engaging with any services and has needed a lot of prompting to come to keywork sessions. He says that he is not feeling motivated to do anything (WDP, college, gardening, etc) and just wants to have a year off to do nothing. I discussed the requirements of engaging while in supported housing, which he understood and agreed to at the assessment. He said that he would not be able to stay clean at the house and that his neighbour Mr Hamilton had been "sorting him out" on payday with gear. He said he wanted to move on to Clearing House so that he wouldn't have people on his back or into an abstinent project which would motivate him to get clean. I discussed the importance of having the support of WDP to address his using but he said he did not need any help.
11/11/11	St Mungo's Broadway records	Action note	Phone call with Ms B2 from Turning Point (Mr I's old drug worker) to discuss concerns about his non-engagement and lack of motivation. Ms B2 stated that when she was working with Mr I he expressed that he felt he had missed out on his youth due to using, and enjoyed doing a lot of informal activities like going for coffee, cooking, gardening and art as Mr I is very practical and creative and is also interested in spirituality/paranormal, alternative therapies like meditation and tai chi. She also said his mental health can deteriorate when he is using and he can get easily frustrated when things take longer than he wants to get in place. Suggested using informal activities as a way to get into discussion with Mr I.

Date	Source	Event	Information
29/12/11	St Mungo's Broadway records	Action note	Ms M received call from Mr Hamilton at Crisis for an update on Mr I as he had been unable to contact him by phone. Ms M stated that Mr I had not been answering his phone and that he had stopped going to Hoxton Trust after a few weeks as he felt the course wasn't right for him. Mr Hamilton stated that he had observed that Mr I had low self esteem and low self-confidence. Mr Hamilton stated that he would send Mr I a letter to offer continued support to other Crisis services. Repair to Mr I's door lock. Mr I reported that someone had broken into his room and stolen his phone SIM card and two model guitars. Mr I was unsure about the detail, as he had taken a valium that he had obtained from "*someone who owed him*".
09/01/12	Patient notes - CNWL	Progress note	Ms P called housing support worker Ms M who confirmed there were no concerns about Mr I's mental state. Copy of care plan sent to Ms M. Plan: discuss in CRM, query discharge.
09/01/12	St Mungo's Broadway records	Action note	Call received by Ms M from Ms P at the EIT enquiring about Mr I who was refusing to engage with them. Ms M recorded that Ms P stated that Mr I can access their service, but if he doesn't engage soon he will be discharged. Ms M advised that Mr I was stable with no serious mental health concerns.
18/01/12	St Mungo's Broadway records	Action note	Support worker Ms M discussed with Mr I whether he felt ready to move on. Mr I said that he wanted to move away from the drug use in the house. Ms M advised that Mr I would need to engage regularly as a requirement of his application and Mr I agreed.
24/01/12	St Mungo's Broadway records	Action note	Ms M apologised to Mr I that she would not be able to make the key work session that afternoon due to another appointment. Arranged to see Mr I on 30/1/12.
30/01/12	St Mungo's Broadway records	Action note	Support worker Ms M checked Mr I's position on the clearing house waiting list. Mr I said that he was feeling good and was continuing to reduce his using.

Date	Source	Event	Information
06/02/12	St Mungo's Broadway records	Action note	Mr I advised that he is starting to say no more [often] to the guys he usually scores with. Support worker Ms M advised that Mr I needed to pay more rent as he was £60 in arrears. Mr I advised that he had to order a new bank card as he had lost his old one and that he would be getting a new SIM card for his phone.
14/02/12	St Mungo's Broadway records	Action note	**Note not entered until after 5/4/12**. Support plan review - Mr I to work on positive spending and continue to attend weekly key work sessions.
06/03/12	St Mungo's Broadway records	Action note	**Note not entered until after 5/4/12**. Support worker took Mr I out for coffee - said he was feeling positive and motivated to move on, but was still finding it difficult in the house with other influences.
15/03/12	St Mungo's Broadway records	Action note	**Note not entered until after 5/4/12** Incident logged by St Mungo's Manager Mr S.
29/03/12	Patient notes - CNWL	Progress note	Ms P discussed Mr I in supervision with Dr R. Agreed to attempt an unannounced home visit and find out his daily movements from support worker. Ms P called housing support worker Ms M - no answer, message left.
05/04/12	Patient notes - CNWL	Progress note	Ms P received call from Ms B2 (interim housing support worker). Ms B2 reported some recent concerns about Mr I becoming threatening and aggressive towards fellow residents. Ms B2 reported that Mr I threatened to stab another tenant and that Mr I's drug use (particularly solvent abuse) had escalated. Ms B2 also reported that she had entered Mr I's room to conduct a routine maintenance check and saw a knife and a hammer on the table. Ms B2 advised that she had not yet seen Mr I to discuss this with him.
05/04/12	St Mungo's Broadway records	Action note	Ms B2 spoke to Ms P at the early interventions team. Updated on situation/ weapons in room etc...Ms P said she would like to do a home visit with a doctor next week to see how he is doing. Ms P said that Mr I did not engage and could get angry about them visiting, but they wanted to give it a try. Ms B2 said she would attend with them.

Date	Source	Event	Information
09/04/12	Metropolitan Police	Mr Hamilton found dead and arrest	Mr Hamilton found dead in his flat by other residents. Mr I arrested with other residents for questioning.
11/04/12	Patient notes - CNWL	Progress note	Ms P called Ms M to arrange to visit Mr I but spoke with housing project manager Mr S who informed Ms P that there had been a serious incident over Easter, which resulted in Mr I being questioned by the police and not being allowed to return to the property. Mr S refused to provide further details other than he was in the process of sourcing alternative accommodation for Mr I who was at Holborn police station until an address could be found for him to be bailed to. Ms P called Holborn police station - message left for someone to call her.
12/04/12	Patient notes - CNWL	Progress note	Discussed in CRM - moved to red zone. Telephone call to Holborn police station to ascertain Mr I's whereabouts. No answer and further message left for someone to call Ms P.
16/04/12	Patient notes - CNWL	Progress note	Ms P called housing who advised that Mr I had left the police station and it was thought he was in touch with Connections at St Martins. Call to Connections, who confirmed that Mr I had been seen several times over the weekend and there were no concerns about his mental state. Believed that Mr I was sleeping rough. Connections advised to contact Ms P with any concerns about Mr I.
17/04/12	Patient notes - CNWL	Progress note	Ms P called Mr S at Broadway housing who confirmed that Mr I had moved into Dean St hostel. Mr S reported no overt signs of mental ill health although he did note that Mr I seemed odd – Mr I seemed calm which could be seen as incongruous given a deceased service user at his former hostel, police questioning, rough sleeping etc. Mr I had provided an explanation for having the knife (kitchen) and hammer (putting up pictures) in his room. Mr S reported that he had spoken with Mr I about EIT and that Mr I was totally against this and didn't event want contact by phone. Plan: discuss in CRM, unannounced home visit with doctor.

Date	Source	Event	Information
27/04/12	Patient notes - Turning Point	Progress note	Appointment made for 30/4 11:30am to for complete assessment. Mr I wishes to gain support for opiate dependency. Mr I was challenged about his behaviour in the reception services - openly discussing criminal activities and when asked to stop, became verbally abusive towards a staff member. Mr I was asked to leave the service.
30/04/12	Patient notes - CNWL	Progress note	Plan: Dr R and Ms P to make unannounced home visit to Mr I's new hostel in Great Chapel Street on 2/5.
02/05/12	Patient notes - CNWL	Progress note	Unannounced home visit by Dr R and Ms P, but were told by substance misuse worker that Mr I had been arrested for shoplifting (the second time in several weeks) and was being held at a police station (location unknown). Told that Mr I had not been engaging with staff at the hostel, therefore not complying with terms of tenancy and was going to be issued a warning. Also reported that Mr I had been using crack a lot so it was difficult to assess his mental state.
04/05/12	Patient notes - Turning Point	Progress note	Mr I spoken to about his behaviour in reception previous week. He was very rude to staff member because he was challenged about discussing stolen goods in reception. Mr I denied that he was discussing stolen goods but apologised for his behaviour. Mr I was reminded to keep to the reception rules while he is in the service. Mr I looked very thin and gaunt and said that his using has escalated and that he is not ready to stop using. Suggested that the first stage will be to get on a methadone script and he agreed. Mr I said that he would wait until Tuesday when the service was open again. Appointment booked at 12.30 Tuesday.
08/05/12	Patient notes - Turning Point	Progress note	New appointment made for scripting 15:00pm - Mr I presented late for earlier appointment at 11:30am. Attended for comprehensive assessment, which was completed. Mr I tested positive for barbiturates morphine, benzodiazepine, opiates and cocaine. Informed hostel dependency worker that Mr I attended SWDAS and the outcome of the assessment and scripting appointment. It was discussed that Mr I's mental health is a concern as well as substance use and that he had seen the resident psychiatrist Dr D for his initial script appointment. Hostel dependency worker also informed that Mr I is on 30mls of methadone oral.

Date	Source	Event	Information
09/05/12	GP records	Email	From Dr D, Turning Point. MT commenced on 30 mg methadone the previous day, MT reported using 6 bags of heroin and 6 rocks of crack daily. MT denied ever seeing a psychiatrist other than as a child for query ADHD.
10/05/12	Patient notes - CNWL	Progress note	Ms P called the hostel and was informed that Mr I had now returned. Staff told Ms P that Mr I had little daytime structure and often left the hostel by 8:00am.
15/05/12	Patient notes - CNWL	Progress note	Dr R and Ms P made an unannounced home visit at 8:00 am. Told by staff on arrival that Mr I was no longer living there and that he was sleeping rough. Staff initially refused to give any further information citing confidentiality, but eventually informed Dr R and Ms P that Mr I had been evicted on Friday due to unacceptable behaviour, secondary to substance misuse. Staff either unable or unwilling to provide further details. Ms P sent email requesting additional information and advising that all contact with Mr I now lost.

Appendix E – Definition of inpatient and residential rehabilitation (Tier 4) services, National Treatment Agency (NTA)

Inpatient services, as defined in the NTA's Models of care for treatment of adult drug misusers: Update 2006

"Inpatient drug treatment interventions usually involve short episodes of hospital-based (or equivalent) drug and alcohol medical treatment. This normally includes 24-hour medical cover and multidisciplinary team support for treatment such as:

- Medically supervised assessment.
- Stabilisation on substitute medication.
- Detoxification/assisted withdrawal from illegal and substitute drugs and alcohol in the case of poly dependence.
- Specialist inpatient treatments for stimulant users.
- Emergency medical care for drug users in drug-related crisis.

The multidisciplinary team can include psychologists, nurses, pharmacists, occupational therapists, social workers, and other activity and support staff.

Inpatient drug treatment should be provided within a care plan with an identified keyworker. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning.

The three main settings for inpatient treatment are:

- General hospital psychiatric units
- Specialist drug misuse inpatient units in hospitals.
- Residential rehabilitation units (as a precursor to the rehabilitation programme)."

Residential rehabilitation services, as defined by Models of care, 2006

"Drug residential rehabilitation consists of a range of treatment delivery models or programmes to address drug and alcohol misuse, including abstinence orientated drug interventions within the context of residential accommodation.

Residential rehabilitation programmes should include care planning with regular keyworking with an identified keyworker. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning.

There is a range of residential rehabilitation services, which includes:

- Drug and alcohol residential rehabilitation services whose programmes to suit the needs of different service users. These programmes follow a number of broad approaches including therapeutic communities, 12-Step programmes and faith-based (usually Christian) programmes.

- Residential drug and alcohol crisis intervention services (in larger urban areas).

- Inpatient detoxification directly attached to residential rehabilitation programmes.

- Residential treatment programmes for specific client groups (for example, drug-using pregnant women, drug misusers with severe and enduring mental illness). Interventions may require joint initiatives between specialised drug services (Tier 3 or 4, depending on local arrangements) and other specialist inpatient units.

- Some drug-specific therapeutic communities and 12-Step programmes in prisons.

- “Second stage” rehabilitation in drug-free supported accommodation where a client often moves after completing an episode of care in a residential rehabilitation unit, and where they continue to have a care plan, and receive keywork and a range of drug and non-drug- related support.

- Other supported accommodation, with the rehabilitation interventions (therapeutic drug- related and non-drug-related interventions) provided at a different nearby site(s).”