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

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Niche Health and Social Care Consulting 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 Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of a mental health service user (Mr L). 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 IN NHS England Serious Incident Framework[1] dated March 2015 and Department of Health guidance[2] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.

1.3 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents.

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 L killed his father, Mr T, in the family home on 13 June 2013. We would like to express our sincere condolences to Mr L'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 L.

Relationship with the victim

1.6 Mr L is the second son of Mr T and Mrs T. Mr L's brother, Mr C, is seven years older than Mr L.

1.7 Mr L had told clinical teams in the past that he looked up to his father, Mr T, saying "*I wanted to be a scientist like him*".

1.8 At the time of the incident Mr L was living at home with his parents and older brother. We understand that at the time family relationships were generally good, although both Mrs T and Mr C have told us that in the two weeks prior to Mr T's death, Mr L was "*very unwell, his hands and legs were shaking and his eyes were wide open*".

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[1] *NHS England Serious Incident Framework March 2015 https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf*

[2] *Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*

Mental health history

1.9 Mr L first became unwell at the age of 22 years old, whilst studying at the University of Hertfordshire. Mr L had inpatient admissions in 2008 and 2009 whilst in Hertfordshire. He received care and treatment from Hertfordshire Partnership University NHS Foundation Trust before returning home to live with his family in London.

1.10 Mr L's care was transferred from Hertfordshire to East London NHS Foundation Trust (referred to as the Trust hereafter) in June 2009 when he was in the care of Newham Early Intervention Team. Mr L was allocated a care co-ordinator who met with Mr L regularly.

1.11 In late 2009 Mr L was reviewed by a specialist trainee doctor who noted that Mr L was suffering from depressive symptoms. The doctor prescribed citalopram[3]. A month later Mr L was reviewed again and it was noted that Mr L was experiencing negative symptoms of schizophrenia. These symptoms worsened into December and Mr L reported that he found them distressing. Therefore, in addition to depot medication of risperidone consta[4] 25mg, Mr L was prescribed 1mg oral risperidone[5] daily.

1.12 From January to April 2010 Mr L was receiving some therapy with a trainee psychologist. He was seen for a medication review in May 2010 when he reported having not been compliant with the oral risperidone. Dr S1, the consultant psychiatrist, prescribed 20mg citalopram in addition to Mr L's antipsychotic medication regime. Mr L continued to report psychotic symptoms in the form of receiving messages from an unknown person. Mr L agreed that on return from a holiday to Sri Lanka he would increase the dose of risperidone consta to 37.5mg every fortnight.

1.13 In November 2010 Mr L was seen by his care co-ordinator and a specialist trainee doctor when Mr L reported that he continued to receive messages. Mr L also admitted previous experiences of receiving messages from the television. Mr L was started on procyclidine[6] to reduce his experience of restlessness.

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[3] Citalopram is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors. https://www.drugs.com/citalopram.html

[4] Risperidone Consta is a long-acting injectable medication approved for the maintenance treatment of treatment of schizophrenia and bipolar disorder. http://www.risperdalconsta.com/

[5] Risperidone is an antipsychotic medication that works by changing the effects of chemicals in the brain. It is used to treat schizophrenia and symptoms of bipolar disorder (manic depression) https://www.drugs.com/risperidone.html

[6] Procyclidine is an anticholinergic drug used in patients with parkinsonism and akathisia, and to reduce the side effects of antipsychotic treatment given for schizophrenia. https://en.wikipedia.org/wiki/Procyclidine

1.14 Mr L was reviewed in January 2011 when he informed the doctor that he had stopped taking his anti-depressant medication as he had found that attending church every morning a helpful alternative. Mr L reported that he had had two good weeks following an exorcism that left him feeling good and different in his head.

1.15 In March 2011 Mr L had a Care Programme Approach meeting. Mr T did not accompany his son at this meeting and Dr S1 suggested to Mr L that Mr T be invited to the next meeting, along with the priest from the church. Mr L reported that he was continuing with the exorcisms and said he would attend until the evil spirits left him. Dr S1 re-started the antidepressant medication.

1.16 In July 2011 Mr L was seen with his father Mr T. Mr L reported that symptoms of psychosis and depression had improved but he continued to experience leg-shaking when he was receiving messages. Mr L was keen to come off his medication. The following month he was reviewed by a specialist trainee doctor when Mr L reported anxiety prior to voluntary work, which resulted in him sometimes not attending. Mr L also reported difficulty in expressing his thoughts and complained of an "*unreal sensation*" when taking citalopram, but was unable to explain this feeling any further.

1.17 In January 2012 Mr L attended his Care Programme Approach meeting accompanied by his father Mr T. Mr L reported that he was working regularly at his father's restaurant and doing various courses including salsa, drama, stand-up comedy, vocal improvement and recruitment. Mr L said that he had stopped taking his antidepressants four months previously and was not keen to restart it. Mr L said that he found psychology sessions and attending church helpful.

1.18 Following the Care Programme Approach meeting in January Mr L developed an abscess from a depot injection and had become anxious about receiving injections and wanted oral medication. Mr T had supported this request and agreed to supervise medication.

1.19 At the next meeting in March 2012, Mr L and his father were keen to try a reduced dose of risperidone. It was agreed that the dose would be reduced to 3mg at night, with close monitoring of Mr L's mental state.

1.20 Mr L was seen again in April 2012, accompanied by his father. Mr L had stopped taking the procyclidine about six week's previously and was feeling lethargic. It was reported that Mr L was taking the risperidone regularly. Mr L talked about tapping his legs with his fingers and that when he did, he felt the urge to put words to the tapping, but was unable to explain this any further. Mr L remained of the view that he did not want to receive injections but wanted to further reduce the dose of risperidone. The specialist trainee doctor reviewing Mr L advised against this.

1.21 In August 2012 Mr L was reviewed and was again accompanied by his father. Mr L still wanted to reduce his medication further and argued that

he had been relatively stable for two years so wanted to see if he could remain well on a reduced dose. Mr L told staff that he had been functioning well, working at the family restaurant and denied any psychotic experiences. Mr L did not want to try another antipsychotic medication and it was agreed to reduce the risperidone to 2mg at night.

1.22 In May 2013 Mr L and his father attended a review with the multi-disciplinary team. Mr L reported that the psychology sessions, which had ended a few weeks previously, had been helpful. Mr L was now seeing an occupational therapist and attending an occupational therapy group weekly. The only symptom described by Mr L was of hearing a voice when he tapped his knee; but he was able to distract himself from it. Mr T reported that Mr L was doing well and was helpful at the family restaurant. Dr S1 suggested an increased the dose of risperidone, to alleviate the psychotic symptoms, but Mr L was resistant to this. Mr L agreed to continue with the occupational therapy input and some interventions from his care co-ordinator focused on structured activity planning.

Offence

1.23 On 13 June 2013 Mr T was at home with his wife (Mrs T) and Mr L. Mrs T left at about 6:00pm to work at the family restaurant.

1.24 Mr L's brother, Mr C, received a call on his mobile from his father's mobile phone, but it was Mr L on the line, who told Mr C that he had killed their father. Mr C asked to speak to their father and Mr L repeated that he had killed Mr T; but then pretended to pass the phone to his father and attempted to impersonate his voice. Mr C informed their mother and his uncle and it was agreed that all the family members would return home. En route to the family home Mr C continued to call his father's mobile phone. Again Mr L answered it, but this time stated that his father had gone out. Mr C reminded Mr L that he had just told him (Mr C) that he (Mr L) had just killed their father and asked Mr L what he (Mr L) had killed Mr T with. Mr L responded "*an axe*".

1.25 When the family arrived at the home address Mr L refused anyone access until his brother arrived.

Sentence

1.26 On 12 March 2014 Mr L pleaded guilty to manslaughter due to diminished responsibility. Mr L was detained indefinitely under sections 37 and 41 of the Mental Health Act. Mr L was already being treated in a secure hospital where he remained after sentencing.

1.27 In sentencing Judge Paul Worslsey QC said:

"This is a tragic case - you are a young man of 27, educated and with no previous convictions.

You are suffering from paranoid schizophrenia and sadly you decided to reduce the dose of your prescribed anti-psychotic medication and as a result you became disturbed.

You believed voices had taken over you and were telling you to kill your father who was evil.

He was anything but evil, he was 68, a decent man, hardworking and educated.

I am entirely satisfied that it's as a result of your medical condition that you committed this offence."[7]

Internal investigation

1.28 East London NHS Foundation Trust ('the Trust' hereafter) undertook an internal investigation that has been reviewed by the investigation team. The internal investigation was completed by a team that included:

- Serious Incident Reviewer (Chair of Panel);
- Director of Psychological Therapies;
- Consultant Psychiatrist, Tower Hamlets Early Intervention Service.

1.29 There were no recommendations made by the internal investigation team. This is highly unusual and was noted as such by the Medical Director in our interview with him. We are aware that the Metropolitan Police refused to allow Mr L to be interviewed by the internal investigation team, as at the time Mr L had not been interviewed under caution by the police.

1.30 The Chair of the Panel interviewed Mrs T and Mr C who requested feedback when the review had concluded. They also took up the Trust offer of some counselling, which the Chair agreed to help arrange.

1.31 It is our view that there were some aspects of Mr L's care and treatment that were not identified during the internal investigation. These have been drawn out in the recommendations of this investigation.

Independent investigation

1.32 This independent investigation has drawn upon the internal process and has studied clinical information, interview transcripts and policies. The team has also interviewed Trust staff who had been in contact with Mr L during the time he was being treated by the Newham Early Intervention Team.

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[7] *murdermap.co.uk*

1.33 We had sight of the Domestic Homicide Review report before its publication in September 2016.

Conclusions

1.34 It is our view that this tragic homicide could not have been predicted. However we consider that there are actions that could have been taken that might have improved Mr L's mental health.

Recommendations

1.35 The recommendations from our independent investigation focus on improvements that we consider should be made to care delivery and support and investigation processes. They have been given one of three levels of priority:

- Priority One: the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems or process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.

- Priority Two: the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems or process objectives. The area of concern does not compromise the safety of patients, but identifies important improvement in the delivery of care required.

- Priority Three: the recommendation addresses areas that are not considered important to the achievement of systems or process objectives. The area of concern relates to minor improvements in relation to the quality of service provision.

1.36 We note that the Domestic Homicide Review report also made a recommendation regarding family involvement, recommending that the Trust '*examine its processes for information sharing with carers and families and effectively involve them in risk assessment. This should include provision of carers' packs and clear written guidelines for carers on the availability of a crisis line. Consideration should also be given to the potential risks to the wider family and community*'.

Priority 1

Recommendation 1

The Trust must provide assurance that carer's assessments and support are offered and documented in line with the Trust strategy and that there is a system for care co-ordinators to initiate monthly contact with carers of clients who are on Care Programme Approach.

Recommendation 3

The Trust must ensure that appropriate support is given to clients wishing to apply for self directed support funding, who are known to have gambling habits.

Recommendation 4

The Trust must assure itself that risk assessments and risk management plans are reviewed when new information comes to light. The Trust must also implement an ongoing audit programme to provide assurance about organisational compliance with this requirement.

Priority 2

Recommendation 5

The Trust must revise the Incident Policy or develop additional guidance, and provide appropriate training, to ensure that staff are clear about:

- the type of records to be created and stored when conducting an internal investigation;
- storage and retrieval of clinical records, and reporting of misplaced clinical records, required for internal and external investigations;

The Policy must also include clear guidance about ensuring that staff who have been involved in serious incidents are given access to the investigation report, and their welfare and support needs are checked after the process has been completed. The Trust should also ensure that where possible, staff being interviewed have access to clients records prior to being interviewed.

Priority 3

Recommendation 2

The Trust must ensure that staff take responsibility for issuing formal invitations to all those they believe should be present at a Care Programme Approach meeting, or document discussions where this intention is changed

Good practice

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

1.38 The Trust provided support to Mr L through the Tree of Life Group. Information provided by the Trust indicates that the Tree of Life programme was originally developed in Australia and was designed for young children who had experienced various forms of trauma and hardship. It was later adapted to run as a group with adults over three sessions and with individuals over several sessions. The pilot implemented by the trust aimed "*to enable individuals to speak about their lives in ways that* [made] *them feel stronger and to help them think about what* [could] *support them in their recovery*". The pilot was planned to run over six sessions culminating in a celebration and certificates:

"*1. Introduction*

2. Tree of Life- Drawing their Trees

3. The Telling- Sharing their stories

4. Creating the Forest- Noticing strengths of each other

5. The Storms

6. Recap, Celebration and Certificates"

1.39 This was an innovative programme and one that was trialled in advance of the revised NICE guidelines for the treatment of psychosis issued in 2014 and should be commended.

1.40 The early intervention service comprised a very stable staff group, which resulted in consistent support being provided to Mr L over a long period of time.

1.41 Mr L was seen for a Mental Health Act Assessment the morning after the incident. He was found not to be fit for interview so was placed on Section 2 of the Mental Health Act and his community consultant psychiatrist involved in the assessment facilitated immediate admission to the forensic medium secure hospital where Mr L was transferred the same day.

1.42 Mr L's family were offered access to family therapy following the incident. Mr L has indicated it has been very beneficial to him and feels it has been an important element of his recovery journey. This response is rarely offered by an organisation following such an incident and is to be commended.

2 Independent investigation

Approach to the investigation

2.1 The independent investigation follows the NHS England Serious Incident Framework dated March 2015 and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services .

2.2 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents. The investigation process may also identify areas where improvements to services are 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. Expert advice was provided by Dr Afzal Javed, Consultant Psychiatrist.

2.5 The investigation team will be referred to in the first person in the report.

2.6 The report was peer reviewed by Carol Rooney, Head of Investigations, Niche.

2.7 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance[8].

Information from Mr L

2.8 We wrote to Mr L's consultant psychiatrist at the start of the investigation to identify whether Mr L was well enough to meet with us. He confirmed that Mr L was sufficiently well to meet with us and was keen to do so.

2.9 We therefore met with Mr L on two separate occasions during when we explained the purpose of the investigation and invited him to share any information with us that he felt was relevant.

2.10 Mr L told us that he had told the Newham Early Intervention Team that he frequently wanted to reduce or come off his medication. The reason for this was that he saw his symptoms as a religious or spiritual issue, not a

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

mental illness. Eventually Dr S1 agreed to reduce his medication and then Mr L reduced it further, without Dr S1's knowledge, in the two weeks before his father's death.

2.11 We understand that Mr L feels he should have been observed more. Mr L was seen every one to two weeks by his care co-ordinator or occupational therapist and Mr L reports that he presented very differently in the period leading up to the incident. He told us that he lost £3,000 in one day through online gambling, he had completely shaved his head and that he could see that his eyes were "*quite piercing*". Mr L told us that he had observed his eyes in the mirror at the time. He also said that when he went to the occupational therapy group in the Caribbean restaurant he was laughing to himself and his behaviour was noticeably different. He recalled that in his mind he thought he was "*married to the occupational therapist and thought he could have telepathic conversations with her*".

2.12 Mr L also told us that before the incident his father made him call Mr P, his care co-ordinator, to report that he had reduced his medication and that he wasn't feeling well. Mr L said that Mr P told him to take his medication and that he would see him again in two weeks.

2.13 When the psychology sessions ended, Mr L was told by clinical staff that he "*didn't need*" them and he told us that he was very unhappy about this. Mr L said that he felt listened to and understood during his psychology sessions and he felt that "*nothing would take the place of it*".

2.14 We asked about Mr L's experience of occupational therapy sessions. Mr L said that he had one-to-one planning sessions with his occupational therapist and they would also communicate via text. Mr L said that he had the opportunity to describe what he wanted to do.

2.15 Mr L said that no plan was agreed with staff of how to let them know if he "*didn't feel right*".

2.16 We asked Mr L about the exorcisms that he had undergone. He told us that "*years ago*" he had exorcisms through the Catholic church and that Dr S1 was aware of that. He was left feeling "*more energised*" after the exorcisms and at the time he felt prayers helped and changed him.

2.17 Mr L told us that a different (Evangelist) Minister had told him that Mr L was suffering because of witchcraft that had taken place in Sri Lanka and that he had demons inside of him. The Minister would say, "*die demon*" during the exorcism. Mr L said that his aunt had been to see this Minister before he had, and that it helped his aunt so his uncle thought it might help Mr L too. Mr L said that after the exorcism with the Evangelist Minister, he started hearing voices in his head and would say prayers in his room. He also remembered believing that his aunt was poisoning the food in the restaurant.

2.18 Mr L told us that his mother and brother were not actively a part of his care. If any family member went with Mr L to appointments, it was usually his father Mr T.

2.19 Mr L was able to describe in great detail how he was feeling in the days prior to the incident. He recalled that he thought his uncle and aunt were putting spells on food in the restaurant, and he then became suspicious of his brother. He recognises now that at the time he was out of touch with reality.

2.20 Mr L said that there was "*lots going on…lots of voices in his head*" and at the time he felt he was having a spiritual experience. He recalled crossing the road with his eyes closed and praying on the floor of the restaurant. At the time his mother had been unwell and he believed his father had "*given the illnesses*" to his mother. This upset Mr L, and he believed if he "*looked at dad's eyes and said die he would die*". Mr L recalls that his father grabbed him by the scruff of his shirt and at the time he felt this reinforced Mr L's belief that his father was hurting his family. He felt this added to the "*proof"* that there were "*spirits and demons*".

2.21 Mr L has done a lot of psychology work since the incident and feels that his attitude towards his mental illness changed when he was started on haloperidol; it was at this point that he recognised that his symptoms were those of a mental illness, rather than spiritual experiences. Mr L has talked to his psychiatrist about the Catholic priest. Mr T had believed a lot in the Catholic faith and believed in priests so Mr L took everything a priest told him was fact. Mr L believes that his father thought that Mr L was not suffering from a mental illness. Mr T was a scientist and had done work on toxicology and Mr L believes that Mr T saw mental illness as a weakness. Mr L told us that one doctor in particular who has been treating him since the incident has been particularly helpful in explaining about how Mr L's medication works.

2.22 Mr L told us that since the incident he, his brother (Mr C), his mother (Mrs T) and his uncle had been seeing a family therapist and that it had helped to heal family relationships after his father's death. Mr L said that he felt he had developed strengths; he does a lot of meditation and is more aware of how he is feeling.

2.23 Mr L suggested that we meet with his mother and his brother together.

2.24 We offered Mr L the opportunity to meet with us to discuss the report findings but he declined. A copy of the report was sent to his clinical team to share with him if he wished to read it.

Information from Mrs T and Mr C

2.25 We met with Mrs T and Mr C towards the end of the investigation. Mrs T told us that in the two weeks prior to the incident Mr L had been very unwell, his hand and legs were shaking and his eyes were wide open. Mrs T described Mr L as "*pacing all the time*" and said that he had shaved

his hair. Mrs T told us that she had "*not seen him* [Mr L] *that unwell previously*".

2.26 On the day of the incident Mrs T recalled that Mr L had been shouting and screaming in the morning, he then had a shower and left the family home to go to a group meeting. Mrs T described Mr L as "*not aggressive just very restless*".

2.27 Mr C told us that he was very concerned about his brother's presentation in the weeks prior to the incident and had told his father "*something had to be done*". Mr C told us that Mr T was the main contact with the clinical team.

2.28 Mrs T and Mr C described an exorcism that Mr L had undergone after he had become unwell. Mrs T's brother knew of a healing pastor and so had asked Mr T for permission to arrange for Mr L to see the healing pastor. Mr C told us that the whole family had gone, although he was reluctant to go Mrs T had persuaded him. During the exorcism Mr L was shouting and then collapsed on the floor. Mr C described the service as "*very different*", the pastor had put his hands on Mr L's head saying "*it's just the devil – come out*". Mr C told us that he didn't believe it was a healing event, describing it as "*just a circus*".

2.29 Mrs T told us that she thought that Mr L had the devil in him and recalled a day when Mr L had said "*Mum, I'm going to die today*". Mrs T said that Mr T had been very religious and had a background in a health profession so she had believed Mr T when he had said that Mr L was possessed. We found no evidence in any of Mr L's clinical records that Mr T had shared these views with clinical staff.

2.30 Mrs T and Mr C remain very concerned that no clinical staff recognised that Mr L wasn't well when he attended the occupational therapy group. Mr L had "*shaved his head, his eyes were popped out, he was restless and shaking*".

2.31 We understand that Mr T did not share information about Mr L's treatment plan or crisis plan with the rest of the family. Mrs T said he would have done this as he wouldn't have wanted to "*worry people*" and that it wasn't directly related to any cultural issues. Mrs T told us that they "*didn't know what to do*" as Mr L was "*already in treatment*". Mrs T said that Mr T would have thought that the exorcism would have been something to help Mr L.

2.32 Mrs T also was not aware of the earlier invitation for a priest to attend a Care Programme Approach meeting.

2.33 Mrs T told us that Mr L had not talked with her about letters he received from the council asking for evidence of how he had spent his self-directed support funding. Mr C told us that Mr L had wanted him to go to jujitsu classes with him. Mr C had told Mr L that he would not be able to attend

as the classes were too far away and he would not be able to fit them in around his work commitments.

2.34 Mr C and Mrs T expressed concern about the last exorcism conducted by a pastor who had "*no belief in mental illness*" and both wanted answers to how this issue could be addressed to prevent others being similarly affected.

2.35 Mrs T wants all family members to know what to do when somebody is unwell so that no family is placed in the position she and Mr C experienced.

2.36 Mr L's family expressed anger about the internal report and told us that they felt that the meeting with the internal investigation team was held "*to cover their own backs*" and that their concerns about Mr L's treatment were not heard.

2.37 We offered Mrs T and Mr C the opportunity to meet with us to discuss the report findings but they chose not to meet.

Clinical records

2.38 We used information from Mr L's clinical records provided by the Trust, Hertfordshire Partnership University NHS Foundation Trust, Newham Council and Mr B's GP records. Records from Hertfordshire Partnership University NHS Foundation Trust were reviewed for the purpose of obtaining information about Mr L when he first became unwell. It should be noted that there is no criticism of Hertfordshire Partnership University NHS Foundation Trust in this report.

2.39 We had sight of the Domestic Homicide Review report in draft form. The Domestic Homicide Review report was published in September 2016.

2.40 As part of our investigation we interviewed:

- Medical Director;
- Director of Nursing;
- Consultant Psychiatrist, Newham Early Intervention Team;
- Specialty Doctor, Newham Early Intervention Team;
- former care co-ordinator, Newham Early Intervention Team;
- former psychologist, Newham Early Intervention Team;
- former occupational therapist, Newham Early Intervention Team (via Skype);
- Head of Information;

- Head of Spiritual Care;
- Serious Incident Reviewer;
- Manager, Newham Early Intervention Team;
- Lead Psychologist, Newham Early Intervention Team.

2.41 The Trust provided us with copies of the electronic records held for Mr L. When we reviewed these records we found that there were no contemporaneous records prior to April 2012. The Trust told us that the team moved to electronic recording around April 2012 and that the paper records would be requested.

2.42 We received some copies of paper entries which didn't appear to be complete, but were advised that this now comprised the entirety of Mr L's records. Some months later we were advised by the consultant psychiatrist, Dr S1, that two volumes of Mr L's paper records were "*not traceable*". Dr S1 advised that two volumes of notes had been archived, but prior to sending them, the team had photocopied "*a few bits and pieces*"; we believe that what we received were copies of these papers. Dr S1 told us that there were "*several places*" that the volumes of clinical records could be, but she believed that somebody at Trust Headquarters had requested the volumes of records when we started the investigation.

2.43 Dr S1 advised that someone at Trust HQ was checking whether the notes were there. The Trust later advised that they "*didn't believe the incident team held the clinical notes*". We have not received any additional records and therefore presume that the two volumes of clinical records have not been located.

2.44 At the time of the incident, the London Borough of Newham mental health social work staff were seconded to the Trust and the Trust had responsibility for all social care activities, including support planning and the support plan. London Borough of Newham was responsible for agreeing the funding on the basis that the support plan had been agreed by the Trust, and providing the "*administrative machinery*" to make payments and follow up on requests for receipts. London Borough of Newham has told us that it would be a matter for the Trust to inform the council of any problems or difficulties.

2.45 The draft report was shared with NHS England, the Trust, Hertfordshire Partnership University NHS Foundation Trust, Newham Council and Shrewsbury Road Health Centre prior to publication. This provided the opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content. Feedback received has been incorporated into this report.

Structure of the report

2.46 Section 4 sets out the details of the care and treatment provided to Mr L. 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.

2.47 Section 5 examines the issues arising from the care and treatment provided to Mr L and includes comment and analysis. Section 6 details our review of three policies key to this investigation: domestic violence policy; adult safeguarding policy; child safeguarding policy.

2.48 Section 7 provides a review of the Trust's internal investigation.

2.49 Section 8 sets out our overall analysis and recommendations.

3 Background of Mr L

Personal history

3.1 Mr L was born in Sri Lanka, as were both his parents and brother. Mr L's father, Mr T was a "*trained doctor of medicine*" and moved the UK in 1987 seeking refuge as a result of the civil war. In Sri Lanka Mr T's family owned a cashew nut farm. The rest of Mr T's family, including Mr L, joined Mr T in the UK in 1990.

3.2 Mr T's medical qualification was not recognised in the UK so he worked for a brief period at a petrol station before going on to work in an academic post as a toxicologist at the University of East London, until he was made redundant. Mr T was made redundant when Mr L was about 16 years old. This resulted in some financial difficulties for Mr T's family and Mr T was often absent from the family home for a period of about three years.

3.3 Mr L had attended Catholic schools and worked hard at school. He reported that from Year 9 (age 13 to 14 years) he began to associate with peers who were more rebellious and that two years later the impact of his father's redundancy contributed to him not wanting to spend much time at home.

3.4 Mr L described a "*good childhood"* and had told his responsible clinician that he had looked "*up to my Dad…I wanted to be a scientist like him*".

3.5 Mr L left the family home to attend university where he studied business management. He first became unwell whilst at university and achieved a 2:1. He had been on course for a first class degree before becoming ill.

Forensic history

3.6 Mr L had no forensic history prior to the incident.

4 Care and treatment of Mr L

4.1 All Trust records (**not** Hertfordshire Partnership University NHS Foundation Trust records) for 2009, 2010, 2011 and early 2012 were taken from the electronic records provided by the Trust. The Newham Early Intervention Team moved from using paper records to electronic patient records in April 2012. Very few contemporaneous records were available to us prior to April 2012 as the Trust was unable to locate two volumes of clinical records. It should therefore be noted that the information relating Mr L's care and treatment by the Trust prior to April 2012 is limited to brief electronic clinical records and staff memory.

2008

4.2 In March Mr L sought out the university counselling service as he was "*finding it hard to cope*". In a telephone call to the Hertfordshire Partnership University NHS Foundation Trust crisis assessment and treatment team the counsellor reported that they were very concerned about Mr L and wanted him seen urgently. Mr L was advised to attend A&E but he was not willing to do so, so an urgent appointment with Dr K, a consultant psychiatrist was arranged for the following day.

4.3 At the appointment with Dr K Mr L complained that he was unable to cope with his housemates and was low in mood. Mr L stated he was concerned about problems in his family and that the family business was not doing well. Mr L felt that his housemates were spying on him and were monitoring him when he went to the toilet, he felt this because there was "*always someone in there when he needed it and it was playing with his head*". Dr K informed Mr L's GP and the local team, provided relevant crisis phone numbers and arranged a follow up appointment with a psychologist. The university also arranged temporary alternative accommodation.

4.4 During March Mr L presented or was contacted by services on 13 occasions and at time reported that he was taking his medication; at other times that he was not. Mr L was receiving support from the university counselling service, the Crisis Assessment and Treatment Team (CATT) and the Early Intervention Team. Mr L was concerned that he "*felt his medication was an experiment or study and was not for his benefit, only the team*".

4.5 During April it was agreed that Mr L would receive daily visits from the CATT in order to improve compliance with his medication. Mr L initially responded well to this and stated that he would like to live with his aunt and uncle in London. It appeared that Mr L returned home to live with his parents as they reported to Dr K that Mr L had "*poor communication, appeared suspicious and did not eat with the family. Mr L bought his own food*". Mr L's parents Mr and Mrs T reported that they were unsure if he was taking his medication and described him as paranoid. Mr T agreed to accompany Mr L to his next appointment with the Early Intervention in

Psychosis team in St Albans. Mr L reported that although the journey time to his appointment was long, he enjoyed being away from the family restaurant.

4.6 Throughout May, June and July Mr L's presentation fluctuated between being up beat and lacking motivation. Mr L's reported his heart racing before appointments and so his GP arranged an ECG[9] that had identified some abnormalities. In late June Mr L called Ms K, his community psychiatric nurse, to advise that he didn't feel like making the journey from London to Hatfield for his medical review and said he was no longer willing to take his medication. Mr L was advised against this course of action. In July Mr L met with Ms K and told her hadn't taken his medication for more than one week, however he felt that he needed to restart risperidone as he felt it did help him.

4.7 In August Mr L missed two appointments with Ms K, due to sleeping late. However he did attend in late August when the dose of risperidone was discussed but Mr L did not want to increase above 1.5mg. Mr L reported that he had been on a family holiday during which time relationships had improved, particularly with his older brother.

4.8 In September Mr L returned to university but did not attend an appointment with Ms K and Dr K. Mr L later apologised and said that he had forgotten about the appointment, as he had been moving into halls of residence that day. Ms K offered to contact Mr L over the following week.

4.9 In October Mr L met with Ms K who introduced Ms C1 as Mr L's new care co-ordinator. Mr L reported that he was doing okay and had gained a degree of insight into understanding the importance of managing his stress. Mr L said that he wanted to stop taking his medication. He was advised to discuss the issue with Dr K. Mr L was advised to stay away from online sites where one could 'test' oneself for a particular disorder; Mr L had completed a test that resulted in "*68% schizoaffective disorder*". At the end of October Mr L had an appointment with Dr K when Dr K agreed Mr L could stop taking the risperidone, noting that the dose of 1.5mg had been "*sub-therapeutic for some time anyway*". However Mr L would continue to see the university counsellor and Ms C1.

4.10 In November Ms C1 left a message for Mr L to contact her to arrange an appointment, however Mr L did not respond.

4.11 In December Ms C1 again left a message for Mr L to contact her, with no response. Ms C1 then rang Mr L's father, Mr T but there was no answer so she left a message.

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[9] *An electrocardiogram (**ECG**) is a simple test that can be used to check your heart's rhythm and electrical activity. Sensors attached to the skin are used to detect the electrical signals produced by your heart each time it beats.*

2009

4.12 On 13 January Ms C1 received a telephone call from Mr T who informed Ms C1 that Mr L remained off his medication and was doing well. This information led to a continuing care plan and risk assessment being completed. Ms C1 also wrote to Mr L to offer him an appointment later in the month. At this appointment Mr L presented with social anxieties and paranoid thoughts. Mr L had reported to police that his housemate had threatened to kill him and Mr L was experiencing shakes and vibrations. Mr L didn't want to have contact with the Early Intervention Service but would continue to see his counsellor who could contact the service if she had any concerns. Ms C1 noted that Mr L kept his heavy outdoor clothing on throughout the meeting, despite the room being extremely warm. Mr L reported that he was gambling online but was okay for money as he was a good poker player. Ms C1 told Mr L that although he didn't want contact with the service, she would contact him periodically to see how he was doing.

4.13 In April Ms C1 received several text messages from Mr L requesting contact as he felt that he was experiencing symptoms again. However, Mr L would follow up with messages saying that he was fine. Ms C1 arranged to meet him at the counselling offices but Mr L subsequently cancelled the appointment.

4.14 In May Ms D, a community psychiatric nurse with the Early Intervention in Psychosis team received a phone call from the university dean advising that Mr L was with one of the security guards and had said he "*could not get through the weekend*" and that he felt people were following him. Ms D advised that Mr L had chosen not to engage with the service and that it was unclear whether he was taking his medication. Ms D recommended that as Ms C1 was on holiday, Mr L should attend A&E.

4.15 When Ms C1 returned from holiday at the beginning of June, she followed up this report and spoke to the university student support worker. Ms C1 was informed that Mr L had been given temporary alternative accommodation. Ms C1 advised that she had received texts from Mr L indicating that he didn't want to take his medication as he felt it would kill him. Ms C1 offered to liaise with the doctor to organise an assessment for the following day.

4.16 On 2 June Mr L presented at A&E with a crush injury to his finger. Staff were concerned about his presentation and the liaison nurse sought advice from Ms C1 about how to proceed, given Mr L was known to Ms C1's team. Ms C1 suggested that the liaison nurse assess Mr L and ask him if he would be prepared to meet his care co-ordinator. The outcome

of the assessment was that Mr L was detained on Section 2[10] of the Mental Health Act and was admitted to Welwyn Ward, a mental health inpatient unit. Mr L had fractured his finger by slamming it in a door, but refused to believe that it was broken despite being shown the x-ray. On 8 June Mr L submitted an application for a mental health review tribunal; this application was withdrawn on 12 June.

4.17 On 17 June Hertfordshire Partnership University NHS Foundation Trust made a referral to East London NHS Foundation Trust early intervention service. The referral noted that Mr L was studying for a degree at Hertfordshire University and had been residing in halls of residence when he became unwell. The referrer advised that Mr L was currently detained on Section 2 of the Mental Health Act and that there were plans to discharge him to the family home in London. East London NHS Foundation Trust responded within two days and requested a full needs assessment and medical review records, but Hertfordshire Partnership University NHS Foundation Trust advised that as Mr L had not engaged with their service, there was no more information available.

4.18 On 29 June Mr L was discharged from Section 2 and remained as an informal patient on the mental health inpatient ward until 1 July when he was discharged to the family home in London. Prior to being discharged Mr L had been on leave with his family.

4.19 Mr L had scheduled appointments on 6 and 13 July with East London NHS Foundation Trust early intervention service but did not attend either one. Records indicate that there were a number of attempts at telephone contact but there is insufficient information to determine whether these calls resulted in telephone contact with Mr L or any of his family.

4.20 On 16 July Mr L and his father attended an appointment with Mr A from the East London NHS Foundation Trust early intervention service. Mr L reported that he was hearing voices and experiencing ideas of people trying to "*kill, harm or poison him*". Mr L said that his medication and concentration had been poor since starting his medication and noted that this had been a side effect in the past. Mr A noted that Mr L's case would be discussed at the allocation meeting the following day and that a named care co-ordinator would be confirmed. It was recorded that Mr L was given advice to contact the office with any urgent concerns and that he would have a medication review two weeks later. At the allocation meeting the following day, Mr M was allocated as Mr L's care co-ordinator

4.21 On 28 July Mr L reported that he was saving up for a course that would cost £4,000. It was noted that Mr L appeared to build a good rapport and had good eye contact. No risks were identified and a plan was made for

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[10] *Section 2 of the Mental Health Act is used to detain a patient for assessment for up to 28 days. The section cannot be renewed or extended.*

Mr L to attend fortnightly meetings with the East London NHS Foundation Trust early intervention service for his depot injection.

4.22 On 10 August Mr L met with Mr L who reported that he was "*feeling great*" about his university results and that he was socialising more. Mr L and Mr M had a lengthy discussion about the Myers Briggs personality test that Mr L had completed.

4.23 On 29 August Mr L attended an appointment and reported that he had been working in the family restaurant. It was noted that his family were less anxious about his mental health and therefore had more trust in him. Mr L said that he wanted to talk to his care co-ordinator about accessing funding for a catering course.

4.24 In September Mr L reported that he wasn't sleeping well and that this was impacting negatively on his energy levels and mood. Mr L would often not get to sleep until 7:00 or 8:00 am and would wake at 2:00 pm. Mr L said that he was no longer working in the restaurant. It is not clear from the notes whether this was a consequence of his poor sleeping pattern or a contributory factor. There were also a number of telephone contacts with Mr L during September prior to an appointment with Dr O, a specialist registrar with the early intervention team. Dr O recorded that during the appointment he had concerns that Mr L was depressed. Mr L initially refused the offer of medication but later in the appointment agreed to take some antidepressants. Mr L reported that he was pursuing cookery classes but some days he would not feel like going so would stay at home. Dr O continued to prescribe risperidone depot 25mg every fortnight and started Mr L on citalopram 10mg once daily.

4.25 When Dr O reviewed Mr L in October Mr L presented with improved alertness, energy and ability to cope with cookery classes. Dr O recorded that he considered that Mr L's mental state had improved and noted that the citalopram to 20mg per day and zopiclone[11] 3.75mg at night despite the fact that Mr L reported he was not using the zopiclone at the time. Later in October Mr M met with Mr L who reported he was again finding it hard to attend his course and that he was due to meet the course organisers the following day to decide whether he should reduce to part time or quit the course altogether. On 16 October Dr O invited Mr L's GP to attend a Care Programme Approach meeting on 29 October. When Mr L attended for his depot injection on 22 October he reported a shaking feeling inside his hip, which he took to be a side effect of his medication. Further investigation identified that the shaking feeling started when Mr L was unwell, prior to starting his medication. Mr L stated he would ignore it but had been reading about his illness and felt more comfortable talking about his symptoms. Although Mr L missed a couple of appointments with his care co-ordinator during October, he did attend his review

[11] *Zopiclone is a hypnotic agent used in the treatment of insomnia https://en.wikipedia.org/wiki/Zopiclone*

meeting with Dr S1, consultant psychiatrist. Dr S1 noted that Mr L was withdrawn and "*amotivated*" and was frequently losing interest in activities that he had previously enjoyed. Mr L had been offered the opportunity to access direct payments[12] however he told Dr S1 that he had decided not to take up this offer. Dr S1 prescribed risperidone 25mg every fortnight and increased citalopram to 20mg daily. Mr L was also encouraged to attend the gym once a week. A Care Programme Approach and medical review was arranged for 12 April 2010.

4.26 Throughout November Mr L reported that he was feeling better and attributed this to the increased dose of citalopram.

4.27 On 17 December Dr O reviewed Mr L who was accompanied by Mr M. Mr L denied any particular problems but reported shaking and jerking movements of his shoulders and neck and an "*involuntary phenomena*". Mr L said that this had never gone following his treatment in hospital earlier in the year, although they had reduced previously, they had now increased significantly. Mr L described conversations that took place inside his head with someone who was contacting him and although he acknowledged this experience was strange he denied any psychosis. Mr L explained an experience where a force had come over him to move him away from junk food and towards healthy food; as he saw this as a positive thing Mr L said that he was not frightened or distressed by the experience. Mr L reported that he had stopped all his cookery classes and Dr O noted that it was clear that Mr L found them stressful. Mr L said that he was spending a lot of time with his family, he was eating and sleeping well and was getting about 90 minutes of exercise each morning. Dr O prescribed risperidone 25mg every fortnight, increasing to 37.5 mg for the following depot, start oral risperidone 1mg at night and planned a further assessment two weeks later to review Mr L's medication.

2010

4.28 On 14 January Mr L reported to Mr A that he was tired following the increase in his medication, but that he had been feeling more positive in the days leading up to his appointment. However he was unsure about the increase in dose. Mr L was advised to "*think about it*" and to discuss the issue in his next meeting. Mr L's direct payment application was submitted.

4.29 In February Ms O, Mr L's new care co-ordinator contacted Mr L to introduce herself and an appointment was made for two days hence. Mr L did not attend this appointment, neither did he attend his appointment with Dr O the following day; however Mr L did not mention any concerns so Dr O booked another medical appointment for four weeks hence. Mr L did

[12] *If you or someone you care for get help from social services, you can apply for direct payments. These let you choose and buy the services you need yourself, instead of getting them from your council. www.gov.uk*

attend an appointment with Ms O later in the month and it was recorded that he was mentally stable, sleeping for six hours a night and still looking for a job. Mr L reported that he wanted Mr A to take over from Ms O as his care co-ordinator. Mr L gave his reason as "*he was used to*" Mr A because he did Mr L's depot every two weeks.

4.30 In March Mr L attended all seven booked appointments with Mr P (his care co-ordinator), Ms A or Ms O. On 26 March Mr L reported to Ms A, trainee psychologist that he would stop playing poker and replace it with the guitar, however he was concerned that he would give up the guitar due to lack of motivation. Mr L said he was looking forward to his exorcism in Sri Lanka because it would get rid of the shaking from another being. On 31 March Mr P met with Mr L who stated that people were following him and that he had to sleep in the library at times. Mr L reported that his family relationships were good and that they were supportive of him. Mr L said that he had stopped taking his antidepressants and "*felt good*" however he had recently been unsuccessful in a job application, which he had found frustrating.

4.31 During April Mr L was present for seven of the eight face to face or telephone contacts with staff.

4.32 In May Mr L was present for all six face to face or telephone contacts with staff. On 17 May Dr O reviewed Mr L and noted that his mental state remained unchanged. Mr L admitted he had stopped taking the additional 1mg of risperidone about two months previously and had also stopped taking the citalopram. Mr L complained of poor sleep and described playing poker and football manager as addictive activities. Dr O recommended that Mr L re-started the risperidone 1mg at night and citalopram 20mg once daily. On 24 May Mr P met with Mr L to discuss Mr L's self directed payments. Mr L advised that he had an interest in learning to play the guitar and stated that part of his plan was to buy an instrument as this would help with his poker addiction. Mr L reported that he had no good friends and therefore this (learning the guitar) would help him to meet new people. Mr L said he had not started his antidepressants but agreed to start taking them that day. Mr L explained the experience of shaking and linking words to the movements and stated it felt like an exorcism.

4.33 In June Mr L attended two appointments with Dr Q and two appointments with Mr P. The appointments with Mr P were to receive his depot injection however there is no record of the content of the appointments with Dr Q.

4.34 In July Mr P met with Mr L who had recently returned from Sri Lanka. Mr L reported that he was physically well after contracting a virus whilst on holiday. Mr L said that he was sleeping well, going to bed at 9:00pm and waking at 8:00am, however he had not taken any citalopram whilst on holiday. Mr L said he no longer wished to complete his psychology course and was unsure what he did want to do, despite having discussed options with his father and brother. Mr L said that the exorcism worked

during his time "*in Sri Lanka and then stopped working when he…*" This entry ends abruptly here at the end of a page and there is no continuing sheet. Mr L attended two further appointments in July; during one of these he reported that the family were planning to sell the business and therefore he would need a structure for daily activities. Mr L said that he had started going to the gym and was concentrating on aerobic exercise.

4.35 During August Mr L attended two of three appointments. Mr L reported that he felt low in mood but was not able to explain why. The duty social worker offered time for Mr L to talk but Mr L declined and stated he would prefer to go home.

4.36 In September Mr L met with Ms A and talked about what he needed in order to become motivated and energised. Mr L said he was interested in martial arts, dancing and generally socialising; Mr L planned that his direct payment would fund these activities. He did not want to revisit the past and felt he didn't need closure although Mr L reported that his sleep was poor since he had started gambling. Mr L also said that the shaking had returned and therefore felt he should have another exorcism. At a later appointment Mr L told Mr P that he was compliant with his antidepressant medication but still felt low in mood with little motivation.

4.37 During October Mr L attended five appointments but did not attend for three appointments. Mr L reported that he had undergone an exorcism on 16 October and "*was feeling good*".

4.38 During November Mr L attended seven appointments with various clinical staff and did not attend for two appointments. The latter of the two appointments Mr L said he was unwell and asked for an appointment the following week, however he "*felt it was difficult to speak face to face*". In letter from Dr S3 to Mr L's GP, Dr S3 noted that Mr L continued to receive messages which were associated with tapping fingers and shaking his leg and had complained of lethargy, low concentration and lack of motivation. Mr L was keen to come off his medication and was aware of the risks of doing so, but wanted to take that risk saying he "*may not relapse after all*".

4.39 During December Mr L attended five appointments and did not attend two appointments; one of these was because Mr L did not feel like walking in the snow. Ms A suggested a meeting at the church to discuss Mr L's link with them, however Mr L wanted to check how they felt about it first. Ms A advised Mr L of the benefit of the involvement of those helping him, in the clinical sessions.

2011

4.40 In January a Care Programme Approach assessment noted that Mr L was feeling lonely and had stopped his medication. The medication regime planned was for Mr L to continue with the fortnightly risperidone injection and procyclidine 5mg. Mr L was encouraged to start taking antidepressants again and to have his bloods taken by the GP. On 24 January Mr L attended a review with Dr S1. Dr S1 noted that Mr L had

stopped taking the citalopram one month previously and that this medication would be ceased as Mr L no longer wished to take it. Mr L had reported that he continued to receive messages through tapping his finger and shaking his leg, although this occurred less frequently. Mr L reported that he converted the tapping into words, which meant, "*why don't you talk to me*" but said he distracted himself by praying. Mr L said that he had been exorcised two weeks previously and felt in a "*good state*" and that he found church was a good alternative to citalopram.

4.41 In February Mr L met with Ms A and spoke about his motivation, sleep patterns, attending church and the problems associated with those matters. Ms A and Mr L spoke about the best use of his time and personality styles. Mr L attended five other appointments with staff that month and cancelled one other appointment as he had overslept.

4.42 At his Care Programme Approach review in March Mr L reported that his motivation was okay, but he couldn't sustain it during activities. Mr L said that he had been seeing Ms A for a few months and had re-started citalopram. Mr L had gained some weight over the previous year but was now going to tango classes once a week. Mr L said that he would experience voices when tapping his fingers and shaking his leg. Mr L told Ms A that he "*protected people*" by "*reassuring them that he was okay*". Mr L said that he tried to stop the shaking because he didn't want his parents to see him. Mr P recommended that Mr L's father, Mr T, and his priest should be invited to the Care Programme Approach meeting, however Mr L's father was busy. Mr L reported that he had received a further exorcism the previous week and that he intended to continue the sessions until the evil spirits had left him. Mr L also reported that the priest advised that he continue taking his medication and that he continued to see his clinical team. In a support plan document dated 30 March it was recorded that Mr L admitted he had paranoid schizophrenia and that he had recently been in hospital due to his religious beliefs and people being able to read this thoughts. Mr L had confirmed that he intended to use his self directed support funding to train at a gym for jujitsu, judo, kickboxing and yoga for daily fitness and that alongside this is intended to train as a career coach. Mr L had agreed to bring his proof of membership to the gym and joining instructions for the coaching course in order that the money could be paid directly into his bank account for his monthly subscription. Mr P noted that he would regularly review the support plan and Mr L stated he would be responsible for making his own decisions and planned to talk openly with his family.

4.43 During April Mr L attended three appointments of four appointments. On 15 April Mr L's individual budget agreement was signed off; the document indicated that Mr L received £850.20 from Newham Council and funded £146.80 himself. The amount of £850.20 was given to Mr L at £32.70 per week over a period of 26 weeks and was to fund martial arts training and career coaching.

4.44 During May Mr L attended six appointments and cancelled one appointment, as he was feeling unwell. Ms A commented that Mr L cancelled at the last minute too often and advised him that he should call at least 15 minutes before his session.

4.45 In June Mr L attended seven appointments and did not attend for two further appointments. Mr L and Ms A discussed Mr L's anger at Ms A talking to Mr P about his attendance at appointments.

4.46 In July Mr L attended all five appointments with staff. On 12 July Mr L and his father met with Dr S1 and Mr P. Mr L was reported not to be depressed and was doing voluntary work for two days a week. It was recorded that Mr L had avoided having his bloods taken for one to two years but the reason for this was not recorded. Mr L reported that he was engaging well with martial arts and career coaching through his self directed support plan but that he lacked motivation to go to the gym because of low energy.

4.47 Mr L cancelled one appointment, did not attend for two appointments and attended five appointments. On 22 August Mr L attended a Care Programme Approach meeting with Mr P and Dr J, but was not accompanied by his father. Mr L spoke about his anxiety before attending work and said that it had got so extreme that he had missed a lot of work days and had considered quitting, however he had a very supportive employer who had encouraged him to continue. Mr P confirmed that Mr L had a pattern of losing interest over time and that this should be something to discuss with the psychologist. Mr L reported that his parents had stated that he "*seemed better*" but he was unable to elaborate on this. Dr J noted that Mr L appeared "*flat*". It was agreed that Mr P would discuss Mr L's case with the psychologist and noted that Mr L was attending church and that there had been no further exorcisms. A letter providing a summary of discussions was sent to Mr L's GP on the same day and was received on 31 August.

4.48 During September Mr L attended six appointments and did not attend for one appointment. Despite Mr L's earlier reluctance to continue taking medication, Dr J issued a prescription for citalopram 20mg to be taken for two weeks.

4.49 During October Mr L attended just three appointments. On 11 October Mr P met with Mr L who reported that he had been feeling tired and found it difficult to get up in the morning. Mr L said that he had made a lot of effort to get to his appointment with Mr P that day and that he had had to act as a sad person in a recent acting class and this had drained him. Mr L told Mr P that he had stopped taking his antidepressants and had stopped attending his voluntary work because he felt depressed. There is no record of the discussion that Mr P had with Mr L of the link between feeling depressed and stopping his antidepressant medication.

4.50 In November Mr L had four appointments, all of which he attended. On 14 November Mr L's father called Mr P to inform him that Mr L had developed an abscess following the depot injection the previous week. Mr L expressed concern about the position of the abscess and why the injection was administered in that position. Mr P informed Mr A of the complaint.

4.51 Mr L had five scheduled appointments during December, but did not attend for two of them. On 22 December Mr P met with Mr L who reported that he was doing well and had now finished taking antibiotics as the abscess had healed. Mr L said that although the abscess had developed on the site of his depot injection he did not want to take the issue any further, however he asked that he didn't see the nurse that had administered the depot in future. Mentally, Mr L reported that he felt much better and didn't have any tremors. Mr L spoke about the activities that were due to start the following month and said that he wanted to discuss medication in his next Care Programme Approach meeting as he was keen to move to oral risperidone. Mr L reported that he was not taking antidepressants as he didn't need them.

2012

4.52 On 12 January Mr L attended for a medical review with Dr S1. The paper records show only a partial entry by Dr S1 and the entry is not dated, however it does correspond with an electronic record of a Care Programme Approach review meeting. Mr L reported that he had stopped taking citalopram four months prior to the Care Programme Approach meeting; he said that he found the medication made him irritable, depressive, "*amotive*" and spaced out. Dr S1 recorded that Mr L was able to take ownership of the messages he received and believe that they were his own thoughts. It was noted that Mr L was to receive psychology support from Ms A. Dr S1 noted that Mr L had developed anxiety regarding depot injections and agreed to convert to oral medication; risperidone 2mg oral twice daily and procyclidine 5mg twice daily. Mr L agreed that he would continue with his activities and Dr S1 noted that a further Care Programme Approach review meeting would be held six months hence, with medication reviews every three months. A summary of the meeting was sent in a letter to Mr L's GP on 16 January.

4.53 On 7 February Mr P wrote to Mr L's GP with an invitation to the Care Programme Approach meeting to be held on 18 June and requesting information regarding Mr L's physical health. Mr L attended two appointments during February; he reported that he felt better since starting on procyclidine. On 28 February Mr L received a telephone call to discuss psychological input and was offered the opportunity to receive four sessions. Initially Mr L declined this but after advice from the early intervention team, he agreed to attend. The first appointment was arranged for the following day and it was reported that Mr L engaged well with no risks identified.

4.54 During March Mr L had eight scheduled appointments, one of which he didn't attend. A medical review was held which was attended by both Mr L and his father, Mr T. Dr M2 noted that both Mr L and Mr T were keen to reduce Mr L's medication and that following extensive discussion it was agreed to reduce risperidone to 3mg daily. Dr M2 wrote to Mr L's GP to provide a summary of the appointment. It was recorded by Ms L, psychologist, that Mr L was engaging well with the psychology sessions and that he had reported that he had made contact with some old friends. It was noted that Mr L's score was borderline for anxiety and depression; no risks were identified and the final psychology session was planned for 21 March. On 28 March Mr T wrote to Mr L, copied to Mr L's GP. Mr T summarised the progress that Mr L had made during the psychology sessions and acknowledged that there were times that he "*experienced emptiness*", however "*completeness came during prayer*" and that procyclidine helped. Mr L had stated that he was a serious person and that by using a social mask he found that it was becoming easier to manage in social situations. Mr L had also reported particular difficulty in social situations with girls and that although he had had a significant relationship previously that had lasted for three years it had left Mr L feeling that the relationship had been a bit dependent and involved too much emotional attachment. Mr L had said he would prefer to work with a male psychologist as he felt it would be easier to talk about potential intimate relationships, however Mr L had agreed to work with the lead psychologist who was female.

4.55 During April Mr L had four scheduled appointments, one of which he did not attend. Mr P helped Mr L to complete a medical form to send to the benefits agency and Mr L reported that he had stopped his courses because the homework was too much. Mr L planned to complete his CV and look for jobs in the local area and said that when he got a job he wanted to speak to Dr M2 regarding his dose of risperidone. On 19 April Dr S2 met with Mr L and his father for an urgent medical review. Mr L reported a lack of energy and motivation "*due to the risperidone*" but the procyclidine had helped with this. It is recorded that Mr L's father reported no concerns and "*stated he was doing fine*" however Mr L had reported that he "*felt a need to put words to his tapping*". Dr S2 continued to prescribe 3mg risperidone at night and procyclidine 5mg bd, to be reviewed a week later. Mr L did not attend this appointment and said that he had forgotten, a further appointment was arranged four days later. Mr L did attend this appointment and reported that he was doing much better, however he was often bored and recognised that he needed to occupy his time. Mr P advised that Mr L reviewed his previous self directed support plan; Mr L was clear that he didn't want to take on too much so agreed to look at one or two activities. Mr L reported that he had not been tapping and denied any auditory hallucinations. Mr L wanted to build his confidence around dealing with relationships because he had met a girl he liked but didn't "*feel ready*".

4.56 Mr L cancelled or didn't attend three of his five appointments during May. When he did meet with Mr P on 17 May to review his self directed support

plan Mr L said that he had not been able to complete some of the course he had enrolled on, however he had benefitted from the classes he had attended. Mr L agreed to write a review of the courses. Mr L spoke at length about family dynamics and said that following a personality course he now understood each family member better. Mr L stated that he felt "*annoyed and unloved*" when his brother had "*rejected the help that Mr L had offered*" but stated that he was able to relate well to his father who understood him more. Mr L said that the procyclidine was helping with the shakes and that he was taking two tablets each day. On 29 May Mr P met with Mr L again who reported that he had completed his review plan and had emailed Mr P the payments Mr L had made for the courses he had chosen. Mr L reported that he was doing well and denied any psychotic symptoms but that his motivation was sometimes poor. Mr L told Mr P that he had the date for his first psychology appointment and that he was looking forward to the psychology work. Mr L reported that he was compliant with his medication and that he was not experiencing any side effects.

4.57 In June Mr L cancelled or did not attend three appointments with Ms L who stressed the importance of attending booked appointments. At a Care Programme Approach review meeting on 18 June Dr S2 noted that Mr L continued tapping but was now able to resist the compulsion to put words to the tapping. Mr L reported that he was taking all his medications, sometimes also taking procyclidine at night; Dr S2 advised that this should only be taken once a day and during the day time. Mr L's sleep pattern was discussed and Mr L admitted that he had missed psychology appointments due to "*sleeping in*" as he found getting up in the morning difficult. Mr L reported that he had applied for self directed support funding for activities but Mr L was advised to consider voluntary work and working at the restaurant, however he was not keen on those ideas. Mr L was advised that reducing medication was a gradual process and Dr S2 wanted to see Mr L engaged with psychology, an improved sleep pattern and more involved in activities before making a decision about reducing medication. Dr S2 prescribed risperidone 3mg and procyclidine 5mg. Mr L's Care Programme Approach assessment, risk assessment and care plan were updated with the information above and copies of the documents were noted as having been sent to Mr L and Mr T.

4.58 On 20 June Mr L reported to Ms L that he had stopped exercising since they had last met and that he had started going to the casino. Mr L said that he felt "*inadequate and annoyed*" about how he was living and expressed frustration at his inability to "*follow through*". Mr L also said that he felt he was "*not worthy*" of friends whom he perceived to be of a higher status because he was on medication, did not have a job and slept during the day. Mr L stated that he could not work or socialise whilst he was still "*ill*" and that every time he took his medication it was further confirmation that he was "*ill*". Ms L advised Mr L to remember the negative feelings associated with the casino and that his "*black and white*" attitude towards his medication were linked to his feelings of "*being stuck*".

Ms L encouraged Mr L to identify short term goals and reminded him of the importance of attending regular appointments to help him build momentum towards his goals. At a meeting with Ms L a week later, Mr L reported that he had been able to get up earlier and spend time at the family business. Ms L advised that she considered that the highs and lows Mr L experienced when spending time at the casino made his mood less stable. Mr L repeated previous thoughts about lacking integrity, as he was not always able to follow things through however he had specifically asked his brother not to invite him to the casino for at least one month. Ms L recommended that Mr L set himself realistic goals and that he completed a weekly activity diary.

4.59 Mr L attended all six appointments during July. Early in the month he reported that he had completed the website for the family restaurant and that he had not been to the casino for two to three weeks, however he noted that he was "*unable to control his temptations when his brother's friend was around*". Later in the month Mr L said that he felt himself slipping back into bad habits as he had been covering his mother's shifts, which meant his sleep routine had been disrupted. He also said that he had thought a lot about going to the casino and had therefore decided to go "*as a reward for his hard work*". Mr L was unable to recap what had been discussed in the previous session with Ms L, or the tasks that had been set. However at the end of the month Mr L reported to Mr P that his sleep had improved and that he continued to help at the family restaurant.

4.60 During August Mr L attended seven appointments with clinical staff. On 15 August Mr L attended a medical review with Dr M; Mr L was accompanied by his father, Mr T. Mr L reported that he was doing fine and had been helping at the family restaurant and requested a reduction in medication. Mr T supported Mr L's request and agreed to monitor Mr L's mental state at home. It was recorded that Mr L had coped very well since taking oral medication and reducing the dose. Dr M2 suggested a change in antipsychotic medication, however Mr L was reluctant to agree to this. Dr M2 therefore agreed to reduce the medication to risperidone 2mg, which was the lowest dose she could recommend. On 20 August Mr L asked to see Mr A whilst he was waiting for his psychology appointment. Mr L explained that his dose of risperidone had been reduced and that he was going to run out in the following few days. Mr L said he did not want to waste a visit to the GP if they were not aware of the change in mediation. Staff suggested that Mr L return the following day to collect a letter to his GP advising of the change in dose. On 28 August Mr L reported that he had had a difficult week and had been to the casino and lost money. Mr L said that his brother had tempted him saying, "*what else are you going to do otherwise*". Ms L helped Mr L to identify periods of time when he had not been to the casino and that this had been linked to when he was socialising and attending courses, therefore it was important for Mr L to identify alternative activities. The following day Mr L met with Mr P to complete a self directed support questionnaire. Mr L stated he was supporting his uncle at the family restaurant whilst his parents were away. Mr L said he was doing well but his appetite had reduced "*due to*

seeing food all day, he did not feel like eating". The self directed support plan indicated that Mr L had "*no difficulties managing money*", didn't need any support, was on benefits and was not in any debt.

4.61 During September Mr L met with Ms L for three psychology sessions. After some discussion at the previous Mr L decided to speak with his mother regarding his gambling and inform her that he had lost some money. He had asked his mother to support him in preventing him from attending casinos and Mr L told Ms L that he had not been gambling that week. Mr L told Ms L about the self directed support application but told Ms L that he had felt low after his last meeting with Mr P when they had discussed relapse prevention. Mr P met with Mr L twice during September and discussed images and experiences of being in hospital in Hertfordshire. Mr L agreed to note these so that he could discuss them at a future meeting. Mr L reported that his parents were working at the restaurant again, which gave Mr L more time to read. Mr L cancelled his next appointment with Mr P and at the following appointment Mr L reported that he had mistakenly taken 3mg of risperidone for a few days, which had left him feeling tired and drowsy. Mr L's parents had just returned from holiday and Mr L continued to work in the restaurant without feeling pressured with responsibilities. Mr L said that he was not gambling or going to the casino. Mr L and Mr P discussed Mr L's self-directed support plan, which was completed. Towards the end of the month Mr L reported that he was struggling with motivation and self doubt. Ms L encouraged Mr L to think about different needs of the business and where he needed to start. Mr L reported to Mr P that he felt frustrated because he wanted to help his family and had ideas of how to improve the business but his parents did not accept them. Mr L reported that when the restaurant was busy he felt tired and the work would get "*too much*".

4.62 In October Mr P wrote to Mr L's GP to invite him to a Care Programme Approach meeting on 19 November. Mr L attended three appointments with Ms L but cancelled two other appointments. Mr L told Ms L that he had gone backwards and "*hadn't achieved anything*" in the previous few weeks. Mr L stated it was "*typical of him*" and that he could "*never see anything through*". Ms L encouraged Mr L to use strategies to help forgive himself if he were to become unwell and reminded him that he had previously found meditation to be helpful when he felt stressed. At the end of the month Mr L reported that his spirits had been lifted after attending church over the previous weekend. Mr L reflected that his mood and productivity fluctuated in a repetitive cycle and Ms L discussed techniques to help him manage this.

4.63 During November Mr L told Mr P that he wanted to work in sales and had a friend who could arrange a "*commission only sales role*". Mr L said he felt confident that he could do a good job although he would need a driving licence so had started to learn to drive. Mr L told Ms L that he had been "*haunted by times he has failed/not seen things through*" which impacted on his commitment when he started something new. On the day of his Care Programme Approach review meeting on 19 November Mr L

did not arrive and when Mr P called him Mr L told Mr P that he was unaware of the meeting, so Mr P and Dr M2 continued without Mr L present. Dr M2 noted Mr L's diagnosis as paranoid schizophrenia – in remission. Mr P reported that there had been no deterioration in Mr L's mental health and that discussion in recent appointments had focussed on social issues. Mr P also reported that Mr L did not struggle with motivation and Dr M2 recommended that Mr L meet with an occupational therapist or employment advisor.

4.64 Mr L's Care Programme Approach paperwork and risk assessment was updated on 19 November. The update included a statement that Mr L "*does not lack motivation but rather commitment to pursue a specific task*". The risk chronology in the risk assessment showed that the latest significant historical risk was in June 2009 when Mr L had been admitted to the inpatient unit in Hertfordshire. The risk assessment also noted that no concerns had been expressed by Mr L's family and that Mr L himself reported that he was settled at that time and had no concerns about his mental health. Although neither Mr L nor his father Mr T were present, it is noted that both were sent a copy of the reports and that the next review date was scheduled as 7 May. Dr M2 also wrote to Mr L's GP with a summary of the discussion at the meeting.

4.65 On 20 November Mr L met with Ms L when he reported that he felt calmer after attending church. Mr L also said that he felt less angry and frustrated after discussions with his father regarding the restaurant. Mr L reported that he had been able to stick to his rules of not spending too much whilst visiting the casino and was able to give an example of how he was able to work through an episode of self-doubt. However a week later Mr L told Ms L that he had little to "*get up for*" and as a result had downloaded a game that he had previously been addicted to. Ms L discussed avoidance behaviour and suggested that Mr L focussed on his goal to start sales work.

4.66 In early December Mr L reported to Ms L that he had suffered a migraine during the week and had been sick, however he was feeling more positive and had attended church over the weekend. Mr L said he had been successful in limiting his time on the computer but said he felt unsure whether he could commit to the sales job as it fulfilled only four of the five criteria that were important to him. Ms L suggested that Mr L ask his friend if he (Mr L) could observe him in the role in order to get a better understanding. Mr L cancelled or did not attend his next three appointments with Mr P and Ms L. However Mr L had three appointments between 17 and 24 December. During this time Mr L reported continued struggles with motivation and ability maintain a structured routine, despite doing unpaid work for his father in the restaurant. Mr L said that he was spending long hours on computer games and Ms L reminded him of the "*rules*" that he had set himself. Mr L said that although he had started to learn to drive and was being taught by his brother, he had not had a lesson in three weeks. Mr L said that his brother was "*difficult to tie down*" but that he found his brother's criticism hard to accept. When Mr P met

with Mr L on 24 December Mr L reported that he was doing "*okay*" and said that he was happy taking risperidone 2mg and procyclidine because he felt that he needed it.

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4.67 On 10 January Mr P reported that Mr L did not attend his appointment because he had overslept. Mr P arranged a further appointment for 14 January. There is no record that this appointment took place or was rearranged.

4.68 Ms L contacted Mr L on 14 January to invite him to attend the Tree of Life Group session the following day. Mr L did attend this session on 15 January and Ms L recorded that he "*participated in group discussions*". Immediately after Mr L had attended this session he met with Mr P. Mr P recorded that Mr L denied any psychotic symptoms and that his mood was fine although he had some difficulty in motivating himself. Mr P recorded that Mr L was compliant with his medication but that the medication made him feel tired at times. Mr L said that he had been helping his father at the restaurant but felt that "*he hadn't done much for himself*" and that he hadn't done any driving in the previous six weeks. Mr L told Mr P that he was still interested in the sales job, but was becoming unsure because of the time that he would have to get up. Mr L said that he had been discussing with Ms S ways to occupy his time in a constructive way.

4.69 On 21 January Mr L attended his psychology appointment with Ms L. Ms L recorded that Mr L had told her that he had started gambling on the computer and he had lost money, however he had won it back. Ms L recapped the previous session and she and Mr L had a discussion about why he started gambling and playing computer games. Mr L reflected that he wanted some "*excitement*" as he often felt bored but recognised that it could also be an "*avoidance*" tactic or to "*escape from reality*". Ms L asked how things were going with Ms S, Mr L reported that he hadn't really got very far as he kept changing his mind about what he wanted to do. Ms L recapped on previous discussions about relapse prevention work and discussed Mr L's care pathway. Ms L said that Mr L had been cared for by the service for four years and that M S had organised a joint meeting with Ms L and Mr P to discuss how the team could best support Mr L over the following year, after which Mr L would be discharged from the early intervention service.

4.70 On 24 January Mr L attended the Tree of Life Group and Ms L noted that he had struggled whilst drawing his tree and Mr L had reflected that he found it hard to put his goals down on paper as they were "*forever changing*". On 29 January Mr L again attended the Tree of Life Group when he participated in the group discussion and shared his past experiences with the group. On the same day Mr L met with Ms S briefly when he reported that he had been struggling to set goals. Ms S suggested that he set weekly goals to help him work towards his large

goal of independence. Mr L initially responded in a "*very passive*" way but with encouragement he agreed to consider this and discuss it in his next session.

4.71 On 4 February Ms L met with Mr L for a psychology session. Ms L recapped on the previous appointment and the meeting with Ms S and Mr P to discuss Mr L's goals for the following year. Ms L said that the focus of those goals had been to increase Mr L's activity levels and to develop more structure to his day. Ms L discussed that the psychology sessions would be coming to an end, Mr L was not happy with this and said that he wanted things to continue and that he wanted to carry on with psychology. Ms L said that Mr L had been symptom free for "*some time*", that he had lots of psychology input and that he had developed a good understanding of his mental health. Ms L said that Mr L's goals were more suited to occupational therapy and that it could become confusing to have both Ms L and Ms S setting goals with him. Ms L encouraged Mr L to continue to participate in the Tree of Life Group

4.72 The following day Ms S met with Mr L, Ms S noted that he was "*calm in presentation*" despite the fact that he was "*not in the best mood*" as he had stayed up late the previous night playing Football Manager. Ms S also noted that it was the earliest Mr L had come into the office for an appointment for a long time (the appointment note was entered at 14:36). Mr L identified that he wanted to continue working at the family restaurant on a Saturday. He also said that he had been gambling a lot both at the casino with his brother and on line (alone). Mr L was able to identify the risk and excitement of winning and was able to set himself boundaries in terms of monetary limits, he told Ms S that going into debt "*makes me sick*". Mr L said that he still struggled with motivation and self confidence in seeing things through and "*not getting bored*". He said that he had gone off the idea of work with the double glazing company (previously mentioned sales job) and had not been in contact with the friend that had suggested it. Mr L was unable to come up with any clear goals and Ms S suggested that they work through a vocational assessment to see if that helped.

4.73 On 12 February Mr L attended the Tree of Life Group and participated in the group discussion. Ms L noted that Mr L made positive comments about others when going through a particular exercise. It was noted that there would be a two week break and that the final session would be held on 5 March.

4.74 The following day Mr L met with Mr P. Mr P recorded that Mr L was doing well, waking up in the morning and not sleeping during the day. Mr L reported that he was compliant with his medication and had no side effects. Mr L was still helping at the family restaurant but had still not been able to pursue his driving lessons. "*No psychotic symptoms*" noted.

4.75 On 14 February Mr L contacted Ms L to try to rearrange his appointment with her as he had seen Mr P the previous day. Ms L advised that she was going on holiday but that she would contact him when she returned.

4.76 On 18 February Mr L met with Ms L when they discussed the end of therapy. Mr L reported that he felt sad about ending as he had found it useful to have a space to reflect. Ms L discussed the importance of setting meaningful goals in his sessions with Ms S.

4.77 Mr L attended the final Tree of Life Group on 5 March. Ms L recorded that he gave positive feedback about his experience of the group and that Mr L was keen to become involved with facilitating any follow up groups in the future. Mr L was given a certificate and a photograph and gave his permission for his photograph to be used in the NHS magazine.

4.78 Ms L wrote to Mr L on 12 March summarising the things they had discussed during the 28 psychology sessions that Mr L had attended since May 2012, and providing a copy of "Back in the Saddle" a guide to relapse prevention. The letter outlined helpful and unhelpful patterns of behaviour that Mr L experienced and the fact that Mr L's goals were more suited to working with an occupational therapist. The relapse prevention guide provided specific thoughts, feelings and behaviours that were warning signs that Mr L was becoming unwell. All were specific to Mr L.

4.79 Mr L then attended his final psychology session with Ms L on 13 March. Ms L noted that they went through the end of therapy report and relapse prevention plan and that she would arrange a three month follow up appointment. When we interviewed Ms L she told us that Mr L gave her a small gift at this final appointment; a pair of earrings with ears. Ms L told us that Mr L had said that he had chosen them because Ms L had "*listened to him well and it was like* [she] *had four ears…*"

4.80 On 20 March Mr L did not attend his appointment with Mr P. Mr P had a telephone conversation with Mr L who reported that he was doing well and had received his self directed support payment for six months. Mr P noted that he had arranged to see Mr L on 25 March.

4.81 Mr L had appointments with both Mr P and Ms S on 25 March. His first appointment was with Ms S during which Mr L discussed his recently gambling losses. Mr L reported that he was bored and had no daily structure since his mother had returned from her holiday, as there were fewer hours available to work at the restaurant. Mr L told Ms S that he had enjoyed the Tree of Life Group because he found the other people interesting and said that many of the courses and activities that he did were not sufficiently challenging. Mr L spoke of "*wanting to work*" but being "*unsure if he could commit*". Ms S noted that Mr L appeared to be "*externalising responsibility for himself onto others, such as his brother was the reason why he had not completed his driving*". Mr L reported to Ms S that he planned to pay the self directed support money back so that he could spend it money on areas that he wanted to, and would do so by

saving his benefits over the following months. Ms S encouraged Mr L to register with a volunteering agency however he was very resistant despite reporting earlier in the session that he would prefer volunteering to work. The plan agreed was for Mr l to research cooking courses that he was interested in and find out start dates and costs; and find out the times of the martial arts courses and Ms S would accompany Mr L to encourage him to attend. When Mr L met with Mr P, Mr L reported that he had lost over £3000 playing roulette. Mr L said he "*felt anxious and low in mood*" but that he had "*now recovered*". Mr L had spoken to his father and felt more in control and said that it wouldn't happen again. Again Mr L reported that he wanted to get involved in volunteering but that he would concentrate on the activities listed in his self directed support plan. Mr L reported that his mental state was fine and that he had been compliant with his medication. We note that on this day Mr L reported two contradictory pieces of information to two members of staff. We can find no evidence that this contradiction was identified or discussed by the members of staff concerned.

4.82 Also on 25 March Mr L completed a "*Permission to Share Information*" document on which he did not identify any sharing restrictions; and an Advance Directive for Mental Health. In the second document Mr L gave permission for his father to be contacted as someone who could speak for him in a crisis or dispute.

4.83 On 28 March Ms S entered a note "*in retrospect*" advising that she and Mr L and another service user had visited INUF[13]. Mr L reported that he would consider joining for the Tai Chi sessions and said that he wanted to visit again when this session was running.

4.84 On 9 April Ms S reported that Mr L had joined the "Tuesday Group" to watch a film at the cinema; Mr L had said he found the film a "*little naff*" and on the return journey he said that he had not had chance to look at the goals to increase his activity. Mr L asked for "*more time*" to look at these and wanted to review them "*in a couple of months*". Ms S discussed the need to build towards goals slowly and Mr L agreed that attending the occupational therapy group every Tuesday would be a start. Mr L said he would benefit from a text or phone call each week as a reminder.

4.85 On 10 April Mr P met with Mr L who reported that he was "*okay*". They discussed the self directed support plan and Mr P advised that the money Mr L had received was for a year's support plan and the next time he could apply for more funding was in one year from then. Mr P discussed sleep hygiene as a routine to help Mr L establish a better sleeping pattern.

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[13] INUF (Independent Newham Users Forum) is an independent user-led mental health charity based in Stratford. Their goal is to improve the lives of their members by enhancing their skills…the atmosphere is informal and relaxed making INUF an inviting place for all to use on a daily basis to socialise, find a voice and improve their every day quality of life.

Mr L reported that his lack of motivation was the worst it had ever been. Mr P discussed Mr L's family relationships and Mr L said that he could not talk about his negative feelings about his brother to his parents. Mr L said that he felt he needed to "*follow spirituality and find peace*" and said that his target was to "*be happy*". Mr L reported that he had recently had a minor surgical procedure but there had been some complication and he had to see his GP for a follow up. Mr L also said that sometimes he felt he had complications in his ear that affected his hearing and that he had had those experiences for a long time. Mr P advised Mr L to see his GP. Mr L said that his mood was fine, he had no voices and was compliant with his medication with no side effects.

4.86 Ms S entered a note on 17 April "*in retrospect*" to report that Mr L attended the Tuesday Group to visit the light show at the Hayworth Gallery. Mr L had bought a guide about different styles of art and commented that he often went through "*addictive stages*" where he would be "*obsessed with one thing such as art and spend a lot of time reading about it*". Ms S noted that Mr L appeared to enjoy the show and said that he would "*like to see more things like this*". Ms S reported that afterwards the group had gone to a local food market and Mr L had briefly disappeared, "returning some 15 minutes later with a beer in his hand". A discussion took place about the appropriateness of drinking alcohol during the group and Mr L apologised and put the beer in the bin. Mr L said that he would drink occasionally at the casino and would mainly drink beer. A general discussion about mental health and the effects of alcohol was had during which Mr L demonstrated some insight stating that alcohol affected him more than "*normal*" but he felt that this was linked to his medication.

4.87 On 23 April Ms S noted that Mr L had attended the Tuesday Group when they had taken the cable cars to North Greenwich. Ms S recorded no concerns reported and "*he stated he was feeling good in himself*". Mr L was observed to engage and "*was observed having long conversations with several of the group*". Mr L reported that he enjoyed the session and planned to attend the employment session the following week.

4.88 Mr L did not attend his meeting with Mr P on 24 April. Mr P called Mr L who said that he had forgotten about the appointment and was sleeping. Mr P recorded that Mr L "*reported to be doing well*". A further appointment was made for 29 April but again Mr L did not attend. Again Mr P called Mr L who reported that he was "*doing fine*" and had forgotten about the appointment as he was watching a movie. A further appointment with Mr P was arranged for 1 May. Ms S noted that Mr L did not attend the Tuesday Group on 30 April.

4.89 Mr L did attend the appointment with Mr P on 1 May and reported that he was doing well. Mr L said that he had "*recently started going out a bit more*"; he had enquired about cookery classes and had gone to the gym but found that his membership had expired. Mr P discussed what Mr L wanted to achieve and Mr L said that he was happy with what he was doing at the time and would continue to do this until he felt more

confident. Mr P also discussed gambling and Mr L reported that he had not had any cravings and had been able to keep away from the poker and roulette machines. Regarding his mental health Mr L denied any strange feelings or thoughts and said that his mood was okay. Mr L said that in the previous week he had been going to bed late as he had been watching comedy programmes on television. Mr L reported that he had been compliant with his medication with no side effects. Mr P briefly discussed Mr L's request made to Ms L to talk to spiritual care but Mr L said that he had "*resolved what he needed to discuss*" and it was no longer an issue but would approach Mr P if he needed to make the request again. Mr P informed Mr L of the multi disciplinary team meeting on 7 May and asked him to bring his father, Mr T with him.

4.90 This meeting actually took place on 8 May when Mr L attended accompanied by his father Mr T, also present were Dr S1 and Mr P. Dr S1 noted that Mr L's medication continued to be risperidone 2mg at night and procyclidine 5mg twice daily. Dr S1 also noted that Mr L would benefit from some routine blood tests and that he would need encouragement to do this as he had a "*phobia of needles*". Mr L reported that he had found the psychology sessions with Ms L useful and was able to recall discussing coping strategies with day to day issues. Dr S1 recorded that Mr L was "*doing relatively well with little evidence of positive psychotic symptoms*". The only symptom Mr L had described was of thinking of a voice when he tapped his knee, however Mr L "*now says it's only him that thinks that way and it is not true*". Mr L said he was able to distract himself and did not know the content of the message. Dr S1 noted that Mr L appeared dull, but that he had denied any depression. Mr L had reported that he was helping out in his father's restaurant and was able to take orders, look after tables, help out in the kitchen, and "*makes good conversation with guests according to father*". Dr S1 noted that Mr L's attendance at Tuesday Group was "*on and off*" and again noted that Mr L was quick to lose interest in new activities. Dr S1 recorded that Mr L was not keen to change medication "*though father discussed this*". The plan from the meeting was that Mr P would revisit the self directed support plan and that input from Ms S, occupational therapist, would continue. Following this meeting Dr S1 wrote to Mr L's GP providing a summary and recommending that routine blood tests were undertaken. The Care Programme Approach paperwork completed on 19 November 2012 indicated that the next Care Programme Approach meeting would be held on 7 May but we have not seen any evidence of Care Programme Approach plans or risk assessments being updated following the meeting on 8 May.

4.91 Mr L did not attend his appointment with Mr P on 8 May. Mr P tried to call Mr L but received no response.

4.92 On 17 May Mr L was sent a copy of the Trust magazine with the article on the Tree of Life Group. A note was also enclosed letting Mr L know that it was hoped the group would run again soon and that staff would be in touch to see if Mr L was still interested in being involved.

4.93 On 21 May Mr L joined the Tuesday Group on a tour of street art at Shoreditch. Ms S noted that Mr L had initially had reservations about attending however had sent Ms S a text message stating "*To round off the experience will I get mugged as well? Yeah I'll probably come.*" A further text message was received "*Ltz 1 of dem tings wher I got an dental appointment in Der morning so if I dnt txt u to cancel meanz I'm coming*". Ms S noted that Mr L was very engaging in his presentation and appeared to manage in a large crowd. Mr L told Ms S that it was the most interesting group so far.

4.94 On 22 May Mr L attended his appointment with Mr P who was accompanied by a student nurse who completed the entry on Mr P's RiO login. It was recorded that Mr L presented as calm and stable in mood and "*he reported to be okay*". Mr L was asked if he felt he would benefit from any further support at home from his family, but he said that he saw his family enough when he helped them at work. Again Mr L expressed a desire to get a job involving mentoring and teaching. Mr L was given information about local community activities and service user participation groups and was encouraged to attend.

4.95 On 28 May Mr L attended the Tuesday Group session on moving on where a presentation was given by Newham Active[14]. Information was provided about gym membership and activities available in Newham. Ms S noted that Mr L engaged well and that no concerns were raised.

4.96 On 31 May Mr P received a telephone call from Mr L who said that he felt his risperidone dose needed to be increased. Mr L reported that lately he had noticed that his leg was shaking a lot and said that although he felt it was natural, his father had pointed out he could be relapsing. Mr P asked whether Mr L was taking his procyclidine; Mr L said that he took them every day. Mr P explained that Mr L needed to be reviewed by the doctor; Mr L said that he would increase the dose of risperidone from 2mg to 3mg and would let Mr P know how he was doing. Mr P noted that he "*planned to discuss* [Mr L's] *case with* [Dr S1] *or* [Dr M] *on Monday*". We have not found any evidence that Mr P discussed this issue with either doctor.

4.97 On 4 June Mr L sent Ms O a text saying he was unable to make it to the Tuesday Group that day.

4.98 On 11 June Mr L attended the Tuesday Group meeting but arrived a little late at the office. Ms S noted that he was "*dressed in casual clothes and had a recent hair cut*". Ms S recorded that Mr L engaged well in conversation with staff and "*with encouragement, with other service users*". It was reported that Mr L initiated conversation about films he had previously enjoyed, made good eye contact and appeared calm

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[14] *Newham Active is a leisure trust with charitable status working in partnership with Newham Council to deliver leisure, sports and volunteering opportunities in Newham*

throughout. Ms S noted that on the return journey Mr L spoke to her and told her that he had "*been stopped attending the casino or online gambling*" and that he had not been playing Football Manager. Mr L asked for support to register with the gym as he had difficulties a couple of weeks previously and Ms S suggested that they would arrange a time to go the gym "*may at one of the future Tuesday Group*" meetings. Mr L said he had been working a lot in the family restaurant but agreed to attend the following week's Tuesday Group to the cinema. Ms S noted that she would send a reminder the following week about the Tuesday Group and would liaise with Newham Active regarding the difficulties registering with the gym.

4.99 On 12 June Ms L reported to Mr P that she had received a text message from Mr L that said, "*Don't ever talk to me again, I don't like my relationship with you and I should never have given you that present, I regret that*". Almost immediately Mr P contacted Mr L to discuss the text message. Mr L reported that he had built an addictive relationship with Ms L and that he shouldn't have sent the text and apologised. Mr P asked if Mr L was relapsing or experiencing any psychotic symptoms but Mr L responded that he was "*good*". Mr L denied hearing voices or any tapping messages and that he had not increased the dose of risperidone. Mr L told Mr P that if he recognised any symptoms and if he felt unwell he would let Mr P know and agreed to see Mr P on 19 June.

4.100 At about 7:30am on 13 June Mr P called his team manager to report that he had received a call from the police station requesting an Appropriate Adult for Mr L as he had allegedly killed his father. Shortly after 9:00am Ms J2 received a call from the custody sergeant who advised that a mental health act assessment had been requested and that a MIND advocate had visited the police station. Ms J2 noted that following this conversation she arranged for "*all team members to gather in the clinical meeting room*" to inform them of the incident and to offer support. Staff were reassured that as it appeared that the team had done everything to support Mr L. Ms J2 advised staff that the police would be conducting a full investigation and that the Trust had been advised not to inform Mr L's family of where he had been admitted, however the Trust would offer Mr L's family support. Ms J2 noted that staff had been informed that she was available and that her door was always open to anyone who wanted to talk, or alternatively staff could talk to and support one another. Ms J2 subsequently contacted Mr L's GP surgery and spoke to the practice manager to inform her of the incident. Ms J2 also liaised with the Trust legal department regarding contact with Mr L's family to offer condolences and support. The entry made by Ms J2 indicated "*no*" to the question "*significant event*?".

4.101 Following assessment at the police station Mr L was detained under Section 2 of the Mental Health Act and was admitted to the medium secure forensic unit run by the Trust.

5 Arising issues, comment and analysis

5.1 The early intervention team had provided significant, consistent support to Mr L over a period of four years and had just started discussions with Mr L about his future care pathway when Mr L killed his father. Mr L had benefitted from a very stable care team, being under the care of the same care co-ordinator since early 2010 and the same consultant psychiatrist since referral from Hertfordshire Partnership Trust.

NICE guidance on the management of first episode of psychosis.

5.2 The NICE guidance on the management of schizophrenia, first published in March 2009 indicates that the following psychological and psychosocial interventions should be offered and started during the acute phase or later:

- Cognitive Behavioural Therapy;
- family intervention to families living with or in close contact with the service user;
- consider offering arts therapies;

5.3 We can find no evidence that family intervention was offered to Mr L's family. However Dr S1 and Dr Q, Lead Psychologist for the Early Intervention Team both told us that Mr L would have been offered family therapy. Dr Q described Mr L first started receiving psychological therapy in 2010 with Ms A and that "*he was not keen on family work of any kind*". Dr Q told us that the summary of Mr L's sessions with Ms A was recorded in "*the 2010 report*" by Miss A. Dr Q told us that she believed that all three of the psychology reports were available to us and had been available throughout. Dr Q confirmed that a psychologist would also make contemporaneous entries into client records following a session, and that these would be recorded on RiO, and prior to the team using RiO, in the paper file. We have not been able to view Ms A's report and have not seen any contemporaneous entries completed by her. We believe this is because we have not had access to the two volumes of paper records that the Trust has been unable to locate.

5.4 However as we have documented in Section 4, Mr L did receive a significant amount of psychological therapy intervention. Dr Q told us that the three separate psychological therapy interventions were to respond to different issues that Mr L wanted support with and the first set of sessions in 2010 dealt with sleep, gambling and body shaking.

5.5 The NICE guidance was updated in 2014[15] when an additional guideline was introduced that recommended assessment for post traumatic stress

[15] *Guidelines for Psychosis and schizophrenia in adults: prevention and management, updated in March 2014*

disorder. The new guidance continued to reference family therapy as a treatment option for first episode of psychosis.

5.6 The Trust provided support through the Tree of Life Group. Information provided by the Trust indicates that the Tree of Life programme was originally developed in Australia and was designed for young children who had experienced various forms of trauma and hardship. It was later adapted to run as a group with adults over three sessions and with individuals over several sessions. The pilot implemented by the Trust aimed "*to enable individuals to speak about their lives in ways that* [made] *them feel stronger and to help them think about what* [could] *support them in their recovery*". The pilot was planned to run over six sessions culminating in a celebration and certificates:

"*1. Introduction*

2. Tree of Life- Drawing their Trees

3. The Telling- Sharing their stories

4. Creating the Forest- Noticing strengths of each other

5. The Storms

6. Recap, Celebration and Certificates"

5.7 This was an innovative programme and one that was trialled in advance of the revised NICE guidelines and should be commended.

Carers' support and assessment

5.8 Mr L's father, Mr T was often present at Mr L's Care Programme Approach meetings and medical review meetings. Early intervention service staff would encourage Mr L to bring his father to meetings and in an Advance Directive completed on 25 March 2013 Mr L listed Mr T as someone to speak for him in crisis.

5.9 However we can find no evidence of any work with Mr T regarding his role as a carer.

5.10 The Trust Carer's Strategy 2013-2016 identified a carer as someone who may undertake a range of activities. Relevant to Mr L's care is:

- "*providing emotional support, social support, supervising someone to keep them safe, and helping someone to deal with difficult emotions*"

5.11 Section 4 of the strategy stated that staff had been given information on how to register carers on RiO and that by the end of March 2014 "*all carers of clients on Care Programme Approach would be registered on RiO*". We can find no evidence that Mr T was ever registered as a carer on RiO however we acknowledge that as the incident was in June 2013, it is possible that the registration process had not been completed by the team at that time.

5.12 Section 5 of the strategy stated that the Trust had rolled out the use of advance directives (which we know that Mr L had completed) and that future actions would include all care co-ordinators contacting "*the main carer for each person on their caseload once a month to share relevant information and* obtain carers input". In our interview with Mr P we asked about Mr T's role in Mr L's care. Mr P told us that Mr T "*knew he could contact me if he needed*" and that as far as Mr P could recall Mr L had a "*good rapport with his father*" and that Mr T was "*very much engaged with* [Mr L's] *care and the services*". However, if monthly contact, or even regular contact, had been initiated by the Trust this would have provided an opportunity for Mr T to share any information, without feeling that he had to have a significant issue to prompt him to call Mr P.

5.13 Section 7 of the strategy stated that the Trust already offered carers regular assessments to take account of their own needs and that there was a carers support worker in Newham (but not in other directorates). We asked Mr P about the policy in place at the time for offering carers assessments; Mr P told us that they "*always offer a carer's assessment to anybody who is caring for somebody who has mental health problems. The carer's assessment would always be offered*". Mr P told us that the Trust had a form that would be used to record the carer's name and details and what support they needed. Mr P told us that this information would be stored in the client's medical file. Mr P told us that there was no separate record for carers and that the completed carer's form would be uploaded to RiO.

5.14 We asked senior staff about where they would expect to see carer's information recorded and they concurred with Mr P that the information should be stored in the client record.

5.15 We have not found any evidence of Mr T ever having been offered a carer's assessment during the four years that Mr L was under the care of the early intervention service.

5.16 The Trust has told us that "*the team knew the family well and were in contact with the father at least on a monthly basis*". However, we can find only two examples of the Trust contacting Mr T proactively, both occasions were in July 2009 shortly after Mr L's care was transferred from Hertfordshire Partnership NHS Foundation Trust.

5.17 We found no evidence of any contact by the service with Mr T after this point, most notably when Mr L was not attending appointments and when Mr L claimed he was well after he sent the text to Ms L on 12 June 2013. We have counted a total of six recorded attendances by Mr T at Mr L's medical review or Care Programme Approach review meetings; two recorded contacts by the service to Mr T and one recorded contact by Mr T to the service. We discussed these findings with Dr S1 who told us "*I can clearly tell you that seems wrong to me. I've seen him more than seven times. I don't know why the numbers are wrong. I've definitely seen him so many times and he's even been on home visits*". The Trust's

view is "*that although there was not a formal carer's assessment, the father had been well engaged and supported*". We believe that Dr S1's memory is so different from the evidence we found in the records because the Trust has not been able to locate two volumes of clinical notes and therefore we have not reviewed the majority of contemporaneous information from 2009 to April 2012.

5.18 The Trust has told us that a "*carer's assessment was captured*" in the case of this patient, however they also acknowledge that "*there was not a formal carer's assessment*". We were informed that the Trust captures carer contacts on RiO and reports this information to commissioners through formal processes. We have not reviewed this information and therefore are unable to provide comment.

Mr T's involvement in medication

5.19 NHS England asked us to consider whether Mr L's father, Mr T who was a pharmacologist, had undue influence in the decisions about Mr L's medication regime.

5.20 We have not found any evidence that this was the case. We raised the issue when we interviewed Dr S1, when we spoke to Mr L and when we spoke to Mrs T and Mr C.

Spiritual care

5.21 When we met with Mr L he told us that the reason he wanted his meds was because he felt it was spiritiual issues. However we found no evidence that this was communicated to staff at the time he was being care for.

5.22 Mr L and his father had reported a number of exorcisms to early intervention service staff. These were discussed at Care Programme Approach review meetings and Mr L often reported that prayers at the church helped him.

5.23 Mr L had reported to Dr S1 that a local priest had performed an exorcism and that the priest had advised Mr L to continue taking his medication as well. A suggestion was made at the Care Programme Approach meeting in March 2011 that the priest be invited to the next Care Programme Approach meeting. We can only find this suggestion recorded in the progress notes and not in the Care Programme Approach paperwork. We can find no record of any discussions about this suggestion during meetings with Mr P after the Care Programme Approach meeting and it appears that no formal invitation was ever sent. It is our view that this was a missed opportunity to engage with a spiritual leader with whom Mr L had a positive relationship at the time.

5.24 Dr S1 suggested that the Catholic priest who had conducted several exorcisms on Mr L be invited to a future Care Programme Approach meeting. It is our view that more could have been done to ensure that the

priest received an invitation directly from the team. There was no indication in the records that Mr L objected to this invitation and so it would have been reasonable for the team to obtain the priest's details so that, as a minimum, Dr S1 could have had a conversation with him.

5.25 We have found no information to indicate that the early intervention service had knowledge of Mr L's final exorcism prior to the death of Mr T, and therefore the staff would not have been able to act on that information.

5.26 The Trust has told us that it is concerned that we have not made any reference to the "*high level of support the spiritual team offered to Mr L*". We had not found any evidence of direct involvement of the spiritual team in Mr L's care and therefore re-reviewed the records and spoke to the Head of Spiritual Care. The Head of Spiritual Care told us that he had no recollection of his team being involved with Mr L and so had checked all the referrals received in that year but none of them was for Mr L. The Head of Spiritual Care advised that his team is well known to the Newham Early Intervention Service and they often received referrals from the team. He described the referral process, which fitted with the information we had seen about Mr L being offered a referral to spiritual care, which he declined.

5.27 The Spiritual Care Team comprises staff that represent different faiths; staff have a core mental health qualification but also a faith role too. For example the Rabbi is also a psychotherapist; the Christian minister is also a psychologist.

5.28 The Head of Spiritual Care told us that in 2013 his team wasn't integrated into RiO (the electronic patient record), however if his team had an interaction with a client that the care co-ordinator should be aware of, his team would write a summary that would be emailed to the care co-ordinator.

5.29 The Head of Spiritual Care told us that most of the team's work is on the acute wards and that any work done with clients who are in the community is done over shorter periods of time and mostly through joining with the client's care team for appointments. He also told us that occasions when his team would work with a client would include situations when a client believed that exorcisms were curing their mental illness. We understand that the Spiritual Care Team run a number of programmes for faith groups in order to break down the stigma about mental illness that exists in some cultures.

5.30 We understand that the Spiritual Care Team provides mandatory and other in-house training for staff:

- Equality and diversity training as part of the Trust induction programme;
- Specific training for junior doctors;

- General training on spirituality and mental health;

5.31 The Trust also has arrangements with the University of East London to provide a certificated programme on spirituality and mental health. Each year a small number of staff attend the programme and when complete, they usually go on to be advocates and a local resource within their own teams.

5.32 There is no evidence to indicate that the spiritual care team were present at any discussions about Mr L's care and treatment.

Self directed support plan

5.33 At the time of the incident, the London Borough of Newham mental health social work staff were seconded to the Trust and the Trust had responsibility for all social care activities, including support planning. London Borough of Newham was responsible for agreeing the funding on the basis that the support plan had been agreed by the Trust, and providing the "*administrative machinery*" to make payments and follow up on requests for receipts. London Borough of Newham has told us that it would be a matter for the Trust to inform the council of any problems or difficulties.

5.34 A constant theme in Mr L's addictive behavioural patterns was a gambling addiction, both at casinos and online. Whilst we can see that there were periods when Mr L was reporting that he was able to have greater control over these behaviours it was clearly reported on several occasions that he had lost significant sums of money; the consequences of which clearly caused Mr L great anxiety.

5.35 Mr P supported Mr L to apply for self directed support funding on three occasions:

- March 2011 when Mr L received £850.20 to attend martial arts training for six months, and attend career coaching course;

- November 2012 when Mr L received £906.88 to attend cookery classes;

- January 2013 when Mr L received £1685 to attend a martial arts school (funding for Mr L and his brother), and a part time NVQ Level 1 cookery course.

5.36 On 7 February Newham Council wrote to Mr L requesting invoices for the martial arts and cookery activities.

5.37 In March 2013 Mr L reported that he intended to repay the self directed support funding so that he can use his own money saved from benefit payments to do activities that he wanted. We can find no further discussion on this matter and, given what Mr L told us about the increase in his gambling in the two months prior to the death of his father, it is our belief that Mr L used this money to fund his gambling activities.

5.38 It appears that Mr L did not respond to the letter from the council and therefore a follow up telephone call was made on 22 May during which Mr L explained that the cookery classes would be starting in September 2013 and he hadn't signed up for the martial arts programme "*due to ongoing health problems*". It is of note that this phone call was received at a time when Mr L was deteriorating and just two months after Mr L had informed Mr P that he had lost £3000 during a gambling session.

5.39 A further letter was sent in October 2013, clearly this was after Mr L had been detained and shortly afterwards the decision was made to close the case and no further correspondence would be sent.

5.40 The Trust advised the Domestic Homicide Review inquiry team that Mr L "*was advised to self-refer to Gambling Anonymous but he declined. However the issue of gambling was regularly addressed…in his care co-ordinator sessions…gambling had a cyclical pattern.*"

5.41 We can find no consideration or discussion of the risks of supporting Mr L to directly receive council funding. It is our view that a more detailed assessment of the risks of Mr L receiving direct funding and exploration of alternatives should have been undertaken prior the application for direct payments being supported.

Risk assessments

5.42 We can find evidence of risk assessments being completed for Care Programme Approach review meetings, however we can find no risk assessments being reviewed following a change in presentation.

5.43 The Trust Clinical Risk Assessment and Management Policy Version 4, dated October 2011 states that:

"*Risks are not static and therefore require regular review and assessment in response to the patient's changing presentation and circumstances.*"

5.44 However the policy goes on to say:

"*Risk assessment and management documents should be reviewed routinely at key intervals in the patient's care spell such as ward round reviews, discharge planning meetings and CPA reviews. Risks should be escalated and de-escalated in response to any changing factors which alter the overall profile of the risk. This will ensure that the process remains dynamic and is therapeutic in responding to the patient's changing presentation and ability to self- care.*"

5.45 The Trust Care Programme Approach Policy dated May 2010 also covers risk assessment and management and states:

"*Risk assessment is an essential and on-going element of good mental health practice and a critical and integral component of all assessment, planning and review processes.*"

5.46 Both statements indicate that risk assessments should be integral to the routine of the therapeutic patient relationship. There were a number of occasions when Mr L was not attending appointments, reporting poor compliance with medication, demonstrating an increase in negative presenting symptoms, or requesting a change in medication when his risk assessment should have been reviewed and was not.

5.47 The most recent Care Programme Approach paperwork (which incorporates the risk assessment and risk management plan) was completed on 19 November 2012. There was no Care Programme Approach paperwork completed following the Care Programme Approach review meeting on 8 May 2013.

5.48 The crisis, relapse and contingency plans indicate Mr L's relapse indicators or warning signs to be:

- "*Paranoid thoughts that others are planning to harm him*";
- "*Non compliance with medication*";
- "*Self injury*";
- "*Hearing voices*";
- "*Being controlled by external forces*";
- "*Involuntary spasms*".

5.49 The crisis plan advises that if concerns are raised during office hours the early intervention team should be contacted and that if concerns need to be raised out of hours the emergency out of hours service should be contacted. However the plan does not draw on any of the work Mr L did with psychologists on warning signs and steps he or others could take in responding early to signs of a relapse.

5.50 Mr L was discussed at team meetings where a traffic light system was used to indicate the level of concern the team had about a client. Table 1 below is an extract from the Operational Policy for the team that describes the criteria and clinical expectation for the traffic light system.

Table 1

	Criteria	Clinical Expectation
Red	Increasing/high levels of risk to self/ others Mental health act assessments No contact or 4 DNAs (Did Not Attend) Non-compliance with care plan/ medication	Medical review Care co-ordinator review **2-3** per week (face:face at least **1x** per week)

	Criteria	Clinical Expectation
	Service users with acutely distressing symptoms such as command hallucinations, DSH (deliberate self harm) ideas, etc. Service users in Police station Concerns from care co-ordinator/ carer/ family/ health professional/ service user Within 4 weeks of incident (DSH/ others) Relapse signature signs evident Clients in prison and/or hospital When client reaches 32 weeks of Pregnancy or has given birth Within 6 weeks post natal period	Multi-disciplinary team review Professionals meeting/Care Programme Approach if required **EXIT ONLY AFTER MEDICAL REVIEW OR MULTI-DISCIPLINARY TEAM DISCUSSION**
Amber	Within 8 weeks of acceptance to NEIS where there is limited or high risk history Within 4 weeks of discharge from hospital As soon as team is informed of Pregnancy (to remain on Amber for the duration of pregnancy) During medication change or discontinuation During discharge planning phase from NEIS Family dynamics leading to increasing risk No Contact or 2 DNAs Safeguarding Children/Adults to be put on Amber stating when alert is raised Any life style changes which are significant or causing an impact (Employment/Education/Marriage/ Divorce/Social/Accommodation etc)	Medical review at least **4-6** weekly Care co-ordinator review at least **once** weekly Multi-disciplinary team review Care Programme Approach/ Professionals meeting if required **EXIT ONLY AFTER MULTI-DISCIPLINARY TEAM REVIEW AND FORMULATED CARE PLAN**
Green	Service users well engaged with NEIS and/ or have good social support Formal risk assessment indicates low risk to self and others In remission or chronic residual symptoms	Care co-ordinator review **2-4** weekly Medical review when requested by the Care co-ordinator

* These patients are currently being discussed as separate lists in MDT meeting
** All care plans discussed in MDT to be documented in service user files
*** Any MDT member can place a patient in above categories.

5.51 During interview Mr P told us that information from traffic light discussions was recorded in both the client record and a separate document covering the whole meeting. However we found no reference to any 'traffic light' changes in Mr L's record. At a later interview the Team Manager told us

that the traffic light status would only be recorded in the separate document and not in the client record.

5.52 We have received copies of the relevant minutes from traffic light meetings held in the weeks prior to the homicide. We can see that at the time of the incident Mr L was classified as amber and had been discussed on:

- 3 May 2013: Mr L's traffic light status was green and the notes indicate he was last seen by the consultant on 16 January 2012. "*No concerns*" were noted;

- 10 May 2013, 17 May 2013, 24 May 2013, 31 May 2013 and 7 June 2013: Mr L's traffic light status was green and the notes indicate he was last seen by the consultant on 8 May 2013. "*No concerns*" were noted;

- 14 June 2013: Mr L's traffic light status was red and the notes indicate he was last seen by the consultant on 8 May 2013. His arrest for murder is noted, along with the possibility that his medication may need to be increased, the text sent to Ms L, and a plan for Mr P to meet with Mr L on 19 June.

5.53 The Trust had advised that Mr L's traffic light status was changed from green to amber on 13 June. Although we have not seen evidence of this, the text contained in the 14 June note indicates that this was probably the case.

5.54 There was a change to Mr L's traffic light status, and reasonable actions were taken to review Mr L following receipt of the text message that he sent to Ms L. This message was out of character for Mr L and appears with hindsight to be a critical point in the change in Mr L's presentation, however we consider that his subsequent actions could not have been predicted or prevented.

6 Internal investigation and action plan

6.1 The internal investigation team comprised:

- Serious Incident Reviewer (Chair of Panel);
- Director of Psychological Therapies;
- Consultant Psychiatrist, Tower Hamlets Early Intervention Service.

6.2 The incident was reported on StEIS[16] on 14 June 2013; the internal investigation report was signed off by the Medical Director on 30 August 2013; and the reported was completed on 2 September 2013.

6.3 The investigation team were unable to interview Mr L as part of the investigation. The reason for this was that the police had not formally interviewed Mr L at that stage and he was therefore the subject of an on going criminal investigation. Clinical reports completed in the months after the incident indicated that Mr L was extremely unwell and therefore an interview would not have been appropriate at that time anyway.

6.4 The investigation team met with Mr C and Mrs T on at least two occasions and the Chair of the Panel facilitated access to some counselling that had been offered to the family by the Trust. Although the Chair of the Panel retained records of these meetings, these were not available to us (see paragraph 6.7 below).

6.5 Staff interviews were conducted with Mr L's consultant psychiatrist, care co-ordinator, psychologist, occupational therapist and the team manager. At the start of our investigation we asked to see copies of records of interviews with staff and meetings with the family but were told by the Trust that "*the process at the time would have been to destroy notes on completion of the review rather than retain them*". We asked if this process was described in a document and whether it was still in place, however we did not receive a response.

6.6 We asked the Medical Director about the lack of such records and he told us that he would expect investigation interviews "*to be minuted*".

6.7 When we interviewed the Chair of the Panel, Dr H, she told us that she had taken handwritten notes during interviews with staff, as is her usual process. These notes were collated with all other documents and paperwork associated with the internal investigation or review and the folder was "*stored in a designated locked cupboard for that purpose*". Dr H advised that "*the folder appears to have gone missing in the move*

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[16] *StEIS (Strategic Executive Information System) is a national database for the recording of serious incidents, their investigations and findings.*

between offices" and that it could not be located. Dr H did not know whether any other investigation folders had gone missing and advised that nobody had asked for an audit to be done. Dr H didn't know whether an incident had been raised regarding the missing records, however she had reported it to the assurance team when we requested the records.

6.8 We raised this issue with the Trust again and were told "*On completion of a serious incident investigation we do routinely keep all information relating to the review. This is stored on a secure drive. Once items have been uploaded to the drive we would not require the originals to be kept (though some reviewers will also retain their own notes)*".

6.9 We did not receive a response to our questions about whether the loss was logged as an incident or whether any checks had been made to identify whether other investigation files were also missing.

6.10 We have reviewed the Trust Incident Policy dated September 2013 and can find no reference to the need for records to be kept of investigation meetings or interviews.

6.11 The internal report was not shared in full with the family because Mr L had not felt able to read the report as it was too distressing for him, and therefore "*couldn't give informed consent that they could see it*". The Chair of the Panel left the issue with Mr L's consultant psychiatrist and shared an executive summary of the report with Mr L's family. Dr H told us that at the time the only issue that the family felt had not been addressed in the internal investigation was that of exorcism. Dr H informed the family that the issue was outside the scope of the internal inquiry but offered to contact the Domestic Homicide Review panel to advise that the family were keen for it to be included in the scope of their review.

6.12 The internal report describes information and support provided to the staff interviewed and states "*all members of staff interviewed…were asked about the level of support provided to them after the incident, whether they were satisfied with the support provided and whether it was adequate for their needs. Any concerns about post incident support are recorded in the report by exception as a service delivery problem*". There are no service delivery problems listed which implies that staff raised no concerns to the internal team. Our interviews with two members of staff were markedly different on this subject.

6.13 We were also told that not all staff had seen the internal investigation report before we had shared it with them in preparation for their interview. We discussed this issue with the Medical Director and the Director of Nursing. We are aware that the Chair of the Panel of the internal investigation team shared the report findings with the team on 30 August 2013. However, it was clear from our interview with the Medical Director that staff may not receive a copy of the report as a matter of course.

6.14 The chronology included covered the five months prior to the incident only. However a report was provided to the internal investigation team by Mr L's consultant psychiatrist that gave details of Mr L's contact with the service from 2009 to the date of the incident. The consultant psychiatrist's report is dated 30 August 2013 and therefore is unlikely to have significantly informed the lines of enquiry of the internal investigation.

6.15 The internal investigation team concluded that there were no care or service delivery problems identified; no contributory factors identified; and the root cause was listed as "*it therefore seems likely that the root cause of the incident was that the patient suffered a relapse in his psychotic illness".* It is understandable that Mr L's family felt that the report was completed for "*staff to cover their own backs*" and that their concerns about Mr L's treatment were not heard, particularly as they did not have sight of the full report due to Mr L's inability to provide informed consent for them to do so.

6.16 The internal investigation failed to identify the lack of carer's assessments and support or the absence of risk assessments and care plans.

7 Overall analysis and recommendations

7.1 It is our view that Mr L's paranoid schizophrenia was not fully in remission, and interventions to treat his symptoms were not sufficiently robust or inclusive, particularly when considering the involvement of family members.

- The dose of antipsychotic was reduced and it may be argued that this dose was not sufficient for a full remission.
- Although some psychological therapies were in place, we consider that family interventions could have been more structured.

7.2 We refer to the NICE clinical guidelines 178 (1.5.7) 'Interventions for people whose illness has not responded adequately to treatment'[17]:

- Review the diagnosis.
- Establish that there has been adherence to antipsychotic medication, prescribed at an adequate dose and for the correct duration.
- Review engagement with and use of psychological treatments and ensure that these have been offered according to this guideline. If family intervention has been undertaken suggest CBT; if CBT has been

[17] *NICE 2014: Psychosis and schizophrenia in adults: prevention and management. https://www.nice.org.uk/guidance/cg178*

undertaken suggest family intervention for people in close contact with their families.

- Consider other causes of non-response, such as comorbid substance misuse (including alcohol), the concurrent use of other prescribed medication or physical illness.

Predictability and preventability

7.3 In its document on risk, the Royal College of Psychiatrists scoping group observed that:

"Risk management is a core function of all medical practitioners and some negative outcomes, including violence, can be avoided or reduced in frequency by sensible contingency planning. Risk, however, cannot be eliminated. Accurate prediction is never possible for individual patients. While it may be possible to reduce risk in some settings, the risks posed by those with mental disorders are much less susceptible to prediction because of the multiplicity of, and complex interrelation of, factors underlying a person's behaviour." [18]

7.4 Predictability is "*the quality of being regarded as likely to happen, as behaviour or an event*".[19] An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.[20]

7.5 Prevention[21] means to "*stop or hinder something from happening, especially by advance planning or action*" and implies "*anticipatory counteraction*"; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

7.6 Mr L had no forensic history and little history of violence towards others; there is one report of him threatening another student with a billiard cue when he was in sixth form. Therefore, it is our view that the staff working very closely with Mr L could not have predicted this tragic event.

7.7 Regarding preventability, all staff we interviewed remained very clear that they saw no signs of Mr L's mental health deteriorating. Some of those

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[18] *Royal College of Psychiatrists (2008) Rethinking risk to others in mental health services. Final report of a scoping group. p23. http://www.rcpsych.ac.uk/pdf/CR150%20rethinking%20risk.pdf*

[19] *http://dictionary.reference.com/browse/predictability*

[20] *Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000)176: 116-120*

[21] *http://www.thefreedictionary.com/prevent*

we spoke to remained very distressed about the impact of Mr L's actions on him and his family, despite the fact that nearly three years had passed since they had last worked with Mr L. Some spoke of the considerable time they had spent reflecting on what they knew and how they had interpreted information and, even with the benefit of hindsight, could find little that would have highlighted any issues. The only exception to this is the text message that Mr L sent Ms L on the day he killed his father.

7.8 We know that Mr P spoke to Mr L after he had sent the text message to Ms L and that Mr L assured Mr P he was fine. This was an action that was completely out of character for Mr L and we have carefully reviewed whether the team's level of response was reasonable. It is our view that Mr P should have sought further information about Mr L's state of mind, and ascertain whether he had been taking the increased medication agreed earlier. Mr P did however arrange for a medical review and change Mr L's traffic light status to amber.

7.9 There is no evidence that Mr P made regular calls to Mr T, and therefore it is possible that this is the reason that Mr P did not call Mr T (Mr P was unable to recall why he did not call Mr T). At interview we asked Mr P whether he had considered the need for a home visit or a more urgent appointment following the text message and phone call. Mr P said that he could not recall. He had previously told us that he had left the Trust in December 2013 and had not had access to the patient records prior to interview.

7.10 It is **possible** that Mr L's mental health might have been improved if the following actions had taken place:

- Mr P had spoken to either Dr S1 or Dr M2 following Mr L's request for an increase in medication on 31 May, and that either doctor had arranged an urgent medication review;

- Mr P had obtained more detail about Mr L's mental state, and the question of whether he had been taking the increased dose of medication on 12 June and that detail had information that caused sufficient concern for an assessment to be undertaken.

- Cues that his mental state was deteriorating were investigated further ie the text message, and shaving his head.

7.11 However we consider there to be no obvious causal link to the homicide of his father that could have been predicted by the Trust.

Recommendations

7.12 The five recommendations from our independent investigation focus on improvements that we consider should be made to care delivery and support and investigation processes. They have been given one of three levels of priority:

- Priority One: the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems or process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.

- Priority Two: the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems or process objectives. The area of concern does not compromise the safety of patients, but identifies important improvement in the delivery of care required.

- Priority Three: the recommendation addresses areas that are not considered important to the achievement of systems or process objectives. The area of concern relates to minor improvements in relation to the quality of service provision.

7.13 We note that the Domestic Homicide Review report also made a recommendation regarding family involvement, recommending that the Trust '*examine its processes for information sharing with carers and families and effectively involve them in risk assessment. This should include provision of carers' packs and clear written guidelines for carers on the availability of a crisis line. Consideration should also be given to the potential risks to the wider family and community'*.

Priority 1

Recommendation 1

The Trust must provide assurance that carer's assessments and support are offered and documented in line with the Trust strategy and that there is a system for care co-ordinators to initiate monthly contact with carers of clients who are on Care Programme Approach.

Recommendation 3

The Trust must ensure that appropriate support is given to clients wishing to apply for self directed support funding, who are known to have gambling habits.

Recommendation 4

The Trust must assure itself that risk assessments and risk management plans are reviewed when new information comes to light. The Trust must also implement an ongoing audit programme to provide assurance about organisational compliance with this requirement.

Priority 2

Recommendation 5

The Trust must revise the Incident Policy or develop additional guidance, and provide appropriate training, to ensure that staff are clear about:

- the type of records to be created and stored when conducting an internal investigation;
- storage and retrieval of clinical records, and reporting of misplaced clinical records, required for internal and external investigations;

The Policy must also include clear guidance about ensuring that staff who have been involved in serious incidents are given access to the investigation report, and their welfare and support needs are checked after the process has been completed. The Trust should also ensure that where possible, staff being interviewed have access to clients records prior to being interviewed.

Priority 3

Recommendation 2

The Trust must ensure that staff take responsibility for issuing formal invitations to all those they believe should be present at a Care Programme Approach meeting, or document discussions where this intention is changed

Appendix A – Terms of reference

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

Specific terms of reference

- How well did the clinical team engage with Mr L and his family in relation to their spiritual needs, primarily around the exorcisms and the impact that these may have had on his mental health and behavior.
- Consider the clinical team's engagement with the family in relation to Mr L's treatment and medication compliance.
- To review risk assessments and action taken when Mr L showed signs of relapse, especially family contact during this time.

Appendix B – Documents reviewed

East London NHS Foundation Trust Documents

- Client records for Mr L
- Trust Serious Incident Review Report dated August 2013
- Trust Incident Policy v8 September 2013
- Carers Pack
- Carer's Service Newham Referral Form 2010
- Carer's Strategy 2013-2016
- Things you always wanted to know about support for carers but were afraid to ask…
- Clinical Risk Assessment and Management Policy October 2011
- Department of Spiritual, Religious and Cultural Care – Newham leaflet
- Early Intervention Service Operational Policy
- Information about the Tree of Life Group

Other Documents

- Hertfordshire NHS Foundation Trust clinical records
- Shrewsbury Road GP Surgery clinical records
- London Borough of Newham support records
- Draft Domestic Homicide Review 'AB'

Appendix C – Professionals involved

Pseudonym	Role
Dr B	GP, Shrewsbury Road Health Centre
Dr H	Serious Incident Reviewer, East London NHS Foundation Trust
Dr I	Associate Specialist, QEII Hospital, Welwyn Garden City
Dr J	Specialist Registrar, Newham Early Intervention Service
Dr K	Consultant Psychiatrist, Hertfordshire Partnership Trust
Dr L1	Specialist Registrar, Hertfordshire Partnership Trust
Dr L2	Staff Grade Psychiatrist, Hertfordshire Partnership Trust
Dr M1	GP, Shrewsbury Road Health Centre
Dr M2	Specialist Registrar, Newham Early Intervention Service
Dr O	Specialist Registrar, Newham Early Intervention Service
Dr P	GP, Shrewsbury Road Health Centre
Dr Q	Psychologist, Newham Early Intervention Service
Dr S1	Consultant Psychiatrist, Newham Early Intervention Service
Dr S2	Specialist Registrar, Newham Early Intervention Service
Dr S3	Specialist Registrar, Newham Early Intervention Service
Dr S4	GP, Shrewsbury Road Health Centre
Dr S5	GP, Shrewsbury Road Health Centre
Dr W	GP, Potterells Lodge Medical Centre
Mr A	Senior EIS Worker, Newham Early Intervention Service
Mr B	Community Support Worker, Hertfordshire Partnership Trust
Mr I	London Borough of Newnham Council
Mr M	Care Co-ordinator, Newham Early Intervention Service
Mr N	Newham Early Intervention Service
Mr P	Care Co-ordinator, Newham Early Intervention Service
Mr S	Community Psychiatric Nurse, Newham Early Intervention Service
Mr T	Newham Early Intervention Service
Ms A	Psychologist, Newham Early Intervention Service
Ms B	Student Nurse, Newham Early Intervention Service
Ms B2	Newham Early Intervention Service
Ms C1	Hertfordshire EIS
Ms C2	Newham Early Intervention Service
Ms C3	London Borough of Newnham Council employee seconded to the Trust
Ms D,	Community Psychiatric Nurse, Hertfordshire Partnership Trust

Pseudonym	Role
Ms G	Counsellor, HPNHST
Ms I	Community Psychiatric Nurse, Hertfordshire Partnership Trust
Ms J	Newham Early Intervention Service
Ms J2	Team Manager, Newham Early Intervention Service
Ms K	Community Psychiatric Nurse, Hertfordshire Partnership Trust
Ms L	Psychologist, Newham Early Intervention Service
Ms M	Newham Early Intervention Service
Ms N	Hertfordshire Partnership Trust
Ms O	Newham Early Intervention Service
Ms R	Newham Early Intervention Service
Ms S	Occupational Therapist, Newham Early Intervention Service
Ms V	Newham Early Intervention Service

Appendix D - Chronology of Mr L's contacts with the Trust, Hertfordshire Partnership NHS Trust, London Borough of Newham Council, and his GP

Date	Source	Event	Information
04/03/08	HPFT	CATT night service	Mr L attended A & E complaining he was unable to cope with the housemates and was low in mood. Mr L stated he was having family problems and the family business was not doing well. Mr L felt like his housemates were spying on him and monitoring when he went to the toilet because there was always someone in there when he needed it and it was '*playing with his head'.* PLAN: Follow up appointment of the psychologist. Inform GP of contact. Inform local team. Temporary accommodation from the university. Relevant phone numbers provided in case of crisis.
04/03/08	HPFT	Telephone call	Ms H received a call from the university counselling service stating that Mr L had arrived very distressed and the counsellor was very concerned about him and wanted him to be seen urgently. Mr L was increasingly paranoid and was finding it hard to cope. It was reported that he was not considered at risk to himself or others. PLAN: attend A&E but Mr L was not willing Advised to see his GP to obtain interim prescription either hypnotic or anxiolytic to calm down or sleep. Mr L declined medication. Urgent appointment with Dr K 5th March.
05/03/08	HPFT	Letter to Potterells Medical Centre	Letter from CATT to GP advising that Mr L had attended A&E the previous night.
05/03/08	HPFT	Appointment	Dr K met with Mr L who had a good rapport and was open about any problems.
06/03/08	HPFT	Telephone call	Mr L stated he was coping and feeling better but still in shock about having to take his medication. Mr L denied any adverse reactions.
07/03/08	HPFT	Appointment	Mr L reported to be much better and relaxed and stated he missed '*not being normal*' as the experience gave him a '*rush*' . Mr L said he slept Wednesday night however not the following night. There had been no affects from the medication. Mr L had not yet spoken to his parents and had been avoiding their calls because he found them stressful. Mr L gave verbal consent to contact his parents. Dr K provided a prescription with new medication dosage to start from the weekend. Mr L was aware of the potential side affects and was asked to report them to the team if he experienced any.
11/03/08	HPFT	Appointment	Mr L reported to Ms H that his mental state remained the same. Mr L had been compliant with his medication however still felt anxious and worried about taking it. He reported that he believed he should not be taking it. Ms H discussed the importance of being compliant with medication. Noted that Mr L's next appointment with Ms H was 14/3.

Date	Source	Event	Information
14/03/08	HPFT	Mental Health Helpline	Mr L telephoned Ms C1 and sounded very confused and was not sure which team he was under. Mr L wanted to complain about the visit he had earlier that day from Ms H however was reported to sound suspicious of Ms C1 and wanted to speak to a team who did not know the EIP. Ms C1 confirmed she did not know them. Mr L had concerns about his medication, although a week ago he was feeling much better he felt his medication was an experiment or study and was not for his benefit, only the team. Ms C1 reminded Mr L that he stated he felt better. Mr L was unable to reconcile this difference in his thoughts. Mr L thought Ms H had done something in his head which made these thoughts. Mr L was guarded and reluctant to share how his thoughts bothered him. Mr L was informed that Ms C1 would contact the CATT team to gain advice and would call Mr L back. Ms C1 contacted the CATT team who confirmed Mr L was not under their service but someone would call him. Ms C1 telephone Mr L to advise him of the above.
14/03/08	HPFT	Appointment	Mr L was reported by Ms H to be guarded and reluctantly answered any questions. Mr L reported his mood to be euthymic and that he was much calmer. He no longer had thoughts about being followed and the vibrations and shakiness had stopped. Mr L reported that he slept well and woke feeling rested. He did not believe his new house mates were conspiring with his parents however still believed his old ones were. Mr L's intention was to stop taking his medication once his monthly supply had run out. Mr L believed his chest was swelling and linked this to his medication - there was no evidence of this. Mr L's medication was discussed and advised to remain taking it. Mr L was informed he would be allocated a care coordinator at the meeting the following week.
15/03/08	HPFT	Telephone call	Mr L contacted CATT to discuss his medication. Mr L was advised to contact the EIP service on Monday or if it was urgent to contact his GP or A&E. Mr L wanted just to speak with someone from CATT and did not wish to speak to EIP. Mr L asked if he had rights to stop his medication - Mr L was advised to discuss this with the team and explore alternatives rather than stop against medical advice. Mr L was reported to sound calm.
17/03/08	HPFT	Late night service	Mr L telephoned the service at 01:40. Mr L wanted to discuss his mental health and medication. He stated he has stopped taking his medication because he felt well. Mr L sounded calm but confused. Mr L was advised to continue taking his medication and Mr L agreed to contact the local team in the morning. Mr L did not think the EIP team listened to him, Mr L was reassured and support would be provided.
17/03/08	HPFT	Telephone call	Mr L called Ms H requesting to see a doctor because he had been experiencing side affects and would like to stop his medication. Mr L also stated he would like to see an alternative worker to Ms H because of the medication. Dr L2 agreed to see Mr L on 19/3.
19/03/08	HPFT	Appointment	Dr L2 reviewed Mr L who advised that he had stopped taking his medication and that he was suspicious of people and some professionals. Mr L recorded the appointment on his mobile stating '*he felt safer if the conversation was recorded*' and was reluctant to engage with the Mental Health Services. Mr L

Date	Source	Event	Information
			refused to see Ms H. Mr L stated he had no problems other than his parents and previous flat mates who were conspiring against him before he moved a week previous. Mr L believed his father gave him diazepam to influence his thoughts and emotions. Mr L said that during an argument one of his flat mates threatened to kill him but was unable to elaborate on what the argument was about. Mr L had informed the police who had advised him to contact his GP; the police closed the case. Mr L was suspicious of the risperidone and asked if it was "off licence". Dr L2 reassured Mr L that the medication was BNF approved. Mr L reluctantly accepted the information. Mr L was adamant the medication had caused his lower intestine harm and felt stiff with an involuntary tremor in his jaw. There was no evidence of this. PLAN: Mr L initially refused to continue his medication although agreed to take 1.5 mg od only for one week. Mr L agreed to stay in touch via telephone on 5/3. Mr L's GP to be advised of the developments and to contact EIS ASAP if Mr L's state further deteriorated. Ms H would be replaced due to Mr L's delusions about her and safety concerns. Ms H to liaise with CATT to inform them of a potential referral.
19/03/08	HPFT	Risk Assessment	Additional or specific risk to health and safety Paranoid delusional thoughts about others: up to ten days previous, Mr L felt his house mates were '*playing his head*' and it felt unsafe to go back home. Passivity phenomena: people causing Mr L vibrations, unsure how. Mr L's bowels were moving, he was unable to explain but thinks the medication was to blame therefore stopped taking them. Homeless or about to become homeless: UH re-housed Mr L Unemployed: Full time student
19/03/08	HPFT	Telephone call	Ms H called CATT to update the team on Mr L following his appointment with Dr L. Ms K, CPN agreed to act as Mr L's primary worker on a temporary basis. Ms K stated she would wait for Mr L to contact the team the following week when she would offer to see him.
26/03/08	HPFT	Telephone call	Mr L did not contact Ms H, despite telling Dr L2 he would. Ms H telephoned Mr L and left a message on his mobile to contact her.
27/03/08	HPFT	Telephone call	Ms H telephoned Mr L who reported he was feeling better since he stopped his medication. Ms H informed Mr L that Ms K would be contacting him to arrange an appointment with him. Mr L agreed. Ms K agreed to make contact with Mr L the following Friday.
28/03/08	HPFT	Telephone call	Ms K called Mr L twice to introduce herself and arrange to see him. Mr L did not pick up the call - two messages left for him.
31/03/08	HPFT	Telephone call	Ms G telephoned the EIS team to confirm she had seen Mr L for an appointment. She had concerns that Mr L's presentation was guarded, suspicious and was socially withdrawn. Mr L reported he felt frustrated and being forced by the Mental Health team to prove that he was not paranoid- he strongly believed he was not. He had no intention of taking his medication.

Date	Source	Event	Information
			Mr L had not responded to messages from Ms K or Ms H PLAN: Continue to contact Mr L to review his mental state- Ms K to be informed. Arrange an appointment with Mr L and Dr K for 14th April at 11am. Mr L to be informed. A CATT assessment to be arranged due to Mr L stopping his medication and at risk of further deterioration. If CATT were unsuccessful in engaging with Mr L, EIS would arrange a MHA.
03/04/08	HPFT	Care Plan	PLAN: CATT to provide short term input to help Mr L's mental health. CATT to visit daily to monitor medication compliance. Mr L was taking 1.5mg Risperidone nocte however CATT to encourage the increased amount of 3mg nocte and monitor if further dosage was required. Mr L to assess for the therapeutic and side affects of the medication. Mr L was to monitor his weight, as he was concerned about weight gain. CATT to introduce positive coping strategies fpr psychotic symptoms. CATT to liaise with EIS for handover of his care following improvements.
03/04/08	HPFT	Appointment	CATT assessment with Dr K and Ms I. Mr L had been experiencing psychotic symptoms consistent with schizophrenia since he had stopped taking his medication and had not been engaging with EIS. Mr L reported to feel agitated and anxious therefore restarted his medication. He stated that it helped with his social anxieties rather than psychosis, which had now gone. Mr L experience paranoid beliefs and was guarded about his mental health state, he also seemed suspicious of the staff. Mr L had concerns about the medication increasing his weight therefore joined a gym to prevent weight gain. Mr L agreed to engage with CATT. PLAN: Mr L to take 1.5 mg that evening. CATT to visit daily in the evenings to monitor medication and mental health state. CATT to encourage Mr L to take medication and re-commence 3mg Risperidone. Mr L to monitor weight.
04/04/08	HPFT	Appointment	CATT assessment: Dr L1 reported Mr L to be calm, quiet and fully cooperative. Mr L was able to smile appropriately and did not appear suspicious. No oddities in his behaviour were noted. Mr L told the CATT team that he was no longer suspicious or paranoid and had no other psychotic symptoms. Mr L stated that since he had moved into the accommodation he could not sleep at night due a noise coming from next door. Mr L agreed to try ear plugs. Mr L was advised to avoid heavy meals late at night along with tea or coffee and to only go to bed if he felt sleepy. Mr L reported there was no difference from the previous day although agreed to continue to take 3mg Risperidone. Mr L was witnessed taking the medication. PLAN: Mr L to take 3mg regularly and this would be monitored by CATT. CATT to visit daily. CATT to encourage Mr L to continue taking medication. Mr L to monitor his weight.
05/04/08	HPFT	Appointment	Mr L was visited in his own home by the CATT team and Mr B. Mr L was reported to be subdued upon their arrival and stated he had difficulty doing his normal activities due to the medication and feeling

Date	Source	Event	Information
			drowsy. Mr L was witnessed taking half his medication. Mr L also expressed that he would like to live with his aunt in London due to feeling isolated in his current accommodation and was happy to engage with the CATT equivalent near to his aunt's house. CATT would discuss the suitability of this idea within the team. CATT spoke to Mr L's uncle who was not aware of the severity of Mr L's mental health however stated he was welcome in his home, liaise with the CATT team and witness Mr L taking his medication. Mr L was relieved that his uncle and aunt were aware of the situation. Mr L was reminded of the importance of taking his medication.
07-Apr	HPFT	Letter	Letter to Dr W from Ms I- discharge notification Mr L accepted treatment on the 03/04/08 and was discharged on 07/04/08. Mr L was referred to CATT following non-compliance with his medication. Following Mr L's discharge he had gone to stay with his uncle in London for a month as he felt isolated in Hatfield. His uncle was aware of the situation and to monitor his medication. Mr L would contact the EIS team for a follow up upon his return.
07/04/08	HPFT	CPA Assessment	Joint EIP CATT assessment. Mr L had stopped taking his antipsychotics and not been engaging with EIS. Mr L was reported to express paranoid ideation about EIP staff and social anxieties and paranoid thoughts. Mr L was guarded about his mental state although there were no overt psychotic symptoms, he did appear suspicious on occasions. Mr L denied any head vibrations, suicidal or homicidal thoughts. Past assessment revealed Mr L had delusional thoughts concerning his parents spying on him through his house mates. One of his housemates was reported to the police as he alleged she tried to kill him. The police advised Mr L to see his GP. More recently the thoughts widened to people following him. Mr L denied any voices but has passive phenomena shakes/vibrations mostly in his head which were supposedly caused by his house mates but unsure how. They are reported to influence his behaviour such as slamming doors, giving hints not in a paranormal way. Physical anxiety to panic attacks observed. Mr L displayed some insight, he believed his psychotic symptoms had gone however still remained socially anxious. Restarted Risperidone 1.5mg however was reluctant to increase the dose due to weight gain and thyroid problems. Mr L had not been in contact with his family for some time due to his current persecutory beliefs. Mr L was deemed low risk.
09/04/08	HPFT	Telephone call	Mr L telephoned Mr S reported he was unable to sleep. Mr S invited Mr L to identify why he may have had an issue and Mr L reported he had ate a lot of food that was sugary late at night. Mr S discussed if he could avoid this again. Mr L wanted to know if the CATT Team would be visiting him and Ms informed Mr L that he had been discharged from the service and they did not intend of visiting him whilst he was still in London. Mr L was advised to contact the EIS team and Mr L agreed.
23/04/08	HPFT	Meeting with parents	Dr K met with Mr L's parents. Mr L had seen his counsellor and the GP the previous day. Mr L had returned home with poor communication, appeared suspicious and did not eat with the family. Mr L bought his own food. Mr L's parents were unsure if Mr L was taking his medication and described him as paranoid however were not aware of any immediate risks. No information could be disclosed to Mr L's

Date	Source	Event	Information
			parents due to confidentiality however Ms K reported the discussion to be supportive. Mr L's father agreed to bring Mr L to his next appointment at St Albans.
24/04/08	HPFT	Appointment	Mr L met with Ms K following calls with the counselling service and Mr L during the previous 7 days. Mr L was euthymic in mood with good eye contact and good rapport. There was no evidence of Mr L being suspicious. Mr L spoke about his medication and that he was only taking 2mg Risperidone because 3mg make him feel tired. Ms K advised Mr L about his medication and agreed to increase to 3mg. Mr L reported the journey to the appointments were long however enjoyed being away from the restaurant. There lots of family dynamics and the situation was complicated. Mr L was seeing Ms G about the issues. Mr L felt calmer and able to relax, he was sleeping better and stated he looked after himself.
30/04/08	HPFT	Appointment	Mr L and his father met with Dr K and Ms K. Mr L's medication was discussed and was informed of all the side affects possible. Mr L confirmed he was taking an increased dose of 3mg Risperidone and reported an improvement in his mental health. Mr L acknowledged this was due to the medication. Mr L had felt more comfortable in social situations during the previous 3-4 days although complained of initial tiredness which appeared to wear off. Mr L continued to visit the gym and had noticed some recent weight gain. Mr L was advised to monitor his weight. Mr L stated he bought his own food and had no concerns of his food being poisoned. Mr L complained of a dull ache in his chest following exercise and was advised to see the GP for an ECG.
09/05/08	HPFT	Letter	Letter to Dr W from Dr K. Mr L attended an appointment with his father and Ms K and reported to be responding well to his medication. He was less paranoid and was able to move back to his parents' home and more recently started to share meals with them. Mr L had also started talking to people in the restaurant and helping more. Mr L did not accept he suffered from psychosis however reported that the Risperidone was helping him and there were no concerns with compliance. PLAN: 3 mg Risperidone. Physical check up from the GP including bloods. EIP would maintain and report regarding Mr L's weight. Next OPA 23/05/08 however could request an earlier appointment.
14/05/08	HPFT	Appointment	Mr L met with Ms K and reported he had been feeling well and was feeling the benefit of his medication. Mr L was able to acknowledge the reasons why he was taking his medication. He was sleeping well with a good diet intake and was also helping at the family restaurant. He reported that the university counsellor was helping him and the GP had discovered some abnormalities from a recent ECG. Mr L was due to have a repeat ECG later that day and reported these make him anxious and could feel his heart rate increase before the appointment. Ms K went through some basic relaxation techniques
03/06/08	HPFT	Letter	Letter to Dr W from Dr K stating that Mr L required physical monitoring. Mr L met with Dr K on 25th May 2008 and reported there had been no major change in his presentation from the month previous. Mr L did not express delusional thoughts and firmly believed that everything that happened before he started the Risperidone was true. Mr L was trying to connect with family and restore contact with his friends whilst planning on returning to university in September.

Date	Source	Event	Information
			Mr L's main concern was his lengthy sleeps and feeling demotivated. He felt he had little to do because his friends were busy studying and still thought they were spying on him for his parents from a couple of months previously. Mr L was willing to have a daily plan to overcome his boredom and lack of motivation. However was not happy to accept a higher dose of Risperidone, despite the advice that it may help him overcome his thoughts about his parents. Mr L did agree to consider alternative medication to Risperidone as this may be contributing to his lack of motivation. Aripiprazole from 04/06/2008. PLAN: 3mg Risperidone until 11/06/08 Aripiprazole 5mg from 04/06/08 Aripiprazole 10 mg 11/06/08 Aripiprazole 15 mg 18/06/08. EIP to maintain weekly contact and monitor mental health- next appointment due to heart palpitations 04/06/08. Next OPA 25/08/08 however Mr L's Care Coordinator could request an earlier date if required.
04/06/08	HPFT	Telephone call	Mr L telephoned Ms K to state he had to cancel the appointment arranged for that day. Mr L appeared bright, cheerful and apologised. Mr L reported something had come up at home but generally felt things were going well. Re-arranged for 10th June.
10/06/08	HPFT	Appointment	Mr L met with Ms K. He appeared stable however stated he would not cope with the tiredness, he was struggling to get out of bed and felt unmotivated throughout the day therefore he was unprepared to take the Risperidone any longer. Ms K advised Mr L that Dr K had prescribed an alternate medication and a prescription had been given. Mr L stated he was unprepared to take 3mg Risperidone for one week however agreed to take 1.5mg and would like to stop his medication as soon as possible. Ms K spent some time advising Mr L to continue with his medication and the rationale behind that. Mr L accepted the information however felt he was symptom-free and wanted to get his life back on track, although was willing to work with the service.
17/06/08	HPFT	Appointment	Mr L met with Ms K at the university. Mr L appeared stable and in mood and mental state, he as bright at times and denied any worrying thoughts. He stated he was very well and had been busy at home. He continued to help his family and admitted he liked to gamble and attended the casino regularly. He stated he made money from gambling and felt he was *'a bit of a hustle*r' however felt in control and believed he had learnt from his previous mistakes.
25/06/08	HPFT	Telephone call	Mr L called Ms K to state he did not feel like making the journey to Hatfield to see Ms K or Dr K for his medical review. He stated he was no longer willing to take his prescribed medication. Mr L was advised against this decision and to wait until his next medical review. He declined the advice and apologised, he stated he was not sleeping well since taking the ability and would like a period of time that was medication-free to decide what he wants to do in September for his university course. Mr L would attend the university the following week for his planned appointment.
01/07/08	HPFT	Appointment	Mr L met with Ms K and stated he had not taken his medication for one week however believed he needed to restart Risperidone and acknowledged it helped him. He did not like the affects of Ability. Mr L stated he felt emotionally blunt and experienced previous symptoms returning. Mr L read an article about

Date	Source	Event	Information
			schizophrenia and could relate to a lot of the symptoms and ticked all of the boxes. Mr L was not willing to take 3mg Risperidone however was prepared to take 1.5mg. Mr L cancelled his appointment with Dr K because he was in France on a family holiday- he was looking forward to this. PLAN: To see Ms G at the university the week commencing 21/07/08. Next EIPS appointment 20/07/08
07/07/08	HPFT	Letter	Letter to Dr W from Dr I to confirm Mr L had failed to attend two outpatient appointments therefore had been discharged with no further follow up. Dr I was happy to see Mr L in September at the university should he need to.
29/07/08	HPFT	Telephone call	Mr L contacted Ms K stating he would not be able to attend the appointment because he had just woken up. Mr L reported he was OK and had enough medication for the week.
05/08/08	HPFT	Telephone call	Dr H1 left a message for Mr L to contact her to regarding his appointment with Ms K tomorrow (Ms K was off sick) and his prescription
06/08/08	HPFT	Telephone call	Dr H1 left a message for Mr L regarding his prescription
12/08/08	HPFT	Telephone call	Mr L contacted Ms K cancelling a planned visit. Mr L stated he had slept in and apologised for cancelling. Agreed to meet 13/08/09 Mr L agreed to contact his GP for a repeat subscription
13/08/08	HPFT	Telephone call	Mr L contacted Ms K very apologetic stating he would not be attending the appointment that day. Mr L felt he did not need support currently and that the journey was a long way. Mr L denied any problems. Ms K advised Mr L obtained his repeat prescription. Ms K discussed with Dr K who advised to seek permission to speak with Mr L's mother or father if he cancelled the appointment booked for the following week.
21/08/08	HPFT	Appointment	Mr L met with Ms K and appeared well. He continued to take his medication and refused to increase the dose because he felt 1.5 was enough. Mr L denied any worrying thoughts and said he recognised the early warning signs, Mr L stated he had a holiday with his family which he enjoyed and felt his relationships had improved, especially with his brother who had become good friends. Mr L was organised for his return to university which he was looking forward to.
30/09/08	HPFT	DNA	Mr L did not attend an appointment with Ms K and Dr K. Ms K contacted Mr L with no answer. Mr L later contacted the service to apologise for not attending the appointment and stated he forgot about it because he was moving into halls that day. Mr L was unsure when he could make the next appointment therefore Ms K agreed to contact him over the next week.
17/10/08	HPFT	Appointment	Ms C1 met with Mr L who appeared suspicious of her presence therefore avoided eye contact. Mr L stated he felt like he was avoiding people who were not his friends of family. Mr L reported that he had noticed a personality change in himself said this concerned him. Mr L had stopped gambling because he

Date	Source	Event	Information
			had no funds and appeared disappointed by this although he still saw his brother at the weekend. Noted that Mr L was not taking the correct dose of medication therefore was advised he may have some residual symptoms. Mr L was taking 1.5 Risperdal due to side effects. Mr L was advised there were other options for his medication and that the service want him to have the least side effects with the highest function. Mr L agreed to discuss his medication with Dr K.
17/10/08	HPFT	Appointment	Mr L met with Ms K and Ms C1. Ms C1 was introduced as Mr L's new Care Coordinator. Mr L reported he was doing okay and gained a degree of insight and understanding of the important of managing his stress which he stated he was addressing with relaxation tapes and hypnosis since returning to university, these were also helping him sleep. Mr L stated he would like to stop taking his medication completely and subsequently spoke for some time educating and discussing RP and the importance of taking medication. Should Mr L stop taking his medication, this would be against the advice that was offered to him. Mr L agreed to continue with his medication and discuss this further with Dr K. Mr L had taken an online test which resulted in 68% Schizoaffective disorder. Mr L was advised to stay away from those sites and to contact the team should he have any concerns. Mr L recognised he may have some untreated symptoms. Mr L was travelling home over the weekend and stated he was looking forward to seeing his family because he had missed them over the previous two weeks.
30/10/08	HPFT	Letter	Letter from Mr K to Dr W Mr K had seen Mr L - reported to be stable with no evidence of psychosis and was getting on well with his family. He had good insight into the nature of his paranoid thought about his family and neighbours. Mr L stopped taking his Risperidone over a week prior to the appointment however the dose had been sub-therapeutic for some time. Mr K advised that Mr L was capable of assessing the decision to discontinue his treatment and understood the risk of relapse. Mr L would continue to meet with his care co-ordinator and counsellor at the university. PLAN: Medication- None (Mr L had 28 Risperidone 2mg 'just in case he were to experience any warning signs') EIP would maintain weekly contact for RP and MH monitoring. Mr L to continue to see his counsellor. Mr L to contact EIP and restart medication should he experience any warning signs. Next OPA to be arranged by Mr L's care coordinator or when Mr L requests. Mr L advised to see Student MH advisor.
30/10/08	HPFT	Letter	Letter to Mr L from Dr K confirming care plan.
30/10/08	HPFT	Appointment	Mr L met with Dr K and stated that he was spending more time on his own however was enjoying life- he was seeing 3 friends and his brother. Mr L reported to enjoy playing poker however would never play roulette again. Mr L denied having a gambling problem. Mr L stated he would go to a casino to gamble and denied any debt or worries. Dr K reported no evidence of psychosis and stated Mr L had developed good insight. Mr L had good contact with his family, particularly his brother.
19/11/08	HPFT	Telephone call	Telephone call from Ms C1 to Mr L to arrange a time to visit. Left a voice message for Mr L to return the call.

Date	Source	Event	Information
03/12/08	HPFT	Telephone call	Telephone call from Ms C1 to Mr L- no answer, however left a message from Mr L to return the call. Ms C1 stated that if she had not heard from Mr L by the end of the week, she would contact his father to check Mr L's progress status.
15/12/08	HPFT	Telephone call	Ms C1 contacted Mr L's father to obtain an update on Mr L's progress. No answer and no message was left.
01/01/09	ELFT records	Appointment	Mr L met with Ms A who was extroverted and confident. Mr L reported an uncomfortable feeling of hearing spirits inside of him. He described that they had been helpful. Mr L reported he had started business plans for counselling and coaching with Oxford Brook University.
12/01/09	HPFT	Letter	Letter from Ms C1 to Mr L- confirmation of the appointment made for 26/01/09. Ms C1 had been unable to reach Mr L by telephone.
27/01/09	HPT	Continuing Care plan	Completed 27/01/09 Ms N met with Mr L who expressed social anxieties and paranoid thoughts and his parents were concerned about delusional thinking. Mr L reported on of his housemate to the police following an allegation that she threatened to kill him, Mr L also experienced shakes/vibrations, mostly in his head caused by previous housemates. The aim was for Mr L to make a full recovery and reduce long term impact of psychosis. PLAN: Mr L did not wish to have contact with the service, although his father had the relevant contact details should the family have any concerns. Mr L to have regular contact with his counsellor, Ms G and Ms G would contact the service should any concerns arise. Mr L had not taken his medication for sometime, although he was able to function reasonably well, border line psychotic and remained guarded. Mr L would contact the service when he felt the need to speak with Dr K. Sufficient evident to suggest Mr L would do so. Noted that Mr L was no danger to himself.
13/01/09	HPFT	Telephone call	Mr L's father contacted Ms C1 to state that Mr L was doing well and remained off his medication. Mr L still had some issues when out in public however was fine amongst his family. Ms C1 was informed that Mr L would be calling her later that day. Mr L had an appointment arranged however Ms C1 had been unable to engage with him. Mr L's father agreed to pass on the message.
16/01/09	HPFT	Standard Risk assessment	Previous us or current threat to use weapons: ? previously used a cue on another student when in school. Additional Health and Safety risk of staff: Suspicious of professionals' motives i.e. recorded assessments on his phone. Deputy Dean of students reported Mr L tried to hug her April (08). Paranoid delusion about others: Previously stopped antipsychotic medication. Paranoid ideation about EIP staff. Expressed social anxieties and paranoid thoughts. No over psychotic symptoms. Delusional thoughts about his parents spying on him. Mr L previously reported his housemate tried to kill him. Mr L had passive phenomena.

Date	Source	Event	Information
21/01/09	GP records	Letter	Letter to Dr M1 from Dr O Mr L did not attend the appointment. Dr O discussed this with Mr M and there were no concerns. Mr L had reported a recent improvement since starting Risperidone and would further discuss a dosage increase and review his mental state.
29/01/09	HPFT	Appointment	Mr L met with Ms C1 and was dressed in heavy outdoor clothing, including a baseball cap and had also grown a full beard. The room was extremely warm however Mr L kept his coat on. Ms C1 noted Mr L was smiling a lot however felt it was difficult to talk with him. Mr L stated he was fed up with his course and was finding it hard, however his family wanted him to complete it. Mr L reluctantly agreed. Mr L reported that he found social interaction difficult and currently had no friends on the campus and would often isolate himself, however denied any paranoid thoughts. Mr L had stopped his medication. Online gambling occupied his spare time and he was doing okay for money because he was a good poker player. Ms C1 advised Mr L that this may not always be the case because the sites had tricks to entice people to continue playing. Mr L just smiled. Mr L stated he found sleep difficult although his hypnosis CD helped him - when he stayed awake late through online gambling he struggled to get up in the morning. Mr L informed Ms C1 that he did not wish to see the service but would call if there was a problem. Ms C1 agreed to this but stated she would call him periodically to see how he was. Mr L agreed.
14/04/09	HPFT	Text message	Ms C1 had received several text messages from Mr L during the week requesting contact due to symptoms arising. Upon Ms C1's response Mr L would state he was fine however had arranged a meeting at the counselling office which was initiated by Mr L- he later cancelled. Mr L stated he was taking his medication again and he had enough.
24/04/09	HPFT	Letter	Letter from Ms N to Dr W stating that Mr L no longer wished to engage with the community service. Mr L agreed to call the emergency out of hours and Ms N was confident he would do that from prior experience. Mr L's father was aware of his decision and stated his son was very well except that he only socialises with his family. Mr L would regularly text to ask to meet Ms N however would cancel at the last minute therefore Ms N had not seen Mr L for some time. Ms N believed Mr L still had psychosis however Mr L was not unwell enough to need a MHA. Mr L reported he took his medication as and when he needed it and Mr L would be kept under the umbrella of community psychiatry until his course finished on June 2009, when he intended to move back home to London.
15/05/09	HPFT	MDT meeting	Ms C1 advised that Mr L had been in regular contact with her however had refused to attend any appointments since she missed an appointment with him due to illness. Ms C1 was concerned about the nature of the text messages which were overfamiliar and bizarre therefore suggested that text messages in this instance were not appropriate. The University counsellor was still engaging with Mr L- Ms C1 would liaise with them is she was unsuccessful in getting a positive response from Mr L.
29/05/09	HPFT	Telephone call	Ms D received a call from the Dean stating Mr L was with one of the security guards at the university stating he felt he could not get through the weekend and felt that people were following him. Ms D

Date	Source	Event	Information
			advised the Dean that Mr L had chosen not to engage with Ms C1 and there were questions surrounding whether Mr L was taking his medication. Ms C1 was on annual leave and MS D advised that Mr L attended A & E. The Dean agreed the course of action.
01/06/09	HPFT	Telephone call	Ms C1 received a call from the university MH support officer stating that Mr L had come to the attention of the Dean due to his concerns and paranoia about his flat mates- he felt they were conspiring to hurt him. Mr L had been provided temporary accommodation. Ms C1 confirmed she had received text messages from Mr L stating that he would not take his medication because he feared it would kill him. Mr Cl advised she would be in touch with the University MH officer and would try and contact Mr L to arrange an assessment with Dr K.
02/06/09	HPFT	Admission Assessment	Mr L attended A & E following a self inflicted crush fracture, he stated he '*lost control'* and slammed his finger in the door. He was unwilling to elaborate. Liaison team reported Mr L to be unwell and responding to hallucinations with guarded speech and recommended admission. Mr L was sleeping well in the run up to the event, he had University exams after 20/06/09 and was studying hard for them, he also reported to play a lot of online poker. Past History: Acute transient psychotic disorder and known to EIPS with a history of non compliance and engagement with the service. Mr L reported that his father had recently become aggressive and had hurt him however was unwilling to discuss this further. Mental state: Mr L was reported to be unkempt with poor eye contact, jerking movements and appeared to exert control over them. Mr L's speech was guarded, very quiet but normal flow. Repeating "*I am quite relaxed, I have a clear conscience, god can see everything*". Mr L was aware he was unwell and would benefit from help however refused to believe his finger was fractured, despite the evidence of the X-ray therefore refused antibiotics. PLAN: Restart medication as previously. Remain informally on the ward. The Duty Doctor to be called if Mr L attempted to leave. Temperature and BP to be monitored.
02/06/09	HPFT	Standard Risk assessment	Previous use or current threat to use weapons: ? previously used a cue on another student when in school. Mental disorder and sustained anger and fear: Has some form of thought disorder. Paranoid delusion about others: Reports that he has felt people are after him and watching him.
02/06/09	HPFT	Admitted	Mr L was admitted under S2 MHA.
08/06/09	HPFT	Tribunal	Mr L requested a Tribunal
09/06/09	HPFT	Care Plan	Care plan: Inform Mr L of his rights on S.2 and have a conversation to discuss the issues. Provide assistance that allowed him to access or exercise his rights. Access to a solicitor if Mr L appeals. Review Mr L's understanding of his rights. S.2. On 5 minute obs. Continuous obs since 2/6/09 and re-graded to 5 mins on 8/6/09 and a further re-grade to 30 mins 11/6/09. Mr L's dressing was to be changed every two days, dry wipe the wounds and only cleanse with sterile water if necessary. The wound was to be

Date	Source	Event	Information
			covered with micropore tape and recovered completely with dry dressing. Mr L's temperature was to be monitored daily whilst healing and a full course of antibiotics was to be completed.
12/06/09	HPFT	Tribunal	Tribunal held, outcome: tribunal application withdrawn by Mr L.
17/06/09	HPFT	Referral	Mr L had been with the Early Intervention Team in Hertfordshire since April 2008. There was no history of contact with the services before. Mr L had been studying in Hertfordshire and residing in halls of residence. His parents lived in East Ham and Mr L had planned to return to Newham to his parent's house indefinitely. At the time of referral Mr L was admitted under Section 2 of MHA, with plans to be discharged to the family home. Hertfordshire requested that Mr L was followed up by the ELFT once he was discharged.
17/06/09	ELFT records	Referral	Mr P received Mr L's referral to the service. Mr L was reported to be known to EIS Hertfordshire since April 2008 with no previous know contact with the mental health services. Mr L was studying for a degree at Hertfordshire University, residing in Halls of Residence. Mr L was currently admitted as an inpatient under Section 2 of the Mental Health Act with thought disorder, hearing voices, feeling persecuted and people were trying to kill him. Mr P would contact the referring service to obtain Mr L's history.
19/06/09	ELFT records	Information input	More information was requested for a Full Needs Assessment and requested medical review letters. Ms C1 informed the service that Mr L did not engage with the mental health services therefore there was no more information to be provided. Mr L was still under Section 2
25/06/08	HPFT	Telephone call	Mr L contacted Ms L stating he was unable to attend the appointment later that day. He had made the decision he was no longer taking his prescribed medication from that day because he felt he was symptom free and no longer required it. Ms K discussed this with Mr L and advised him against that decision and at least wait a week to discuss this further. Mr L agreed to wait until his appointment
29/06/09	ELFT records	Telephone call	Telephone contact made with Mr A
30/06/09	ELFT records	Telephone call	Telephone contact made with Mr A
30/06/09	ELFT records	Telephone call	Mr A telephoned the Welwyn Ward who informed him that Mr L may be discharged soon however he was currently on leave at his parents house in Newham.
30/06/09	ELFT records	Telephone call	Mr A telephoned Mr L's parent's home to obtain whether Mr L would be moving back to Newham, Mr A left a voice message.
01/07/09	ELFT records	Appointment	Face to face meeting booked however outcome was telephone contact.
01/07/09	HPFT	Letter	Letter to Mr L confirming his discharge date of 29/07/09

Date	Source	Event	Information
01/07/09	HPFT	Enhanced risk assessment	Mr L reported that in sixth form he hit a pupil with a billiard cue however no aggression had been reported since. Mr L experienced paranoia about EIP staff, university housemates and felt unsafe to return home, he had also been non compliant with his medication. Mr L was reported to be floridly psychotic with extreme paranoia, suspicion, hearing voices and felt controlled by unknown forces. Mr L described feeling prosecuted and that people were trying to kill him or poison him. At risk to self, psychotic episode in remission. Before Mr L's admission he was suspicious of professionals' motives and would record assessments on his mobile. The Deputy Dean at the university reported Mr L tried to hug her on 03/04/08. He was reported to have fantasies about his counsellor that she is his mother and has been in her house- unfounded. On admission Mr L was found to have a knife in his holdall. Mr Ls section 2 was rescinded on 30/06/09 due to the significant progress he had made. He no longer had paranoid delusions about his broken finger, both speech and behaviour had been appropriate during the previous two weeks. Mr L's insight had improved and no evidence of hallucinations. Warning signs: disengaging with mental health staff, stopping medication and becoming socially withdrawn. Contingency: Referred to Eastham EIS, discharged from Welwyn Ward, medication: Consta 25mg 2 weekly, 3 weeks oral risperidone
01/07/09	ELFT records	Telephone call	10:12am Mr A called the family home and left a voice message asking Mr L's father to contact him 10:16 Mr A called Ms C1 and left a message 10:19 Mr A called Welwyn Ward requesting CPA documents, Part One Summary and an updated Risk Assessment- the ward agreed to fax the documents however informed Mr A that they were unlikely to have the Part One document.
06/07/09	ELFT records	Telephone call	Telephone contact made with Mr A at 16:55
06/07/09	ELFT records	Appointment	Appointment with Ms J - DNA
07/07/09	ELFT records	Telephone call	Telephone contact made with Mr L
13/07/09	ELFT records	DNA	Appointment with Ms J - DNA
14/07/09	ELFT records	Telephone call	Telephone contact made with Mr L
14/07/09	ELFT records	Telephone call	Mr A called the family home- Mr L's father was not available however Mr L spoke with the service and was provided an appointment date. Mr L confirmed he would attend with his father.

Date	Source	Event	Information
16/07/09	ELFT records	CPA Review	Mr A reviewed Mr L following the referral dated 17/06/09. Mr L presented with psychotic symptoms- paranoid ideas, persecutory ides of people trying to kill him, harm him or poison him. Also hearing voices. Medication: Risperidone 4mg- to finish 22/07/09; Risperdal Consta 25 mg every 2 weeks. Last depot 14/07/09 - this was the second dose. Next depot due 28/07/09. Mr L was very quiet although stated he had friends but was always different around them which was dependant on how safe he felt around them. He continued to fear people around him although he was not scared that they would harm him. Also Mr L noted that being alone made him feel afraid although he did not feel depressed. He denied any current voices and the paranoid thoughts had subsided. Mr L was able to reason around the information. Mr L's speech was slow and sluggish with his responses with monotone responses regardless of the subject. Since Mr L started his medication his memory and concentration had been poor and had been poor in the past when previously on medication. At the time, Mr L had good insight into the current and past situation and found he was able to challenge paranoid thoughts. He had a short term goal of working in the family restaurant to gain some work experience. PLAN: Case to be discussed at Allocation Meeting the following day; Care Coordinator to be confirmed- advice given to contact the office with any urgent concerns; Medication review in 2 weeks.
16/07/09	ELFT records	New Patient Assessment	Appointment with Mr A- attended
16/07/09	ELFT records	Appointment	Mr L attended an appointment with Mr A with his father. Mr L's case could be discussed at the clinical meeting the following day.
17/07/09	ELFT records	Clinical meeting	Mr L was allocated Mr M as his care coordinator. Mr M or the Duty Coordinator to contact Mr L to arrange an appointment
20/07/09	ELFT records	DNA	Appointment with Ms J - DNA
22/07/09	GP records	Letter	Letter to Ms C1 confirming receipt and action of Mr L's EIS referral
23/07/09	GP records	Letter	Letter to Dr B from EIS Confirmation that the GP referral had been sent to EIS Stratford
23/07/09	ELFT records	Telephone call	10:00am Telephone call CMHT to Duty Worker confirming that EIS Newham would have to administer Mr L's medication. Risperidone Consta 25mg.
23/07/09	ELFT records	Telephone call	10:30 Duty worker telephoned Mr L's father who agreed to pass the message to Mr L regarding his medication
23/07/09	ELFT records	Telephone call	15:30 Mr L contacted the Duty Worker who confirmed the situation about his medication

Date	Source	Event	Information
28/07/09	ELFT records	Appointment	Treatment with Mr A- attended
28/07/09	ELFT records	Appointment	Mr L was saving up for a course that would cost £4000. Mr L appeared to build a good rapport, euthymic mood with good eye contact. He had some self awareness regarding his symptoms and mood. No risks identified. PLAN: fortnightly meetings with EIS for his depot injection
05/08/09	ELFT records	Appointment	Treatment with Mr A- attended
05/08/09	ELFT records	Telephone call	Telephone call from Mr M to Mr L who was shopping with his parents. Call was to update on how Mr L was and an appointment was arranged for 10/08/09
10/08/09	ELFT records	Appointment	Mr L met with Mr M who stated he was feeling great following good results from his university course and was socialising more. Mr L spoke about his good and bad days regarding his confidence. Mr L advised it may be difficult to talk to people if Mr L did not know what his triggers were. There was a significant discussion about the personality test that was completed by Mr L (Myers test)
11/08/09	ELFT records	Appointment	Treatment with Ms I- attended
28/08/09	ELFT records	Appointment	Mr L working the in the family restaurant therefore woke late at 13:00, he did not present any signs of relapse and it was noted that his family were less anxious about his mental health therefore had more trust in him. Mr L will be looking for CPD funding for a catering course with his care coordinator. No side affects from his medication. Risperidal Consta 25mg administered.
28/08/09	ELFT records	Telephone call	Mr L was called to state that Mr L's appointment with Mr M was cancelled. Mr L raised no concerns
08/09/09	ELFT records	Appointment	Treatment with Mr A- attended at 12:45
08/09/09	ELFT records	Appointment	Appointment with Mr M- attended at 12:00
08/09/09	ELFT records	Appointment	Mr L met with Mr M who reported he was not sleeping very well which was impacting negatively on his energy levels and his mood. Very often Mr L could not sleep until 7-8am and woke at 2pm. Mr L appeared low in mood and stated he spent most of his time at home because he was no longer working at the restaurant.
22/09/09	ELFT records	DNA	Appointment with Mr A- DNA at 12:00

Date	Source	Event	Information
22/09/09	ELFT records	Telephone call	Telephone contact made with Mr A at 11:55
23/09/09	GP records	Letter	Letter to Dr M1 from EIS Admin team informing the GP that Mr L's assigned social worker was Mr M
24/09/09	ELFT records	Appointment	Treatment with Mr A- attended at 16:00
24/09/09	ELFT records	Appointment	Telephone contact made with Mr A at 09:50
24/09/09	ELFT records	Appointment	Mr L met with Dr O for his depot and started Citalopram 10mg, Zopiclone 3.75 mg
25/09/09	GP records	Letter	Letter from Dr O to Dr M1, GP During the previous appointment Dr O had concerns that Mr L was depressed, Mr L refused the offer of medication, however was provided a short supply of Zopiclone for 7 days at 3.75. Mr L reported to feel tried at times and flat in mood, he mentioned he was no longer getting the enjoyment from his console games therefore completely avoiding them which was unlike him. Mr L changed his mind and was ready to explore the option of anti depressant medication. Mr L was pursuing cookery classes however some days would not feel like going therefore would stay at home. His self care was reasonable, his speech slightly slowed and no evidence of psychotic symptoms. PLAN: to continue Risperidone dept at 25 mg-two weekly, start Citalopram 10 mg once daily, GP to complete full bloods, liver function, thyroid, glucose and ESR to exclude medical causes for fatigue, Mr L to continue contact with Mr A and Dr O to review Mr L on 5/10
01/10/09	ELFT records	DNA	Appointment with Mr M- DNA
01/10/09	ELFT records	DNA	Mr L did not attend an appointment with Mr M. Mr M telephoned Mr L who stated he was still taking his Citalopram and was feeling good. The appointment was rearranged for 05/10/09
05/10/09	GP records	Letter	Letter from Dr O to Dr M1, GP Medication: Increase citalopram to 20mg per day, Zopiclone 3.75 at night (not currently using). Mr L presented with improved alertness, energy and ability to cope with cookery classes since starting citalopram and had to use very few Zopiclone. Mr L showed overall good self care, slightly brighter in mood, although spoke slowly and his emotional expression had improved. Dr O reported that he believed Mr L's mental state had improved. PLAN: Increase Mr L's Citalopram to 20 mg once per day, continue with Risperidone Depot 25 mg two-weekly, GP to arrange bloods, Dr O to review Mr L in one month
05/10/09	ELFT records	Appointment	Appointment with Mr M- attended

Date	Source	Event	Information
08/10/09	ELFT records	Appointment	Treatment with Mr A- attended at 16:35
08/10/09	ELFT records	Appointment	Appointment with Mr M- attended
13/10/09	ELFT records	DNA	Appointment with Mr M- DNA
15/10/09	ELFT records	Appointment	Appointment with Mr M- attended
15/10/09	ELFT records	Appointment	Mr L met with Mr M and reported that he was finding it hard to attend the course. He was meeting with them the following day to identify if he should go part time or quit.
16/10/09	GP records	Letter	Letter to Mr L from Dr M1 inviting Mr L to attending clinic to discuss the letter sent to Dr M1 from Dr O on 05/10/2009
16/10/09	GP records	Letter	Letter from Dr O sent to the GP surgery inviting them to attend a CPA meeting 29/10/09
22/10/09	ELFT records	Appointment	Treatment with Mr A- attended
22/10/09	ELFT records	Appointment	Mr M sent Mr L a reminder text message for his appointment for that day. Mr L attended his appointment for his depot 25mg Risperidal Consta. Mr L reported a shaking feeling inside on his hip which he associated with side affects of his medication. Further investigation indicated that the shaking feeling started when he was unwell, prior to starting his medication. Mr L stated he would ignore this however had been reading about his illness and felt more comfortable to talk about his symptoms. PLAN: Medical review with Dr O. Complete LUNSERS within the next meeting. Next depot 05/11/09
23/10/09	ELFT records	DNA	Appointment with Mr M- DNA
29/10/09	ELFT records	Appointment	Review with Mr M- attended
03/11/09	GP records	Letter	Clinic 29/09/09 Letter from Dr S1 to Dr M1, GP Mr L had grandiose delusions and psychosis with schizophrenic symptoms during March 2008. He stopped his medication and relapsed again in June 2009 after he lost control and slammed his finger in a door. He was noted to be paranoid and hearing voices about being controlled by other forces. Mr L recognised his depressive symptoms in subsequent medical reviews and was responding well to Citalopram. At direct interview Mr L did not present positive psychotic or mood symptoms. Negative symptoms of being withdrawn, asocial and amotivated were described and loses interest in activities

Date	Source	Event	Information
			within an hour. He reported some shaking of his hips during a psychotic event. Refused the offer of Direct Payments. PLAN: GP to action medication- injection Risperidal Consta 25 mg intramuscular two weekly. Citalopram 20 mg once a day. Mr L to attend the gym once a week. Mr O to monitor Mr L's mental state and risk in the community and work towards rehabilitation. Medical review to be arranged and Care Programme Approach meeting on 12/4/10 16:00.
05/11/09	ELFT records	Appointment	Treatment with Mr A- attended
05/11/09	ELFT records	Appointment	Mr L met with Mr A for his depot injection. Mr L reported to be feeling better and attributed this to his Citalopram.
10/11/09	ELFT records	Appointment	Appointment with Mr M- attended
10/11/09	ELFT records	Appointment	Mr L met with Mr M who reported to be in good spirit and stated he was feeling normal
19/11/09	ELFT records	Appointment	Treatment with Mr A- attended
17/12/09	GP records	Letter	Letter from Dr O to Dr M1, GP Medication: Citalopram oral 20mg once a day, injection risperdal consta two-weekly. Dr O reviewed Mr L with Mr M. Mr L denied any particular problems, although he noticed shaking and jerking movements of his shoulders and neck as an involuntary phenomena. Mr L recognised this as unusual and reported the movements had never gone following his hospital treatment, although they had reduced, recently he had noticed the experiences had increased significantly. Mr L described receiving thoughts and was able to clarify the thoughts were not his own. There would be a conversation with someone inside him, between himself and the person apparently contacting him. He described involuntary physical responses, such as shaking or nodding of the head which were a result of a signal sent by the person communicating with him. Mr L was able to recognise this sounded strange however denied any psychosis. Mr L further explained an experience where a force came over him to move him away from the junk food and towards the healthy food, he saw this as positive therefore was not frightened or distressed by the experience. Mr L's mood was good, he had stopped dail cookery classes around 1 month- Dr O advised it was clear Mr L found them stressful. Mr L spends a lot of time with his family, eating and sleeping well and taking up 1.5 hrs of exercise each morning. Mr L had reasonable self care, he was able to smile and even laugh at times, he was very pleasant and forthcoming. Mr L denied any auditory hallucinations, however Dr O reported that Mr L was suffering from positive psychosis. PLAN: To continue Risperidone Consta 25 mg every 2 weeks, to start an oral Risperidone 1mg at night, an assessment in 2 weeks to review medication, review Mr L's plans and progress, Mr L to continue contact with Mr O.

Date	Source	Event	Information
24/12/09	ELFT records	Appointment	Appointment with Mr M- attended
31/12/09	ELFT records	Appointment	Treatment with Ms I- attended
04/01/10	ELFT records	Cancellation	Mr L's appointment was cancelled due to staff sickness
06/01/10	GP records	Letter	Clinic 17/12/09 Letter from Dr O to Dr M1, GP Mr L saw Dr O on 17th and 31st December. Mr L admitted to Dr O that he had not been taking the additional Risperidone as agreed on 17th December. Mr L was honest about his non-compliance and agreed to start his medication with immediate affect. Mr L's admitted his psychotic symptoms- he was shaking and was able to demonstrated the movements and confirmed he felt he had no control over the movement. He heard reassuring voices. Dr O explained his concerns to Mr L about how the voices and movement may progressively get worse and or becoming negative. Mr L was happy to continue with the medication. PLAN: start 1mg Risperidone at night. Normal depot of 25 mg and increase to 37.5 for the next depot. Mr L will see Mr O 4th January. A long appointment arranged with Dr O and Mr L
06/01/10	ELFT records	Telephone call	Mr L was informed about his appointment on the 14/01/10
14/01/10	ELFT records	Appointment	Treatment with Mr A- attended
14/01/10	ELFT records	Appointment	Mr L reported to be tired following the increase in medication although over more recent days had been feeling more positive but was unsure about the increase in dose. Mr L was advised to think about it and discuss the issue in the next meeting but should also remain on 25mg Risperidone Consta. Mr L's direct payment application had been submitted
28/01/10	ELFT records	Appointment	Treatment with Ms O- attended
28/01/10	ELFT records	Appointment	Mr L met with Mr A for his injection and reported to be feeling good on his current treatment regime. Mr L was looking into Project Management following a positive interview. Risperdal Consta 25 mg.
01/02/10	ELFT records	Telephone call	Telephone contact made with Ms O
01/02/10	ELFT records	Telephone call	Ms O telephoned Mr L to introduce herself and an appointment was made for 03/02/10

Date	Source	Event	Information
03/02/10	ELFT records	DNA	Appointment with Ms O- DNA
04/02/10	ELFT records	Letter	Clinic 21st January 2010. Letter from Dr O to Dr M1, GP Mr L did not attend his appointment with Dr O. Mr M did not mention any concerns. A review rebooked for 4 weeks time.
08/02/10	ELFT records	Appointment	Appointment with Ms O attended
11/02/10	ELFT records	Appointment	Mr L met with Mr P for his depot injection. Risperidone consta 25mg.
19/02/10	ELFT records	Appointment	Appointment with Ms O attended
19/02/10	ELFT records	Appointment	Mr L met with Ms O and reported to be mentally stable and still looking for a job. He was currently sleeping for 6 hours a night. Mr L reported that he would like Mr A to take over from Ms O and his Direct Payment application required following up.
10/03/10	ELFT records	Appointment	Appointment with Dr Q attended at 15:15
10/03/10	ELFT records	Appointment	Home visit with Ms O at 11:30
11/03/10	ELFT records	Appointment	Treatment with Mr P attended
16/03/10	ELFT records	Telephone call	Telephone contact made with Mr A
25/03/10	ELFT records	Appointment	Treatment attend with Ms O at 14:30
25/03/10	ELFT records	Appointment	Treatment with Mr P attended at 12:45
26/03/10	ELFT records	Appointment	Mr L met with Ms A and discussed the theories that he had been reading about. Mr L would stop poker and replace it with the guitar however Mr L had concerns that he would give it up due to lack of motivation. During the period when he was ill Mr L like poetry. It was reported that Mr L was looking forward to his exorcism in Sri Lanka because it would get rid of the shaking from another being.

Date	Source	Event	Information
31/03/10	ELFT records	Appointment	Appointment with Mr P- attended
31/03/10	ELFT records	Appointment	12pm. Mr L met with Mr P and stated that people were following him and reported to sleep in the library at times. Mr L had a good relationship with his parents and would talk with them regularly rather than just his mum and had no pressure from his family since his illness. The family had been supportive of him. Mr L reported that his mood was now good and was interested in self help and tried to remain positive. Mr L stated he had stopped his antidepressants and felt good. Mr L had recently applied for a job however was not successful which he found frustrating. Risperidone Consta 25mg (depot) Risperidone 1mg (oral) Citalopram 20mg (stopped a week previous) No concerns raised.
31/03/10	ELFT records	Appointment	3pm- Mr L met with Ms A and discussed what to expect from the therapy sessions and what he wanted from Mr L decided to meet every Wednesday between 12-1pm so he can attend the group activities.
06/04/10	ELFT records	Telephone call	Telephone contact made with Mr P
08/04/10	ELFT records	Appointment	Treatment with Mr A- attended
14/04/10	ELFT records	Appointment	Appointment with Dr Q attended
14/04/10	ELFT records	Activity Group	Appointment with Mr P- attended
21/04/10	ELFT records	Appointment	Appointment with Mr A- attended
22/04/10	ELFT records	Appointment	Appointment with Mr P- attended
26/04/10	ELFT records	Telephone call	Telephone contact made with Mr P at 12:30
26/04/10	ELFT records	DNA	Appointment with Mr P- DNA at 12:00
06/05/10	ELFT records	Appointment	Appointment with Mr P- attended
12/05/10	ELFT records	Community Appointment	Community appointment with Ms M- attended

Date	Source	Event	Information
17/05/10	ELFT records	New Patient Assessment	Appointment with Mr P- attended
19/05/10	ELFT records	Community Appointment	Community appointment with Mr N- attended
20/05/10	ELFT records	Appointment	Treatment with Mr P attended
24/05/10	ELFT records	Appointment	Mr L met with Mr P and spoke about Mr L's self directed payments. Mr L had an interest in learning to play the guitar and stated that part of his plan was to buy one as this would help with his poker addiction. Currently Mr L felt that he had no good friends, therefore this would help him meet new people. Mr L stated he had not yet started his ant-depressants however agreed to start them that day. Mr L explained the experience of shaking and linking words to the movements and stated it felt like an exorcism. Mr L reported his mood to be fine.
28/05/10	GP records	Letter	Clinic- 17th May 2010 Letter from Dr O to Dr S4 Current meds - 25mg Risperidone depot & restart 20mg Citalopram. Mr L's mental state remained unchanged and recently admitted to stopping the additional 1mg of Risperidone oral per day for around 2 month. Mr L also stopped the Citalopram despite previously responding well. Mr L's main complaint was regarding poor and broken sleep. Poker and Football Manager were described as addictive by Mr L whilst also struggling with motivation. The level of psychotic symptoms remained the same as the previous two appointments. Mr L informed the consultant that he would be travelling to Sri Lanka around the time his depot was due. Mr L was reasonable with his self-care, appeared relaxed and forthcoming. Although his speech was slower and lower in tone. He appeared mildly depressed therefore Dr O recommended 1mg Risperidone oral to prevent any furthur deterioration. PLAN: To restart Citalopram 20 mg once daily and Risperidone Depot 25mg 2 weeks. Mr L to have oral Risperidone if a depot is missed during his visit to Sri Lanka. 37.5mg Risperidone injection upon Mr L's return. Continue current level of contact with Mr P.
02/06/10	ELFT records	Appointment	Treatment with Mr P attended
02/06/10	ELFT records	Appointment	Mr L met with Mr P for his depot injection. Risperidone consta 25mg.
09/06/10	ELFT records	Community Appointment	Community appointment with Ms C2 - attended
14/06/10	ELFT records	Appointment	Treatment with Mr P attended

Date	Source	Event	Information
16/06/10	ELFT records	Appointment	Appointment with Dr Q attended
30/06/10	ELFT records	Appointment	Appointment with Dr Q attended
30/06/10	ELFT records	Appointment	Treatment with Mr P attended
30/06/10	ELFT records	Appointment	Mr L met with Mr P for his depot injection. Risperidone consta 25mg.
06/07/10	ELFT records	Appointment	Appointment with Mr P- attended
06/07/10	ELFT records	Appointment	Half of the progress note was missing. No signature nor confirmation of the clinician. Mr L reported to be physically well after contracting a virus in Sri Lanka. Mr L reported to be sleeping well and was able to go to bed at 9pm and wake at 8am. Mr L had not taken any Citalapram during his holiday therefore had not had any dosage of this medication for 3 weeks and was unsure what to do about his medication. Mr L stated that he no longer wished to complete his psychology course however was unsure what he wanted to do. He had discussed options with his father and brother. Mr L reported that the exorcism worked for him during his time in Sri Lanka but then stopped....
14/07/10	ELFT records	Appointment	Treatment with Mr P attended
14/07/10	ELFT records	Appointment	Mr L met with Ms A and talked about the pros and cons of playing poker and what it would offer him. His course started in September 2010 and was interested in guitar lessons.
26/07/10	ELFT records	Telephone call	Telephone contact made with Mr A
28/07/10	ELFT records	Appointment	Treatment with Mr A- attended
28/07/10	ELFT records	Appointment	Mr L met with Mr A with no concerns regarding his mental state or side affects from his medication. The family were planning to sell the business therefore would need a structure for daily activities. Mr L had started going to the gym to and was concentrating on aerobic exercise.
11/08/10	ELFT records	Telephone call	Telephone MH assessment with Ms B2

Date	Source	Event	Information
11/08/10	ELFT records	Appointment	Mr L met with the Duty Social Worker for his depot. Mr L was noted to be low in mood but couldn't explain why and admitted that he was not feeling 100% Mr L was offered time to talk about things however he declined and stated he would prefer to go home.
18/08/10	ELFT records	Telephone call	Telephone contact made with Mr P at 13:00
18/08/10	ELFT records	DNA	Appointment with Mr P- DNA at 12:00
18/08/10	ELFT records	DNA	Mr L contacted Mr P to say he would not be able to attend the appointment however felt fine. The appointment was rearranged for 25th August.
25/08/10	ELFT records	Appointment	Appointment with Mr P- attended
01/09/10	ELFT records	Activity Group	Appointment with Mr P- attended
01/09/10	ELFT records	Appointment	Mr L met with Ms A and talked about what Mr L needed in order to become motivated and energised such as martial arts, dancing and generally socialising
08/09/10	ELFT records	Telephone call	Telephone contact made with Mr P
08/09/10	ELFT records	Appointment	Mr L met with Ms A and discussed going to the gym and doing cardiovascular workouts. Mr L spoke about his book he was reading about how to make his work quicker and effective. Mr L spoke about not wanting to revisit the past and felt he did not need closure.
08/09/10	ELFT records	Appointment	13:30 Mr L attended his appointment with Mr P for his 25mg Risperidone depot injection
09/09/10	ELFT records	Appointment	Appointment with Mr P- attended
09/09/10	ELFT records	Appointment	Mr L attended the appointment and spoke about his interest in Salsa dance and would also like to enrol with Newham College but the course was already full. Mr L also spoke about martial arts classes which would be paid for with his Direct Payment. Currently Mr L had poor sleep ans was not going to sleep until 4am and waking at 11am which started since he started gambling. Mr L mentioned the shaking and that it had stopped during his time in Sri Lanka however it had returned since he had been home therefore he should have another exorcism.
13/09/10	GP records	Letter	Letter from Mr P inviting Dr M1 to a CPA meeting on 23/09/10

Date	Source	Event	Information
16/09/10	ELFT records	DNA	Appointment with Mr P- DNA at 13:00
16/09/10	ELFT records	Telephone call	Telephone contact made with Mr P at 11:45
20/09/10	ELFT records	Appointment	Appointment with Mr P- attended
20/09/10	ELFT records	Appointment	Mr L met with Mr P who spoke about the salsa course which started that week and was looking forward to the class. Mr P spoke about the Direct Payments and agreed that the long term plan was to find a job. Mr L stated he was compliant with his anti-depressant medication but reported to still be low in mood and felt lethargic with little motivation. Depot injection was due 22/09/10
22/09/10	ELFT records	Appointment	Treatment with Mr P attended
23/09/10	ELFT records	CPA Review	Appointment with Mr P- attended
23/09/10	ELFT records	CPA Review	Mr L met with Mr P and Dr S1, his father was unable to attend the appointment. Mr L was having too much time at home. Mr L was non compliant with his medication with irregular dosage. Mr L slept well following an exorcism in Sri Lanka June 2010, he tapped less and his head movements were reduced, this stopped for 2 weeks but then returned. Mr L stated that someone else was making him move.
27/09/10	GP records	Letter	Clinic 23/09/10 Letter from Dr S1 to Dr P, GP Mr L described a lot of negative symptoms; tiredness, laziness, lethargy, a-movitation and a degree of anhedonia. Mr L reported the link between tapping and the messages he received, although they are neutral in content- initially he thought it was a friend trying to communicate but later thought it may have been God. No hallucinations, alienation phenomena or delusion. A lengthy discussion between Dr S1 and Mr L regarding increasing Mr L's depot to reduce his problems. Mr L found the sessions with Ms A useful. Mr L was currently attending Salsa, martial arts, participating in Wednesdays groups and helping his father's business
06/10/10	ELFT records	Progress note	Mr P spoke with Dr S1 to provide feedback about Mr L's experience during his exorcism. Mr E reduced the medication as per the request of Mr L. Risperidone every two weeks.
07/10/10	ELFT records	Appointment	Treatment with Mr P attended
07/10/10	ELFT records	Appointment	Mr L attended an appointment with Mr P for his injection.

Date	Source	Event	Information
12/10/10	ELFT records	DNA	Appointment with Mr P- DNA
16/10/10	ELFT records	Appointment	Mr L attended an appointment with Mr P and reported that he had had a full exorcism earlier that day and was feeling good. His sleep had improved. Mr L had his injection of 37.5 mg Riseridone.
18/10/10	ELFT records	DNA	Appointment with Mr P- DNA
19/10/10	ELFT records	Progress note	PLAN: To discuss medication with Dr S1. Mr P left a message with Mr L to call Mr P if he was having any issues with his medication
20/10/10	ELFT records	Appointment	Appointment with Dr Q attended
20/10/10	ELFT records	Appointment	Mr L met with Ms A to discuss future plans, courses (coaching, salsa, comedy and acting) and also his exorcism.
21/10/10	ELFT records	Telephone call	Telephone contact made with Mr P
21/10/10	ELFT records	Appointment	Mr L met with Mr P for his depot injection. Mr L was also given a prescription of PEN Procyclidine 5mg to address any side affects.
28/10/10	ELFT records	DNA	Appointment with Mr P- DNA
28/10/10	ELFT records	Cancellation	Mr L cancelled his appointment because he had overslept. Another appointment was arranged for 2/11/10 at Stratford Office Village
02/11/10	ELFT records	Telephone call	Telephone contact made with Mr P at 16:00
02/11/10	ELFT records	DNA	Appointment with Mr P- DNA
02/11/10	ELFT records	Appointment	Mr L met with Mr P and stated that he felt tired. He would continue his medication Risperidone 35mg because his parents want him to. He had recently had a minor surgery therefore would restart his salsa class shortly.
04/11/10	ELFT records	Appointment	Appointment with Mr P- attended
04/11/10	ELFT records	Appointment	Mr L met with Mr L for his injection on 37.5mg Risperidone.

Date	Source	Event	Information
17/11/10	ELFT records	Appointment	Appointment with Dr Q attended
18/11/10	ELFT records	Appointment	Treatment with Mr P attended
22/11/10	ELFT records	Appointment	Review with Mr P attended
22/11/10	ELFT records	Medical Review	Mr L still had movements of his body parts, tapping his fingers and still received message although he did not know who they were form. Mr L struggled with concentration, lack of motivation and restless.
24/11/10	ELFT records	Cancellation	Mr L called Ms A to stated he could not attend his appointment because he was unwell. Mr L stated that he would like to attend an appointment the following week however he felt it was difficult to speak face to face. Ms A encouraged Mr L to talk about how he felt about counselling and that the feedback he gave would be useful to help address what was going on and what made him unhappy. Mr L would attend an appointment the following week.
29/11/10	GP records	Letter	Clinic 22/11/10 from Dr S3 to Dr P, GP Dr S3 reviewed Mr L's progress with the increased Risperdal Consta, Mr L continued to receive messages which were associated with tapping fingers and shaking his leg and was unsure whether he had seen a reduction of the messaged. Mr L complained of lethargy, low concentration, calm restlessness and lack of motivation. Mr L wanted to come off his medication and was aware of the risks if he did so but wanted to take the risk saying he '*may not relapse after all*'. He sleep was erratic with an appetite more than normal. Side affects of pacing and restlessness were confirmed by Mr L's father.
29/11/10	ELFT records	Appointment	Appointment with Mr P- attended
01/12/10	ELFT records	Appointment	Appointment with Dr Q attended
01/12/10	ELFT records	Cancellation	Mr L cancelled his appointment because he did not feel like walking in the snow. Ms A advised a meeting at the church to discuss his link with them however Mr L wanted to check how they felt about first. Ms A advised Mr L of the benefit of the involvement of those helping him in their sessions.
02/12/10	ELFT records	Appointment	Treatment with Mr P- attended
08/12/10	ELFT records	Appointment	Appointment with Mr P- attended

Date	Source	Event	Information
13/12/10	ELFT records	DNA	Appointment with Mr P- DNA
16/12/10	ELFT records	Appointment	Appointment with Mr P- attended
30/12/10	ELFT records	Appointment	Appointment with Mr P- attended
01/01/11	ELFT records	CPA Assessment	Mr L was feeling lonely and had stopped his medication. PLAN: Risperdal Consta injection. Procyclidine 5mg. If Mr L was aware of his depressive symptoms he should start antidepressants. Encourage Mr L to have bloods taken with his GP.
01/01/11	ELFT records	Progress note	There was information missing from the progress note with Mr E- 4. Exercise at least once a week 5. M/R 22/08/11
01/01/11	ELFT records	Medical Review	Mr L met with Dr S1. No side affects. PLAN: Risperdal Consta 25mg 2 weekly, Citalopram 20mg. Bloods monthly. Mr L to attend the gym once a week. Mr L to meet with Mr M. CPA in six months time and medical review once a year
06/01/11	ELFT records	DNA	Appointment with Mr P- DNA
12/01/11	ELFT records	Appointment	Appointment with Dr Q attended
13/01/11	ELFT records	Appointment	Treatment with Mr P attended
24/01/11	ELFT records	Appointment	Review with Mr P attended
27/01/11	ELFT records	Appointment	Mr L met with Mr P for his injection- 37.5 mg Risperidone
28/01/11	GP records	Letter	Clinic 24/01/11- Letter from Dr S1 to Dr P Current med- Risperdal Consta 37.5 mg intramuscular 2 weekly. Citalopram 20 mg oral once in the morning (Mr L stopped taking this medication out of his own volition one month ago). Procyclidine 5mg bd (using since last prescribed one month ago). Change in med- Stop citalopram as Mr L no long wishes to take it. Dr S1 advised procyclidine as a PRN. Mr L continued to receive messages through tapping his finger and shaking his leg although this happened far less frequently. Mr L converts the tapping into words which mean *'why don't you talk to me'*. Mr L distracted himself by praying and had stopped

Date	Source	Event	Information
			responding to the messages. He was exorcised two weeks previously and felt in a '*good state'.* Mr L reported that he found church was a good alternative to Citalopram.
02/02/11	ELFT records	Appointment	Mr L met with Ms A and spoke about his motivation, his sleep patterns and attending church and the problems associated with them. They spoke about the best use of time and personality styles.
07/02/11	GP records	Letter	Letter from Mr P inviting Dr P, GP to a CPA meeting on 1st March 2011
09/02/11	ELFT records	Appointment	Appointment with Dr Q attended
10/02/11	ELFT records	Appointment	Treatment with Mr P- attended
10/02/11	ELFT records	Appointment	Mr L met with Mr P for his depot injection 37.5 Risperidone and discussed the increase dose which Mr L refused and would continue with 37.5 mg.
16/02/11	ELFT records	Cancellation	Mr L called Ms A to cancel his appointment because he had overslept.
18/02/11	ELFT records	Appointment	Appointment with Mr P- attended
18/02/11	ELFT records	Appointment	Mr L met with Mr P who discussed his Direct Payment. Mr L had completed a Support Plan but was unsure what he wanted to do but was interested in coaching. Mr L went onto discuss is exorcism and that he had not been to church in a while although he felt better when he did.
24/02/11	ELFT records	Appointment	Appointment with Mr P- attended
24/02/11	ELFT records	Appointment	Mr L was advised to continue his medication and had his depot injection. 37.5 Risperidone
01/03/11	ELFT records	CPA Review	Appointment with Mr P- attended
01/03/11	ELFT records	CPA Review	Mr L's motivation was okay but not sustained during activities. Mr L had been seeing Ms A for a few months and had restarted his Citalopram. Mr L was not suicidal now however had seen some weight gain over the year and back pain over the last two weeks. Mr L attended Tango once a week and the drama course had finished. Mr L would experience voices when tapping his fingers and shaking of his leg but no other psychological side affects.
02/03/11	ELFT records	Appointment	Mr L met with Ms A who was 10 minutes late for his appointment. Mr L spoke about how he protects people by reassuring them that he was okay. He stopped the shaking because he did not want his parents to see him. Mr L spoke about his social life and friends, expectations and getting disappointed.

Date	Source	Event	Information
10/03/11	ELFT records	Appointment	Appointment with Mr P- attended
16/03/11	GP records	Letter	Clinic 02/03/11 To Dr P from Dr S1. Mr P recommended Mr L's father and priest attended the Care Programme Approach meeting, however Mr L's father was busy. Mr L had a further exorcism the previous Thursday and would continue these sessions until the evil spirits left him, however the priest advised he continued his medication and continue to see the ELFT. The voices occur 2-3 times a day.
16/03/11	ELFT records	Appointment	Appointment with Dr Q attended
24/03/11	ELFT records	Appointment	Appointment with Mr P- attended
24/03/11	ELFT records	Appointment	Mr L met with Mr P to have his depot injection of 37.5 Risperidone. No concerns were raised.
30/03/11	London Borough of Newham	Support Plan	Mr L admitted he was paranoid schizophrenic and had recently been in hospital due to religious beliefs to do with God and people being able to read his thoughts. Mr L was able to recognised he was better however still had some side affects of his condition. Mr L stated he was not very trusting of people and spent most of his time at home where he felt safe, he also recognised the importance of interacting with other people however he struggled with commitment to activities to help him start his conversation. Mr L would like to lose weight following a two stone gain from his Risperidone depot, he also reported that concentration was an issue because of his medication. His goal was to an ideal weight and be normal when interacting with people without feeling anxious. Mr L stated he would like to work out regularly, make friends and spend less time at home. He would like to spend his money on addressing the side affects of his medication. Mr L thought that learning martial arts would provide him with discipline and confidence, he was very clear that coaching was the career he wanted therefore the training would help him obtain a job. Mr P and Dr S1 would monitor and support Mr L's progress. Mr L also confirmed that he had good support from his family and support through the martial arts training. Mr L confirmed he intended on using the money to train at Gracie gym in London for jujitsu, judo, kickboxing and yoga for daily fitness. Alongside this he would train and a career coach at the Blackford Institute to learn the fundamentals of that career. Mr L would bring proof of his membership to the gym and coaching course in order for the money to be paid directly into his bank account for his monthly subscription. Mr P would regularly review the plan. Mr L stated he would be responsible for making his own decisions and planned to talk openly with his family. Mr L was aware he needed to exercise more and stated 3 times a week would be a realistic target. He

Date	Source	Event	Information
			felt that the variety of activities in London left him with no excuses not to undergo exercise. Mr L had looked into the coaching syllabus and would study part time to build up his concentration levels.
30/03/11	ELFT records	Cancellation	Mr L called Mr A to cancel his appointment because he had overslept. He had been taking his anti-depressants, which made him sleepy during the day but was unable to sleep at night. He was on antibiotics following an infection where he had had a leg injection. Mr L spoke about his laziness, which stopped him from leaving the house and doing activities.
07/04/11	ELFT records	Appointment	Treatment with Mr P- attended
14/04/11	ELFT records	DNA	Appointment with Mr P- DNA
15/04/11	London Borough of Newham	Individual budget agreement	Signed by Ms C3 15/04/2011, Mr L 14/04/2011, Mr P 14/04/2011 Total cost of Martial Arts Training and Career Coaching courses was £997.00. Mr L received £850.20 and funded the last 146.80 himself
21/04/11	ELFT records	Appointment	Appointment with Mr P- attended
21/04/11	ELFT records	Appointment	Mr L attended an appointment with Mr P for his injection. 37.5mg Risperidone
05/05/11	ELFT records	Appointment	Appointment with Mr P- attended
06/05/11	ELFT records	Appointment	Treatment with Mr P- attended
06/05/11	ELFT records	Appointment	Mr L met with Mr P for his depot injection. Risperidone consta 25mg. There was no update regarding his benefits and Mr L stated he did not want to continue to call the service therefore would try next week. Mr L complained of feeling tired and had not been taking his antidepressants
10/05/11	ELFT records	Appointment	Appointment with Mr P- attended
13/05/11	ELFT records	Appointment	Appointment with Mr P- attended
16/05/11	ELFT records	Appointment	Appointment with Mr P- attended
18/05/11	ELFT records	Cancellation	Mr L called Ms A to cancel his appointment because he was feeling unwell. Ms A stated that he did this too often and that he should call 15 minutes before the session.

Date	Source	Event	Information
19/05/11	ELFT records	Appointment	Appointment with Mr P- attended
02/06/11	ELFT records	DNA	Appointment with Mr P- DNA
03/06/11	ELFT records	Appointment	Appointment with Mr P- attended
08/06/11	ELFT records	Appointment	Appointment with Mr P- attended at 13:30
08/06/11	ELFT records	Appointment	Appointment with Dr Q at 11:30
10/06/11	ELFT records	DNA	Appointment with Mr P- DNA
17/06/11	ELFT records	Appointment	Appointment with Mr P- attended
17/06/11	ELFT records	Appointment	Entry from 15/06/2011 Mr L attended his appointment one hour late due to work and he stated he had enjoyed working with people. Ms A went through his progress in therapy and themes that had emerged to be included in the 'end of therapy' report.
27/06/11	ELFT records	Appointment	Entry from 08/06/11 Mr L attended his appointment with Ms A and talked about the misunderstanding and him being angry with Ms A for talking to Mr P regarding his attendance. Ms A advised she would notify him of the future dates.
30/06/11	ELFT records	Appointment	Treatment with Mr P- attended
30/06/11	ELFT records	Appointment	Mr L met with Mr P for his depot injection 37.5 Risperidone Mr L reported to be doing well and denied any psychological symptoms. Mr L was volunteering to help him gain confidence and boost his self esteem.
05/07/11	ELFT records	Appointment	Appointment with Dr Q attended
12/07/11	ELFT records	Appointment	Review with Mr P attended
12/07/11	ELFT records	Medical Review	Mr L met with Dr S1, his father and Mr P. Mr L was reported to not be depressed and was undertaking voluntary work two days a week 8-4. Mr L had avoided having his bloods taken. Mr L was engaging with

Date	Source	Event	Information
			martial arts and career coaching through SDS but lacked motivation to go to the gym because of his low energy.
13/07/11	GP records	Letter	Letter typed 19th July 2011- Dr S1 to Dr P, GP Mr L was keen to come off his medication and had researching nutritional supplements he could take to support this. Mr P provided Dr S1 with a print out of an article Mr L had sent him however Dr S1 advised the supplements may not be affective and may come with side affects. St John's Wart herbal medication was suitable for depression.
15/07/11	ELFT records	Appointment	Treatment with Mr P- attended
15/07/11	ELFT records	Appointment	Mr L attended his appointment for his injection. 37.5 Risperidone Costa with Mr P
21/07/11	GP records	Letter	Letter to Dr S5 from the Hackney Benefit Centre confirming Mr L's Employment Support Allowance effective from 02/02/2011
03/08/11	ELFT records	Appointment	Appointment with Mr P- attended
12/08/11	ELFT records	DNA	Treatment with Mr P- DNA
12/08/11	ELFT records	DNA	Mr L did not attend his appointment with Mr P. Telephone contact was made and Mr L stated he had just woken up. Mr L would have his injection the following week.
15/08/11	ELFT records	DNA	Treatment with Mr P- DNA
15/08/11	ELFT records	Cancellation	Mr L cancelled his appointment ad rearranged for 16/08/11
16/08/11	ELFT records	Appointment	Treatment with Mr P- attended
22/08/11	GP records	Letter	Letter from Dr J to Dr P, GP Mr L reported to feel anxious about his voluntary work which caused him to miss around 50% of his attendance, he was unable to elaborate any further than 'I don't feel like going'. Mr L had a supportive employer who encouraged him to continue when he was considering quitting. Mr P advised he would discuss Mr L's case with the EIS psychologist to consider further help. Mr L was attending church with no further exorcisms. Mr L had been compliant with his Risperidone and Citalapram however complained of an '*unreal sensation*' when taking the Citalapram but was not able to elaborate more. After prompting, Mr L acknowledged the reduction of paranoid thoughts.

Date	Source	Event	Information
			At the previous medical review Dr S1 had recommended an increase in Citalopram although Mr L declined and did not want to take medication long term.
22/08/11	ELFT records	Appointment	Appointment with Mr P- attended
22/08/11	ELFT records	CPA Review	Mr L attended the appointment alone and spoke about his anxiety before work. Mr L had considered quitting and had missed a high volume of work. Mr P confirmed that Mr L had a pattern of losing interest over time and this would be something to discuss with the psychologist. Risperidone Consta 37.5 mg every two weeks. Citalopram 20 mg. Mr L reported an unreal sensation. There were variable benefits, paranoid thoughts but his parents stated he 'seemed better' but were not able to elaborate. On observation Mr L appeared flat but reported his mood was good and enjoyed work but was lethargic. Mr L still experienced abnormal experiences but these were reduced.
30/08/11	ELFT records	Appointment	Treatment with Mr P attended
30/08/11	ELFT records	appointment	Mr L attended his appointment for his injection. 37.5 Risperidone Costa with Mr P. He was reported to be bright in mood and also informed Mr P that he was going to France for a wedding.
07/09/11	ELFT records	Appointment	Appointment with Mr P- attended
07/09/11	ELFT records	Clinical Discussion	Mr P discussed Mr P's case in a consultation slot. Mr L was due to start psychology with Mr T.
12/09/11	ELFT records	Prescription	Prescription for Citalopram 20mg prescribed by Dr J for 2 weeks. Mr L would attend the office for his depot and collect the prescription
13/09/11	ELFT records	Appointment	Appointment with Mr P- attended
27/09/11	ELFT records	DNA	Appointment with Mr P- DNA
28/09/11	ELFT records	Appointment	Appointment with Ms B2 - attended at 15:30
28/09/11	ELFT records	Appointment	Appointment with Ms B2 - attended at 13:30
28/09/11	ELFT records	Appointment	Appointment with Mr P- attended at 13:00

Date	Source	Event	Information
29/09/11	ELFT records	Appointment	Mr L attended his appointment for his injection. 37.5 Risperidone Costa with Mr P
11/10/11	ELFT records	Appointment	Appointment with Mr P- attended
11/10/11	ELFT records	Appointment	Mr L met with Mr P who reported he had been feeling tired and found it difficult to get up in the morning. Mr L informed Mr P that he had made a lot of effort to get to his appointment that day. Mr L stated he had to act as a sad person in a recent acting class which had drained him. Mr L had stopped taking his anti-depressants and had stopped attending his voluntary work because he felt depressed. Mr L spoke about his direct payment an was reassured that the process would be followed up. Mr L received his injection.
17/10/11	GP records	Letter	Letter from Mr P inviting Dr P, GP to a CPA meeting on 12th January 2012 and also requesting physical information.
25/10/11	ELFT records	Appointment	Appointment with Mr P- attended
03/11/11	ELFT records	Appointment	Appointment with Mr P- attended
08/11/11	ELFT records	Appointment	Treatment with Ms V attended
14/11/11	ELFT records	Telephone call	Mr L's father called Mr P to inform him that Mr L had an abscess following his depot from last week. There was a concern about the position of the abscess and why the injection was administered in that position. Mr A was made aware of the complaint
22/11/11	ELFT records	Appointment	Treatment with Mr P attended
06/12/11	ELFT records	DNA	Appointment with Mr P- DNA
07/12/11	ELFT records	Appointment	Treatment with Mr P attended
21/12/11	ELFT records	DNA	Appointment with Mr P- DNA
22/12/11	ELFT records	Appointment	Appointment with Mr P- attended

Date	Source	Event	Information
22/12/11	ELFT records	Appointment	Mr L met with Mr P and reported to be doing well and was off his antibiotics because the abscess was healed. The abscess was where the depot was administered in his lower quadrant but he did not want the issue to go further however did not want the same nurse to do his depot in the future.
22/12/11	ELFT records	Appointment	Mr L reported to feel much better and did not have any tremors. Mr L spoke about his activities that were due to start in January 2012. Mr L stated he would like to discuss his medication in his next CPA meeting and request to go onto tablet Risperidone. Mr L did not take antidepressants because he did not need them.
05/01/12	ELFT records	DNA	Appointment with Mr P- DNA
06/01/12	ELFT records	Appointment	Appointment with Mr P- attended
06/01/12	ELFT records	Appointment	Mr L attended for his injection and reported to be doing well. Mr L had been helping his parents in the restaurant and had been keeping himself busy. The communication tapping was manageable and his mood was normal….
12/01/12	ELFT records	Appointment	CPA review with Mr P attended
12/01/12	ELFT records	Progress note	Review with Dr S1. Mr L to receive psychological support from Ms A. Mr L wanted to reduce his depot however there were major risk associated with doing so. Mr L would stop Risperidone Consta on 20/01/2012 and start Risperidone 20mg oral bd and Procyclidine 5mg bd. Mr L would continue with his activities. CPA review 6 monthly and M/R 3 monthly.
16/01/12	GP records	Letter	Clinic 12/01/12- Letter from Dr S1 to Dr P, GP Mr L had stopped taking Citalopram four months previous to the CPA review - when taking the medication he became irritable, depressive, a-motive and spaced out. Mr L was able to take ownership of the messages he received and believed they were his own thoughts. Psychology support with Ms A. Mr L discussed an abscess he had after he took his depot, however did not wish to make a complaint. Although as a result had developed some anxiety with his injections and would prefer oral medication. Dr S1 agreed to convert to oral medication given Mr L's improvement.
25/01/12	ELFT records	Appointment	Appointment with Mr P- attended
07/02/12	GP records	Letter	Letter from Mr P inviting Dr S4, GP to the CPA meeting on 18th June 2012
07/02/12	ELFT records	Letter	Letter from Dr S1 to Dr P requesting information regarding Mr L's physical health

Date	Source	Event	Information
09/02/12	ELFT records	Appointment	Appointment with Mr P- attended
20/02/12	ELFT records	DNA	Appointment with Mr P- DNA
20/02/12	ELFT records	Appointment	Treatment with Mr P attended
20/02/12	ELFT records	Appointment	Mr L attended his appointment for his injection. Mr L reported that his concentration had been poor since starting his tablets and also being on the depot. He also felt restless but since starting the Procyclidine he felt much better and spoke about his acting classes. He appeared bright in mood.
28/02/12	ELFT records	Telephone call	Telephone contact made with Mr T
28/02/12	ELFT records	Telephone call	Mr L received a call to discuss psychological input and was offered the opportunity to receive four sessions. Mr L initially declined the offer however following some advice from the EIS team, he agreed to attend.
29/02/12	ELFT records	Appointment	Treatment Mr T attended
29/02/12	ELFT records	Appointment	Mr L received the first of his psychology appointments and was reported to engage well. No risks identified
06/03/12	ELFT records	Appointment	Appointment with Ms I attended
06/03/12	ELFT records	Appointment	Mr L was reported to be happy within his family setting, he was attending classes and courses. Mr L had tried taking his medication at different times of the day due to feeling sleepy.
07/03/12	ELFT records	Appointment	Treatment with Mr T at 14:00
07/03/12	ELFT records	Appointment	Mr L attended his second scheduled psychology appointment. Mr L spoke about his anxiety and discomfort in social situations. No concerns reported
14/03/12	ELFT records	Appointment	Treatment with Mr T at 10:00
14/03/12	ELFT records	Appointment	Mr L was seen for an ongoing assessment and was reported to engage with activities the previous week. Mr L was pleased with the re-engagement with old friends. Following the completion of BSSC and

Date	Source	Event	Information
			HIADS, Mr L's score was borderline for anxiety and depression. No risk identified and the final session was planned for 21/03/12
15/03/12	GP records	Letter	Dictated 12/03/12 Letter from Dr M2 to Dr P, GP Mr L had reported feeling drowsy and sleepy mainly in the morning despite taking the dose at night. Dr M2 reported Mr L to be a well kept young man and neatly dressed in sports clothes. During the appointment he was quiet and polite. Mr L criticised the control phenomena he use to for past experiences, however found a way to cope without impacting his emotion or behaviour.
15/03/12	ELFT records	Appointment	Appointment with Dr Q at 15:45
21/03/12	ELFT records	Appointment	Mr L attended his fourth and final psychology assessment. Mr L reported to be preoccupied with new relationships and had found himself drawn into a 'love feeling' however would like to take a more gradual approach to this.
28/03/12	GP records	Letter	Letter from Ms L to Mr L- Dr P, GP copied in to the letter summarising the content of the appointment Mr L felt he had progressed well, also described feel 'future-orientated' and had been taking part in group activities. There were moments that he experienced emptiness however completeness came during prayer and procyclidone also helped. Following questionnaires it was highlighted than anxiety and mood were currently not an issue. Mr L spent some time talking about his social anxieties and developed a number of strategies to address that, he described feeling like he wore a social mask. Mr L reported to be nervous speaking to a group for a presentation however described feeling disconnected from this .Mr L stated he was a serious person and spent a lot of time in his head but recognised it was important to not always be alone during difficulties. Mr L's father was the authority of the family due to cultural aspects of family life and found it difficult that his older brother had perceived special treatment. Mr L's psychosis developed after reading books about power and ended up leaving home and university because of these thoughts. Mr L felt that long term relationships became easier and that when he met people for the first time he would have to wear a mask and pretend to be an extrovert.... Final page of the letter was missing.
29/03/12	ELFT records	Appointment	Appointment with Dr Q- attended at 14:45
29/03/12	ELFT records	Appointment	Treatment with Mr T at 14:30
30/03/12	ELFT records	DNA	Appointment with Mr P- DNA
03/04/12	ELFT records	Appointment	Mr L required help from Mr P with completing his medical form to send to the benefit agency. Mr L informed Mr P that he had stopped his courses because the homework was too much therefore wanted

Date	Source	Event	Information
			to concentrate on work and planned to have a consultation job. Mr L planned to complete his CV and look for jobs in the local area. Mr L stated he would like to speak with Dr M2 regarding his dose of Risperidone when he gets a job. Mr L reported to sleep a lot during the day however goes to the gym with friends. No current risks.
19/04/12	ELFT records	Appointment	Mr L and his father met with Dr S2 and reported a lack of energy and motivation due to the risperidone. The procyclidine had helped with this symptom. His sleep was poor and going to bed late around 2-3am and waking in the afternoon. Mr L's father had no concerns and stated he was doing fine. PLAN : to continue with 3mg Risperidone at night and procylidine 5mg BD Next appointment 26/04/12
20/04/12	GP records	Letter	Dictated on 19/04/12 Letter from Dr S2 to Dr P, GP following an urgent medical review on 19th April 2012. Mr L had been re-referred to psychology. Mr L attempted to try a six week period without procyclidine, following advice from Dr M. Mr L reported he felt a need to put words to his tapping. However his mental state was stable.
26/04/12	ELFT records	DNA	Mr L did not attend his appointment with Mr P. Mr L stated he had forgotten about the appointment and was not feeling well. Further appointment on 30/04/12
30/04/12	ELFT records	Appointment	Mr L reported to Mr P that he was doing much better however recognised he needed to occupy his time as he was often bored therefore wanted to structure activities. Mr P advised reviewing his previous SDS and Mr L was clear he did not want to take on too much so agreed to look at 1 or two activities so he could cope. Mr L had not been tapping, denied audio hallucinations. He was sleeping well however went to bed late so would sometimes stay in bed late. Mr L stated he would like to build his confidence around dealing with relationships because he had met a girl he liked however did not feel ready. Next appointment 8/05/12
May-12	ELFT records	DNA	Mr L did not attend his appointment with Mr P. When Mr P telephoned Mr L, he stated he was asleep and forgot about the appointment. Appointment rearranged for 14/05/12 at 11:00
14/05/12	ELFT records	Cancellation	Mr L sent Mr P a text requesting he rescheduled his appointment for that day because he felt tired and wanted to sleep. Mr P rearranged the appointment for 15/05/12 at 16:00
17/05/12	ELFT records	Appointment	Mr L met with Mr P and discussed the SDS Review Plan. Mr L was not able to complete some of the courses he enrolled onto, however benefitted from the classes he attended. Mr L agreed to write a review of the courses. Mr L spoke at length regarding his family dynamics and each member following a personality course he attended to help understand them better. Mr L stated he felt annoyed and unloved when his brother rejected the help Mr L offered. He stated he was able to relate well with his father who understood him more. Mr L stated the procyclidine was helping with the shakes and was taking 2 tablets a day. Mr L also informed Mr P that he would take them at night to help him sleep. Next appointment: 23/05/12

Date	Source	Event	Information
23/05/12	ELFT records	Cancellation	Mr L cancelled his appointment for that day - rescheduled for 28/05/12
29/05/12	ELFT records	Appointment	Mr L met with Mr P and discussed the SDS. Mr L had completed his Review Plan and also emailed Mr L payments he made for the courses he chose. Mr L reported he was doing well however struggled with motivation sometimes. Mr L had his psychology appointment arranged and was looking forward to exploring some issues. Mr L was compliant with his medication with the adverse side effects linked to the Risperidone previously experienced not present. Next appointment 11/06/12
08/06/12	ELFT records	Cancellation	Mr L telephoned Ms L to cancel the appointment arranged for that day. Appointment rescheduled for 15/06/12 at 15:00
11/06/12	ELFT records	DNA	Mr L stated he forgot about his appointment and was still in bed when Mr P telephoned him. Appointment was rescheduled for 18th June 2012- medical review to see Dr S2
15/06/12	ELFT records	DNA	Ms L received a text from Mr L at 3pm (the time of the appointment) to ask if she had an appointment that day. Ms L called Mr L to inform him the appointment was at 3pm. Mr L requested if he could see Ms L at 4pm, but this was not possible. Ms L stressed the importance of the appointment because he had missed a few. Appointment rescheduled for the following Wednesday 20th June.
18/06/12	ELFT records	CPA Review	Dr S2 met with Mr L to discuss the reduction of medication- 3mg Risperidone to 2mg Risperidone. Mr L was noted to continue his tapping, although this had significantly reduced since taking procyclidine and now able to not put words to the tapping. Mr L attended on his own because is father was unable to accompany him. Mr L stated that would take his Procyclidine twice a day, sometime at night- Mr L was advised to only take this once a day and during the day time. Mr L's sleep pattern was poor; going to bed late and waking late in the morning. A discussion around adjusting his sleep pattern took place to enable Mr L to wake earlier. Mr L stated he had missed psychology appointments due to sleeping in and admitted he enjoyed his sleep. Getting up in the morning was an issue depending on his activities during the day. Mr L reported he had applied for SDS for activities. Mr L was advised to think about voluntary work and working at restaurant, however Mr L was not keen on the idea. It was reported that Mr L's mood was okay, his mental state was settled and he was eating well. Mr L was advised that reducing medication was a gradual progress and Dr S2 would like to see Mr L engaging with psychology, improving his sleep pattern and becoming better involved with activities in order to be in a position to make a decision about Mr L's medication.
18/06/12	ELFT records	CPA Review	Mr L's mood was okay with no psychologist side affects. Mr L appeared brighter. Mr L had received Direct Payment for activities and voluntary work was advised by Mr P, Mr L agreed to think about it. Risperidone 35mg and Procyclidine 5mg. Mr L's movements had reduced. Mr L was encouraged to engage with psychological support to help keep him motivated.

Date	Source	Event	Information
20/06/12	ELFT records	Appointment	Mr L reported to Ms L that he had stopped exercising since they last met and had started going to the casino. He felt inadequate and annoyed about how he was living and that he did not follow through. He also felt he was not worthy of friends with a higher status because he was on medication, not working and sleeping during the day. Mr L stated he was angry with the CPA not reducing his medication so he would work towards being healthy. Mr L stated he could not work or socialise whilst he was still '*ill*' and every time he take his medication it was further confirmation that he is *'ill'*. Ms L advised it was understandable why he kept being drawn back to the casino following a discussion about the excitement, however Mr L was advised to remember the negatives also associated with it. Ms L advised Mr L about his 'black and white' attitude towards coming off medication and how this would link to his feelings of being stuck. Therefore it was important for Mr L to develop short term goals. It was established this was an issue for Mr L because his long term goals, of being a life coach remained very consistent. Mr L was reminded of the importance of attended regular appointments to build momentum with him towards his goals - missing so many recently at that time might have been a reflection.
22/06/12	GP records	Letter	Appointment date: 18th June 2012 Letter from Dr S2 to Dr P, GP. Mr P had noticed no psychotic symptoms during his follow ups with Mr L. Mr L reported his mental health as stable and his mood was fine.
27/06/12	ELFT records	Appointment	Mr L reported to Ms L that he had been feeling good during the week and much better over the last couple of days. He had managed to get up earlier and spend time at the family business, whilst exercising twice that week. Mr L mentioned he had been to the casino that week and reflected that it made his mood less stable; the excitement of winning and the low feelings if he lost. Mr L stated he felt he had lost some of his integrity because he was not able to always follow through with what he said he was going to do. Mr L intended not to go to the casino during the coming week as his brother's friend was a way for a month. He had asked his brother not to invite him therefore set a goal to not attend for an entire month. Upon reflection Mr L was no longer angry at his CPA regarding his medication and was able to recall that if he put more effort in to develop a routine, this would indicate he was doing well and the psychiatrist would see improvements. Mr L had recently brought some videos about business and sales to help improve the family business. However Mr L found it hard to concentrate for more than 45 minutes and stick to the development because there was no deadline. Mr L had set himself a goal to finish the development of the family business website. GOALS: Be up by 10am, exercise for 15 mins, have breakfast. Study 11-12. Be at the restaurant 12-3 3-5. Study/website/gym asleep by midnight. Ms L advised that previously Mr L had set himself unrealistic target and Mr L was able to reflect that he spent a lot of time procrastinating. PLAN: Mr L to complete a weekly activity diary. Next appointment 4/04/12
05/07/12	ELFT records	Appointment	Mr L attended his appointment the previous day following a confusion about the date. Ms L was unable to see Mr L as she was with another client.

Date	Source	Event	Information
			Mr L reported he was able to follow the agreed schedule that was agreed in the previous meeting for a couple of days, however old habits started to make their way back into Mr L's routine, such as waking late and not doing much with his day. However Mr L was able to complete exercise on 5 occasions throughout the week and resist the temptation of attending the casino. Mr L found it difficult to set goals and constantly asking himself '*why' 'what is the purpose?'.* Ms L and Mr L discussed the issue that Mr L finds it hard to engage with the small steps towards the high expectations of his life. Ms L advised Mr L to focus on the reasons why creating a bigger picture were important and make a structured plan. PLAN: next appointment 9th July. Mr L to decide what he would like the focus of the following sessions to be and the reasons why.
09/07/12	ELFT records	Appointment	Mr L reported to Ms L that he had had a good weekend after completing the website for the family restaurant. Mr L and Ms L reflected on the previous session about why it was important for Mr L to complete certain tasks to motivate him. Mr L realised during the weekend that he was a private person therefore was unsure if he was ready to share reasons behind his goals. Mr L also expressed his anxiety about having notes regarding personal issues on the system. Ms L agreed to complete brief therapy notes and would check any letters with Mr L before they were sent. PLAN: appointment in 2 weeks. Mr L to complete questions about his goals for 1 and 5 years time.
16/07/12	ELFT records	Appointment	Mr P met with Mr L and discussed at length Mr L's gambling habit and how he was unable to control his temptations when his brother's friend is around. Currently he was on holiday and Mr L had not been to the casino for 2-3 weeks. Mr L did not lack motivation however stated he felt tired from working at the restaurant but was unable to go to sleep until late if he was tired due to the length of time it took Mr L to unwind. Mr L's sleep continued to be erratic although his tapping had reduced with the procyclidine. Next appointment 30/07/12
23/07/12	ELFT records	Appointment	Mr L reported to Ms L that he felt himself slipping back into bad habits because he had recently been covering his mother's shifts which meant his routine had been disrupted by going to sleep at 3am. Mr L stated he had thought about going to the casino a lot, therefore decided to go as a reward for his hard work. Mr L was unable to recap what was discussed in the previous session with Ms L or the home tasks that were set. Ms L reminded Mr L that *'Where would I like to be in one and five years time'.* Mr L stated he would like to be working five days a week in one year's time for a recruitment company, as well as reducing his medication. Mr L was asked to reflect how this might feel, in response Mr L thought he would be stressed and would look back and feel he should have enjoyed the present time more, due to the amount of time he had available to him. Mr L wanted to be coaching 1-1 with his life coach business in five years time. Next appointment: 30th July

Date	Source	Event	Information
30/07/12	ELFT records	Appointment	**16:00** Mr L explored with Ms L his ambivalence regarding working and compared the pros and cons. Mr L identified his medication and the restaurant as a block however he felt he needed to support his family. Mr L currently had two positive narratives for his future, however wasn't feeling satisfied with either.
30/07/12	ELFT records	Appointment	Mr P met with Mr L who stated his sleep had improved and continued to help at the family restaurant. Mr L reported that on the days he had not taken is procyclidine he felt restless. Mr L spoke about wanting a settled relationship, but first wanted a job to help with his self esteem and confidence. In order for Mr L to have a job, he wanted his health to be back to normal. Mr L requested a review with Dr M2 to discuss a reduction in his medication. PLAN: Next appointment 13/8
03/08/12	GP records	Letter	Letter from Ms L to Mr L- Dr P, GP copied in to the letter summarising the content of the appointment
06/08/12	ELFT records	Appointment	Mr L went through the re-assessment report with Ms L and stated he was happy with the content. Mr L discussed the conflict of the two career options of being a life coach yet feeling a sense of duty towards the family business. Mr L was advised that not everyone was able to make sense of their destiny, however it was important for Mr L to make decisions to prevent the feeling a '*being stuck'* which he had previously spoken about. Next appointment 13/8.
13/08/12	ELFT records	Appointment	Mr L met with Ms L and stated he was feeling more positive and was able to identify that people may value him for who he is rather than what job he did. They discussed developing an RP plan whilst reducing Mr L's medication. Next appointment 13/9.
15/08/12	ELFT records	Appointment	**14:13** Mr L attended a medical review today with Dr M2 and also brought his father to the appointment. Mr L reported he was doing fine and had been helping his family at the restaurant. Mr L requested a reduction in medication, supported by his father who agreed to monitor Mr L's mental state. Mr L had coped very well since coming off the injection and on the reduced dose of Risperidone. Mr L stated that if he did not take his Procyclidine he did not feel very good, lacking energy and very tired. However functioned very well when taking it. Risperidone to be reduced to 2mg daily and continue with procyclidine. Next appointment- 29/8.
15/08/12	ELFT records	Appointment	Mr L requested an appointment with Dr M2 to request a reduction in his medication because he had been stable for two years. Dr M2 was happy with Mr L's evolution and kept himself busy and remained active. Dr M2 reported Mr L's manner to be spontaneous and less stiff since the last time they met. Mr L had great insight into his illness. Dr M2 suggested a change in anti-psychotic medication due to neurolepsis from the risperidone, however Mr L was very reluctant to change.
15/08/12	GP records	Letter	Letter from Dr M2 to Dr P, GP following a medical review Dr M2 confirmed that Mr L's treatment had been reduced without any incidents and Mr L's family commented on the significant improvements in Mr L's presentation. Mr L remained active and worked at the family restaurant 5 days a week and had made such improvements that he was able to deal with

Date	Source	Event	Information
			customers independently. Mr L enjoyed the social side of the environment. Mr L's manner and contact was more spontaneous, however he remained slightly stiff. Dr M2 informed Mr L that he had reduced his medication to 2mg Risperidone which was the lowest dose he could recommend and did not think his medication should be reduced any further. Mr L was complying with the prescriptions.
20/08/12	ELFT records	Appointment	DUTY ENTRY: Mr L requested to see Mr A whilst waiting for his psychology appointment. Mr L explained that his Risperidone had been reduced but was due to run out in a few days. Mr L did not want to waste a visit to the GP if they had not been made aware of the change in medication. No GP was available to write Mr L a prescription. PLAN: Mr L would return to the following day to collect a letter to the GP informing them of the change in medication.
20/08/12	ELFT records	Appointment	Ms L met with Mr L who claimed he was having a good week and more energy since he had reduced his medication, which had improved his mood. Ms L & Mr L worked through the RP and explored the onset of Mr L's psychosis and thoughts, feelings and behaviours at the time. Mr L was asked to reflect over the order of these to begin to create a RP signature. PLAN: Reflect over onset of psychotic episode and sequence of events. Next appointment 28/08/12
28/08/12	ELFT records	Appointment	Ms L reported that Mr L had a difficult week and he had broken his losses re: casino and had lost money. His brother had tempted him and Mr L gave in *'What else are you going to do otherwise?' .* They identified periods of time where Mr L did not attend the casino, which was linked to when he was socialising and attending courses. Therefore it was important for Mr L to find a replacement for the Casino. Mr P agreed to look at short courses including a chef course so that Mr L could meet people and socialise. Mr L reported his mood had improved an felt like he had more energy since reducing his medication. PLAN: Ms L to discuss with Mr P re short courses. Ms L to continue working with Mr L regarding PR. Next appointment 5/9.
29/08/12	ELFT records	Appointment	Mr L met with Mr P and completed the SDS assessment questionnaire. Mr L stated he was supporting his uncle at the restaurant whilst his parents were in France for a wedding. Mr L reported he was doing well however his appetite had reduced due to seeing food all day, he did not feel like eating. Mr L reported he was not sleeping late into the afternoon, sleeping around 8-9 hours. Mr L had been compliant with his medication with no side affects. PLAN: Next appointment 12/09/12
29/08/12	London Borough of Newham	Self Assessment Questionnaire	**Personal Care**- Mr L was fully independent and needed no support with this area of his life **Physical, mental health and well being**- Mr L was well and no one had raised concerns about his health or welfare. Mr L felt stable and was compliant with his medication, he was also engaging with the mental health services. He stated he felt better than before and had improved since his last onset of illness. Mr L indicated that the warning signs for him becoming unwell were withdrawal and making paranoid conclusions. Mr L would watch comedy as a distraction strategy, meditate, use the counselling service and focus on other things. Mr L was currently taking 2mg Risperidone daily and procyclidine 10 mg daily.

Date	Source	Event	Information
			He stated his appetite was reduced due to the work environment and was finding it hard to sleep and waking early. Mr L had ongoing back pain but stated this did not affect his mental health and was able to manage the pain. He did not use any other drugs than the one prescribed and socially/occasionally drank. **Developing and maintaining relationships-** Mr L had very few relationships, maybe only one or two but this was not enough for him. Mr L needed support making new friends and keeping them. **Being part of the local community**- Mr L did not do much in the community and was very lonely, he did not have any relationships. He would benefit from more social contact and needed support to make relationships and keeping them. Mr L stated he undertook basic activities in the community and went to the shop on his own, attended EIS activity groups and occasionally helped at the family restaurant. Mr L would read books and watch television to occupy his time. He enjoyed watching football, reading and listening to audio books and occasionally go to the cinema, cooking and exercise. Mr L was undertaking voluntary work because he was currently unemployed. He was registered with Newham Volunteer Service and occasionally helped at the family restaurant. Mr L stated he would like to do a cookery class, have more discipline and overcome fears- he saw martial arts as a way of doing that. He would like SDS to fund the activities. **Home environment-** Mr had no problems using his home, both inside and out, he lived in a 3 bed house with his parents. **Managing money-** Mr L reported he had no difficulties managing his money and did not need any support. He was in receipt of benefits and was not in any debt. **Meals and nutrition**- Mr L stated he needed all his meals provided for him or prepared by someone else but did not need help to eat or drink. **Family Carer and Social Support-** Mr L was able to get only some of the help he needed from adult family and friends and reported he needed significant paid support. **Time spent with support**- Mr L reported he let people know when needed help and could go out without support. **Complex needs and risks-** Mr L reported he had never done think which people find difficult or dangerous. **Staying safe from harm**- Mr L stated he needed help from others to make sure he stayed safe. He was happy and no one had raised any concerns about his welfare. Mr L reported that he felt frustrated and anxious attending CPA meetings and when people lie. Mr L would try to talk to someone, take time away from the situation and avoid confrontation or try to calm down by listening to music to deal with the situation. Mr L was most proud that he completed his studies and helped his family. He felt he was a good problem solver, good at keep perspective, worked well within a team, a good listener and proactive. Mr L wanted to find a job and be in paid employment within the next 12 months. He felt that Self Directed Care would help raise the course fees and help him with the activities to encourage engaging with the public and rebuild relationships. Making a new circle of friends was important to Mr L.
05/09/12	ELFT records	Appointment	Mr L and Ms L recapped the previous session. Following this, Mr L decided to speak with his mother regarding his gambling and informed her he had lost some money. Mr L requested the support of his mother to prevent him from attending casinos. Mr L reported that he had not been gambling this week. Mr L had met with Mr P to complete an SDS to provide funding for courses to fill the void gambling had left. Mr L reported he had felt low following the previous meeting with Mr P regarding Relapse

Date	Source	Event	Information
			Prevention. Ms L explored with Mr L the areas of difficulty to enable him to manage this better in the future. The session focused on the sequence of events leading up to Mr L's relapse and the Relapse Prevention Signature. PLAN: Next appointment 10/9
10/09/12	ELFT records	Appointment	Mr L met with Mr P and upon reflection of the last few months stated he had tried to forget some of the images and experiences whilst in hospital and descried them as being lodged in his memory. Mr P advised that some of the memories may be feel traumatic and experience images whilst processing the information from his past. Mr P supported Mr L by discussing how to manage the images, as a result Mr L agreed to make a note of any that come to mind so they could be discussed at another meeting. Mr L reported that his parents were working at the restaurant again whilst gave Mr L more time. He had been spending 30 minutes a day reading a self-discipline book and taking notes. Mr P advised a strategy to compare Mr L's life at the present and what had changed or got better. PLAN: Next appointment 17/9 at 16:00
12/09/12	ELFT records	Cancellation	Mr P reported that Mr L called to cancel the appointment for this date. Mr L reported he did not sleep well and was tired, therefore requested the appointment was rearranged. PLAN: Next appointment 13/09/12
13/09/12	ELFT records	Appointment	Mr P met with Mr L who reported that Mr L had mistakenly take 3mg of Risperidone for a few days, therefore had been feeling tired and drowsy. Mr L had reduced the medication to 2mg and reported to be sleeping much better without staying in bed late in the morning. Mr L's parents had recently returned from holiday, Mr L continued to work in the restaurant and did not feel pressured with responsibilities. Mr L reported he was not gambling or going to the casino. There were not concerns or negative thoughts raised. Mr P and Mr L discussed his SDS which was completed and sent to Mr H. PLAN: Next appointment 25/09/12
17/09/12	ELFT records	Appointment	Mr L reported to Ms L that he had had a productive week working at the family restaurant and reading a book with 30 pages of notes. Mr L had been focusing on applying the techniques he had learnt in the book to help motivate him and see things through. Mr L had been working in the family restaurant. During the appointment Ms L and Mr L recapped on the previous session and revisited to timeline of events which had led to his hospitalisation. Mr L made some amendments to the document. Mr L confirmed the types of coping strategies and forms of meditation he was using; breathing, acceptance, visualisation & gratefulness. PLAN: Next appointment 24/9
24/09/12	ELFT records	Appointment	Ms L reported that Mr L was struggling motivate himself to apply the learning he obtained from a book he had recently finished to the restaurant business. Mr L was experiencing self-doubt and low motivation and discussed how his previous experiences impacted this. Ms L advised Mr L to identify the different needs of the restaurant and where he needed to start. Mr L was able to identify that he wanted to begin a marketing strategy and write a proposal for developing the business into a catering business. PLAN: Mr

Date	Source	Event	Information
			L to focus on the marketing strategy. Mr L to read a book about the catering industry for 30 mins Mon-Fri. Next appointment 08/10/12
27/09/12	ELFT records	Appointment	Mr L completed the SDS with Mr P. Mr L spoke about the family business at length and how he had been frustrated because he wants to help his family and had some ideas of how to improve the business and but his parents did not accept them. Mr L reported that when the restaurant was busy he felt tired and the work would get *'too much'.* Mr L's mood and motivation were OK. No negative thoughts. Compliant with medication. Eating and sleeping well. Procyclidine reported to help Mr L. PLAN: Next appointment 11/10/12
04/10/12	GP records	Letter	Letter from Mr P inviting Dr P, GP to a CPA meeting on 19th November 2012
11/10/12	ELFT records	Appointment	Mr L reported to Mr P that his mood was good with no negative thoughts. Mr L spent some time speaking about how the family business was not doing well and that he had some ideas however his parents were not willing to listen to him. Mr L was compliant with his medication, sleeping well and a good appetite. No concerns.
16/10/12	ELFT records	Appointment	08/10/12 Mr L telephoned to cancel his appointment as he was unwell and the appointment was re-arranged for 16/10 day. He attended the appointment and informed Ms L he had '*gone backwards*' and hadn't achieved anything in the last few weeks. Upon reflection Mr L stated this was *'typical of him*' and that he '*can never see anything through*' then discussed how he gets angry with himself if he did not attend the restaurant and would stop attending altogether for a few weeks. Ms L advised Mr L of strategies to help forgive himself should he become unwell or take a break from the business. Mr L was reminded of previous strategies that helped him re-motivate himself such as meditation and reminding himself why his goals were important. Ms L advised that Mr L did not set a date for targets, therefore he could not fail, but could also show his progress. PLAN: next appointment 22/10/12
22/10/12	ELFT records	Appointment	Mr L reported to Ms L that he had recently recovered from a cold and was feeling better. He stated he was annoyed with himself as he was feeling de-motivated and was experiencing self-doubt. '*Why he is where he is in life, that he is getting older and has little to show for it.'* Ms L went through techniques that previously helped Mr L feel motivated. 1) *why he wants to achieve his goal of developing the family business 2) his values (learning and family) 3) Using techniques including motivation and sleep hygiene methods 4) re-connect with God by either praying, attending church or using meditation.* *PLAN:* Mr L decided to prioritise one of the techniques by listening to 15 minute motivation self-help guide. Mr L would also pray to help with self-doubt. Next appointment 29/10
25/10/12	ELFT records	Cancellation	Mr L telephoned Mr P to cancel the appointment. He stated he was fine and has no concerns. Next appointment 1/11 15:30

Date	Source	Event	Information
29/10/12	ELFT records	Appointment	Ms L reported that Mr L's spirits had been lifted after attending church over the weekend. Mr L had also been reading a new self help book and was feeling more productive. Mr L and Ms L discussed how to use the tools and techniques earlier before his mood dipped, as Mr L reflected his mood and productivity fluctuated in a repetitive cycle. Mr L felt he was motivated to make changes to the family restaurant however becomes tried and less motivated as a results of working shifts there. PLAN: Mr L to think of ways to shift the pattern as he is feeling stuck. Ms L to discuss with Mr P regarding funding for courses. Next appointment 5/11.
01/11/12	ELFT records	DNA	Mr L did not attend an appointment with Mr P. Mr P called Mr L who stated he had forgotten about the appointment and apologised. Mr L stated he was doing well and raised no concerns. PLAN: appointment arranged for 08/11/12
08/11/12	ELFT records	Appointment	Mr P completed the SDS with Mr L, who stated he would like to work in sales and has a friend who could arrange a commission only sales role. Mr L felt confident he could do a good job once he had had the necessary training, although he needed a driving licence. As a result he had started learning to drive. Mr L also helped his father in the restaurant. Mr L stated that the Risperidone that he took at night made him tired in the morning, however the Procyclidine helped him feel better. He has no side affects from the medication. Mr L was able to motivate himself if he had plans in the morning or during the day. No psychotic symptoms and his mood was fine. PLAN: Next appointment 22/11/12
12/11/12	ELFT records	Appointment	Ms L reported Mr L had been working on improving on his sleep pattern and learning to drive. They discussed increasing his self-belief and explored ways to stay well and productive to support this. Mr L reported he felt *'haunted by times he has failed/not seen things through.*' which impacted on his commitment when starting something new. PLAN: Mr L to monitor thoughts when initiating work around the restaurant. Next appointment 20/11
19/11/12	ELFT records	CPA Review	Mr L reported to Mr P that he was unaware of the CPA review. Mr P and Trainee Dr M2 continued without Mr L to discuss his treatment. Diagnosis: Paranoid Schizophrenia- in remission. Medication: Risperidone 2mg nocte. No reports of mental health deterioration. Recent appointments between Mr P and Mr L involved discussions social issues relating to his father's struggling business and Mr L's lack of commitment to pursue tasks. Mr P reported Mr L did not struggle with motivation. Trainee Dr M2 recommended Mr L met with OT or an Employment Advisor. Mr L's latest blood tests revealed eGFR at 87 (lower limit 90) Trainee Dr M2 advised a repeat of bloods. No physical health issues. PLAN: Continue on CPA with regular CCo meetings; arrange medical review ASAP; continue medication; Mr P to discuss OT intervention; Mr L to continue to meet with Ms L; GP to refer for routine blood investigations and communicate results.
19/11/12	GP records	Letter	Letter to Dr P from Dr M2 Mr L did not attend his CPA review meeting as he was still in bed and did not know about the appointment. There had been no recent reports regarding Mr L's mental state and Mr L

Date	Source	Event	Information
			informed Dr M2 that he had spend their sessions discussing the family restaurant. Mr L lacked commitment rather than motivation. There were no concerns.
20/11/12	ELFT records	Appointment	Ms L met with Mr L who reported that he felt calmer after attending church. Mr L also felt less angry and frustrated after discussions with his father regarding the restaurant and who helped him understand the situation from his father's perspective. Mr L confirmed he had been able to stick to his rules of not spending too much whilst visiting the casino during the week. Mr L provided an example of how he was able to work through self-doubt and negative self talk. Mr L decided to focus on improving his sleep pattern and identify priorities outside of business. PLAN: Next appointment 26/11
22/11/12	ELFT records	Cancellation	Mr L called Mr P to cancel his appointment - Mr L felt tired following a late night. PLAN: rescheduled to 27/11/12 at 10:30am
27/11/12	ELFT records	Appointment	Mr L met with Mr P and reported he felt good. Mr P made a referral to Occupational Therapy and would be under Ms S who attended their previous appointment to explain her role. Meeting with Ms S 14th December. Mr L reported no negative thoughts or psychotic/depressive symptoms however did mention he had felt sleepy. His medication had been reduced from 3mg to 2mg of Risperidone and Mr L reported to feel the same. He continued to take procyclidine because without it '*he did not feel good*' Mr L had no side affects. His appetite was good. Mr L stated he had had a busy week where some days he would be awake until 4-5am and reported he was *'catching up on his sleep'* which impacted his sleep cycle. Mr L recently started driving lessons with his brother he reported he was nervous on the road therefore avoided busy times. PLAN: next appointment 11/12/12 11:00am
28/11/12	ELFT records	Appointment	Ms L reported that Mr L had little to *'get up for'* and as a result had downloaded a game which previously he had been addicted to. Mr L reflected this was something he enjoyed however voiced concerns about becoming addicted again. Ms L and Mr L discussed this may be an area of avoidance, similar to the casino and also recapped on themes that were previously discussed regarding therapy and barriers to productivity. Ms L refocused Mr L with his goal to start sales works. PLAN: Next appointment 3/12 16:00
03/12/12	ELFT records	Appointment	Mr L reported to Ms L that he had had a migraine during the week and been sick, however was feeling more positive and had attended church over the weekend. Mr L had also been successful in limiting his time on the computer and also discussed that he was unsure if he could commit the sales job because it only filled 4 & 5 of the criteria that was important to him. 1) Something to get up for 2) Opportunity to meet people 3) Sense of achievement 4) Feels worthwhile 5) Develops confidence. Mr L's decided his plans to become a life coach would be put on hold because of the family business. Ms L advised he explored roles that were worthwhile and meaningful him. Mr L reported that helping the family business was meaningful and the sales job could enable him to accommodate this whilst also working. PLAN: Mr L to feel '*connected to it*' (the sales job) remind himself what skills the role would give him, including the financial impact. Mr L to connect with his friend to observe the role.

Date	Source	Event	Information
10/12/12	ELFT records	Cancellation	Ms L received a text from Mr L asking for the appointment for the day to be cancelled as he was not feeling well. PLAN: Re-scheduled for 19/12 at 4pm
11/12/12	ELFT records	DNA	Mr P reported Mr L did not attend the appointment. PLAN: Re-arrange another appointment
14/12/12	ELFT records	DNA	Ms S confirmed Mr L DNA's his appointment and requested it was rescheduled to the following Monday.
17/12/12	ELFT records	Appointment	Mr L met with Ms S who reported his mood was 'alright' but continued to struggle with his motivation and ability to maintain a structured routine. Mr L was able to identify his strengths and weaknesses following a work role interview. Strengths: '*Nurturing, ability to think ahead, leadership, working within a certain level of pressure, pleasure in seeing others do well.* Challenges: *'working in a disruptive environment, working under an authoritarian boss, looking far ahead and miss what was going on in the present, poor concentration.'* Mr L reported to continued to work unpaid for his father and stated he would put money into the restaurant when it was not doing so well in order to support his family. Mr L stated his long term goal was to be a life coach however struggled to complete the small tasks to aid him getting there such as a daily routine and waking up on time. However, Mr L was putting money aside for training courses. Mr L had spoken to a friend about working within sales but had some concerns about taking time away from the family restaurant until January. Mr L also expressed an interest in volunteering to gain experience for his life coaching. PLAN: Next appointment 14/1 to assess if Mr L was ready to start work and identify if there was a need for an OT to help structure Mr L's day.
19/12/12	ELFT records	Appointment	Mr L reported to Ms L that he had been spending long hours on computer games which had affected his sleep, by going to bed late and waking late. Ms L and Mr L recapped on the '*rules'* Mr L had set himself with regards to computing and reasons why he had set them. During the session Mr L and Ms L discussed the goal of starting work and Mr L was able to identify '*smaller steps of working towards this including: speaking with a friend (Mr L had achieved this the previous week) improving sleep using meditation, limiting computer game use, learning to drive (including theory and practical) shadowing on a work placement, attending meetings, reading sales books, going for the week training course, organising cover at the restaurant and start working part time.* Mr L reported he had started to learn to drive with his brother however had not had a lesson in 3 weeks. Mr L highlighted his brother was '*difficult to tie down'* but also found his criticism hard to accept. Mr L would arrange another lesson in during the following weeks and use meditation. PLAN: Next appointment 7/1/13. Ms L to liaise with Ms S and Mr P to set common goals.
24/12/12	ELFT records	Appointment	Mr P met with Mr L who reported to be *'doing OK'*. Mr L informed Mr P that he had missed his medication for one day because the pharmacy failed to obtain his prescription from the GP. He had arranged for the pharmacy to provide him 5 days of medication and the rest of the medication would be sorted out later that week. Mr L reported to be happy taking Risperidone 2mg with no side affects and Procyclidine

Date	Source	Event	Information
			because he felt he needed it. Mr L continued to help his father in the restaurant and if he is not at home, he confirmed his concentration and attention was good. Mr L's mood was fine with no negative thoughts and both his appetite and sleep was good. PLAN: Next appointment 10/01/13 14:00
10/01/13	ELFT records	DNA	Mr P reported Mr L did not attend the appointment because Mr L overslept. PLAN: Appointment rearranged for 14/1/13 at 15:45
14/01/13	ELFT records	Telephone call	Ms L invited Mr L to the Tree of Life Group on 15/01/15
15/01/13	ELFT records	Appointment	**14:20** Mr L informed Mr P that he was doing well and denied any psychotic symptoms, suicidal ideations or negative thoughts however had some difficulty motivating himself. He was compliant with his medication although he complained of feeling tired at times but with no other side affects. Mr L reported he had helped his father in the family restaurant but felt he had not done much for himself. Mr L had stopped his driving lessons for six weeks. Mr L was interested in a sales job however was also unsure because of the time he would have to get up. Mr L confirmed he had discussed this with Ms S and how he would occupy his time constructively. PLAN: next appointment 28/01/13
15/01/13	ELFT records	Tree of Life Group	**14:00** Ms L reported that Mr L attended the Tree of Life group
21/01/13	ELFT records	Appointment	Mr L reported to Ms L that he had started gambling on the computer. He reflected the reasons were to find some excitement as he often feels bored and also to avoid/escape reality. There were plans with Ms S before Christmas for Mr L to think of activities he would want to get up for, however Mr L reported he had not got very far as he kept changing his mind. Mr L and Ms L went through the Relapse Prevention work and discussed his pathway of care and the fact he had been with the service for four years. Ms S had organised a joint meeting with Ms L and Mr P to discuss how they would support Mr L over the following year when he will be discharged from EIS and also to discuss what focus Mr L would like. PLAN: Next appointment 29/1 with Mr P and Ms S
22/01/13	ELFT records	Tree of Life Group	Ms L met with Mr L who participated in group discussions and activity. He was reported to struggle with drawing his tree and found it difficult to think of his goals and hopes for the future because they were always changing.
29/01/13	ELFT records	Tree of Life Group	Ms S met with Mr L before he attended th Tree of Life Group. Mr L reported to struggle with setting goals although still spoke of working for a friend selling double glazing. Mr L was very passive when Ms S spoke about setting weekly goals in order to work towards the larger goal of being independent and working. However with some encouragement Mr L agreed to discuss his goals within the next session with Ms S. Ms S reported Mr L had good eye contact and was well presented. He denied any suspicious

Date	Source	Event	Information
			idea or negative thoughts and engaged well with the session. PLAN: OT vocational session with a goal setting and motivational interviewing technique as a focus.
29/01/13	London Borough of Newham	Support Plan	Mr L admitted he was paranoid schizophrenic and had recently been in hospital due to religious beliefs to do with God and people being able to read his thoughts. Mr L was able to recognised he was better however still had some side affects of his condition. Mr L stated he was not very trusting of people and spent most of his time at home where he felt safe, he also recognised the importance of interacting with other people however he struggled with commitment to activities to help him start his conversation. Mr L would like to lose weight following a two stone gain from his Risperidone depot, he also reported that concentration was an issue because of his medication. His goal was to an ideal weight and be normal when interacting with people without feeling anxious. Mr L reported he was aware of the importance of exercise now and he felt more balanced after undertaking some however he was not consistent with it. He would like someone to help motivate him and follow through with a plan. Mr L stated his intention was there but lacked the will and perseverance. Mr L stated that cookery classes would support him in obtaining a life skill that would help him for many years. Mr L received support from Mr P, Dr S2 and his family. Mr L would like the money to be spent on attending Diesel gym in London where he can complete yoga, Jujitsu, Judo and kickboxing to build up his confidence around people. Mr L would also like his brother to attend to motivate and encourage him because he was unable to do this by himself. Mr L would like to undertake a cookery course part time at Romford. Mr L was provided £1685 to cover his martial arts classes, his brother's martial arts classes and NVQ Level 1 Professional Cookery course. Mr L stated the money was to be paid into his bank account to enable him to pay for a monthly subscription to the gym. Mr L would provide the relevant documentation for the classes. The plan would be reviewed by Mr P. Signed by Mr P and Mr L on 29/01/13, by Mr I 04/02/13 to be reviewed in January 2014
04/02/13	ELFT records	Appointment	Ms L recapped the previous session with Mr L and also previous meetings with Mr P and Ms S. The goals were to increase the activity and structure of Mr L's day. Mr L stated he wanted to continue with the psychology sessions, however Ms L stated he had been symptom - free for some time and Mr L had developed a good understanding of his mental health. The main focus for Mr L was around goal setting, which would cause confusion if both Ms L and Ms S were involved. Mr L was informed he could carry on with the Tree of Life and help facilitate the group - Mr L agreed he would like to do this. Mr L's family had the opportunity to review the plan, however Mr L refused their involvement. PLAN: Ms L to complete the End of Therapy report; next session was in two weeks.
05/02/13	ELFT records	Tree of Life Group	**17:00** Ms L reported Mr L participated in group discussions at the Tree of Life group.
05/02/13	ELFT records	Appointment	**14:36** Ms S met with Mr L and reported he was calm in presentation however was not in the best mood due to sleeping late, although the appointment was the earliest Mr L had attended in some time. Mr L

Date	Source	Event	Information
			reported he had been gambling a lot online and in casinos within his brother but was able to identify the risk, changing environment, working out strategies and the excitement of winning kept him wanting to go back. Despite this, Mr L was able to set himself financial limits which he would try and stick to. Mr L reported the thought of being in debt '*makes me sick'.* Mr L was able to identify previous achievements and skill for a job application although he recognised he still struggled with motivation, self confidence and seeing things through. He had not contacted his friend who suggested employment with a double glazing company and was unable to identify clear goals for the future. Ms S and Mr L would complete a vocational assessment. PLAN: Next appointment the following Thursday.
13/02/13	ELFT records	Appointment	Mr P saw Mr L who reported to be doing well and that his sleep had improved, although he was still not going to sleep until late. He was compliant with is medication and was occasionally helping his family in the restaurant. No concerns raised. PLAN: Next CC appointment 20/3/13
14/02/13	ELFT records	Telephone call	Mr L requested an appointment with Ms S following an appointment with Mr P the previous day. Ms S explained she would be on annual leave however agreed to contact Mr L upon her return. Mr L reported to be well but tried.
18/02/13	ELFT records	Appointment	Ms L met with Mr L to discuss ending the therapy. Mr L reported he found the sessions a useful space for reflection and was sad for them to end. Ms L discussed the importance of meaningful goals set with Ms S. PLAN: Next appointment 11/3.
05/03/13	ELFT records	Tree of Life Group	Mr L attended the final Tree of Life Group with Ms L. He provided positive feedback and expressed an interest in being involved with facilitating future follow up groups.
12/03/13	ELFT records	Tree of Life Group	Ms L reported Mr L had made positive comments about others when he attended the Tree of Life group. PLAN: A two week break, final session 5/3
13/03/13	ELFT records	Appointment	Mr L attended his final psychology session with Ms L. There was a discussion regarding End of Therapy Report and Relapse Prevention Plan. PLAN: 3 month follow up appointment to be arranged
19/03/13	GP Records	Letter	Letter from Mr P inviting Dr P, GP to the MDT meeting on 7th May
20/03/13	ELFT records	DNA	Mr L did not attend an appointment with Mr P. In a telephone conversation Mr L reported to be doing well and had recently received his SDS payment for 6 months. An appointment was rearranged for 25/03/13 at 12:00 EIS office.
25/03/13	ELFT records	Appointment	**16:23** Mr P reported that Mr L had had a bad week because he had lost £3000 on online Roulette and had felt anxious and low, however had recovered from this by the time of the appointment. Mr L reported to feel more in control following a discussion with his father. He stated he '*did not know why this happened, he was bored and had not hobbies.... needed to find some activities'.* Mr L did not want to

Date	Source	Event	Information
			undertake voluntary work and did not need to work because he had some money, therefore would use this to undertake the activities listed on his SDS plan.
25/03/13	ELFT records	Appointment	**15:00** Mr L reported the recent gambling losses and the issue of being without a daily structure. His mother had recently returned from holiday, therefore he was working fewer hours at the restaurant. Ms S reported that Mr L was *'externalising responsibility of himself onto others*'. Activities would often not meet Mr L's expectation therefore he would quickly become bored and involved in a negative cycle. Mr L stated he would like to work, however later stated he was unsure if he could commit therefore would like to volunteer. Mr L had a lack of motivation but also stated he would like something to commit to, he would find it difficult to make a concrete decision with regards to the activities he wanted to engage with. Mr L was resistant when encouraged to register with newhamactive.com despite stating earlier in the appointed that he wished to volunteer. PLAN: Mr L to research cooking courses that interested him; Mr L to find out the cost of martial arts and session times; Ms S to attend the first martial arts session to encourage attendance; Mr L to contact Ms S with regards to the information above
28/03/13	ELFT records	Appointment	Mr L attended a community based appointment with Ms S and another service user to visit INUF. Mr L stated he would consider joining Tai Chi and would like to visit again.
09/04/13	ELFT records	Appointment	Ms S reported that Mr L attend the EIS Tuesday Group- cinema trip GI JOE. Mr L stated he had not had chance to look into his goals therefore requested more time for this and review them in a couple of months. There was a discussion about building towards Mr L's goals slowly and the Tuesday group would work towards that. Mr L stated he would benefit from a text or phone call as a reminder each week, this was agreed. Mr L appeared calm with no concerns raised.
10/04/13	ELFT records	Appointment	Mr L attended an appointment with Mr P and discussed the matter of SDS, Mr P informed Mr L that the money was for a one year support plan and could re-apply for the money in one year's time. Mr L reported to continue to sleep late and found it difficult to get out of bed. Mr L found it difficult to motivate himself and felt he was '*worse than ever'.* Mr L was able to talk to Mr P about the relationships with his family, however could not talk about his brother due to negative comments. He had set goals of to follow spiritually and find peace and a target to be happy. Mr L reported that his mood was fine with no voices or complaints about medication. PLAN: Next meeting 24/04/13
16/04/13	ELFT records	Appointment	Entered retrospectively 17/04/13 Mr L attended the EIS Tuesday group - visit to the Central London Hayworth Gallery light show. Mr L reported '*he went through addictive stages, where he would obsess over one thing, such as art'.* Ms S reported that Mr L appeared to enjoy the show and following this, attended a food market. Mr L disappeared for 15 minutes and returned with a beer in his hand. Ms L was informed that alcohol was not appropriate for the groups and he was compliant. After a further conversation Mr L reported to drink 1-2 times a week and demonstrated some insight into the affects of alcohol and his mental health.

Date	Source	Event	Information
23/04/13	ELFT records	Appointment	Ms S confirmed Mr L attended the EIS Tuesday group - Cable Cars to North Greenwich. There were no concerns reported and Mr L was seen to engage well with other service users. Mr L was reported to enjoy the group and planned to attend the employment support session the following week.
24/04/13	ELFT records	DNA	Mr P made a telephone call after Mr L DNA'd the appointment. Mr L '*forgot about the appointment and that he was sleeping. He reported to be doing well'* an appointment had been rearranged to 29/04/13 at 14:00
26/04/13	London Borough of Newham	Letter	Letter from London Borough of Newham to Mr L confirming Mr L's one off payment of £1,685 and requesting receipts for Mr L's purchases.
29/04/13	ELFT records	DNA	Mr P made a telephone call after Mr L DNA'd the appointment. Mr L '*forgot about his appointment and got carried away watching a movie'* and reported to be well. Another appointment was arranged for the 1/05/13 at 15:00
30/04/13	ELFT records	DNA	Ms S confirmed Mr L did not attend the Tuesday Group employment support session.
01/05/13	ELFT records	Appointment	Mr P met with Mr L. Mr L reported he was doing well and had started to go out more, he was happy doing what he was doing however would look to do more once Mr L's confidence increased. He reported he was able to avoid poker and roulette machines and had no cravings. Mr L denied any strange thoughts or feelings and that his mood was okay. He equally recognised that his patterns of watching TV had to change to create a better routine of watching movies during the day. Mr P reported that Mr L had been compliant with his medication with no side affects and also breifly spoke about spiritual care. Mr L confirmed that the need for spiritual care had been resolved and was no longer an issue. Mr P advised Mr L to contact him if he felt the need to speak with someone again. Mr P confirmed that MDT meeting for the 7/5 at 13:45
08/05/13	ELFT records	CPA Review	
08/05/13	ELFT records	MDT meeting	**17:26** Mr L attended an MDT meeting with his father (See Dr S1 entry)
08/05/13	ELFT records	MDT meeting	**16:09** Dr S1 reported a diagnosis of F20.0 Paranoid Schizophrenia, at the time, negative symptoms. Cluster 12. Medication: Risperidone 2mg Nocte; Procyclidine 5mg twice a day, last dose by 6pm. GP to continue prescribing with routine blood results however Mr L was reluctant to continue with these due to a phobia of needles. Mr L reported that he found psychology work with Ms L very useful and recalled discussions regarding coping strategies with day to day issues. Dr S1 reported little evidence of positive symptoms and Mr L doing relatively well, although he did describe symptoms of of thinking of a voice when he taps his knew however Mr L was able to distract himself. Mr L was helping out in his father's

Date	Source	Event	Information
			restaurant and his father reported Mr L was able to manage tables, help in the kitchen and make conversation with guests. He would only help out on and off when the restaurant was busy. When Mr L started voluntary work or courses, he would lose interest after a few weeks. PLAN: GP to continue prescribing; structure activities for the morning; Ms S to continue OT support; CPA in 6 months time.
08/05/13	GP records	Letter	Letter to Dr P, GP from Dr S1. The GP was asked to continue prescribing the medication as previously agreed, following an MDT meeting. Mr L was not keen to change his medication. Mr L presented relatively well with little evidence of positive psychosis. Mr L stated that when he *'was thinking of a voice, he would tap his knee*', however was able to distract himself. He denied depression however appeared dull and Mr L said he was sleeping late as he was on the internet.
15/05/13	ELFT records	DNA	Mr P was due to see Mr L for an appointment, however Mr L did not attend. Mr P tried to contact Mr L on his mobile but had no response. PLAN: Next appointment 22/05/13 at EIS office.
17/05/13	ELFT records	Letter	Ms R posted a copy of the Trust magazine which included the Tree of Life Group article. A note was also included stating Ms R would like to run the group again and would be in touch to gage Mr L's interest.
21/05/13	ELFT records	Appointment	Ms S reported that despite initial reservations, Mr L attended the Tuesday EIS group - Street art tour. Mr L sent a text to Ms S "*To round off the experience, will I get mugged as well? Yeah ill probably come...".* A further message was received "*Itz 1 of dem tings wher iz got an dental appointment in Der morning so if i dnt txt u to cancel meanz i'm coming."* Despite this, Mr L presented as very engaged, appeared to manage in a large crowd moving around central London and reported graffiti was very interesting. He attended the full duration of the group and stated it was the most interesting group so far.
22/05/13	ELFT records	Appointment	Ms B1 saw Mr L in an appointment and reported that Mr L was in a calm and stable mood and Mr L reported to be okay. He was concordant with his medication with no side affects, although he noted his leg shaking and hand tapping. However he stated he was in control of this. Mr L denied needing further support at home from his family because he saw them enough when he helped them at work. He also expressed an interest in obtaining a job in mentoring and coaching. Ms B1 advised Mr L of local community activities and services and Mr L was encouraged to attend these. Appropriate information was given to Mr L and he had planned to engage with the activities. No concerns were raised.
22/05/13	London Borough of Newham	Care First entry	Concerns were raised that Mr L had not submitted receipts or invoices for his cookery class or martial arts. The service telephoned Mr L who explained that his cookery class did not start until September 2013 and had he had not signed up to the martial arts class due to ongoing health problems. The service would follow up Mr L in September 2013
28/05/13	ELFT records	Appointment	Ms S confirmed Mr L attended the EIS Tuesday group - moving on session. Mr L engaged well with information given about gym memberships and activities available in Newham.

Date	Source	Event	Information
31/05/13	ELFT records	Telephone call	Mr L called Mr P stating he felt his Risperidone needed to be increased because he noticed his leg shaking a lot. Mr L's father felt he may have been relapsing, however Mr L felt the leg shaking was natural. Mr L confirmed he was taking procyclidine every day with no side affects. Mr P explained that Mr L needed to be reviewed by a doctor. Mr L said he would increase his Risperidone from 2mg to 3mg and keep Mr P informed. Mr L planned to contact the doctor if his symptoms stayed the same.
04/06/13	ELFT records	Text message	Ms S had a text from Mr L stating that he was not able to attend the group today. EIS Tuesday Group.
11/06/13	ELFT records	Appointment	Mr L attended an appointment with Ms S, EIS group today and reported he was doing well, said he was fine and had no concerns.
11/06/13	ELFT records	Appointment	Tuesday Group Caribbean meal Stratford. Mr L arrived a little late, he was dress in casual clothes and a recent hair cut. Mr L was engaging with staff and, with encouragement, service users. Mr L had good eye contact and appeared calm - Mr L stayed the duration of the session. Mr L informed Ms S that he had stopped attending the casino and using online gambling in addition to stopping Football Manager - Mr L felt this was a good thing. He requested support for signing up at the gym as he had difficulty a couple of weeks ago. He agreed to attend next week's Tuesday despite working a lot at the restaurant. PLAN: Send a reminder next week re: Tuesday Group. Liaise with Newham Active regarding difficulties registering.
12/06/13	ELFT records	Contact with other professional	**14:30** Ms L reported that she had received a text message from Mr L. Content of the message "Don't ever talk to me again, I don't like my relationship with you and I should have never given you that present, I regret it"
12/06/13	ELFT records	Telephone call	**15:07** Mr P contacted Mr L following a text Mr L had sent Ms L. Mr L stated he had built an addictive relationship with Ms L and recognised he should not have sent the text message. Mr L denied he was relapsing, psychotic symptoms, hearing voices or any tapping messages. Mr L had been taking the same dose of Risperidone and had not increased and confirmed he recognised the symptoms of feeling unwell therefore would contact Mr P. Mr L agreed to see Mr P on 19/06/13 at 1100.
14/06/13	ELFT records	Admitted	Admitted to West Ferry at 17:00 PLAN: Mr L to be nursed in seclusion over the weekend.
01/10/13	London Borough of Newham	Care First entry	The service sent Mr L a follow up letter requesting receipts for the cookery class that was due to have started in September 2013. Mr L had not submitted any invoiced or receipts for the martial arts class.
10/10/13	London Borough of Newham	Care First entry	The monitoring officer ceased their involvement due to the homicide incident.