Niche PATIENT SAFETY

NHS England

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

December 2015

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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.

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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 S). 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 Mr S killed Mr J in November 2012, during a burglary at Mr J's home. We would like to express our sincere condolences to Mr J's family. It is our sincere wish that this report does not add to their pain and distress, and goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Mr S.

Mental health history

1.6 Mr S first had contact with mental health services in 2005 when he was seen by the child and adolescent mental health service in Oxford. His school referred him due to concerns about his behaviour. The child and adolescent mental health service reviewed him and concluded that it could not help him, as he did not have a mental illness but rather a conduct disorder with emerging dissocial personality disorder. There were a number of later attempts to secure assessment from a child and adolescent mental health service, however these attempts failed as Mr S was never anywhere long enough to 'get through' the waiting list. Each time he was moved to another institution and a referral was made to mental health services, waiting times started again. However in 2007 attempts were made by Central & North West London NHS Foundation Trust for Mr S to be seen by the child and adolescent mental health service provided. These attempts were not successful as neither Mr S nor his mother, Ms H, engaged in the process.

1.7 Mr S's next contact with mental health services was in March 2009 when he was referred to the in reach mental health team at HMYOI Feltham after he threw hot water in the face of another prisoner. He was subsequently transferred to HMYOI Ashfield in April 2009 where he was seen by a

psychiatrist who prescribed a low dose of risperidone[1], however Mr S only took this medication for a short period.

1.8 In May 2009 Mr S was further transferred to HMYOI Castington where he presented with aggressive behaviour. He was eventually transferred back to HMYOI Feltham where he continued to present with aggressive behaviour, eventually making an unprovoked assault on another inmate for which he was charged with actual bodily harm.

1.9 In October 2009 he underwent a period of assessment at the Wells Unit[2] under Sections 47 and 49 of the Mental Health Act 1983[3]. This assessment continued until his release date on 18 January 2010. The assessment at the Wells Unit concluded that there was no evidence of psychotic symptoms or other acute mental health disorder but that Mr S displayed behaviours that were consistent with ADHD[4] and that he may have experienced transient psychotic symptoms due to stress.

1.10 No community mental health service follow up was put into place upon discharge from the Wells Unit.

1.11 Mr S's next known contact with mental health services was on 2 April 2012 after he had presented at St Mary's A&E department with a stab wound. He became abusive towards nursing staff and following arrest was assessed in the cells. The nurse assessing Mr S found no symptoms of mental illness.

1.12 On 21 September Mr S presented at Chelsea and Westminster Hospital A&E after taking an overdose of over the counter medication. The psychiatric liaison nurse assessed Mr S and found no evidence of mental illness. Mr S was discharged and offered a follow up appointment two days later. The liaison nurse discussed Mr S's case with the offender management team and contacted probation. The offender management team said that as Mr S did not meet the criteria for being managed on Care Programme Approach[5], that the Assessment and Brief Treatment team should be asked to offer Mr S an assessment. The Assessment and Brief Treatment team offered Mr S an appointment on 11 October 2012 but Mr S did not attend. A further appointment was offered on 13 November. Mr S did not attend as he was then in custody having been arrested for the murder of Mr J.

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[1] *Risperidone is an anti-psychotic medication used to treat symptoms of schizophrenia and bipolar disorder (manic depression). It is also used in autistic children to treat symptoms of irritability.*

[2] *The Wells unit is a ten bed male inpatient unit for adolescent young men aged between 12 and 18 years, which is part of the secure forensic mental health service for young people. The unit provides a highly specialised, multi-disciplinary assessment and treatment service for young males aged between 12 and 18 years with severe mental illness who are a danger to themselves or others, and who may have committed criminal offences.*

[3] *http://www.legislation.gov.uk/ukpga/1983/20/contents*

[4] *Attention Deficit Hyperactivity Disorder (ADHD) is a group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness. www.nhs.uk*

[5] *The Care Programme Approach is a way that services are assess, planned, co-ordinated and reviewed for someone with mental health problems or a range of complex needs.*

Accommodation

1.13 Mr S has not lived in settled accommodation since he was 13. In 2004 (aged 11) he became a Looked After Child and from 2006 (aged 13) he ceased to have any settled placement. He was excluded from his first residential school and his future placements included residential school, various youth offending institutions, residential children's home, secure psychiatric unit, and a semi-independent unit.

1.14 Mr S was homeless on release from the secure adolescent psychiatric service in 2010 and again on release from prison on 2012. We can find no evidence that Mr S received any support after he was discharged, either from West London Mental Health NHS Trust (the organisation responsible for providing the service at the Wells Unit), or Central & North West London NHS Foundation Trust. Mr S was supported by the Leaving Care Team[6] to find a place at a hostel in Warwick Road, London.

1.15 Mr S remained resident at the hostel until the time of the offence.

Offence

1.16 On 10 November 2012 Mr J was found dead at his home in West London, he had been stabbed multiple times. Mr S was arrested and charged with the offences of murder and aggravated burglary. Mr S was remanded to a Young Offenders' Institution[7] prior to being transferred to prison. He was subsequently transferred to Broadmoor[8].

1.17 Mr S had a long history of offending since the age of 11; his offences included assault and battery, criminal damage, robbery and possession of an offensive weapon. He had been in contact with youth offending services from the age of 12 and management of his case was then transferred to the probation service in 2011 (aged 18).

1.18 There is no information to indicate that Mr S knew Mr J.

Sentence

1.19 Mr S was sentenced in February 2014 to life imprisonment with a minimum term of 32 years. In his sentencing remarks HHJ Pontius noted that Mr S had:

"made a conscious decision to commit burglary armed with a lock knife in his shorts knowing that a situation might arise where he would need to deal with a householder roused from sleep confronting him in the act of burglary. That in

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[6] *The Leaving Care Team is provided by the local authority to advise, support and help young people under the age of 21 who have been looked after by the council. The term 'looked after' means that the local authority has had parental responsibility for a young person.*

[7] *A Young Offenders' Institution is a type of prison for offenders between the ages of 18 and 20.*

[8] *Broadmoor Hospital is a specialist service that provides assessment, treatment and care in conditions of high security for men from London and the south of England. It is one of three high-security psychiatric hospitals in England and treats people with mental illness and personality disorders who represent a high degree of risk to themselves or others. wlmht.nhs.uk*

fact was more than a possibility; it was a realistic likelihood which I have no doubt he fully recognised".

1.20 In December 2014 the length of the sentence was changed by appeal judges[9] after they concluded that the "*overall sentence was too high and accordingly manifestly excessive*". The sentence was substituted for a term of 28 years.

Internal investigation

1.21 Central & North West London NHS Foundation Trust ('the Trust' hereafter) undertook an internal investigation that has been reviewed by the investigation team.

1.22 The investigation was completed by a panel that was chaired by a non-executive director and facilitated by a consultant from a company specialising in investigations. Unusually, the panel interviewed a number of individuals from organisations external to the Trust. This provided useful information, insight and evidence and the approach is to be commended.

Independent investigation

1.23 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 Trust staff who had been in contact with Mr S or who had attempted to meet with him. We also interviewed Trust staff who were responsible for managing services that received a referral for Mr S, and staff from the Youth Offending Team.

Conclusions

1.24 It is our view that this tragic homicide could not have been prevented by mental health services.

1.25 Youth Offending Team assessments had previously indicated that Mr S was at a high risk of a further violent offence and Mr S had been subject to MAPPA[10] oversight at both Levels 1 and 2. Therefore there is clear evidence that a violent assault had been predicted, unfortunately neither this information, nor Mr S's mental health history was known to adult mental health staff treating him in late 2012.

1.26 However, had the relevant information been available to mental health services in September 2012 adult mental health staff would have had sufficient information to be able to predict a further violent offence.

1.27 This leaves the issue of preventability, had relevant information been shared. This is much more difficult to comment upon. It is **possible** if:

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[9] *Approved Judgment from the Court of Appeal (Criminal Division) dated 17 December 2014.*

[10] *Multi-Agency Public Protection Arrangements (MAPPA) are in place to ensure the successful management of violent and sexual offenders. www.gov.uk*

- Trust staff knew about Mr S's significant history of violent offences, and;
- Trust staff knew about Mr S's MAPPA history, and;
- Trust staff had therefore taken a more assertive approach in engaging with Mr S, and;
- Mr S had responded well to an identified treatment programme;

that Mr S might not have committed a burglary that resulted in the death of Mr J. However there are too many variables with unknown outcomes for us to be able to say that the death of Mr J was likely to have been preventable by mental health services.

Recommendations

1.28 The independent investigation supports the recommendations made by the Trust internal investigation team, and has not repeated them here. The recommendations from our independent investigation focus on improvements that we consider should be made to record keeping and information sharing across agencies.

Recommendation 1

The Trust must ensure that when a team is liaising with a secure inpatient unit regarding care for a patient following discharge, the receiving team must ensure that they are clear what legal framework applied to the period of inpatient care and treatment.

Recommendation 2

West London Mental Health Trust must ensure that prior to discharging a detained patient from inpatient services, a section 117 aftercare meeting is held and that appropriate mental health aftercare plans are identified and put into place.

Recommendation 3

The Trust must undertake a review of record keeping across the Trust, paying particular attention to the child and adolescent mental health service, and implement an on-going audit programme to ensure that appropriate standards are maintained.

Recommendation 4

The Trust must undertake an audit across the organisation to identify the degree of compliance with the record keeping policy. Where there are concerns about compliance, the Trust must implement a training programme to ensure that all staff understand the importance of all communications regarding a patient being filed within the clinical record. The Trust must also implement on on-going programme of audit to provide assurance that records are completed correctly.

Recommendation 5

The Trust must ensure that when placing records into storage and archive, correct procedures are followed to ensure successful retrieval at a later date. An audit programme must also be implemented on each occasion to provide assurance that records have been stored correctly.

Recommendation 6

The Trust must work with partner agencies providing accident and emergency services to ensure that the joint operational policies are complied with, in particular that clinical records are available to psychiatric liaison staff in a timely fashion, to facilitate fully informed assessment of patients.

Recommendation 7

The Trust must ensure that operational policies are followed. The Trust must implement a process to ensure that staff understand the importance of key aspects of policies. The Trust must also implement a systematic process to provide assurance regarding compliance.

Recommendation 8

The Trust must review the risk assessment policy to clarify how risk assessments should be managed when the service user has a history that indicates a significant risk, but the clinical team is unable to meet with the service user to fully analyse the current risk.

Recommendation 9

Commissioners of child and adolescent mental health services must have systems in place to assure themselves that child and adolescent mental health service providers respond in a timely fashion to requests for assessments when the young person is in an institutional setting.

1.29 It is not within the remit of this report to make formal recommendations to non-NHS agencies. However, we suggest that if they have not already done so, the Youth Offending Team and the Probation Service may wish to consider the following suggestions. We acknowledge that the Probation Service has already investigated this matter internally, and may have reviewed these points already.

Comment for Youth Offending Team

1.30 The Youth Offending Team should review the process used when transferring management responsibility for a case to the Probation Service. Records should clearly indicate which documents have been included in the transfer 'bundle' and a copy of that 'bundle' should be retained.

Comment for Probation Service

1.31 The Probation Service should review policies, systems and processes to ensure that when staff receive a request for information about a individual's history and risk profile, appropriate information is shared in a timely manner. An ongoing audit programme should also be implemented to ensure that appropriate standards are being maintained.

Good practice

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

1.33 The records provided to us by the Youth Offending Team were extremely comprehensive. All activities related to Mr S appear to have been entered, including by the supervisor of Ms L, Mr D, following supervision sessions when Mr S had been discussed. This enabled us to have a very clear picture of the efforts being made by Ms L on Mr S's behalf.

1.34 In addition Ms L was tireless in her attempts to secure a psychiatric assessment for Mr S, contacting numerous organisations promptly when she knew that Mr S had been, or was about to be, moved. This approach is to be highly commended.

2 Independent investigation

Approach to the investigation

2.1 The independent investigation follows the Department of Health guidance (94) 27[11], 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.

2.2 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.

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

2.4 The investigation was carried out by Naomi Ibbs, Senior Independent Investigator for Niche, with expert advice provided by Dr Mark Potter, Consultant Psychiatrist. The investigation team will be referred to in the first person in the report.

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

2.6 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance[12].

2.7 We used information from Mr S's clinical records provided by the Trust, West London Mental Health Trust, Chelsea and Westminster Hospital NHS Foundation Trust and Mr S's GP records.

2.8 In order for us to properly assess the care and treatment Mr S received from the Trust, we have considered the involvement of non-NHS organisations that had dealings with Mr S. The Trust was not acting in a vacuum. Giving consideration to the role of other agencies is necessary to enable us to provide effective recommendations to the Trust. It is not, however, the aim or intention of this report to provide any formal findings and recommendations in respect of such organisations, and it is for those organisations to conduct their own investigations as felt appropriate.

2.9 We were not able to access the assessments undertaken by the National Probation Service London to inform Mr S's MAPPA level, nor were we able to

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[11] *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*

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

access the relevant minutes from meetings where Mr S's case was reviewed. We were instead provided with a summary report of the Serious Further Offence Review. This report left us with some unanswered questions, where this is the case we have indicated so in our report.

2.10 When we reviewed the records from West London Mental Health Trust we noted that we would have expected that Central & North West London NHS Foundation Trust to have held records for Mr S from the child and adolescent mental health service[13]. The Trust indicated that all their records would have been sent in the original bundle, however they agreed to double check. The Trust confirmed at that time that they held no records for Mr S as a child or adolescent.

2.11 As part of our investigation we interviewed:

- the manager of the community forensic team (FoCuS) for the Trust;
- the nominated lead for MAPPA for the Trust;
- the director for addictions and offender care for the Trust;
- the manager of the Psychiatric Liaison Service;
- the manager of the Police Liaison Service;
- the manager of the Youth Offending Team for the Royal Borough of Kensington & Chelsea;
- a consultant psychiatrist working in child and adolescent services in the Trust;
- the psychiatric liaison nurse based at Kensington and Chelsea Hospital.

2.12 When we interviewed the manager of the Youth Offending Team she indicated that there had been contact with the consultant psychiatrist working in child and adolescent mental health services in the Trust. We reviewed the records from West London Mental Health Trust again and noted that the consultant was the same one mentioned in the discharge planning report from 2010. We therefore contacted Central & North West London NHS Foundation Trust again and arranged to interview the consultant psychiatrist. Central & North West London NHS Foundation Trust subsequently confirmed that records for Mr S as a child/adolescent did exist and copies of those records were sent to us.

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

2.14 We have adhered to the Salmon and Scott principles as outlined below:

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[13] *Child and Adolescent Mental Health Services (CAMHS) are specialist NHS services. They offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties. www.youngminds.org.uk*

"The 'Salmon Process' is used by a public Inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1966 Royal Commission on Tribunals of Inquiry. The Salmon Report set out general principles of an adversarial process for conducting an inquiry, similar, in essence, to what may be expected in a court of law. However it was recognised by Lord Justice Scott, during his 1992 inquiry into the sale of arms to Iraq, that it is not practicable or appropriate in all cases to conduct an inquiry with a full adversarial process. Whilst recognising that it is proper that all witnesses must be able to adequately present their evidence, and have access to legal advice if required, it is not necessary to allow a full process of examination and cross-examination by legal counsel in order to achieve fairness in the course of proceedings. In many cases, the financial and logistical implications of such a process would have a significant detrimental impact on the ultimate aim of the inquiry; to reach conclusions on the issue under consideration."

2.15 The draft report was shared with NHS England, the Trust, West London Mental Health Trust, Chelsea and Westminster Hospital NHS Foundation Trust, National Probation Service and Kensington and Chelsea Youth Offending Team 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. We received comments from NHS England, the Trust and Chelsea and Westminster Hospital NHS Foundation Trust.

2.16 We also met with Mr S and his sister prior to formal publication of the report.

Mr S's views

2.17 We wrote to Mr S at the start of the investigation, explained the purpose of the investigation and asked to meet him. Mr S gave written consent for us to access his medical and other records and agreed to meet with us. Mr S told us about his experiences in the weeks leading up to the offence. In particular Mr S told us that he felt he started becoming unwell after a new suit had been stolen from him and he felt that he "*would never be able to get a job*" because of his history. Mr S described his flat as "*becoming a tip"* (it previously having been clean and tidy, as noted by the social worker and reported to the internal investigation team) and not wanting to leave his room. He also told us that he never received the letter offering an appointment with the Assessment and Brief Treatment team. We have not been able to identify the exact reason for this, but we suspect that this was because Mr S was not leaving his room and therefore had not collected his post.

2.18 We asked Mr S if he would like us to make contact with any member of his family. Mr S told us that he wished for us to make contact with his father and told us that the staff caring for him had his father's contact details. Staff at Broadmoor provided us with the contact details for Mr S's father, we wrote to him twice but did not receive a response. We met with Mr S again when the report was ready for publication. We explained that we had not received a

response from Mr S's father; Mr S indicated he wasn't surprised to hear this and asked that we contact his sister or his mother.

Mr S's family views

2.19 We met with Mr S's sister, Miss R to explain the purpose of the investigation, present the key findings and recommendations and to ask if she had any information that she wanted included in the report.

2.20 We explained that the reason we had asked to meet with Miss R was because Mr S had asked us to contact his sister or his mother. Miss R was pleased that we had got in touch and explained that when Mr S refers to his mother, he is actually referring to Miss R's mother, as Mr S has no contact with his birth mother, Ms H. Miss R explained that she and Mr S share a father, and although she didn't now about the existence of Mr S until after her own parents separated, she and Mr S have a very close bond.

2.21 Miss R told us that Mr S was brought up believing that Mr H (his mother's husband) was his father and that this led to Mr S being "*confused about why his skin was a different colour"* from his 'parents'. We understand that Ms H (Mr S's mother) Miss R told us that Mr S was a very vulnerable young man and that he was open to suggestion, particularly by their father, Mr S senior.

2.22 Miss R said that Mr S had been very positive about turning his life around when he left prison in early 2012. He was very focussed on his religion and wanted to get a job, but he started "*losing control*"; Miss R said that Mr S had gone to see her mother and had started rambling and appeared paranoid. Mr S had been spending time with Miss R's young brothers but later believed they wanted to hurt him.

2.23 Miss R described that after Mr S had killed Mr J he had been remanded to the same prison where their father, Mr S senior, was being held for another offence. Mr S senior told Mr S not to say anything about his mental health during the trial so Mr S followed his advice. Miss R told us that she was extremely concerned about Mr S at this point, and would visit him in prison. However when she started talking to him about his mental health Mr S stopped sending her visit invitations. It wasn't until Mr S was moved to Broadmoor and was in receipt of treatment that Miss R was able to see him again. Miss R told us that she is the point of contact for staff at Broadmoor and had also fulfilled this role when Mr S had been at the Wells Unit. However Miss R said that she was not always taken seriously by all staff, she thought this may have been because she was so young.

Mr J's family views

2.24 Mr J's son was identified as the point of contact for the victim's family. We spoke with him at the start of the investigation, explained the purpose of the investigation and provided him with further written information. At that point Mr J's son told us that he did not wish to meet us but that he would be interested in seeing a copy of the draft report.

2.25 During the drafting of the report we contacted Mr J's son to establish how he wished for his father to be referred in the report. Mr J's son did not have a strong view about whether we should name his father in this report, or maintain his anonymity. We informed him that his father was currently referred to as Mr J in the report. Mr J's son was very happy with this, as coincidentally, this was how his father had often been known.

2.26 When a draft of this report was available we contacted Mr J's son to arrange to meet with him to discuss the findings. Mr J's son asked for some time to think about whether he wanted to meet with us and decided that he did not wish to meet us. We have let Mr J's son know that the report will be a public document and that it is possible that there may be media interest, but have given him an assurance that NHS England does not proactively seek media interest when publishing reports of this nature.

Structure of the report

2.27 Section 3 sets out the details of the care and treatment provided to Mr S. We have included a full chronology of his care at Appendix C in order to provide the context in which he was known to services in London.

2.28 Section 4 examines the issues arising from the care and treatment provided to Mr S and includes comment and analysis.

2.29 Section 5 provides a review of the Trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

2.30 Section 6 sets out our overall analysis and recommendations.

3 The care and treatment of Mr S

Childhood and family background

3.1 Mr S is the second of four sons born to his mother, the first and third son share the same biological father, and Mr S and the fourth son share another biological father.

3.2 Mr S presented with behavioural difficulties shortly after the third son was born when Mr S was about 8 years old. A report completed in 2013 states that Mr S's mother reported that he "*became increasingly difficult to manage, being overtly energetic and naughty with violent tantrums*". Mr S's mother reported that Mr S was diagnosed with Attention Deficit Hyperactivity Disorder from an early age but never received treatment.

3.3 When Mr S was seven years old, armed police forced entry to his home to arrest his father. A BBC news article from June 2002 reported that Mr S senior was one of a "*gang of robbers who used lottery funding as a front for carrying out armed robberies*".

3.4 Mr S's mother reported that Mr S had been traumatised by this event and that during the year Mr S had spent with his biological father, their relationship had been positive.

3.5 In 2009 it was reported that Mr S's father was serving a 23 year sentence for armed robbery and that Mr S's paternal half brother was remanded in custody under a charge of murder.

Schooling

3.6 Mr S was excluded from nursery for his behaviour and when at school he frequently disrupted others and could be verbally and physically aggressive to pupils and staff. Mr S had a statement of special educational needs, which reported that his difficulties related to:

- emotional and behavioural problems;
- short term attention span;
- difficulties in creating and maintaining appropriate peer relationships;
- attention seeking behaviour.

3.7 Mr S's family was first known to social services in January 2001 when a referral was received informing social services that Mr S's biological father had moved into the area and was residing with Mr S's mother. It is not known from where this referral came, however it was noted that Mr S's biological father was known to services due to domestic violence incidents.

3.8 In 2003 when Mr S was ten, his mother requested a special educational needs assessment on the basis that his behaviour was demanding and aggressive, and he required a disproportionate amount of her attention compared with the other children. Mr S was issued with a statement of educational needs in 2004, which specified that he presented with emotional and behavioural difficulties and had attention deficits.

3.9 In September 2004 Mr S became a Looked After Child (LAC)[14] accommodated under Section 20 of the Children Act[15]. He was placed in a joint funded residential Special Educational Needs school placement. This placement was originally a term time only placement but was changed to a 52-week placement as Mr S's mother reported that she was unable to look after him.

3.10 Mr S was registered at the placement for over two years but there were periods of suspension and criminal activity resulting in youth court sentencing.

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[14] *Looked After Child - the term 'looked after' refers to children who are under 18 and have been provided with care and accommodation by children's services. Often this will be with foster carers, but some looked after children might stay in a children's home or boarding school, or with another adult known to the parents and children's services.* www.eastsussex.gov.uk

[15] *Section 20 of the Children Act is a voluntary arrangement between the local authority and the parents where the parents retain full parental responsibility.*

Therapeutic provision and one-to-one keyworker support was provided but despite these interventions Mr S was permanently excluded in November 2006 after he took the school bus and drove it from the school. He subsequently returned home to the full time care of his mother.

3.11 It is recorded that concerns remained about Mr S's mother's capacity to parent any of her children, given her own mental health needs and lack of understanding of the complexity of the issues. Mr S's mother had support from her own mother who took on a significant role in meeting the needs of Mr S and his siblings to attend school.

3.12 Concerns also remained about Mr S's criminal behaviour and gang activity. In June 2007 Mr S was remanded to Local Authority Care, from here a pattern of criminal activity and involvement with the criminal justice system continued throughout his adolescence. Although a wide range of intervention and support plans were deployed from a number of agencies over this time, it appears that this made little impact.

3.13 Between March 2008 and September 2010 Mr S was subject to twelve moves between placements in a school, six Youth Offending Institutions whilst on remand, breach of licence or sentence and four community placements. There were ongoing concerns about Mr S's mental health and his capacity to control his emotions and recognise triggers for violence.

3.14 Given these concerns about Mr S's mental health, whilst on remand at Feltham Youth Offending Institution in 2010, he was seen by a psychiatrist who highlighted that Mr S had traits of a personality disorder. Staff from the family services social work team sought further advice from a consultant psychiatrist specialising in adolescent forensic work.

Psychiatric history

3.15 It was reported in the case review conducted by Kensington and Chelsea Children and Families' Service that as a child Mr S was diagnosed with Attention Deficit Hyperactivity Disorder but did not receive any medication.

3.16 In June 2004 a referral was made by social services to the child and adolescent mental health service provided by the Trust in order that a psychological assessment on Mr S could be undertaken. Dr W spoke with children's social worker who advised that Mr S's mother, Ms H disagreed with his (the social worker's) formulation and that Ms H did not want the further help that was being provided and suggested for the future.

3.17 An appointment was offered to Ms H on 7 July 2004 but she cancelled the appointment on the day it was due to take place. Neither Ms H nor Mr S were seen by the child and adolescent mental health service at this point and the referral was closed by Dr W in August 2004 as (a) matters were progressing for Mr S to have a place in an educational and behavioural difficulties boarding school as a termly boarder and (b) any further CAMHS input offered by Dr W's service would be similar to the input being offered by children's social care.

3.18 Mr S's first contact with mental health services was at the age of 12 following episodes of disruptive, aggressive and challenging behaviour displayed whilst at Bessels Leigh School in Oxfordshire. In 2005 he was assessed by child and adolescent mental health services in Oxfordshire and diagnosed with conduct disorder coupled with a risk of developing dissocial personality disorder. The recommendations from this assessment set out in a letter dated 20 September 2005 were:

- *"consistent management of his behaviour and* [for] *others at school to model socially appropriate behaviour;*
- *referral for a psychotherapy assessment to address his abnormal emotional development and amoral behaviour which if unaltered places him at high risk of offending with violence again;*
- *contact with father appears to be beneficial…future placement after leaving school will need careful planning to ensure that* [Mr S] *is helped to develop further.."*

3.19 The child and adolescent mental health service staff that assessed Mr S indicated that they would not be offering further input for Mr S unless the situation changed or Mr S asked for input. We have not seen any evidence of the referral for, or outcome of the recommended psychotherapy assessment.

3.20 In 2007 Mr S was seen by Oxfordshire child and adolescent mental health service. The report noted "*concerns re some degree of sociopathic tendency*". It should be noted that we have not seen this report and this information was found in the case review undertaken by Kensington and Chelsea Children and Families' Service.

3.21 In February 2007 Ms L, Kensington and Chelsea Youth Offending Team worker attempted to secure a psychiatric assessment for Mr S whilst he was detained at Medway Secure Training Centre. Medway staff completed an initial mental health screening but "*a more intrusive assessment*" would be undertaken.

3.22 Later that month Ms L made a referral to Central & North West London NHS Foundation Trust child and adolescent mental health service to request a psychiatric assessment of Mr S on release from Medway. Concerns were expressed by Dr W that an assessment had not been undertaken whilst Mr S was in Medway and that planning "*would be much more difficult*" as a consequence of this not having been done. A telephone discussion between Ms L and Dr W, recorded by Ms L, indicated that Dr W was concerned that as no assessment had been undertaken Mr S would be released without his risk at that time being quantified, this in turn would lead to no measures being in place for risk reduction. Dr W felt that it would be appropriate for licence conditions to be set to require Mr S to attend mental health sessions at the Youth Offending Team and that the child and adolescent mental health service would discuss Mr S's referral at the team meeting the following week.

3.23 Ms L raised concerns about the lack of a psychiatric assessment with staff at Medway. The response she received was that it had been agreed by Medway that a mental health referral to services local to Medway would not be completed during Mr S's detention there "*due to timescales and the need for consistency of services*".

3.24 On 15 March Mr S was released from Medway and on 21 March he attended a health assessment with Ms L. Ms L reported that he engaged well during the hour long session but that it was apparent that Mr S struggled to control his anger at times and that this resulted in his out of control behaviours. Ms L indicated that she felt these issues would be addressed as part of the psychiatric assessment so she would therefore not undertake any anger management work with Mr S. Ms L discussed the referral for psychiatric assessment with Mr S. Mr S expressed reluctance about engaging with it but Ms L reminded him that it was part of his licence conditions and that it would be one of the two statutory appointments he had each week.

3.25 By late March Mr S had already started to miss appointments with the Youth Offending Team, had failed to attend an appointment with his caseworker and had been arrested for criminal damage.

3.26 Dr W offered an appointment for Mr S on 10 April 2007 and asked Ms L to contact Mr S's mother, Ms H to ask whether she would like to attend the appointment with Mr S. Ms L offered to meet Ms H at home and accompany her to the appointment with Dr W however Ms H said that she did not want to attend. Ms H indicated that she was keen for Mr S to have a psychiatric assessment and that she would try to remember to remind Mr S to attend, but felt that he might not listen to her. Mr S did not attend the appointment with Dr W so Dr W offered a further appointment on 25 April. Dr W asked that Ms L ask Mr S's Ms H to attend with Mr S as Dr W would need to speak to her.

3.27 Ms L subsequently learned from Mr S's social worker that Mr S had a scheduled visit on 25 April so would be unable to attend the appointment with Dr W. Dr W offered an alternative appointment date on 2 May.

3.28 On 10 May Ms L emailed Dr W to advise that she had been trying to contact Ms H without success. Ms L had been told that Ms H was in the house that day but was in bed asleep. Ms L informed Dr W that she would write to Ms H to let her know that she (Ms L) would do a home visit the following week. Ms L asked Dr W if he wanted to arrange a further appointment for Mr S the following week. Dr W remarked that Ms H's presentation was unusual and suggested that he and Ms L did a joint home visit once Ms L had made contact with Ms H. Dr W stated he felt it would be "*much more valuable to meet mum with* [Mr S]" if that were possible.

3.29 Ms H agreed to meet with Dr W and Ms L and indicated that although she would try to ensure that Mr S was present, she was unable to guarantee this as he didn't always listen to her.

3.30 Ms L met with Mr S on 15 May and discussed the psychiatric assessment with him. He was unhappy about his mother being involved and said that he "*didn't*

see why she should be punished for what he has done". Ms L agreed with Mr S that he could talk to his mother about the assessment the following week, which would take place at his home, and that Ms L would call Ms H after Mr S had spoken with her (Ms H).

3.31 On 21 May Ms L called Ms H to discuss the planned home visit. Ms H told Ms L that she had changed her mind and was no longer prepared to meet with Ms L and Dr W. Ms H spoke very negatively about professionals and said that she felt that "*everybody had let them down*". Ms L persuaded Ms H to speak to Dr W on the telephone and arranged a time for the following day.

3.32 When Ms L informed Dr W of her discussion with Ms H, Dr W suggested that Ms L accompany Mr S and that the three of them could have a four way conversation via speakerphone with Ms H. There are no records to indicate whether this planned meeting and telephone conversation took place, however the following entry in the Youth Offending Team records implies that it did not.

3.33 On 5 June Ms L called Mr S's social worker to discuss the decision that had been made to close the referral for psychiatric assessment as neither Mr S nor his mother, Ms H were engaging with the assessment. The social worker informed Ms L that he would contact Dr W to let him know who to contact within the special educational needs department. On the same day Ms L had a brief meeting with Mr S to discuss the reason why the psychiatric assessment had been cancelled. Ms L told Mr S that if he changed his mind about the assessment he should let his caseworker know.

3.34 There appears to have been no further input from child and adolescent mental health services until 2009.

3.35 In October 2009 Mr S was transferred under Sections 47 and 49 of the Mental Health Act[16] from HMYOI Feltham to The Wells Unit, a secure forensic mental health service for young people.

3.36 By the time of the Care Programme Approach meeting on 30 December 2009 Mr S had been nursed on two to one observations for most of the time since his admission and had been secluded on four occasions. There was evidence of Mr S's behaviour being disruptive, hyperactive and impulsive and he was often sexually inappropriate in both word and gesture with female staff.

3.37 Staff discussed the possibility that Mr S had ADHD however, Mr S refused medication and commented that he "*knew what it was*", his "[younger brother] *had it and he knew that he (Mr S) did not*".

3.38 The consultant reported that she had discussed Mr S's admission with a community consultant psychiatrist. And that "*in view of the fact that [Mr S] does not have a severe and enduring mental illness, is refusing to consider*

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[16] *Section 47 of the Mental Health Act is used to transfer sentenced prisoners from prison to hospital if the person has a mental illness that the prison cannot manage. Section 49 of the Mental Health Act is a restriction order, which means that permission is required from the Ministry of Justice before the person can leave hospital. www.rethink.org*

medication for ADHD and is reluctant to engage in psychological interventions, it was agreed that [the community consultant psychiatrist] *would not formally take over the care of* [Mr S]".

3.39 Mr S remained at The Wells Unit for the remainder of his sentence, until January 2010.

3.40 The discharge report dated 22 January 2010 stated that Mr S had problems with relationships, sexual language and violent threats, regulation of emotions, and hyperactivity and inattention. No evidence was found of psychotic symptoms or any other acute major mental health disorder, however the clinical team indicated that it was possible that high levels of arousal and sensitivity to threats could have led to Mr S experiencing transient psychotic symptoms due to stress. It was also reported that Mr S displayed behaviours that were compatible with ADHD.

3.41 The discharge report also provided details of the SAVRY[17], which indicated that Mr S was high risk in all areas. The recommendation was that following release, interventions should be targeted in the following areas:

- "*engagement in prosocial activities and prosocial peer groups;*
- *encouragement and support of family relationships in a monitored way, informed by previous family interactions and considering and anticipating interventions to avoid or overcome potential frictions, particularly in the relationship with his mother;*
- *introduction of consistent social figures: mentors, group workers, professionals. Of special significance when organising this work would be the long term planning and involvement trying to minimise turn-over of staff involved with Mr S;*
- *consideration of Mr S's presentation in a developmental context, taking into account his lack of social skills as a way of preventing and managing potential escalation of risky behaviours;*
- *link with regular activities with one to one support to provide him with the benefits of routine and structure.*"

3.42 No community mental health service follow up was put into place upon discharge from the Wells Unit and we can find no evidence of a Section 117 planning meeting to agree a care plan for community mental health follow up, post discharge.

3.43 Mr S's next known contact with mental health services was on 2 April 2012 after he had presented at St Mary's Hospital A&E with a stab wound. He

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[17] *Structured Assessment of Violence Risk in Youth (SAVRY) is a risk assessment tool used to assist professional evaluators when making decisions about a young person's risk of violence. justice.gov.uk*

became abusive towards nursing staff and following arrest was assessed in the cells. The nurse assessing Mr S found no symptoms of mental illness.

3.44 On 21 September Mr S presented at Chelsea and Westminster Hospital accident and emergency after taking an overdose of over the counter medication. The triage form completed by accident and emergency staff stated that "*the patient has taken overdose of 60 sleeping tablets, 8 beechams, 12 headache tablets, 2 cans of guiness at* 7am".

3.45 The nursing documentation completed at 8:30 am by Chelsea & Westminster Hospital staff stated that "*intentional overdose on pills – apparently 8 beechams, 60 sleep aid tabs* [tablets]*, 12 h/a* [headache] *pills and 2 cans of beer*".

3.46 At 9:00 am Dr B examined Mr S. Dr B recorded that Mr S reported that he wanted to die at the time and that he wasn't sure if he wanted to repeat it. Dr B recorded that he had researched Toxbase[18] and recorded the following:

- From toxbase – sleep aid NAD; beechams phenylephrine [illegible writing]
- If paracetamol total in beechams and headache tablet = 10,000 is <75mg/kg

3.47 The psychiatric liaison nurse Mr M assessed Mr S and found no evidence of mental illness. Mr M completed his entry in the Chelsea and Westminster records at 10:30 am.

3.48 At interview Mr M described the overdose as "*minor*". When asked how he could consider an overdose of a total of 80 tablets as minor Mr M told us that he had no recollection of being informed of the quantity of tablets that Mr S had taken and said that he had no memory of the information that we had reviewed in the A&E records being available to him at the time he assessed Mr S. Mr M said that his memory is that it was not a medically significant overdose and that Mr S was otherwise medically fit. Mr M said that sometimes he was asked to see a patient before A&E staff had finished writing their records and that he was sometimes asked to leave space for staff to complete their entries when he made his entries.

3.49 Mr M also expressed a view that Mr S may not have actually taken the quantity of tablets that the records indicate as Mr S presented to Mr M without any adverse effects on his level of consciousness. Mr M told us that he was concerned about Mr S but that he did not feel that he could ask too many questions, as he was concerned at how Mr S would react. We asked Mr M why he felt this way; he said that Mr S had said that he had a diagnosis of DSPD which Mr M said meant either dangerous and severe personality disorder or dis-social personality disorder. Mr M said either way, for Mr S to

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[18] *Toxbase.org is the primary clinical toxicology database of the National Poisons Information Service. It is a service commissioned by Public Health England on behalf of the UK Health Departments.*

have known the label and used in reference to himself, meant that he had a concerning history.

3.50 Mr S was declared medically fit by the medical staff and discharged from A&E. Mr M offered Mr S a follow up appointment two days later, which he did not attend. Mr M told us that at the time best practice in the liaison psychiatry service was to offer all patients who had committed deliberate self harm a follow up appointment a week after the initial assessment. Mr M said that he was so concerned about Mr S that he offered him a more immediate follow up appointment.

3.51 At about 4:00pm on 21 September Mr M referred Mr S's case to the FOCUS team (the offender management team). The referral email and accompanying letter provide the wrong surname for the client. On 24 September Ms B, the FOCUS team manager responded seeking clarity about which client Mr M wanted to refer. Ms B also advised that as Mr S "*doesn't require CPA we wouldn't pick him up but ABT might work with him for a brief period of time*". Mr M responded to Ms B the same day to clarify the name of the client he was trying to refer and stated, "*I am not sure if he requires CPA*".

3.52 Mr M referred Mr S to what he thought was the Assessment and Brief Treatment team on 29 September. Mr M's referral letter described a young man who had just come out of prison and who had a long history of violent offences. Mr M also stated that Mr S was feeling socially isolated and low in mood and that he had "*taken some sleepeze and some beechams tablets with two cans of Guinness at 7:30* am".

3.53 The quantity of tablets that Mr S had taken was not mentioned and as described above, we now understand that Mr M has no memory of being aware of the quantity that Mr S took.

3.54 On 1 October Mr M received an email from a mental health primary care liaison nurse asking whether the referral was actually intended for the Assessment and Brief Treatment team. Mr M responded on the same day indicating that he thought that the nurse was part of the Assessment and Brief Treatment team and asked for the email address for the Assessment and Brief Treatment team.

3.55 On 1 October Mr M referred Mr S through the correct email address to the Assessment and Brief Treatment team.

3.56 On 3 October Mr M received an email from Ms F, Mr S's probation officer advising that Mr M's fax had just been passed to her and asking whether Mr S had attended his follow up appointment. Ms F noted that Mr S's contact with probation was due to end on Friday of that week [the email was sent on the Wednesday]. Mr M responded promptly indicating that Mr S had not attended the follow up appointment and that he had referred Mr S to the Assessment and Brief Treatment team. Mr M copied the Assessment and Brief Treatment team into his response to the probation officer.

3.57 In response to being copied into the email from Mr M to the probation officer, the Assessment and Brief Treatment team asked Mr M to clarify what the referral was for: for the team's information in case Mr S walked in to the clinic or for assessment and if so, assessment for what. Mr M responded the same day indicating that the referral was for assessment as Mr S had said he was "*depressed*[,] *socially isolated and had a previous dx* [diagnosis] *of dspd*".

3.58 The Assessment and Brief Treatment team wrote to Mr S on 8 October offering him an appointment on 11 October 2012, but Mr S did not attend. Mr S told us that he never received that letter.

3.59 On 11 November Mr B, a registered mental nurse in the Assessment and Brief Treatment team, recorded that he had a telephone conversation with Ms F, Mr S's probation officer on 1 November. Mr B noted that the entry had been written in retrospect as he had been off sick. Mr B recorded that Ms F advised that Mr S was closed to probation and as such she could not send any information. Ms F advised Mr B to call Ms R, Mr S's social worker. Mr B did so and asked for a history and risk assessment as he had been referred by the psychiatric liaison service but with little history. Mr B recorded "*Ms R reported that the team she worked in does not keep risk assessments for the young adults. Reported that his risk was low and that he did not want to see us".* Ms R did not raise any concerns regarding Mr S's mental health. Mr B recorded that he advised Ms R that the Assessment and Brief Treatment team would send another appointment anyway and that if Mr S did not attend the team would discuss his case and consider what action to take next.

3.60 A further letter was sent on 8 November offering an appointment on 13 November. Mr S did not attend as he was then in custody having been arrested for the murder of Mr J.

Contact with criminal justice system

3.61 Mr S has a significant history of contact with the criminal justice system. His first offence was in July 2005 when he was aged 12 years. As at January 2015 (aged 22 years) Mr S's offender profile showed 47 offences with 26 associated convictions.

3.62 Appendix D provides details of all Mr S's offences.

3.63 Mr S had significant contact with the Youth Offending Team over many years. His first contact was in 2005 when a referral order was made for criminal damage, Mr S having sabotaged a teacher's car at Bessel's Leigh School.

3.64 Detailed records of Mr S's contact with the Youth Offending Team start in 2007 when the YOT Health Worker Ms L met with a clinical psychologist to discuss a psychiatric assessment. This meeting followed an assessment by the occupational therapist at the Children and Family clinic in Abingdon who determined that Mr S had a long standing conduct disorder and that he would benefit from support in managing his behaviours and exploring his mental state. It was also reported that there were "*concerns re some degree of sociopathic tendency*".

3.65 The Youth Offending Team felt that a psychiatric assessment would help in identifying an appropriate package of care for Mr S on release from Medway Secure Training Centre.

3.66 Significant efforts were made by Ms L to secure a psychiatric assessment from child and adolescent mental health services for Mr S, both whilst Mr S was at Medway Secure Training Centre and after his release.

3.67 The local child and adolescent mental health service for Kensington and Chelsea would not agree to assess Mr S whilst he was in Medway, citing that Mr S was not resident locally, and that services local to Medway were better equipped to assess a 'captive audience'. However Medway advised that Mr S would not be with them long enough for them to refer and for him to be assessed by the local child and adolescent mental health service.

3.68 Prior to Mr S's release from Medway in February 2007 Ms L referred his case to the local child and adolescent mental health service for psychiatric assessment. The consultant psychiatrist Dr W expressed concern about the complexity of, and risk presented by Mr S and again indicated that Medway should have organised an assessment whilst they were responsible for Mr S's care. Dr W also expressed concern that Mr S would be released without his risk being quantified, therefore no mitigating measures could be put into place and as a consequence Mr S's risk to the public on release would be unnecessarily increased.

3.69 In March 2007 Mr S met Ms L for a health assessment and engaged well with her. Ms L reported that Mr S struggles to control his anger at times and this results in out of control behaviours. Mr S reluctantly agreed to the psychiatric assessment after Ms L reminded him it was a condition of his licence.

3.70 At the end of March Mr S started to miss his appointment with youth offending team staff and was arrested again.

3.71 In April 2007 Mr S did not attend his appointment with Dr W for a psychiatric assessment and Dr W agreed to offer a further appointment, however Dr W asked Ms L to ensure that Mr S's mother, Ms H also attended the appointment, as he would need to speak with her. Mr S did not attend the rescheduled appointment in May. He was later arrested again for going equipped to steal.

3.72 Towards the end of May 2007 Ms L contacted Mr S's mother, Ms H to remind her of the appointment for psychiatric assessment the following day. Ms H informed Ms L that she had changed her mind about contributing and no longer wished to participate. Ms H cited a lack of trust in professionals as her reason for this decision. Ms L persuaded Ms H to speak to Dr W on the telephone and Dr W subsequently suggested that Ms L arrange to bring Mr S to Dr W's clinic so that the three of them (Ms L, Dr W and Mr S) could speak together with Ms H via the speakerphone in the clinic.

3.73 We believe that the planned meeting described above did not take place as Ms L's next entry in June records that the decision had been made to close

the referral to child and adolescent mental health services as neither Mr S nor his mother were engaging in the process.

3.74 In July 2007 Mr S was sentenced to a six month supervision order and arrested a further twice for possession of a knife and criminal damage.

3.75 In August 2007 Mr S was arrested for arson and sentenced to an 18 month supervision order for the offences in July.

3.76 In September 2007 Mr S was sentenced to four months at Medway Supervision and Training Centre and in January 2008 he was moved to Huntercombe YOI as a consequence of 17 incidents that had taken place whilst he was at Medway.

3.77 In August 2008 Mr S was moved from Huntercombe YOI to Periton Mead School, Somerset. Over the following month it is reported that there were allegations of bullying and sexual activity with girls. Mr S went home for a visit and then refused to return to Somerset. It was decided that Mr S would remain at home with his mother, but this was short lived as Mr S had an altercation with his older brother that resulted in Mr S threatening to stab him. Ms H refused to have him back and Mr S was remanded to local authority care and placed at St Mark's Children's Home on Section 20 of the Children Act.

3.78 In November 2008 Mr S spent five weeks at Feltham YOI when he was involved in a number of violent altercations.

3.79 In December Mr S was released from Feltham YOI and moved to Short Stop.

3.80 In January 2009 Mr S was sentenced to ten months at YOI Feltham. At the time of his arrest Mr S was already in breach of bail conditions resulting from an assault on a police officer earlier that month.

3.81 During February Mr S was involved in four incidents at Feltham YOI and in March he was sentenced to a further 18 months Detention and Training Order for robbery, assault, stealing a vehicle, and resisting arrest.

3.82 In April 2009 Mr S was assessed by an adolescent psychiatrist when it was noted that he described auditory hallucinations, and the psychiatrist recorded impulsivity and "*a belief that he is God*". The psychiatrist recorded that Mr S was unsure if Mr S was delusional and noted that he would require further monitoring to see if the delusion developed.

3.83 In May 2009 a YOT worker spoke to a Ministry of Justice case worker expressing concern that Mr S was being moved to YOI Castington, which is a long way from London. The YOT worker described the effect this would have on the team's ability to provide support to Mr S. The case worker advised that it was hoped that it would be an opportunity for a fresh start for Mr S and that hopefully he would not continue to be managed in segregation. The YOT worker sought assurances that Mr S would not be moved again but the case worker indicated that this would depend on Mr S's behaviour. The YOT worker contacted YOI Castington to enquire about local support services but was advised to call back on the day that Mr S was moved. The YOT worker

alluded to the fact that Mr S presented as a "*young man who may have autism but due to previous refusals to engage in the assessment processes a proper evaluation had not been achieved*". Mr S was moved to YOI Castington and it is reported that he continued to display concerning behaviours, including threats to staff, which resulted him being placed in a three man unlock in segregation.

3.84 Through June and July 2009 Ms L continued attempts to secure a psychiatric assessment for Mr S. This resulted in him being moved to Ashfield and then YOI Feltham in August. A psychiatric report shared with Ms L at the end of August concluded in describing an anti-social personality disorder but that there was no evidence of a developing psychosis as Mr S was then saying that he had "*made it all up*".

3.85 Over the following two months there were reports of Mr S indecently exposing himself and assaulting a cleaner. A Youth Justice Board report completed at the time concluded that "*Mr S does not appear to have any empathy/victim awareness…YOT concerned that once released Mr S will cause harm to others through assault/beating and reckless behaviour"*.

3.86 In late October 2009 Mr S was transferred to the Wells Unit, a secure adolescent psychiatric unit, under Sections 47 and 49 of the Mental Health Act.

3.87 In November 2009 a multi-professionals meeting was held at the Parkside Clinic. At the meeting were the child and adolescent consultant psychiatrist plus one other, the manager of the Youth Offending Team, Ms L's supervisor, and Ms L. Mr S was discussed as an individual case and it was highlighted that he was at the Wells Unit, he had reoffended whilst in custody and would now be released in January 2010. It was reiterated that Mr S was both a high risk of serious harm to others and a high risk of reoffending and that managing those risks in the community presented significant challenges. Dr W was made aware of Mr S's release date and Dr W had stated he would be in contact with Dr A from the Wells Unit and would attend Mr S's discharge meeting.

3.88 In December there was contact between Dr A and Dr W regarding a Care Programme Approach meeting, a discharge planning meeting and a professionals' meeting. Despite indicating an intention to do so, Dr W did not attend any of these meetings. Dr W emailed Dr A advising that "*although psychiatric responsibility will not be transferred formally to me, I am very happy for him and/or his mother to self refer to the clinic…I will keep in touch with professionals who will be seeing him, including those from the YOT, and will offer consultation if appropriate*".

3.89 On 22 January 2010 Mr S was released from the Wells Unit into the care of the Youth Offending Team and social services. Mr S was provided with an emergency placement "*due to the local authority being let down by a semi-independent agency*".

3.90 On the same date Ms L emailed Dr W asking for reasons why the child and adolescent mental health service would not be seeing Mr S on his release from the Wells Unit. Ms L advised that she understood Mr S had been offered therapy sessions with a psychologist within the Wells Unit and thought this may continue in the community. Ms L stated she had hoped that Dr W would be able to have some input into how Mr S's risk in the community could be reduced. Dr W responded providing copies of email exchange between him and Dr A in December and suggested to Ms L that they *'catch up on the phone*'.

3.91 On 22 January Ms L met with her supervisor Mr D. The discussion focused on Dr W's agreement to attend the discharge meeting at the Wells Unit, however he had not attended the Care Programme Approach meeting and had not agreed to see Mr S on his release from the Wells Unit. It was noted that Dr W had offered to see Mr S and/or his mother if he self-referred to the clinic. Mr D recorded "*Having reflected on this we are in a position where a high risk young person who was in a tier 4 service is not going to be seen by CAMHS* [child and adolescent mental health service] *unless he self refers. Furthermore Dr W didn't attend the Care Programme Approach meeting and is not undertaking psychiatric responsibility…Therefore we will be actively promoting self referral and arranging a consultation with Dr W to assist us with managing risk in the community.*"

3.92 In February 2010 Mr S was remanded to Feltham YOI for burglary. He was assessed on 4 February but denied any experiencing any mental health symptoms. On 19 February it is recorded that "*he pretended to hang himself, and laughed when staff attended him*".

3.93 During March and April Ms L sought advice from Dr A about future placement possibilities for Mr S on release from Feltham. Dr A informed Ms L that she had seen Mr S since he had returned to Feltham and that although he had been pleasant to her, he did not see the point in seeing Dr A again unless he was going to be transferred to the Wells Unit again. Dr A advised Ms L that Mr S needed to be engaged in an intensive structured programme in order to mitigate his risk to others.

3.94 Throughout April and May Ms L worked with Mr S's social worker to identify potential future placements. Mr S was released into a placement on 1 June with:

- weekly visits to the placement by the Youth Offending Team;
- weekly subsistence allowance;
- 24 hour support from a key worker;
- purchase of a gym membership;
- an allowance for television and essential items.

3.95 In mid-June Mr S told Ms L that he found it difficult to remember to attend appointments now that his case worker was away, as she used to remind him. Ms L discussed how Mr S was managing now that he was living independently and recorded that he appeared to be managing and "*was clearly looking after himself, hygiene etc*". Mr S spoke about being organised, having self respect and managing on a small amount of money.

3.96 In July 2010 Mr S was remanded to YOI Feltham for seven offences. He was subsequently given a conditional discharge.

3.97 In September 2010 planning took place for Mr S's release when he was accommodated in Waltham. Mr S was subject to a 12 month youth rehabilitation order, intensive supervision and surveillance and a tagged curfew.

3.98 In November 2010 Mr S was further arrested for robbery when he was remanded into custody at Feltham YOI. He was sentenced in December to a 12 month detention and training order. Later that month, his case was closed to the Looked After Children's team.

3.99 In May 2011 the Youth Offending Team recorded that Mr S had been visited in prison. The feedback from the visit indicated that Mr S was engaging in the adult literacy and numeracy programme and that he wished to continue with these on his release. Mr S had reported some family visits and that he was hoping that his father would send him some gym clothing when he was released. It was noted that Mr S had commented that serving his sentences in isolation for so long had made him "*very cold towards developing relationships with others, even family members*".

3.100 Between May and August 2011 there were a number of communications between the Youth Offending Team and the Probation Service in order to hand over Mr S's case now that he was an adult – his 18th birthday had been in January 2011. As part of this process an Asset Core Profile was completed by the Youth Offending Team, this recorded that a MAPPA meeting in October 2009 classified Mr S as MAPPA Level 2 which was "*quite exceptional for a youth*".

3.101 The Probation Service supervised Mr S during a prison sentence from which he was released on license in February 2012. Mr S received a further custodial sentence during that period of license and was re-released in July 2012. Mr S was supervised on that license until the beginning of October when the license expired. However during the time of the license Mr S had received an unpaid work penalty for a relatively minor offence that he had committed in February 2012. He was still completing that work at the time when the incident took place.

3.102 The criteria that determined Mr S as a MAPPA case was Category Two:

"*Violent offenders: offenders convicted of a specified violent offence and sentenced to imprisonment /detention for 12 months or more, or detained under a hospital order. This category also includes a small number of sexual*

offenders who do not qualify for the notification requirements that apply to Category 1 offenders and offenders disqualified from working with children."[19]

3.103 Mr S was a MAPPA Level 1 case when the Probation Service was supervising him. There are three levels at which offenders are managed which reflect the level of multi-agency co-operation required to implement effectively the individual offender's risk management plan. Offenders may be moved up or down the levels to reflect changes in the level of risk that they present or the action required to manage it.

- **"*Level 1 -*** *Ordinary Agency Management. These offenders are subject to the usual management arrangements applied by whichever agency has the lead in supervising them. Information will usually be exchanged between relevant agencies, especially between police and probation, but formal multi-agency meetings will not be held to discuss the offender's case.*

- ***Level 2 -*** *Active Multi-agency Management. The risk management plans for these offenders require the active involvement of several agencies via regular multi-agency public protection meetings.*

- ***Level 3 -*** *Active Multi-agency Management. As with offenders managed at Level 2, the active involvement of several agencies is required; however, the risk presented by offenders managed at Level 3 means that the involvement of senior staff from those agencies is additionally required to authorise the use of additional resources, such as for specialised accommodation."* [20]

3.104 There was a point at which there was some debate about whether it was appropriate for Mr S's case to be moved to Level 2 however the justification to remain on Level 1 was that there were various agencies involved in his case. A view expressed by the Assistant Chief Officer for London Probation during an interview with the internal investigation team was that "*with the benefit of hindsight…one might say that he* [Mr S] *should have been Level 2*".

3.105 At the time of Mr S being a MAPPA Level 1 case a Screening Meeting took place that received the details of all new cases that were being referred into MAPPA. The Senior Probation Officer and the Police Inspector with responsibility for MAPPA would screen the cases and decide which cases would be suitable for:

- single agency involvement;

- multi-agency environment;

- multi-agency meetings.

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[19] www.gov.uk *Multi-Agency Public Protection Arrangements Annual Report 2012/13*

[20] www.gov.uk *Multi-Agency Public Protection Arrangements Annual Report 2012/13*

3.106 A plan would be agreed to manage the relevant risks and a decision made about when the cases should next be discussed at a MAPPA Level 2 meeting.

3.107 Two Individuals from the Probation Service were interviewed as part of the internal investigation. During that interview the Senior Probation Officer in Probation advised that although their records indicated that the service was aware that Mr S had been admitted to the Wells Unit there was no clinical diagnosis. The Senior Probation Officer added that they were not "*informed of any diagnosis that would have helped our risk assessment*".

3.108 In addition the Assistant Chief Officer for London Probation advised that no reference could be found on the electronic log to the discussions between the Probation Service and the mental health service. At that time the paper file was with the Probation Service internal investigators so the Assistant Chief Officer for London Probation was unable to clarify whether any written correspondence had been received.

3.109 In April 2011 Mr S was sentenced to 18 months in a young offenders' institution for an offence of assault that was committed in November 2010. The National Probation Service Management Summary Report (Management Summary Report) identified that there were no specific concerns identified relating to his mental health during this period.

3.110 In February 2012 a meeting took place with Mr S and the London Probation Offender Manager, the youth offending team worker and a social worker from the independent support team. The Management Summary Report indicates that the key issue facing Mr S on release was that of accommodation; "*it was agreed that as a former looked after child it was the responsibility of social services After Care Team to secure suitable housing for* [Mr S] *until his 21st birthday*". It is reported that Mr S was initially placed in temporary accommodation, a hotel provided by social services, which was not considered suitable.

3.111 During March and April 2012 the Management Summary Report describes concerns about Mr S's mental health being raised by Mr S's mentor. These concerns stemmed from Mr S's behaviour at the hostel; for example Mr S had been hoovering his room at 3am and the mentor had observed Mr S's inability to handle certain situations appropriately.

4 Arising issues, comment and analysis

4.1 It is our opinion that five significant factors contributed to Mr S remaining without support from mental health services after discharge from the Wells Unit and without intervention after he overdosed on over the counter medication:

- no active follow up by mental health services in the community, after discharge from Sections 47 and 49 of the Mental Health Act;
- issues with record keeping by the child and adolescent service resulting in no information about Mr S being recorded after 2007;

- issues with record storage by the child and adolescent service resulting in a paper record being temporarily 'lost';

- incomplete or inaccurate information held by the Probation Service about Mr S's mental health history;

- psychiatric assessment in accident and emergency undertaken with incomplete information;

- Central & North West London NHS Foundation Trust risk assessment after Mr S presented at Chelsea & Westminster A&E that contained minimal information

4.2 In addition we noted that the records of the discussions with the probation officer and social worker instigated by the Assessment and Brief Treatment Team nurse were not entered in a timely fashion. The discussions were held on 1 November 2012 but the record was not entered until 11 November, after the Trust had been notified that Mr S had been arrested for the death of Mr J. It is not our view that had this entry been made sooner, the outcome for Mr J would have been different. However, timely record entry is important in ensuring that clinical colleagues have access to relevant and up to date information.

Section 117 aftercare responsibilities

4.3 Despite being detained under Sections 47 and 49 of the Mental Health Act whilst being assessed at the Wells Unit, Mr S did not receive any Section 117 aftercare from either West London Mental Health Trust or Central & North West London NHS Foundation Trust.

4.4 We have found no evidence of a Section 117 meeting being held; there are no invitations and no reports or minutes in either the West London Mental Health Trust records.

4.5 Dr W communicated by email and telephone with Dr A from the Wells Unit, and was informed of and invited to a Care Programme Approach review meeting on 30 December 2009 as well as a planned professionals meeting. Dr W did not attend the Care Programme Approach meeting and subsequently advised the Youth Offending Team that Mr S could self-refer to the child and adolescent mental health service in order to be seen with his mother.

4.6 We discussed this issue with Dr W who told us that he was unaware of the obligations of Section 117 aftercare in Mr S's case. Dr W told us that he knew Mr S was under Section 20 for local authority but that he had not appreciated that Mr S had been at the Wells Unit detained under the Mental Health Act. Dr W told us (in hindsight) "*there was clearly a duty there that I was unaware of*".

4.7 Dr W has no recollection of contact between himself and Dr A. His best recollection was of an invitation by a member of staff to one particular date. Dr W believes it is most likely that the date he recalls was the Care Programme Approach meeting on 30 December 2009. Dr W has

subsequently checked his work diaries and has confirmed he was on annual leave for this date. Dr W has indicated that although there appears to be no record to verify it, he felt it unlikely that he would not have informed the Wells Unit of this fact. Had appropriate records been kept at the time, Dr W would not have had to rely upon his memory of these communications.

4.8 Dr W told us that it was not the case that Mr S had to be seen with his mother. As Mr S did not want contact with community child and adolescent mental health services, Dr W recalled that he had suggested that either Mr S or his mother could make a referral to be seen at CAMHS.

4.9 Dr W has indicated that he disagrees with the assertion that no community follow up was provided in 2010. His assertion was that Mr S was offered the opportunity for his mother or him to self-refer directly to Dr W should they wish mental health input. In addition Dr W said that he was "*in contact with the Youth Offending Team, who knew that [Dr W] would provide consultation, should be it requested*". It is our opinion that offering a self-referral route to a young person who was difficult to engage, and who was being discharged from a secure psychiatric unit where he had been detained under the mental health act is not an appropriate aftercare package.

4.10 The duty to provide aftercare services continues until the health commissioning organisation and the local social services authority are both satisfied that the individual is no longer in need of such services. No assessment or monitoring of Mr S's progress was undertaken following his discharge from the Wells Unit and therefore the duty set out in Section 117 of the Mental Health Act was never met.

Record keeping within the child and adolescent mental health service

4.11 When we interviewed Dr W he told us that he vaguely recalled having a conversation with Dr A in late 2009 but that he had not received copies of the Care Programme Approach paperwork. Within the clinical records we received from the Trust, there were no records of the discussions, no copies of emails and no copy of the discharge report that appears to have been sent to Dr W.

4.12 In addition, there were no records relating to the contact that Dr W and other member/s of the child and adolescent mental health team had with Ms L and Mr D from the Youth Offending Team after 2007. We received copies of the emails between Dr W and Dr A via the Youth Offending Team.

4.13 There is no record of Dr W having received a copy of the discharge report from the Wells Unit despite the document indicating that Dr W was one of the three recipients.

4.14 Dr W told us that he had found some correspondence on the shared drive that was not included in Mr S's child and adolescent mental health service paper record that was eventually located. Dr W expressed concern about his level of confidence in the system for filing information within his service.

Record storage within the Trust

4.15 The clinical records for this case were provided by the Trust at the start of the investigation. However this did not include any records from child and adolescent mental health services.

4.16 Upon review of the information provided by West London Mental Health NHS Trust, the Trust responsible for the service at the Wells Unit, we found references to a community service on discharge.

4.17 We subsequently made enquiries with Central & North West London NHS Foundation Trust to establish whether any records existed for Mr S within child and adolescent services. We were told at that time that no records could be found.

4.18 When interviewing the Youth Offending Team Manager we learned that there had been significant contact between her service and the child and adolescent mental health service based at Parkside. We also learned that a community consultant named in one of the reports from the Wells Unit was a consultant who worked at Parkside.

4.19 We spoke to the consultant who advised us that a child and adolescent record did exist for Mr S. Further attempts were made by the Trust to locate the file and these were successful. We were told that the record had been misfiled when the child and adolescent mental health service records were put into storage.

4.20 As we had not been provided with any records prior to Mr S's assessment in April 2012, and we were told that we had been sent all the available records, we believed that there was nothing on Mr S's electronic patient record to indicate any prior history with the Trust.

4.21 We therefore asked what process was put into place to ensure accurate migration when the Trust moved from using Epex to Jade. The Clinical Safety Manager informed us "*an extensive programme with robust processes was implemented across the Trust to support staff through the transition and also support the migration of records from Epex to Jade. The Jade Team provided training for all teams and services to ensure that staff were able to use the new system competently*".

4.22 The Caldicott Guardian confirmed that when transferring patient record information from Epex to Jade, the Trust policy was followed. At the point that the Trust made this transition, all clinicians were made aware that the existence of a patient's Epex record is indicated on the Jade summary page. All staff were informed that if an Epex case is indicated, this means that there are paper records which form part of the care record. We understand that Epex records only contain certain activities (eg referrals) and so never formed part of the Trust's care record. Epex records are regarded as a partial electronic copy of the paper record so there is no requirement for clinicians to routinely access Epex records. Therefore paper records should be routinely sought if there is any indication that they exist.

4.23 The Clinical Safety Manager also told us that in the case of Mr S, the "*electronic information was printed from Jade only as the administrator was not aware of the need to search the Epex field in order to identify the patient's contact with other services*" prior to Jade being implemented. We understand that a memo has now been disseminated to the Serious Incidents and Safety Teams reminding all staff of the importance of accessing the Epex field when printing clinical information from Jade.

4.24 We asked the Clinical Safety Manager to clarify whether there was any information on the Jade record for Mr S to indicate that there was a record pre-Jade that could be relevant. She confirmed that the Jade record for Mr S clearly indicates on the clinical summary page the fact that there was Epex data that started on 4 June 2004.

Assessment conducted with incomplete information

4.25 On 21 September 2012 Mr S was taken via ambulance to the accident and emergency department at Chelsea and Westminster where he underwent an initial assessment. The record of this assessment indicated that Mr S had taken an overdose of 60 sleeping tablets, 8 Beechams, 12 "headache tablets" and two cans of Guinness at 7am. Initial examination indicated he was alert, reluctant to give history and had minimal eye contact. This document was not timed.

4.26 A nursing document completed at 08:30 stated that Mr S had taken an "*intentional overdose on pills – apparently 8 Beechams, 60 sleepaid tabs, 12 headache pills and two cans of beer*". It is also recorded that Mr S stated he just wanted it to end, but that he denied attempting suicide in the past.

4.27 An assessment completed by an accident and emergency department doctor was recorded at 09:00. The document states that Mr S "*took 60 x sleep aid, 8 x Beechams which include paracetamol and 12 x headache tablets*". The doctor also recorded that Mr S didn't plan the event and that he had never done it before and that he wasn't sure if he wanted to repeat the overdose. The doctor observed that Mr S was well dressed, interacting with short answers and had poor eye contact but no obvious thought disturbance.

4.28 At 09:45 a nursing document recorded that Mr S was complaining of nausea and was given medication for this. It was also noted "*awaits psych liaison and blood work @ 1100*".

4.29 A patient care record document completed by Mr M at 10:30 stated that Mr S had been seen and that an assessment and plan was attached. It also records Mr M's offer to Mr S to return for follow up on 23 September at 4pm.

4.30 This entry is in line with the Joint Operational Policy for the Psychiatric Liaison Service at Chelsea and Westminster Hospital. Section 42 of this policy states:

"*In the ED the Liaison Team will document their assessment either straight into the Emergency Department Medical record, or 'Cas Card' as its often referred to, and then copy into the discharge summary on Lastword or straight*

onto the Lastword discharge summary and print a copy off that goes into the patients 'Cas Card'."

4.31 Mr M told us that that when he came on duty on 21 September Mr S was already waiting in accident and emergency. Mr M said his memory was very clear that he was told it was a minor overdose. We can find no evidence that Mr M asked Mr S how many tablets he had taken.

4.32 Mr M said he had not had sight of any of the records that had been completed by accident and emergency staff that indicated the size of the overdose that Mr S had reported. Mr M told us that he could not recall why he hadn't seen the records that appear to have been completed before he assessed Mr S.

4.33 We asked about the process in place for referring patients to the psychiatric liaison service. We understand that written information is not always available to the liaison nurse prior to assessing a patient. Mr M was unable to quantify the frequency that this occurred but said that it was not uncommon. Mr M also told us that when completing his entry for a patient, he is sometimes asked to leave four or five lines of space for another professional to finish completing their entry at a later date. Mr M has clarified the casualty card used to record assessments at Chelsea and Westminster Hospital is very small, and additional loose pages frequently needed to be added to records. Mr M told us that staff often negotiated that space be left for entries to be completed.

4.34 We spoke to the former manager (Mr H) of the liaison service at Chelsea and Westminster Hospital to establish how common the issues were that Mr S raised. Mr H confirmed that patient records sometimes cannot be located as they can get temporarily mislaid or misplaced. He also told us that spending time trying to locate records is a common occurrence for liaison nurses. However Mr H said that the expectation is that a nurse gathers as much information as possible from all available sources before seeing a patient.

4.35 Mr H told us that he was never aware of staff being asked to leave space for other professionals to finish completing their entries at a later date. We understand that lots of other issues had been raised about managing documentation, particularly when accident and emergency is busy, however none of Mr H's staff (Mr M included) had ever raised "leaving space" as an issue.

4.36 Mr M told us that he was particularly concerned that Mr S had described himself using the label "DSPD". Regardless of whether that meant "dangerous and severe personality disorder" or "dissocial personality disorder" the fact that Mr S knew the label meant that Mr M felt Mr S had done something dangerous. Mr M said that he did not see any obvious signs of paranoia, which he described as looking around and responding to voices.

4.37 Mr M described being frustrated at not being able to refer Mr S to the forensic service, the team that he (Mr M) felt was the appropriate team. Mr M's referral to the forensic team was not accepted, as Mr S was not on Care Programme Approach. Mr M told us that he felt this was a paper issue and that putting somebody on a Care Programme Approach could be done by anybody. Mr M

said that he was pushed into referring Mr S to the Assessment and Brief Treatment team, that he was concerned they would take a long time to see Mr S, and that Mr M felt that Mr S wouldn't attend unless "*somebody knocked on his door*".

4.38 We asked the Trust to advise whether anybody had requested the paper records as part of information gathering after Mr S had presented at A&E and been referred to the Assessment and Brief Treatment Team. The Trust has told us that there is no record on Jade of the notes being tracked and the organisation "*has not been able to identify whether the notes for this patient were requested*".

Risk assessment

4.39 The risk assessment for Mr S completed by Mr M after he saw him in accident and emergency is very brief. It simply states:

- the risk was that Mr S was seen in accident and emergency following an overdose of medication
- no known triggers for the overdose other than isolation and ongoing personality difficulties.

4.40 Section 2 of the risk assessment does not give any details of the outcome or service user perspective of the risk identified in Section 1. Neither does it provide any information about the concerns that Mr M described to us about the degree of Mr S's isolation and the label of DSPD.

4.41 We found a more detailed text document completed by Mr M that was filed in the accident and emergency records held by Chelsea & Westminster Hospitals NHS Trust. This document provided significantly more details about his assessment of Mr S. We found this more detailed assessment embedded in a fax sent to the Probation Service and included in the progress notes. Although this information was contained within Mr S's record held by the Trust, it was not in a formal risk assessment and therefore there was the risk that it could have been overlooked.

4.42 Mr M has told us that he was a new member of staff at the time and therefore he was "*still in learning mode with the JADE system*" and that the recorded history, mental state exam and management plan recorded in the progress notes was his risk assessment. We understand that Mr M was appointed to his role as a liaison nurse at Central & North West London NHS Foundation Trust on 2 July 2012. We have been advised that Mr M completed training on the JADE system on 6 and 26 July and that he completed the five-day Trust induction programme and a local induction. The Trust induction programme included a session on the Clinical Risk Policy.

4.43 In addition, some of the content of this document was shared with Mr S's GP in the form of a letter, and the same text was included in referral letters to the forensic team and the Assessment and Brief Treatment team.

4.44 The Joint Operational Policy for the Psychiatric Liaison Service at Chelsea and Westminster Hospital, in place at the time states at Section 42:

"*The Liaison Team will always upload the same information on the CNWL Electronic Patient record system – JADE.*"

4.45 The Clinical Risk Assessment and Management Policy and Adult Services Procedure 2009 states the principles of clinical risk assessment and management as:

- *"All service users that have contact with secondary or tertiary mental health services must have a risk assessment;*
- *The risk assessment must be clearly recorded;*
- *Subsequent action plans are essential to minimise risk;*
- *Past history of risk must be taken into consideration;*
- *Staff must consult the full case records before reaching conclusions regarding risk.*
- *Members of the multi disciplinary team (MDT) must be made aware of the underlying risk factors and whenever possible be involved in the process of assessing and managing risk*."

4.46 Page 22 of the same policy describes the procedure for adult services clinical risk assessment and management procedure. This includes the completion of detailed risk assessments where there is a risk of:

- "*Risk of/from substance misuse (RA 2.1)*
- *Risk of self-harm/suicide (RA 2.2)*
- *Risk of self-neglect/vulnerability (RA 2.3)*
- *Risk of violence or sexual assault (RA 2.4)*
- *Risk to children (RA 2.5)*
- *Risk from eating disorder (RA 2.6)"*

4.47 Page 23 of the policy sets out the quality standards for initial assessments when a service user is accepted by a community-based team. The document states:

"*A risk management plan RA3 and Risk Event History RA4 MUST be completed in all cases and will be used to communicate the outcome of the risk assessment between professionals."*

4.48 Page 24 of the policy indicates, "*For service users who fall within the following categories, the full risk assessment is advised*". Those categories include:

- "*Service users with a known history of violence, the use of weapons, assault, serious self-harm or a serious attempt of self-harm, self-neglect, vulnerability, substance misuse or a history of other risk taking behaviours, access to children."*

4.49 We could not find any evidence of these assessments because although the community team accepted Mr S's referral, nobody from that team ever met with Mr S. He did not attend the first appointment offered to him and he had already been arrested for the index offence at the point of the second appointment. The policy is not clear about how risk assessments should be managed when the service user has a history that indicates significant risk, but that the clinical team has not met with the service user to fully analyse that risk.

Incomplete or inaccurate information held by the Probation Service

4.50 The Youth Offending Team planned the transfer of Mr S's case to the Probation Service over a number of weeks. Appropriate officers from both agencies attended planning meetings and a final meeting was held in August 2011 to formally hand over relevant documents. It is unfortunate that there is no record of exactly which documents were handed over by the Youth Offending Team and that final minutes of the transfer meeting are not held in the Youth Offending Team records.

4.51 We have not had access to the records held by the Probation Service to establish what information they received from the Youth Offending Team.

4.52 The Management Summary Report completed by the National Probation Service makes reference to Mr S's mental health assessment under Section 47/49 of the Mental Health Act at the Wells Unit. The "*mental health assessment report"* states that Mr S was "*discharged back to Feltham with a report stating that there was no evidence of psychotic symptoms or any other acute major mental health disorder*". Mr S was never discharged back to Feltham. He was released into the community from the Wells Unit at the end of his sentence in January 2010. The mental health assessment report, which we believe to be the discharge report dated 22 January 2010 goes on to state that it was "*entirely possible that* [Mr S]*…could have experienced transient psychotic symptoms due to stress*" and that this needed to be "*taken into consideration carefully if in the future there were further concerns about his mental health*".

4.53 The interpretation by the Probation Service that Mr S had not suffered any acute major mental health disorder contributed to the lack of awareness at MAPPA discussions about Mr S's mental health needs. As we have not had access to any of the assessments completed by the Probation Service we are unable to comment upon the accuracy of their content as regards Mr S's mental health history.

4.54 The Probation Service undertook their own investigation, which is standard practice for any statutory case where the offenders have committed a Serious

Further Offence. We have not seen a copy of that investigation report and therefore cannot comment upon the issues that it identified.

4.55 To provide some context to the number of Serious Further Offence investigations undertaken each year we reviewed the Multi-Agency Public Protection Arrangements Annual Report for 2012/13. The number of MAPPA eligible offenders charged with a Serious Further Offence in 2012/13 who remained charged as at 31 March 2013 in was eight. Four of which were Category One offenders and four of which were Category Two offenders.

MAPPA discussions

4.56 Ms B, manager of the forensic team, told us at interview that she had no recollection of any mental health issues having been raised at the MAPPA meetings. Ms B advised us that Mr S "*came in at Level 2, and was discussed and went out at Level 1*". Following interview Ms B reviewed the minutes of the relevant MAPPA meetings and confirmed that her recollection was correct. Ms B told us that a MAPPA meeting was held on 22 December 2011 to discuss Mr S. Action points to manage Mr S's risk were formulated and Ms B confirmed that these were achieved by the next meeting on 26 January 2012, when Mr S's case was moved to Level 1.

4.57 Ms B told us that no mention had been made of Mr S having been detained under any section of the Mental Health Act. She also told us that when she receives the list of cases on the agenda for a MAPPA meeting she checks the names against the databases she has access to. Ms B did this when she received the agenda with Mr S's name on and found nothing. Ms B also told us that if she had been aware of the information about Mr S being detained under Sections 47 and 49 of the Mental Health Act, it would have made a significant difference to the pathway for him after he had presented at accident and emergency.

Accessing a psychiatric assessment

4.58 In addition to the issues raised above we feel it is important to highlight the numerous attempts by the Youth Offending Team to secure a psychiatric assessment for Mr S whilst he was a young adolescent.

4.59 These attempts were unsuccessful due to the frequency and number of imposed moves between institutions across the country. This meant that Mr S was rarely in one place sufficiently long to wait the length of time required for assessment to commence.

4.60 There were also issues about which organisation was responsible for conducting an assessment whilst Mr S was in Medway for a four month period from January 2007. This led to delays in securing an assessment and a lack of understanding of Mr S's risk.

4.61 We have considered whether a recommendation to address these difficulties would be appropriate. We recognise, given the length of time that has passed, that the currently situation may be markedly different. However we

have included a final recommendation for commissioners of child and adolescent mental health services.

5 Internal investigation and action plan

5.1 The internal investigation team comprised:

- a non-executive director who was also the Chair of the Panel;
- a consultant psychiatrist and clinical director;
- a deputy service director and lead nurse;
- a lead for social care mental health;
- an external facilitator from an investigations company.

5.2 The team were able to interview a broad range of professionals from within the Trust and external agencies that had contact with Mr S in the period prior to the offence. This is unusual in an internal investigation and is to be commended.

5.3 However the report fails to identify that records from the child and adolescent mental health service were missing and that Mr S should have received Section 117 aftercare following discharge from the Wells Unit.

5.4 We support the recommendations made by the internal investigation team. These were:

1. *"The Trust should examine means for police liaison staff to have access to the Trust databases when accessing clients at police stations. Arrangements should also be made for staff to be able to use the Trust risk assessment proforma without opening each person as a client onto the Central & North West London NHS Foundation Trust database.*

2. *We recommend that the managers of the Focus Team review the referral exception criteria to bring clarity to the circumstances it is intended to cover.*

3. *The offender service line should produce guidance to be distributed to all areas that sets out how urgent forensic advice can be obtained.*

4. *The Focus Team should clarify whether someone with a severe personality disorder but not a severe mental illness is eligible for services from the team.*

5. *We recommend that in the light of the changes to service lines the Trust undertake a review of referral pathways to ensure that the principle of a comprehensive service is maintained, in particular that there are clear forensic pathways for advice and support to other teams and practitioners."*

5.5 When reviewing the progress made by the Trust in implementing the recommendations we found the following evidence:

1. The Trust has advised that since February 2013 police liaison nurses have had laptops with access to Jade via a wireless 'dongle'. In addition liaison nurses are now registered as a team on Jade which means they can now open cases and record assessments. *Source: Trust Action Plan updated January 2014.*

2. Referral inclusion and exclusion criteria have been discussed and agreed by a meeting of senior operational staff from across the Trust. The decision has been made to only accept clients from Assessment and Brief Treatment team for level one and two assessments except for exceptional circumstances, to be determined by the forensic team. All cases for level three/four management will come from the recovery service line. Referrals from the Assessment and Brief Treatment team for level four management will not routinely be accepted by the forensic team unless the usual case management route has been tried first. Such referrals will happen only in very exceptional circumstances as defined and agreed by the forensic team. *Source: Trust Action Plan updated January 2014.*

3. "*The plan for the distribution of the revised summary of Level 1 consultation and advice was discussed in the Senior Cross Trust Performance Meeting on 16th December. It will be taken forward at the next KCW Service Manager Interface Meetings and also the KCW Team Manager Interface Meetings. These meetings have been reviewed and are due to follow a new timetable from January 2014.*" *Source: Trust Action Plan updated January 2014.* A revised referral process and referral criteria was incorporated into the Kensington & Chelsea FoCUS Team's Operational Policy by April 2014. The Kensington & Chelsea and Westminster FoCUS Teams have had a single manager since 1 November 2014 and the referral processes were reported in March 2016 as "*now being brought together*".

4. Service users with a diagnosis of personality disorder are assessed under the Operational Policy for a service from the forensic team. The service offered is considered by the assessing clinicians on a case-by-case basis and referring teams receive reports on their referrals. *Source: Trust Action Plan updated January 2014*. We asked the Trust for the year 2014/15 how many referrals of service users with a diagnosis of personality disorder the team has (a) considered, (b) accepted and (c) what has happened to those referrals that have been rejected. We have been told that 65 service users were referred of which eight had a diagnosis of personality disorder. Those eight referrals had the following outcomes:

    A. Referred for care management following detention under Section 37/41 and admission to a medium secure unit. Taken onto caseload.

    B. Referred for risk assessment. Service user did not attend any appointments so case closed. Main agency remains Jigsaw Unit.

C. Referred to Assessment and Brief Treatment Team, then referred on to FoCUS for risk assessment. Service user due to appear in court, did not attend any appointments and was given a criminal justice disposal.

D. Referred to Assessment and Brief Treatment Team, then referred on to FoCUS for risk assessment. Service user was on probation for assaulting a member of staff, engaged in the personality disorder pathway within probation attending the local MBT group.

E. Referred for a risk assessment, which was completed with service user being referred to the local personality disorder treatment centre, where they remain.

F. Referred and risk assessment completed. Service user now under Care Programme Approach with the community mental health team.

G. Referred for risk assessment, which was completed. Service user was under Care Programme Approach with the community mental health team.

H. Referred for risk assessment. Service user was in breach of their license and was recalled to prison. In reach team at the prison were asked to become involved.

5. The Operational Policy has been reviewed in line with the information provided in points two and three above. *Source: Trust Action Plan updated January 2014*

6 Overall analysis and recommendations

6.1 A number of errors led to Mr S's mental health history not being available to adult mental health services. In addition Mr S was mistrustful of professionals, borne out of considerable periods of his life spent in segregation in various institutions. It is the opinion of the panel that this mistrust led to Mr S's somewhat hostile interaction with Mr M and minimal information being shared about his past history.

Predictability and preventability

6.2 As an assessment document completed by the Youth Offending Team indicated, a serious assault resulting in death or life changing injuries was predicted. It is for this reason that Mr S was placed on MAPPA Level 2. However this information does not appear to have been known to mental health services.

6.3 When Mr S's name appeared on the agenda for a MAPPA meeting, the Trust database was checked to see if Mr S was known to the service. No information was found. It is unclear why this was. Clinical staff have told us that they could find no historic information for Mr S when they searched Jade. We were therefore initially of the view that the transfer of Mr S's clinical data

from Epex to Jade had not been completed correctly and therefore staff were unaware that a mental health history existed. However we have subsequently learned that the Jade record clearly indicates a previous episode of care when the Trust used Epex to record clinical events. This information in itself also tells staff that a paper record exists for a client.

6.4 However, the clinical records for Mr S held by the child and adolescent service were incomplete and therefore even if the paper records had been requested, the key information relating to Mr S's detention under Sections 47 and 49 of the Mental Health Act, and his subsequent management under MAPPA was missing.

6.5 Ms B told us that had she known Mr S's mental health history when she checked the database upon receiving the MAPPA meeting agenda, she would have proposed a very different response from the forensic team.

6.6 When staff from the Assessment and Brief Treatment team contacted the Probation Service they were told that no information could be provided about Mr S's history and risk as his case was closed to the service. Probation Service staff acknowledged during interview with the internal investigation team that this was poor practice and not in line with their own policies. If this information had been shared it would have resulted in a different assessment by Trust staff of Mr S's risk.

6.7 As we have demonstrated, some organisations involved with the care and treatment of Mr S knew his full history and risk profile, however this information was not known to adult mental health services. Therefore we consider that the tragic death of Mr J could not have been predicted or prevented by adult mental health services.

6.8 However, had the information about Mr S's detention under Sections 47 and 49 of the Mental Health Act been properly recorded by the Trust this would have resulted in a different response from the forensic team when Mr M attempted to refer Mr S. This information, combined with the knowledge of Mr S's MAPPA history would have presented a very clear picture of an individual with a significant history of violent offences. On this basis, it is our view that had these key pieces of information been available to Trust staff in September 2012, a further violent offence could almost certainly have been predicted.

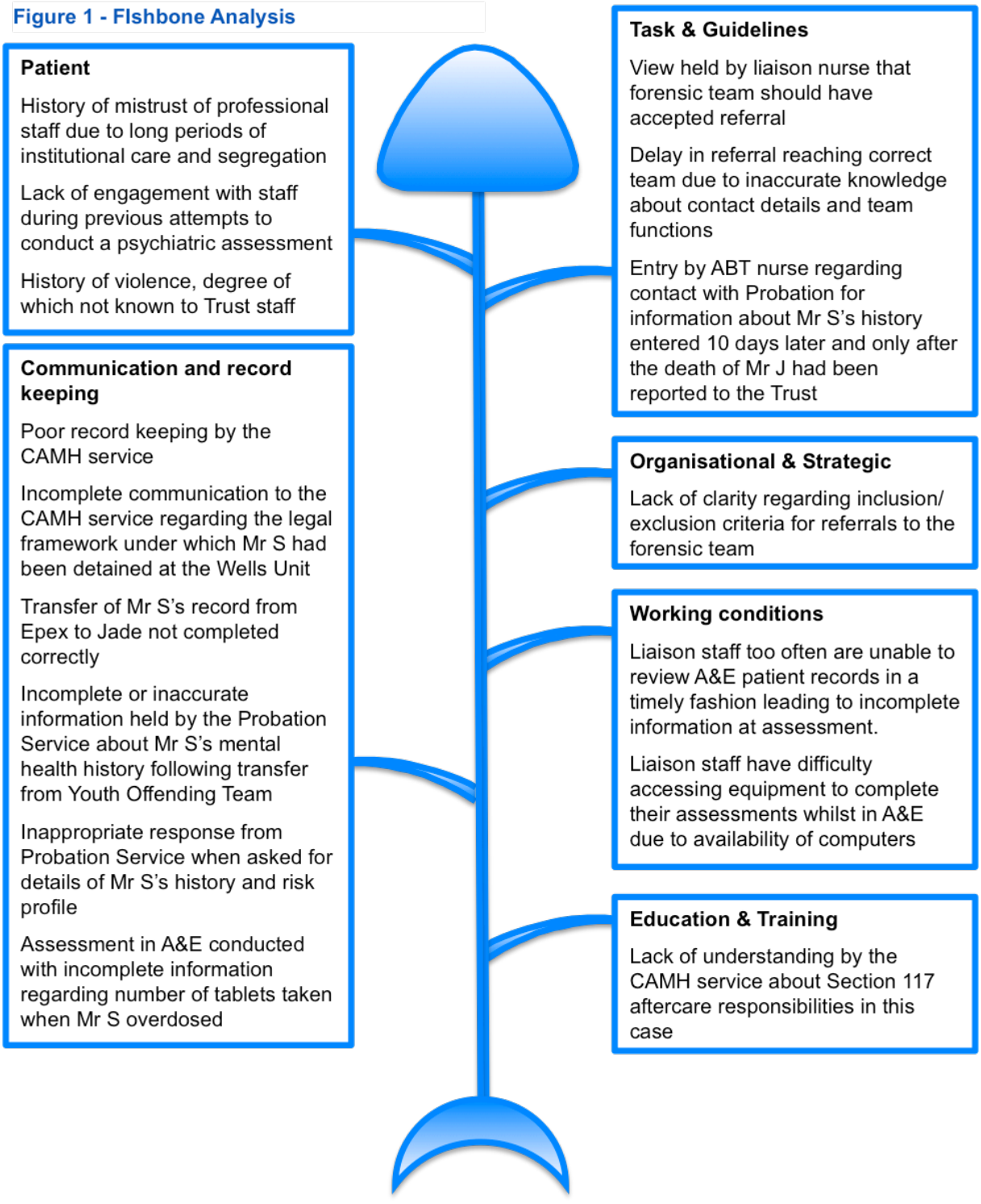
6.9 This leaves the issue of preventability, had relevant information been shared. This is much more difficult to comment upon. It is **possible** if:

- Trust staff knew about Mr S's significant history of violent offences, and;
- Trust staff knew about Mr S's MAPPA history, and;
- Trust staff had therefore taken a more assertive approach in engaging with Mr S, and;
- Mr S had responded well to an identified treatment programme;

that Mr S might not have committed a burglary that resulted in the death of Mr J. However there are too many variables with unknown outcomes for us to be able to say that the death of Mr J was likely to have been preventable by mental health services.

6.10 The fishbone diagram at Figure 1 on the following page sets out the key issues we have identified.

Figure 1 - FIshbone Analysis



Recommendations

Recommendation 1

The Trust must ensure that when a team is liaising with a secure inpatient unit regarding care for a patient following discharge, the receiving team must ensure that they are clear what legal framework applied to the period of inpatient care and treatment.

Recommendation 2

West London Mental Health Trust must ensure that prior to discharging a detained patient from inpatient services, a section 117 aftercare meeting is held and that appropriate mental health aftercare plans are identified and put into place.

Recommendation 3

The Trust must undertake a review of record keeping across the Trust, paying particular attention to the child and adolescent mental health service, and implement an on-going audit programme to ensure that appropriate standards are maintained.

Recommendation 4

The Trust must undertake an audit across the organisation to identify the degree of compliance with the record keeping policy. Where there are concerns about compliance, the Trust must implement a training programme to ensure that all staff understand the importance of all communications regarding a patient being filed within the clinical record. The Trust must also implement on on-going programme of audit to provide assurance that records are completed correctly.

Recommendation 5

The Trust must ensure that when placing records into storage and archive, correct procedures are followed to ensure successful retrieval at a later date. An audit programme must also be implemented on each occasion to provide assurance that records have been stored correctly.

Recommendation 6

The Trust must work with partner agencies providing accident and emergency services to ensure that the joint operational policies are complied with, in particular that clinical records are available to psychiatric liaison staff in a timely fashion, to facilitate fully informed assessment of patients.

Recommendation 7

The Trust must ensure that operational policies are followed. The Trust must implement a process to ensure that staff understand the importance of key aspects of policies. The Trust must also implement a systematic process to provide assurance regarding compliance.

Recommendation 8

The Trust must review the risk assessment policy to clarify how risk assessments should be managed when the service user has a history that indicates a significant risk, but the clinical team is unable to meet with the service user to fully analyse the current risk.

Recommendation 9

Commissioners of child and adolescent mental health services must have systems in place to assure themselves that child and adolescent mental health service providers respond in a timely fashion to requests for assessments when the young person is in an institutional setting.

6.11 We have reviewed the difficulties that agencies had in securing a successful mental health assessment for Mr S. Those difficulties were exacerbated by repeated enforced moves from one institution to another and Mr S was frequently not in one place long enough to be seen.

6.12 We have considered whether a recommendation to address these difficulties would be appropriate. We have concluded that, given the length of time that has passed that the current situation is likely to be markedly different and therefore have chosen not to make a specific recommendation on this occasion.

6.13 It is not within the remit of this report to make formal recommendations to non-NHS agencies. However, we suggest that if they have not already done so, the Youth Offending Team and the Probation Service may wish to consider the following suggestions. We acknowledge that the Probation Service has already investigated this matter internally, and may have reviewed these points already.

Comment for Youth Offending Team

6.14 The Youth Offending Team should review the process used when transferring management responsibility for a case to the Probation Service. Records should clearly indicate which documents have been included in the transfer 'bundle' and a copy of that 'bundle' should be retained.

Comment for Probation Service

6.15 The Probation Service should review policies, systems and processes to ensure that when staff receive a request for information about a individual's history and risk profile, appropriate information is shared in a timely manner. An ongoing audit programme should also be implemented to ensure that appropriate standards are being maintained.

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 S's first contact with services to the time of his offence.
- Review the appropriateness of the treatment of Mr S 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 S harming himself or others.
- Examine the effectiveness of Mr S's 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

- Client records for Mr S
- Trust Final Serious Incident Investigation Report dated July 2013
- Trust Action Plan
- Transcripts of interviews conducted during the internal investigation
- Reports of any audits undertaken relating to recommendations in the action plan
- Operational policy in place in April 2012 for Police Liaison Community Mental Health Team
- Operational policy currently in place for Police Liaison Community Mental Health Team
- Operational policy in place in September 2012 for Psychiatric Liaison Service
- Operational policy currently in place for Psychiatric Liaison Service
- Operational policy in place in September 2012 for Focus Team
- Operational policy currently in place for Focus Team
- Risk Assessment policy in place covering the period April 2012 to September 2012
- Current Risk Assessment policy
- Service structure covering the period April 2012 September 2012
- Current service structure
- Policy in place covering the period April 2012 to September 2012 for the management of patients with a personality disorder
- Policy in place currently for the management of patients with a personality disorder
- Policy for the involvement of families in Serious Untoward Incidents
- Summary of the organisational change that took place during the period November 2010 to June 2012 and rationale for the change

Kensington & Chelsea Youth Offending Team

- Case recording summary
- Children and Families Case Review for Mr S completed February 2015
- Pre-sentence report for Mr S dated 23 December 2010
- Asset Core Profile for Mr S dated 27 June 2011
- Asset Risk of Serious Harm for Mr S dated 24 June 2011
- Closing and Transfer Summary for Mr S dated 19 September 2011
- London Probation Area Sentence Notification for Mr S dated 6 April 2011
- Feltham YOI Proposals for the Training Plan (T1:A) for Mr S dated 22 February 2011
- Feltham YOI DTO Initial Planning Meeting (T1:P) for Mr S dated 22 February 2011
- Feltham YOI Review of Vulnerability Assessment (T1:VR) for Mr S dated 22 February 2011
- HMP/YOI Isis Sentence Planning and Review Meeting Notes for Mr S dated 21 June 2011: notes in draft form and incomplete
- Police print of PNC record
- West London Mental Health Trust Multi-disciplinary Report for Care Programme Approach for Mr S dated 30 December 2009
- West London Mental Health Trust Care Programme Approach Report for Mr S dated 23 November 2009
- West London Mental Health Trust letter to YOT dated 8 December 2009 enclosing copies of the care plan and review report following the Care Programme Approach/Section 117 meeting that took place on 23 November 2009
- West London Mental Health Trust Discharge Report for Mr S dated 22 January 2010

Other Documents

- West London Mental Health NHS Trust clinical records
- Chelsea & Westminster NHS Foundation Trust clinical records
- GP records
- National Offender Management Service & National Probation Service Management Summary of Serious Further Offence Review dated April 2015

Appendix C - Chronology of Mr S's contacts with the Trust, his GP, Youth Offending Team, Leaving Care Team, and events leading up to the homicide

Date	Source	Event	Information	Age
2001	RBKC records	Children and Families Service Case Review	Family first known to RBKC Family Services in relation to Mr S senior joining the family. Mr S senior previously known for domestic violence incidents. Mr S witnesses Mr S senior being arrested by armed police.	8.0
2002	RBKC records	Children and Families Service Case Review	Barlby School concerned at Mr S's behaviour. Not viewed as having learning difficulties, "is bright and articulate but displays disruptive behaviour which causes him to underachieve". A range of support put in place including School Action Plus.	9.0
18/01/02	RBKC records	Children and Families Service Case Review	Mr S assaulted by a member of the public.	9.0
12/09/02	RBKC records	Children and Families Service Case Review	Mr S's mother (Ms L) requests support re Mr S's behaviour - fighting, running away from home, starting to become involved in criminal activities. Issues identified with Ms L's parenting - mental health difficulties, establishing boundaries. Plans put in place to support family. Counselling offered to Mr S and Ms L for behaviour management.	9.6
2003	RBKC records	Children and Families Service Case Review	Barlby School requests LEA undertake statutory assessment of Mr S's Special Educational Needs.	10.0
03/07/03	RBKC records	Children and Families Service Case Review	SEN statement made for Mr S. Long term emotional and behavioural difficulties. Mr S viewed to have short attention span, but good general knowledge and [considered] to be intelligent child.	10.4
29/08/03	RBKC records	Children and Families Service Case Review	Mr S threatened by parent of a friend. Police involvement - NFA.	10.6

Date	Source	Event	Information	Age
Oct-03	RBKC records	Children and Families Service Case Review	Referral to Children's Resource Team (CRT) for work to be undertaken with Ms L and Mr S.	10.7
Dec-03	RBKC records	Children and Families Service Case Review	Mr S moves to Vernon House School in Brent. Variable attendance - escort to school arranged.	10.8
Jun-04	RBKC records	Children and Families Service Case Review	Mr S moves to Bessels Leigh School in Oxfordshire. LEA and Social Care agree joing funding given difficulties. Mr S becomes Looked After Child (LAC) Section 20 to establish SEN (36 week) residential placements. Returns home for visits and holidays.	11.3
Jun-04	RBKC records	Children and Families Service Case Review	Multi-agency network meeting to address concerns re Ms L's self reported agoraphobia and impact on children. Offered transport and CAMHS sessions re parenting/boundaries. Ms L encouraged to seek CAMHS support.	11.3
04/06/04	CNWL CAMHS records	Referral	CAMHS referral form completed by social services, requesting that somebody from Parkside Clinic attended a meeting the following week to discuss child protections concerns. Psychological assessment of Mr S also requested.	11.3
09/06/04	CNWL CAMHS records	Record of meeting	Notes of the meeting held to discuss the concerns about Mr S and siblings. Notes provided by social services, supporting papers also present.	11.3
17/06/04	CNWL CAMHS records	Telephone call	Call from Dr W to a social worker Mr G. Dr W recorded that he did "not see a role for CAMHS as family therapy was indicated but Ms H did not want further help from professionals. Dr W happy to participate in a four-way meeting if required.	11.3
18/06/04	CNWL CAMHS records	Telephone call	Call from Dr W to social worker Ms K. Dr W recorded that Ms K agreed with Dr W's approach in his discussion the previous day with Mr G. Ms K agreed to discuss with Ms H.	11.3
07/07/04	CNWL CAMHS records	Cancelled appointment	Ms H called to cancel her appointment with Dr W planned for that day.	11.3

Date	Source	Event	Information	Age
16/08/04	CNWL CAMHS records	Letter	From Dr W to Ms K to advise that he had closed Mr S's file at that time as Mr S had been offered a place in a termly EBD boarding school and that any further CAMHS input would be similar to the input being offered by the social worker Mr G.	11.3
26/02/05	RBKC records	Children and Families Service Case Review	LAC review notes Mr S's sadistic behaviour - involved in killing sheep and sabotage of teacher's car. Mr S trying to get stimulation from asphyxiation. Recommendation that Mr A is assessed by child psychologist.	12.1
Jun-05	RBKC records	Children and Families Service Case Review	Mr A becomes a 52 week placement at Bessels Leigh School to provide stability and protect other children in the home.	12.3
22/07/05	RBKC records	Children and Families Service Case Review	3 month referral order for criminal damage	12.5
12/09/05	RBKC records	Children and Families Service Case Review	3 month referral order for criminal damage to the school bus.	12.9
20/09/05	GP records	Letter	To GP from Oxford CAMHS advising that they had diagnosed Mr S with conduct disorder, coupled with risk of developing dissocial personality disorder. Recommendations were for consistent management of his behaviour, referral for psychotherapy assessment to address abnormal emotional development and amoral behaviour which if unaltered placed him at high risk of offending with violence again; and future placement after leaving school would need careful planning to ensure that Mr S was helped to develop further.	12.9
15/12/05	RBKC records	Children and Families Service Case Review	Oxford CAMHS consider Mr S for referral but consider inappropriate, as he does not have a mental illness - rather a conduct disorder with developing personality disorder.	12.9
2006	RBKC records	Children and Families Service Case Review	Mr S's grandfather dies.	13.0

Date	Source	Event	Information	Age
20/01/06	RBKC records	Children and Families Service Case Review	3 month Action Plan Order for battery - assaults at school.	13.0
02/03/06	RBKC records	Children and Families Service Case Review	Suspended from Bessels Leigh School for 4 days following 2 further episodes of bullying.	13.1
07/04/06	RBKC records	Children and Families Service Case Review	9 month supervision order for battery - assaults at school.	13.2
23/06/06	RBKC records	Children and Families Service Case Review	Mr S causes £2000-£3000 worth of damage after dispute with staff.	13.4
03/07/06	RBKC records	Children and Families Service Case Review	Mr S due to have 2 week assessment by the Portman Clinic. Mr S refuses to attend, but sees school therapist.	13.4
14/09/06	RBKC records	Children and Families Service Case Review	Mr S involved in theft of keys to school bus, driving and crashing it. Suspended for 10 days.	13.6
09/11/06	RBKC records	Children and Families Service Case Review	Suspended for 2 weeks for bullying other children and stealing keys from school office.	13.8
10/11/06	RBKC records	Children and Families Service Case Review	1 year supervision order - driving without a licence, aggravated vehicle taking (school bus) no insurance. Returns to family home supervised by RBKC YOT.	13.8
22/11/06	RBKC records	Children and Families Service Case Review	Mr S permanently excluded by Bessels Leigh School. Concerns that he poses risks to staff and students. LEA begin to seek alternative placement.	13.8

Date	Source	Event	Information	Age
09/12/06	RBKC records	Children and Families Service Case Review	Mr S injured himself as a result of fooling around with a lawn mower after a sponsored mow. Spends 4 days in hospital. Placement terminated and Mr S returns home to live with mother Ms L.	13.9
30/12/06	RBKC records	Children and Families Service Case Review	Arrested for breach of Court imposed curfew.	13.9
05/01/07	RBKC records	Children and Families Service Case Review	Remanded to LA care by Youth Court following arrest for burglary.	13.9
15/01/07	RBKC records	Children and Families Service Case Review	4 month DTO (Detention and Training Order) sentence burglary and theft. Medway Secure Training Centre.	14.0
Feb-07	RBKC records	Children and Families Service Case Review	Mr S seen by CAMHS Oxfordshire. Report notes "concerns re some degree of sociopathic tendency".	14.0
05/02/07	RBKC YOT records	Meeting	Meeting between Ms L and a clinical psychologist. Discussed psychiatric assessment that was considered appropriate following assessment by OT in Abingdon. Felt that Mr S had long standing conduct disorder and he would benefit from support in managing behaviours and understanding mental state. Psychiatric assessment could help in identifying an appropriate package of care following release.	14.1
07/02/07	RBKC YOT records	Meeting	Email from Ms J regarding the psychiaitric assessment. Ms J advised that the CAMHS team responsible for the assessment would be the one for Medway, as long as Mr S was resident there. Ms J said this is the outcome she suspected, and it was confirmed by Dr W when she raised the issue in the team meeting.	14.1

Date	Source	Event	Information	Age
08/02/07	RBKC YOT records	Meeting	Telephone call from Mr C social worker for Mr S to Ms L. Mr C advised that Mr S did not have a formal diagnosis but it was felt that he had anti-social personality disorder. Mr C said that they were looking for a psychiatric report and risk assessment to be completed and that Medway staff have completed an initial mental health screening but they will undertake a "*more intrusive*" assessment.	14.1
22/02/07	RBKC YOT records	Email	Email from Ms L to Mr C to advise that she had been unable to contact someone at Medway to discuss the assessment. Ms L advised that she would attend the CAMHS meeting on 26/2 to ask whether Mr S could be offered a psychiatric assessment asap on release.	14.1
26/02/07	RBKC YOT records	Referral	Ms L attended CAMHS Parkside and gave a completed referral for Mr S, requesting psychiatric assessment.	14.1

Date	Source	Event	Information	Age
26/02/07	RBKC YOT records and CNWL CAMHS records	Email	Email from Ms L to Ms J, copied to Dr W, advising that she had attended CAMHS for the meeting today to learn that the meeting had taken place an hour earlier. Ms L outlined her attempts to secure an assessment for Mr S. Ms L mentioned that the SEN department had suggested Sedgemore School. Advised that the current plan was for Mr S to return home to his mother on release although his mother had expressed concerns about being able to cope with Mr S's behaviour. Mr S's mother has said she is afraid to leave Mr S with her younger children as he assaults them. Ms L advised that a discharge planning meeting would take place on 2/3 at Medway when Mr S's licence conditions would be discussed. Ms L said that it would be very helpful if CAMHS did agree to carry out the psychiatric assessment. Response from Dr W stated 'this is quite clearly complex and risky' indicating that Medway should have organised an assessment as they were responsible for his medical care and that local CAMHS would find planning more difficult as a consequence. Dr W agreed to discuss the referral at the team meeting the following Monday. Call from Ms L to Dr W to discuss whether CAMHS were able to offer psychiatric assessment. Dr W was concerned that the assessment should have been done by the CAMHS local to Medway and that they should have had Mr S's risk assessed prior to release. Dr W expressed concern that Mr S would be released without his risk being quantified, therefore no measures could be put into place, therefore his risk to the public on release was unnecessarily increased.	14.1

Date	Source	Event	Information	Age
08/03/07	CNWL CAMHS records	Letter	From Dr W to Ms L to advise that his understanding was that the YOI was responsible for the medical care of detained young people and that medical services should not be delivered by the provider serving the young person's home area. Dr W noted that it was preferable to conduct a psychiatric assessment whilst a young person was in secure accommodation as trying to do so in the community presented significant challenges regarding attendance at appointments. Dr W concluded that he did not feel it appropriate to give an appointment time to meet with Mr S as he noted that one of the options being considered for Mr S on discharge was for him to live with his grandmother. If this were to be the case then Mr S would be outside Dr W's catchment area.	14.1
09/03/07	RBKC YOT records	Email	Email from Medway to Ms L outlining why a psychiatric report was not actioned by Medway. Initial planning meeting at Medway held 25/1 the mental health process at Medway was explained to YOT. Medway advised that they were unable to provide a psychiatric assessment and it was agreed that a mental health referral should not be completed at that time due to timescales and the need for consistency of services.	14.1
12/03/07	CNWL CAMHS records	Email	Copy of email sent from Ms L to Medway forwarded to Dr W. Dr W responded advising that a hard copy letter had been sent to Ms L.	14.1
15/03/07	RBKC records	Children and Families Service Case Review	Released from Medway and continues to reside at home.	14.1

Date	Source	Event	Information	Age
21/03/07	RBKC YOT records	Health visit	Mr S attended his appointment with Ms L for a health assessment and engaged well during the hour. It appears that Mr S struggles to control his anger at times and this results in out of control behaviours. Ms L discussed referral for psychiatric assessment with Mr S, he expressed reluctance about engaging but Ms L reminded him it was a condition of his licence, which he appeared to accept. Mr S said that social services had cancelled the planned visit to the residential school and that arrangements had been made for him to attend the Latimer Centre for an assessment. Ms L noted that she would contact Dr W about dates for a psychiatric assessment but that it may not be immediately forthcoming as the referral was discussed at a CAMHS meeting and it had not been classed as a priority or urgent as Medway had not considered it to be one.	14.1
26/03/07	RBKC YOT records and CNWL CAMHS records	Email	Email from Dr W to Ms L offering to meet with Mr S and suggesting that he join a planned session with Ms L.	14.2
26/03/07	RBKC YOT records and CNWL CAMHS records	Email	Email from Ms L to Dr W advising when she would be seeing Mr S. Ms L also noted that Mr S had started to miss YOT appointments and that he had been arrested for criminal damage during the previous week. Dr W responded advising when he was available to meet with Mr S and suggested that Ms L contact Mr S's mother to see whether she would like to attend with Mr S.	14.2
29/03/07	RBKC records	Children and Families Service Case Review	Arrested for attempted burglary - charge downgraded to criminal damage.	14.2

Date	Source	Event	Information	Age
10/04/07	RBKC YOT records	Health visit	Mr S did not attend the appointment for psychiatric assessment with Dr W. Dr W has said that he would offer a further appointment on 25/4 at 2:15pm. Dr W asked Ms L to ask Mr S's mother to attend the appointment, as Dr W would need to speak to her. Ms L recorded that that she and Dr W discussed that Mr S's mother was agoraphobic and that Ms L would offer to also accompany. Ms L informed Dr W that Mr S was due in court for breach on 16/4. Ms L later informed Dr W that having spoken to Mr S's social worker she had been advised that Mr S had a scheduled visit on 25/4 so he would be unable to attend an appointment then. Dr W due to see Mr S on 2/5.	14.3
01/05/07	CNWL CAMHS records	Email	Emails bewteen Ms L, Dr W and another YOT worker regarding Mr S's appointment the following day. Dr W noted that Ms H was able to "*get out quite a lot despite her diagnosis*".	14.3
02/05/07	RBKC YOT records	Psychiatric assessment	Mr S did not attend.	14.3
09/05/07	RBKC records	Children and Families Service Case Review	Arrested for going equipped to steal.	14.3
09/05/07	CNWL CAMHS records	Letter	From Dr W to Ms L advising that he had attended the Youth Offending Team on 2 May to meet with Mr S who arrived as Dr W was leaving, as Mr S was late. Dr W suggested a joint home visit	14.3

Date	Source	Event	Information	Age
15/05/07	RBKC YOT records	Health visit	Mr S attended a visit with Ms L. Discussed the psychiatric assessment, Mr S was unhappy about his mother being involved and said he didn't see why she should be punished for what he had done. Ms L discussed with Mr S why he felt this way – he reluctantly engaged and spoke about Ms L not understanding him; that Ms L only did her job for money and didn't care about him. Ms L agreed that Mr S could talk to his mother about the assessment the following week, that this would be a statutory appointment and that Ms L would call her. Mr S understood that he was required to be present.	14.3
21/05/07	RBKC YOT records	Telephone call	Ms L called Mr S's mother Ms H to remind her about the home visit. Ms H said that she had changed her mind and that she was no longer prepared to meet with Ms L and Dr W. Ms H said this was because she felt that everyone has let them down, she spoke negatively about professionals and was unwilling to consider meeting for the purposes of the psychiatric assessment. After some persuasion she did agree to talk with Dr W on the phone the following day. Ms L subsequently informed Dr W and Mr C of Ms H's decision. Dr W suggested that Ms L brought Mr S to the CAMHS clinic and that the call to Ms H took place with Dr W, Ms L and Mr S in the room.	14.3
24/05/07	CNWL CAMHS records	Letter	From Dr W to Mr S's mother regarding the psychiatric assessment he had been asked to do. Dr W advised that, as he was unable to meet with her, he was not in a position to do a thorough assessment. Dr W advised that he had offered Mr S three appointments but that he had only been able to see Mr S for a few minutes on one occasion on 2 May when Mr S was late. Dr W informed Ms H that he did not consider he could compel Mr S to complete an assessment as there was no evidence that Mr S was suffering from a major mental illness that required psychiatric treatment. Dr W concluded that he had let the Youth Offending Team know that he was not in a position to progress the assessment. However if Dr W was able to meet with Ms H and she could help in ensuring Mr S's attendance at appointments she was welcome to contact him.	14.3

Date	Source	Event	Information	Age
31/05/07	RBKC records	Children and Families Service Case Review	Family Group Conference held. Plan made with family to include: * outings with step father Mr L * stays with grandmother * regular visits home/quality time with mother Ms L * increased telephone contact * engagement in mentoring programme.	14.3
05/06/07	RBKC YOT records	Telephone call	Ms L called Mr C to advise that the decision had been made to close the referral for CAMHS for psychiatric assessment as neither Mr S nor Ms H were engaging. Mr C advised that Mr S had said that he would like to attend the Latimer Centre and that Mr C was arranging for Mr S to be assessed for the DPU.	14.4
10/06/07	RBKC records	Children and Families Service Case Review	Arrested for breaching bail conditions. Found in mother's loft.	14.4
19/06/07	RBKC records	Children and Families Service Case Review	Remanded to LA care and accommodated at St Mark's Children's Home.	14.4
25/06/07	RBKC records	Children and Families Service Case Review	Mr S on role of Pupil Referral Unit and remains on role until he leaves formal education in 2009. Attends some sessions at Riverview College (25 hours per week).	14.4
02/07/07	RBKC YOT records	Telephone call	Ms L received a call from St Mark's Children's Home to advise that Mr S had been arrested and needed an appropriate adult. Attempts to call mother had failed. North social services agreed that as Mr S was a looked after child, one of their team would attend.	14.4
02/07/07	RBKC records	Children and Families Service Case Review	6 month supervision order, 3 month curfew order. At home. Going equipped.	14.4

Date	Source	Event	Information	Age
07/07/07	RBKC records	Children and Families Service Case Review	Arrested for possession of a knife. Charged without bail. Remanded to LA care by youth courts. Resides St Mark's Children's Home.	14.4
21/07/07	RBKC records	Children and Families Service Case Review	Arrested for criminal damage.	14.5
06/08/07	RBKC records	Children and Families Service Case Review	Arrested for arson. Set light to a tree outside St Mark's. Request for secure accommodation. Non available so held in custody.	14.5
13/08/07	RBKC records	Children and Families Service Case Review	18 month supervision order. Having a bladed article.	14.6
22/08/07	RBKC records	Children and Families Service Case Review	18 month supervision order. Interfering with a motor vehicle.	14.6
06/09/07	RBKC records	Children and Families Service Case Review	Mr S missing since 26/8/7. Arrested and placed in custody.	14.6
11/09/07	RBKC records	Children and Families Service Case Review	4 months and 4 months consecutive DTO Medway Supervision and Training Centre. Arson and having a bladed article.	14.8
28/09/07	RBKC records	Children and Families Service Case Review	Arrested from St Mark's for breaching curfew.	14.7
19/10/07	RBKC records	Children and Families Service Case Review	Found a home following period of missing for 2 weeks.	14.7

Date	Source	Event	Information	Age
29/01/08	RBKC records	Children and Families Service Case Review	Moved to Huntercombe YOI due to 17 incidents reported at Medway.	15.0
22/04/08	RBKC records	Children and Families Service Case Review	Recalled to Huntercombe for breach of licence. No Longer LAC.	15.2
08/07/08	RBKC records	Children and Families Service Case Review	Released from Huntercombe and resides at Periton Mead School.	15.4
11/07/08	RBKC records	Children and Families Service Case Review	Refuses to return to school following day visit home. Decision that Mr S will stay at home.	15.5
03/08/08	RBKC records	Children and Families Service Case Review	Released from Huntercombe YOI on Section 20, placed at Periton Mead, Somerset - over next month alleged bullying incidents and sexual activity with girls.	15.1
09/09/08	RBKC records	Children and Families Service Case Review	Has altercation with older brother results in Mr S threatening to stab him. Mr S leaves home and mother refuses to have him back.	15.6
22/09/08	RBKC records	Children and Families Service Case Review	Remanded to LA care, placed on Section 20 at St Mark's.	15.7
29/10/08	RBKC records	Children and Families Service Case Review	Charged with burglary - bailed.	15.8
03/11/08	Internal report	Detained at F	At YOI Feltham between 3/11/08 and 8/11/08 and was involved in a number of violent altercations during this time.	15.8

Date	Source	Event	Information	Age
03/11/08	RBKC records	Children and Families Service Case Review	Arrested for assault of staff member. Remanded to Feltham YOI.	15.8
08/11/08	Internal report	Released	Released from Feltham YOI	15.8
08/12/08	RBKC records	Children and Families Service Case Review	Released from Feltham and moved to Short Stop.	15.9
16/12/08	RBKC records	Children and Families Service Case Review	Found guilty of common assault on member of staff.	15.9
30/12/08	RBKC records	Children and Families Service Case Review	Education and Intensive Supervision and Surveillance Programme (YOT) assessment received.	15.9
Jan-09	Internal report	Sentenced	Sentenced to 10 months at YOI Feltham in January 2009. At time of arrest Mr S was already in breach of bail conditions when he assaulted a police officer on 14/1/09.	15.9
14/01/09	Internal report	Assault	Assault on police officer	16.0
15/01/09	RBKC records	Children and Families Service Case Review	Arrested for ABH, having assaulted a police officer. Had been missing since 9/1/09.	16.0
19/01/09	RBKC records	Children and Families Service Case Review	DTO 10 months. Burglary, common assault, possession of class C drug. Remanded to Feltham YOI. During period at Feltham several incidents of fighting, making a weapon, placement in segregation unit.	16.0

Date	Source	Event	Information	Age
Feb-09	Internal report	Assaults	During February 2009 Mr S (1) assaulted an officer by spitting on him (2) had three separate fights with other offenders on the segregation unit (3) made a weapon out of metal which he stored in his room (4) threw hot water in the face of another offender	16.0
27/03/09	RBKC records	Children and Families Service Case Review	DTO 18 months. Robbery, ABH, aggravated vehicle taking, resist constable. Ashfield YOI.	16.2
07/04/09	Internal report	Assessment	Assessed by Adolescent Forensic Psychiatrist. Mr S described auditory hallucinations, impulsivity and a belief that he was God. Psychiatrist unsure if Mr S was delusional and wrote that he would require further monitoring to see if the delusion developed.	16.2
07/04/09	RBKC records	Children and Families Service Case Review	Assessed by Adolescent Forensic Psychiatrist. Mr S described auditory hallucinations, impulsivity and a belief that he is God. Psychiatrist unsure if Mr S was delusional and wrote that he would require further monitoring to see if the delusion developed.	16.2
18/05/09	RBKC YOT records	Telephone call	YOT worker spoke with MoJ expressing concern that Mr S had been moved so far away from London to Castington (beyond Newcastle) and the effect that this would have on the ability of the YOT to provide support to Mr S. MoJ advised that it was perceived that this was an opportunity for a fresh start for Mr S and that hopefully he would not have to be managed by being in segregation. YOT worker asked if she could be confident that there would be no further moves as she would then arrange for Mr S to access support from the local area. MoJ indicated that this would depend on his behaviour and that every effort would be made to keep Mr S at Castington. YOT worker called Castington to ask about local support provision and was told to call back on the day that Mr S actually arrived. YOT worker alluded to the fact that Mr S presented as a young man who may have autism but due to previous refusals to engage in relevant assessments, a proper evaluation had not been achieved.	16.3

Date	Source	Event	Information	Age
18/05/09	RBKC records	Children and Families Service Case Review	Moves to Castington YOI Northumberland due to violent and challenging behaviours. During period here Mr S reported to display concerning behaviours, threats to staff, results in him being placed on a three man unlock with segregation.	16.3
26/06/09	RBKC YOT records	Telephone call	Ms L called Health Care Manager at Castington YOI and asked whether Mr S had seen a mental health specialist. If not Ms L asked whether it would be possible for Mr S to be seen by a psychiatrist to assess whether he would be suitable for an interim hospital order. Ms L described how it had not been possible to obtain a psychiatric assessment in the past due to non compliance, but that they were concerned that Mr S was presenting as extremely paranoid and appears to have symptoms indicative of depression.	16.4
30/06/09	RBKC YOT records	Multi-professional meeting	YOT Manager chaired multi-professional meeting including MoJ, allocated social worker, senior social worker, Ms L, and YOT case manager. The purpose of the meeting was to establish what action should be taken given the high level of incidents Mr S had been involved in whilst in custody and the continual containment in segregation units as a management strategy. YOT is concerned that this management strategy will exacerbate Mr S's anger issues and any underlying mental health problems. MoJ worker stated that his role was to manage the most difficult young people in custody nationally, and that Mr S was one of eight young people. Concerns about Mr S making weapons whilst in custody and that he had presented as paranoid and depressive. YOT had concerns about being able to manage Mr S on release and therefore wanted to explore possibility of obtaining a hospital order on release. MoJ worker stated that the best CAMHS team in custodial institutions was in Wetherby and that he would explore the potential for Mr S to be assessed there. Agreed to make a referral to MAPPA.	16.4

Date	Source	Event	Information	Age
30/06/09	RBKC YOT records	Telephone call	Ms L spoke to Mental Health Nurse from Castington. Ms L was told that Mr S had been prescribed a neuroleptic (rispiridone) as Mr S had described convincing audtiory and visual hallucinations. The plan was for Mr S to take the medication and then be reviewed in 6 weeks, however this didn't happen as Mr S was moved from the establishment.	16.4
21/07/09	RBKC YOT records	Supervision	Mr D met with Ms L for supervision and Mr S was discussed. Noted that a psychiatric report was to undertaken whilst Mr S was at Ashfield Hospital. The report recommended that Mr S was monitored to establish whether or not he was *'frankly psychotic*'. Ms L to liaise with Dr C to get another psychiatric report. If the report found Mr S to be psychotic the YOT would apply for an interim hospital order. Response received the following day to say that Mr S would be assessed by a psychiatrist and that he would only be admitted to hospital if he were to be found to be experiencing a psychotic illness.	16.5
21/07/09	RBKC YOT records	Email	Email from Ms L to Dr D, psychiatrist at WLMHT regarding Mr S. Ms L said that Mr S was due to be released on licence in November and that there were concerns within YOT about his mental state and level of risk. Ms L advised that Mr S had been in segregation most of the time he had been inside and was very aggressive and violent. Mr S had been seen in April by a psychiatrist in Feltham who felt he needed longer term monitoring. Mr S was then moved to Ashfield where he saw another psychiatrist who prescribed a low dose of respiridone, which Mr S took sporadically, then stopped. Ms L advised that she had met with Mr S in the past and at that time she felt he was very withdrawn and low in mood. He had engaged in a session with Ms L but seemed very apathetic about his future, affected by his difficult relationship with his mother and his complex/traumatic family history. Ms L advised that at the time she attempted to get Mr S seen by a psychiatrist but his mother refused to engage in the assessment process so it didn't happen.	16.5

Date	Source	Event	Information	Age
22/07/09	RBKC YOT records	Email	Email from Dr D, psychiatrist at WLMHT to Ms L advising that they will organise another psychiatrist to assess Mr S. Dr D noted that a significant number of young people in Feltham report hearing voices but only a minority have a psychotic illness.	16.5
Aug-09	RBKC records	Children and Families Service Case Review	Referred to MAPPA for number of convictions, robbery and assaults.	16.5
05/08/09	RBKC records	Children and Families Service Case Review	Moves to Feltham YOI - over next 2 months allegations of indecent exposure, attack on a cleaner. YJB risk of harm report concludes "Mr S does not appear to have any empathy/victim awareness…YOU concerned that once released Mr S will cause harm to others through assault/beating and reckless behaviour".	16.5
11/08/09	Internal report	Report	Youth Justice Board risk of serious harm report concluded that Mr S does not appear to have any empathy/victim awareness and that the YOT are concerned that violent behaviour will continue on release.	16.5
27/08/09	RBKC YOT records	Discussion with colleague	Copy of the psychiatric assessment for Mr S shared with Ms L. Conclusion is that there is no evidence of a developing psychosis as Mr S is now saying he made it all up.	16.6

Date	Source	Event	Information	Age
03/09/09	RBKC records	Case discussion	Held between Ms L, Mr D, Operational Manager and YOT Case Worker. Noted that the YOT had increasing concerns about Mr S. Firstly there was an acute concern in relation to his mental health and the significant risks he posed if released. Mr S had a high likelihood of reoffending and presented as a very high risk of serious harm to others. It had been the YOT's intention to apply for a hospital order, for this to have happened the court must be satisfied (on the evidence from two registered medical practitioners) that Mr S was suffering a mental disorder and that the disorder is of a nature or degree that warrants his guardianship under the act. YOT were unable to recommend a hospital order as the second assessment stated that ther was no evidence of developing psychosis as Mr S was now saying that he made it all up. The assessment described anti-social personality disorder but no demonstration of psychosis, which ruled out the option of a secure hospital order upon release. It was noted that the Operational Manager had contacted another psychiatrist from CNWL Dr L to ask for his opinion, however he was on leave at the time of the meeting.	16.6
26/10/09	Internal report	Assessment	Assessment at W Forensic Adolescent Unit, run by WLMHT	16.8
26/10/09	WLMHT records	Care Plan	Admitted to the Wells Unit from HMPYOI Feltham under Section 47/49 MHA. Section will cease on 18/1/10 when custodial sentence ends.	16.8
26/10/09	WLMHT records	Admitted to The Wells Unit	Admitted from HMYOI Feltham under Section 47/49 MHA	16.8
26/10/09	RBKC records	Children and Families Service Case Review	Discharged to Wells Unit (secure adolescent psychiatric unit). Discharged from there on 18/1/10. Assessment by consultant adolescent psychiatrist concludes Mr S did not show any signs or symptoms of psychotic illness. Attended some anger management sessions.	16.8

Date	Source	Event	Information	Age
25/11/09	RBKC records	Children and Families Service Case Review	Professional and planning meetings held to plan for Mr S's release: * housing in self contained accommodation with 20 hours support, near K&C * liaison with CAMHS * CAMHS YOT worker to offer sessions to Mr A through his licence * education sessions, eg gym, music * liaison with MAPPA * provision of weekly subsistence * detailed arrangements for day of release	16.8
03/12/09	RBKC YOT records	Meeting	Mr D attended a meeting at CAMHS Parkside Clinic with the YOT Manager, someone from CAMHS, the consultant psychiatrist Dr W, and Ms L. It was noted that Mr S was discussed as an individual case and highlighted that he was currently at the Wells Unit; he had reoffended whilst in custody and would now be released in January 2010. It was reiterated that Mr S is both a high risk of serious harm to others and a high risk of reoffending and that managing those risks in the community presented significant challenges. It was noted that Dr W was made aware of Mr S's release date and Dr W had stated he would be in contact with Dr A and would attend Mr S's discharge meeting.	16.8

Date	Source	Event	Information	Age
03/12/09	RBKC YOT records	Email	Email from Dr A, Consultant Psychiatrist at the Wells Unit to Dr W child and adolescent psychiatrist to advise of a Care Programme Approach meeting arranged for 30/12. Also advised that if Dr W couldn't make that date then a professionals meeting was being organised for the following week. Dr A indicated that she was unsure on the mental health input that would be appropriate on discharge as Mr S had reported convincing auditory hallucinations but would not engage with professionals in prison for assessment. Dr A said that Mr S had definitely not be psychotic, and that although he appeared to have ADHD he was refusing medicaiton. Dr A said that Mr S had marked conduct symptoms, a dysfunctional belief system around the role of aggression in relationships, and respect. Dr A said that Mr S was functioning much better at the Wells Unit than he did in prison, engaging with education and therapy programme to a limited extent. Dr A noted that Mr S appears to have been markedly neglected in terms of education and emotional development.	16.9
04/12/09	RBKC YOT records	Email	Email from Dr W to Dr A advising that "*although psychiatric responsibility will not be transferred formally to me, I am very happy for him and/or his mother to self refer to the clinic…I will keep in touch with professionals who will be seeing him, including those from the YOT, and will offer consultation if appropriate*."	16.9
18/01/10	Internal report	Discharged	Discharged into care of YOT and Social Services	17.0
18/01/10	WLMHT records	Significant event	MHA Section 41 (5) - Notional 37	17.0
18/01/10	WLMHT records	Leave	F901 - hyperkenetic conduct disorder. F911 - unsocialised conduct disorder. Diagnosed by Dr VF	17.0
18/01/10	RBKC records	Children and Families Service Case Review	Released from Feltham. Psychiatric summary concludes "*our assessment shows that Mr S not suffering from mental illness*". Provided with emergency placement due to LA being let down by semi independent agency.	17.0

Date	Source	Event	Information	Age
18/01/10	RBKC YOT records	Email	Email from Ms L to Dr W asking for reasons why CAMHS would not be seeing Mr S on release from the Wells Unit. Ms L advised that she understood Mr S had been offered therapy sessions with a psychologist within the Wells Unit and and thought this may continue in the community. Ms L stated she had hoped that Dr W would be able to have some input into how Mr S's risk in the community could be reduced. Dr W responded providing copies of email exchange between him and Dr A in December and suggested to Ms L that they '*catch up on the phone*'.	17.0
22/01/10	WLMHT records	Discharge	Discharged to temporary place of residence.	17.0
22/01/10	RBKC YOT records	Supervision	Mr D met with Ms L for supervision and Mr S was discussed. Discussion focussed on Dr W's agreement to attend the discharge meeting at the Wells Unit, however he didn't attend the Care Programme Approach meeting and has not agreed to see Mr S on his release from the Wells Unit. Ms L had asked for the reason that CAMHS are not going to see Mr S and wondered if it was because Mr S had refused to engage with CAMHS. It was noted that Dr W had offered to see Mr S and/or his mother if he self-referred to the clinic. Mr D recorded "*Having reflected on this we are in a position where a high risk young person who was in a tier 4 service is not going to be seen by CAMHS unless he self refers. Furthermore Dr W didn't attend the Care Programme Approach meeting and is not undertaking psychiatric responsibility…Therefore we will be actively promoting self referral and arranging a consultant with Dr W to assist us with managing risk in the community.*"	17.0
28/01/10	RBKC records	Children and Families Service Case Review	Arrested for public order offence - bailed.	17.0
02/02/10	RBKC records	Children and Families Service Case Review	Arrested for suspected theft.	17.0

Date	Source	Event	Information	Age
11/02/10	RBKC records	Children and Families Service Case Review	Remanded into Feltham until 8/3 for burglary. During assessment denies experiencing any mental health problems. Assessed by psychiatrist on 4/3. On 19/3 Mr S pretended to hang himself, and laughed when staff attended him.	17.0
15/03/10	RBKC YOT records	Supervision	Mr D met with Ms L for supervision and Mr S was discussed. It was noted that when Mr S was released from the Wells Unit Parkside [clinic base of the child and adolescent mental health service] decided it wasn't necessary to attend his discharge meeting despite the discharge report describing Mr S has having emotional and behaviour problems linked to emotional and educational neglect and traits of anti-social personality disorder. It was noted that Mr S was due to be sentence the previous day and that Ms L was liaising with Dr A, Consultant Psychiatrist at the Wells Unit.	17.2
29/03/10	RBKC YOT records	Email	Email from Ms L to Dr A, Consultant Psychiatrist at the Wells Unit asking for suggestions about potential placements that could offer Mr S the level of therapeutic input and boundaries that he required, whilst being able to cope with his high level of aggressive behaviour. Ms L advised she was considering the Cassel Hospital as they take patients up to the age of 25.	17.2
31/03/10	RBKC YOT records	Email	Email from Dr A to Ms L advising that she would be happy to contribute to the thinking about on going care for Mr S. Dr A indicated that the Cassel would not be appropriate as it is intensively therapeutic and Mr S did not have the necessary level of ability to tolerate such a therapeutic environment. Dr A stated that she had discussed with Mr S the possibility of him staying at the Wells Unit at the end of his sentence but he was adamant he would not stay in hospital if he was not in custody. Dr A said that she had seen Mr S once during his current period of custody and although he was pleasant to Dr A, Mr S did not see the point in seeing dr A again unless she was going to transfer him to the Wells Unit again.	17.2
01/04/10	RBKC YOT records	Email	Email from Ms L to Dr A, Consultant Psychiatrist at the Wells Unit seeking advice about how to arrange Mr S's release and requesting assistance in considering potential placements for Mr S.	17.2

Date	Source	Event	Information	Age
12/04/10	RBKC records	Children and Families Service Case Review	DTO 4 months, x3. Battery x2, burglary and theft. Feltham YOI.	17.2
20/4/10	RBKC YOT records	Discussion with colleague	Ms L called Ms C to discuss the possibility of Mr S being put forward for a children's home that specialises in working with children with challenging behaviours and emotional disorders. Ms C agreed that Mr S "*gained immensely in terms of new social skills and improved behaviour from his short period of time in the Wells Psychiatric Unit*" and that Ms L's proposal was worth considering as Mr S's current level of everyday living skills were very inadequate. Ms L & Ms C discussed what the consultant psychiatrist from the Wells Unit had said about engaging Mr S in an intensive structured programme in order to manage his risk to others.	17.2
26/04/10	RBKC YOT records	Discussion with colleague	Discussion between Ms L and Ms C regarding placement plans for Mr S. Ms C advised that two potential placements had been identified and that the St Luke's assessment plans should be placed on hold until after the placement planning meeting.	17.2
27/04/10	RBKC YOT records	Email	Email from Ms L to St Luke's Healthcare regarding identification of a potential placement within St Luke's. Advised that the social worker from children and families would be taking the case to a placement planning meeting to request funding.	17.2
19/05/10	RBKC records	Children and Families Service Case Review	Planning for Mr S release. Includes: * weekly visits to placement from YOT * weekly subsistence * 24 hours key worker support * purchase of gym membership * allowance for TV and essential items.	17.3
01/06/10	RBKC records	Children and Families Service Case Review	Released from Feltham.	17.3

Date	Source	Event	Information	Age
18/06/10	RBKC YOT records	DTO appointment	Mr S told Ms L that he found it difficult to remember appointments now that his caseworker was away as she usually reminds him. Ms L discussed how Mr S was coping with living independently. Recorded that he seems to be managing and is clearly looking after himself ie hygiene etc. Also recorded that Mr S spoke about being organised and having self respect and managing on a small amount of money.	17.4
29/06/10	RBKC YOT records	Appointment	Ms L called Mr S to say that she was unable to see him for his health appointment that day and rearranged it for Friday at 11am.	17.4
06/07/10	RBKC records	Children and Families Service Case Review	Remanded into custody (Feltham) following arrest for commission of 7 offences.	17.4
02/08/10	RBKC records	Children and Families Service Case Review	Appears in court in relation to charges of burglary, aggravated motor vehicle taking, driving without licence and failure to produce sample for drug test.	17.5
03/09/10	RBKC records	Children and Families Service Case Review	Planning for Mr S release. Includes: * re-accommodation * package of support until 18th birthday.	17.6
20/09/10	RBKC records	Children and Families Service Case Review	12 months Youth Rehabilitation Order. Intensive Supervision and Surveillance, including tagged curfew. Burglary, aggravated TWOC, dangerous driving, possession of a bladed article, no insurance or licence. Supervision of order undertaken by Greenwich YOT.	17.7
21/09/10	RBKC records	Children and Families Service Case Review	Released from Feltham and accommodated in Woolwich.	17.7
29/11/10	RBKC records	Children and Families Service Case Review	Remanded into custody, robbery. Feltham YOI.	17.8

Date	Source	Event	Information	Age
29/12/10	RBKC records	Children and Families Service Case Review	12 months DTO, robbery. Feltham YOI.	17.9
30/12/10	RBKC records	Children and Families Service Case Review	Case closed to LAC.	17.9
04/01/11	RBKC records	Children and Families Service Case Review	Joint psychiatry and psychology review concludes that Mr S not psychotic or depressed. Noted he has difficulties controlling his behaviour and working within social constraints. Mr S engages in weekly psychology sessions.	17.9
06/04/11	RBKC records	Children and Families Service Case Review	Custody YOI - adult sentence 18 months. ABH x2. HMP Isis. Transferred to Probation June and July.	18.2
17/05/11	RBKC YOT records	Case note	Recorded that feedback from a prison visit indicated that Mr S was engaging in the adult literacy and numeracy and that he wanted to continue with this. Mr S had reported that he had been using the gym regularly and that it was something he looked forward to. Mr S reported visits from family members and that he was hoping his father would send him some gym clothing when he was released. Mr S said that he didn't want to get too close to the other prisoners as he felt they couldn't be trusted. Mr S said that serving his sentences in isolation for so long had made him very cold towards developing relationships with others, even family members.	18.3
19/05/11	RBKC YOT records	Email to Probation	Email from YOT social worker to Ms F, probation officer requesting that Ms F attend a meeting on 21/6 to discuss the case transfer.	18.3
21/06/11	RBKC YOT records	Transfer to Probation	Case closed to RBKC YOT as Mr S now an adult and therefore his case should be transferred to Probation. Mr S currently serving a long custodial sentence (18 months) alongside his DTO. Mr S will never be released under his Notice of Supervision.	18.4
21/06/11	RBKC YOT records	Email with meeting notes	Email from Ms H, YOT social worker to all professionals invited to transfer meeting. [Details of minutes not available to us as not within the YOT record.] Request for Ms F to contact Ms H to hand over all relevant documents.	18.4

Date	Source	Event	Information	Age
22/06/11	RBKC YOT records	Email from Probation	Email from Ms F providing availability for meeting the following week, prior to going on leave for a week.	18.4
24/06/11	RBKC records	Asset Risk of Serious Harm	Conclusion that Mr S presented as high risk of harm to others and that the recommendation was that MAPPA Level 2 was appropriate. Noted that Mr S was on the list for Operation Blunt[21] 2 and Deter Panel.	18.4
27/06/11	RBKC records	Asset Core Profile	Improvement noted in Mr S's lifestyle, for the first time he had been able to keep away from fights. Possibility noted that during the prolonged period of segregation in prison Mr S experienced high levels of arousal and sensitivity to threats. Suggestion that Mr S could have experienced transient psychotic symptoms due to stress. Noted that this information needs to be taken into consideration carefully in the future if there were further concerns about his mental health. Recorded that Mr S did not want to engage with probation on release. Noted that MAPPA meeting in October 2009 classified Mr S as MAPPA Level 2 which was "*quite exceptional for a youth*".	18.4
14/07/11	RBKC YOT records	Meeting between Probation and YOT	Planned meeting to hand over documents did not take place due to urgent strategy meeting that Ms H needed to attend for another client. Ms H suggested that she and Ms F met in early August.	18.5
19/09/11	RBKC records	Closing and Transfer Summary	Report completed whilst Mr S was serving a long custodial sentence (18 months).	18.6
05/11/11	RBKC records	Children and Families Service Case Review	Family relocate to Hillingdon.	18.8

[21] *"Operation Blunt 2…represents a significant enhancement of enforcement tactics in response to public concern regarding public place violence in London, notably that affecting young people and involving the use of knives." Metropolitan Police Authority, Strategic and Operational Policing Committee 8 June 2009 Report by T/Assistant Commissioner Territorial Policing on behalf of the Commissioner. http://policeauthority.org/metropolitan/downloads/committees/sop/090608-20-exemptreport.pdf*

Date	Source	Event	Information	Age
Feb-12	RBKC records	Children and Families Service Case Review	Personal advisor begins work with Mr S re education, training and employment.	19.0
02/02/12	Interview transcript	Accommodation arrangements	Ms R and Mr A took Mr S to Warwick Road Hostel for an interview which he failed. Mr S then interviewed by Homeless Person's Unit who offered him accommodation for about 31 days at Aveley Hotel.	19.0
02/02/12	Interview transcript	Accommodation arrangements	Ms R and Mr A took Mr S to Warwick Road Hostel for an interview which he failed. Mr S then interviewed by Homeless Person's Unit who offered him accommodation for about 31 days at Aveley Hotel.	19.0
04/02/12	Internal report	Treatment	Treated for stab wounds and arrested at St M Hospital. Assessed by staff from the Trust Police Liaison Service. Mr S was hostile, denied a history of mental illness. Requested an Appropriate Adult. Assessed as fit to be interviewed and not in need of an Appropriate Adult.	19.2
02/04/12	CNWL records	Referral	Arrested on public order offence at St Mary's Hospital. Following admission to hospital ward Mr S became verbally abusive and threatening to staff displaying violence. Mr U, community psychiatric nurse attempted to assess Mr S in his cell due to Mr S having been abusive whilst in custody. Mr S made brief eye contact then looked away. Hostile in manner, denied any history of mental illness, denied any contact with services. Currently has a stab wound, no other medical history. Mr U checked police database: numerous arrests for robbery, handling [stolen goods], theft, public order. Mr S had been sentenced in a young offenders' institution in the past. Patient database showed contact with services in 2007. Mr U attempted to ask Mr S about this but Mr S was not forthcoming. Mr U recorded no symptoms of mental illness at time of assessment.	19.2
02/04/12	RBKC records	Children and Families Service Case Review	Treated for stab wounds at St Mary's Hospital. Denied history of mental illness. Assessed as fit to be interviewed.	19.2

Date	Source	Event	Information	Age
02/04/12	CNWL records	Progress note	Assessment in cells following arrest at St Mary's Hospital, where Mr S presented at hospital with a stab wound. Mr S became verbally abusive and threatening towards staff. He denied any contact with services, but when staff member checked police database, found that Mr S had numerous arrests for multiple offences. Conclusion: no symptoms of mental illness present, fit for interview, no appropriate adult required.	19.2
02/04/12	CNWL records	Risk Screening Form RA1	Identifies risks of previous violence towards others, intimidating/threatening/aggressive behaviour at assessment, history of detention under the MHA or prison. However no detailed assessments provided for the risks identified.	19.2
May-12	Internal report	Release	Following release at F arrangements made for Mr S to have a place at a hostel.	19.3
25/05/12	RBKC records	Children and Families Service Case Review	Hostel. Probation risk assessment OASYS states high probability of re-offending, and high risk of harm.	19.3
Jun-12	Interview transcript		Planning meeting with IST - Mr S back in HMYOI Isis.	19.3
Sep-12	Internal report	A&E	Taken by ambulance (self-requested) to A&E at CW Hospital. Taken large umber of over-the-counter sleep aiding tablets, headache tablets and two cans of Guinness. After treatment Mr S was considered medically fit for discharge but also referred to the A&E Psychiatric Liaison Service.	19.6
21/09/12	CNWL records	Referral	Assessed by Mr M psychiatric liaison nurse. Mr S presented with overdose of over the counter medication: sleepeze, beechams tablets and Guinness. "*Alone in a probation hostel and isolated - family are in Norfolk*" and Mr S had just come out of prison in Leicester where he service one month for possession of a knife. Mr S gave the name of his probation officer. Mr S could not pin point any triggers other than referring to his childhood which he blamed for his problems. PLAN: discharge when fit, letter to GP, see in follow up 23/9, patient aware to return any time if in crisis, discuss with offender care and contact probation.	19.7

Date	Source	Event	Information	Age
21/09/12	CNWL records	Referral	Mr M called offender management team (FOCUS) and left a message regarding referring Mr S. Mr M noted that the overdose seemed to be a cry for help "*in the context of his recent release and social isolation*".	19.7
21/09/12	CNWL records	Progress note	Assessed in Chelsea & Westminster Hospital by CNWL psychiatric liaison nurse, Mr M. Mr S presented following overdose of over the counter medication - sleepeze and beechams, followed by two cans of Guinness. No evidence of psychotic symptoms, auditory/visual hallucinations, paranoia or thought disorder. Mr S said he had been diagnosed with dissocial personality disorder, but not under psychiatric services. Plan: discharge from A&E when fit, letter to GP, follow up by liaison service 23/09, discuss with offender care and contact probation.	19.7
21/09/12	CNWL records	Progress note	Mr M contacted offender management team to refer Mr S to their service.	19.7
21/09/12	CNWL records	Risk Assessment	Identifies risks of harm to others or property and deliberate harm to self. Very brief details of risk provided on page 2 of assessment with no outcome or service user perspective completed.	19.7
21/09/12	CNWL records	Email	From Mr M to the forensic service referring Mr S. Although Mr M had documented the incorrect surname for Mr S, he subsequently corrected this and clarified the referral was indeed for Mr S.	19.7
21/09/12	CNWL records	Email	From Mr M to Ms H, Case Manager, but unclear for which team.	19.7
24/09/12	CNWL records	Email	From Ms B to Mr M stating that if Mr S did not require Care Programme Approach they wouldn't pick him up, but that the ABT team might work with Mr S for a brief time.	19.7
29/09/12	CNWL records	Case note	Mr M recorded that Mr S did not attend his follow up and that therefore he would refer to ABT at the suggestion of Ms B, FOCUS team.	19.7
29/09/12	CNWL records	Progress note	Noted that Mr S did not attend follow up on 23/9. Mr M to refer to ABT as suggested by offender management team.	19.7

Date	Source	Event	Information	Age
01/10/12	CNWL records	Email	From Mr M to the ABT Team with a referral letter attached.	19.7
03/10/12	CNWL records	Email	From Probation Officer, Ms F, to Mr M requesting information about Mr S's attendance at the follow up appointment offered on 23/9. Ms F also states that Mr S's contact with Probation was due to end on the coming Friday but that she would be interested to know if Mr M had decided on a diagnosis as 'many of those working with Mr S have said that they think he is suffering from some sort of mental illness'. Mr M responded advising that Mr S had not attended the appointment and that he had referred Mr S to the Assessment and Brief Treatment Team.	19.7
03/10/12	CNWL records	Email	Between Mr M and the ABT Team clarifying that Mr S's referral was for assessment.	19.7
08/10/12	CNWL records	Letter	From ABT Team to Mr S offering an initial appointment on 11/10/12 @ 11:30.	19.7
01/11/12	CNWL records	Case note	**Note entered on 11/11/12.** Mr B, ABT team recorded that he had a conversation with probation when he asked for information about Mr S's history. Mr B was advised that the case was closed to probation and therefore no information could be sent. Mr B was advised to call Ms R, Mr S's social worker. Ms R told Mr B that her team does not keep risk assessments for young adults, but reported that Mr S's risk was low and that he didn't want to see the ABT team. Ms R did not raise any concerns regarding Mr S's mental health. Advised that ABT would send another appointment and then discuss his case in MDT if Mr S did not attend.	19.8
08/11/12	CNWL records	Letter	From ABT Team to Mr S offering a further initial appointment on 13/11/12 @ 14:00.	19.8

Date	Source	Event	Information	Age
10/11/12	Internal report	Detained by police	Taken into police custody following a fatal knife injury to a 72 year old man during a burglary. Mr S fled the scene but was subsequently detained by police. Mr S's solicitor asked for a MHA assessment during police interview. Charged whilst in police custody. Following court appearance and whilst in custody Mr S was transferred to hospital on S.48/49 MHA	19.8
13/11/12	CNWL records	Progress note	Telephone call from custody nurse at Belgravia Police Station asking if Mr S is known to services after he had been arrested for murder. Information received by Mr U who recorded that he would inform the ABT.	19.8
14/11/12	CNWL records	Progress note	Mr U spoke with Westminster Magistrates and Hammersmith Magistrate Court Diversion Team. Discussion about Mr S's mental state, Mr S's solicitor wanted a MHA but the custody nurse did not have any concerns about Mr S's mental health.	19.8
16/11/12	CNWL records	Progress note	Entry related to activity the previous day, 15/11/12. Mr U had discussion with Ms H who advised that Mr S's social worker, Ms R, had spent a lot of time over the previous two days at the police station with Mr S. Ms R had said that she had not had any concerns about Mr S's mental health.	19.8

Appendix D – Summary of convictions

Source: PNC record provided by the Youth Offending Team

No	Offence date	Age	Offence	Offence location	Plea	Plea	Disposal (sentence)	Date of disposal
1.1	10/11/12	19	Murder	Hazlebury Road, London	Guilty	Guilty	Life imprisonment Reduced to 28 years on appeal	28/02/14 17/12/14
1.2	10/11/12	19	Aggravated burglary	Hazlebury Road, London	Guilty	Guilty	12 years imprisonment to run concurrently with above offence	28/2/14
2	23/05/12	19	Possession of knife blade/sharp pointed article in a public place	Hammersmith Police Station, London	Guilty	Guilty	Young Offenders' Institution - 8 weeks	25/05/12
3	29/02/12	19	Interfering with a vehicle	Imperial College, London	Not guilty	Guilty	Unpaid work requirement	29/08/13
4	01/04/12	19	Using threatening, abusive, insulting words or behavior with intent to cause fear or provocation of violence	St Mary's Hospital, London	Guilty	Guilty	Young Offenders' Institution - 21 days	03/07/12
5	29/11/10	17	Assault occasioning actual bodily harm	HMP Feltham Young Offenders' Institute	Guilty	Guilty	Detention and Training Order - 12 months	06/04/11
6	29/12/10	17	Assault occasioning actual bodily harm	West London Magistrates' Court	Not known	Guilty	Young Offenders' Institution – 9 months concurrent (S20110524)	16/09/11
7	27/11/10	17	Robbery	Galloway Road, London	Guilty	Guilty	Detention and Training Order - 12 months	29/12/10

No	Offence date	Age	Offence	Offence location	Plea	Plea	Disposal (sentence)	Date of disposal
8.1	05/07/10	17	Fail/refuse to provide sample of fluid for purpose of ascertaining whether Class A drug is in body	QD Police Station, London	Not known	Guilty	Fine £50 or 1 day (served)	02/08/10
8.2	05/07/10	17	Burglary and theft	Brondesbury Road, NW6	Guilty	Guilty	Youth rehabilitation order with ISSP[22] – 12 months Supervision requirement Curfew requirement 3 months with electronic tagging	20/09/10
8.3	05/07/10	17	Aggravated vehicle taking	Dudden Hill Lane, London	Guilty	Guilty	Youth rehabilitation order with ISSP – 12 months Supervision requirement Curfew requirement 3 months with electronic tagging Disqualified from driving – obligatory 18 months Driving licence endorsed	20/09/10
8.4	05/07/10	17	Using vehicle whilst uninsured	Dudden Hill Lane, London	Guilty	Guilty	No separate penalty Driving licence endorsed	20/09/10

[22] *Intensive Supervision and Surveillance Programme – launched to provide the sort of disposal which courts would view as suitable for young people who were persistently offending and/pr had committed serious offences. Youth Justice Board, ISSP The Final Report, 2005*

No	Offence date	Age	Offence	Offence location	Plea	Plea	Disposal (sentence)	Date of disposal
8.5	05/07/10	17	Possession of knife blade/sharp pointed article in a public place	Dudden Hill Lane, London	Guilty	Guilty	Youth rehabilitation order with ISSP – 12 months Supervision requirement Curfew requirement 3 months with electronic tagging	20/09/10
8.6	05/07/10	17	Driving whilst disqualified	Dudden Hill Lane, London	Guilty	Guilty	Youth rehabilitation order with ISSP – 12 months Supervision requirement Curfew requirement 3 months with electronic tagging Driving licence endorsed	20/09/10
9	09/02/10	17	Burglary and theft	Dalgarno Community Centre, W10	Guilty	Guilty	Detention and training order – 4 months	22/03/10
10.1	01/02/10	17	Theft – shoplifting	Somerfield, Earls Court Road	Not known	Guilty	No separate penalty	12/04/10
10.2	01/02/10	17	Battery	Somerfield, Earls Court Road	Not known	Guilty	Detention and training order – 4 months	12/04/10
10.3	01/02/10	17	Battery	Somerfield, Earls Court Road	Not known	Guilty	Detention and training order – 4 months concurrent	12/04/10
11	19/09/09	16	Assault occasioning actual bodily harm	Ibis Unit, HMYOI Feltham	Guilty	Guilty	Detention and training order – 10 months consecutive	20/10/09
12.1	14/01/09	15	Assault occasioning actual bodily harm	Dalgarno Gardens, W10	Guilty	Guilty	Detention and training order – 12 months	27/03/09

No	Offence date	Age	Offence	Offence location	Plea	Plea	Disposal (sentence)	Date of disposal
12.2	03/10/08	15	Robbery	Barlby Road, W10	Not guilty	Guilty	Detention and training order – 12 months	27/03/09
12.3	14/01/09	15	Resist or obstruct constable	Dalgarno Gardens, W10	Guilty	Guilty	No separate penalty	27/03/09
13	01/11/08	15	Battery	St Mark's Children's Home, W11	Guilty	Guilty	Detention and training order – 4 months	19/01/09
14	29/10/08	15	Burglary and theft – non dwelling	Bramley Road, W10	Guilty	Guilty	Detention and training order – 10 months concurrent	19/01/09
15	27/10/08	15	Possess cannabis a Class C controlled drug	St Helen's Gardens	Guilty	Guilty	No separate penalty Forfeiture of cannabis	19/01/09
16	30/07/08	15	Burglary with intent to steal – non dwelling	Albourne Road, W12	Guilty	Guilty	Detention and training order – 10 months	19/01/09
17	31/07/08	15	Aggravated vehicle taking	Delgarno Way, W10	Guilty	Guilty	Detention and training order – 6 months consecutive Disqualification from driving 12 months extended test Driving licence endorsed	27/03/09
18	13/04/08	15	Fail to comply with detention and training order	Within the jurisdiction of the CCC	Guilty	Guilty	Unserved from original sentence of 09/11/07 Imprisonment 79 days (YOI)	21/04/08
19	11/08/07	14	Arson	o/s St Mark's Children's Home	Guilty	Guilty	Detention and training order – 4 months	09/11/07

No	Offence date	Age	Offence	Offence location	Plea	Plea	Disposal (sentence)	Date of disposal
20	21/07/07	14	Having article with blade or which was sharply pointed in public place	Melton Road, Notting Hill	Not guilty	Guilty	Detention and training order – 4 months Forfeiture of large brown handled kitchen knife	09/11/07
21	10/07/07	14	Interfering with vehicle	St Anne's Road, Notting Hill	Guilty	Guilty	Supervision order (young offenders) Order revoked	22/08/07
22.1	07/07/07	14	Having article with blade or which was sharply pointed in public place	Clarendon Walk, Clarendon Road	Guilty	Guilty	Supervision order (young offenders) 18 months Order revoked	20/08/07
22.2	14/07/07 – 16/07/07	14	Breach of supervision order	Within the jurisdiction of the CCC	Guilty	Guilty	Resulting from original conviction of 02/07/07 Order revoked	20/08/07
23	02/07/07	14	Use disorderly behaviour or threatening/ abusive/ insulting words likely to cause harassment or distress	St Helen's Gardens, W10	Guilty	Guilty	Conditional discharge 18 months	20/08/07
24	24/05/07	14	Going equipped for theft (other than theft of motor vehicle)	Uxbridge Road, London	Not guilty	Guilty	Supervision order (young offenders) 6 months Forfeiture Order revoked Subsequently varied – supervision order (young offenders) 18 months	20/08/07
25.1	29/03/07 – 30/03/07	14	Fail to comply with detention and training order	Within the jurisdiction of the CCC	Guilty	Guilty	Resulting from original conviction of 15/01/07 Order to continue	21/05/07

No	Offence date	Age	Offence	Offence location	Plea	Plea	Disposal (sentence)	Date of disposal
25.2	29/03/07 – 30/03/07	14	Breach of supervision order	Within the jurisdiction of the CCC	Guilty	Guilty	Resulting from original conviction of 15/01/07 Order to continue Fine £10	21/05/07
26	14/11/06	13	Burglary and theft	Millwood Street, London	Guilty	Guilty	Detention and training order – 4 months	15/01/07
27.1	13/09/06 – 14/09/06	13	Aggravated vehicle taking	Bessels Leigh School, Abingdon	No plea taken	Guilty	Supervision order (young offenders) 18 months Programme requirements participate in an offending behaviour programme Reparation order 20 hours Driving licence endorsed Disqualified from driving – discretionary 12 months	10/11/06
27.2	13/09/06 – 14/09/06	13	Driving other than in accordance with a licence	Bessels Leigh School, Abingdon	No plea taken	Guilty	No separate penalty Driving licence endorsed	10/11/06
27.3	13/09/06 – 14/09/06	13	Using vehicle while uninsured	Bessels Leigh School, Abingdon	No plea taken	Guilty	No separate penalty Driving licence endorsed	10/11/06
28	04/02/06	13	Battery	Bessels Leigh School, Abingdon	Guilty	Guilty	Supervision order (young offenders) 9 months	07/04/06

No	Offence date	Age	Offence	Offence location	Plea	Plea	Disposal (sentence)	Date of disposal
29	09/01/06	12	Battery	Bessels Leigh School, Abingdon	Guilty	Guilty	Action plan order 3 months with conditions Subsequently varied 07/04/06 Order revoked	20/01/06
30	23/11/05	12	Battery	Bessels Leigh School, Abingdon	No plea taken	Guilty	Action plan order 3 months with conditions Subsequently varied 07/04/06 Order revoked	20/01/06
31	13/10/05	12	Destroy or damage property	Bessels Leigh School, Abingdon	Guilty	Guilty	Referral order 3 months original order extended by 3 months	09/12/05
32	21/06/05	12	Destroy or damage property	Bessels Leigh School, Abingdon	Guilty	Guilty	Referral order 3 months	22/07/05

There are also two offences that resulted in a reprimand, warning or caution relating to destroy or damage property and theft (from motor vehicle) committed in October 2004 and September 2004 respectively.