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

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

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Contents

1 Executive summary

1.1 NHS England, London commissioned Niche Health & Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of a mental health service user (Mr E). 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 the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights,[2] 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 occurring.

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

1.5 Mr E killed Miss A during a violent attack at his flat in London in December 2012. We would like to express our sincere condolences to Miss A'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 E.

Mental health history

1.6 Mr E's first contact with mental health services was in 1998 when at the age of 13 he presented with depression following his parents' divorce. Mr E took antidepressants for one month and recovered very quickly.

1.7 Mr E subsequently presented to mental health services in 2005 aged 20 with an "*acute and transient psychotic disorder*".[3] He was admitted to hospital at that point. He had subsequent hospital admissions in 2007, 2009 and 2011. Some of these admissions were as a consequence of Mr E being detained under the Mental Health Act.

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

[3] *Letter dated 28 November 2011*

1.8 Mr E has a history of poor engagement with services in the community. He has previously refused depot medication and declined a referral to supported housing.

1.9 Mr E was under the care of the Lambeth Early Onset Team provided by South London and Maudsley NHS Foundation Trust (the Trust hereafter) from between 2006 and March 2010 at which point responsibility for his care and treatment was transferred to the Lambeth South West Support and Recovery Team, a community mental health team. Mr E was allocated to a care co-ordinator, Ms L. His diagnosis in late 2010 remained "*acute and transient psychotic disorder*".

1.10 During 2011 and 2012 Mr E frequently did not attend planned appointments but would arrive at the community mental health team base asking for his medication, help with his accommodation, help sorting his benefits or to use the telephone. When Mr E presented in this way, staff did not conduct a thorough mental state examination and would sometimes provide Mr E with his medication with no assessment of his mental state at all.

1.11 In May 2012 Mr E was assessed by the criminal justice liaison service after he was arrested for assaulting his girlfriend/ex-girlfriend. Mr E was released on police bail and the community mental health team agreed that they should see him as soon as possible. Attempts to contact Mr E were unsuccessful and more than two weeks later the police were contacted at which point the community mental health team were informed that Mr E had been detained in prison.

1.12 From July 2012 Mr E did not receive any benefits and frequently sought help from the community mental health team to resolve his financial problems. The psychiatrist wrote to the benefits agency in support of Mr E's claim but this did not change the decision.

1.13 In late October 2012 community mental health team staff were concerned about Mr E's presentation as he had reported to his probation officer that he had not been taking his medication. The probation officer had reported this information to the community mental health team. Staff met with Mr E and discussed alternative medication options and offered medication via injection. Mr E did not want to do this as he had a fear of needles. Mr E agreed only to continue with olanzapine on a lower dose. Staff discussed the possibility of a referral to the home treatment team, however Mr E was reluctant to take this approach and agreed to attend the community mental health team base twice a week.

1.14 In mid-November Mr E was assessed by the criminal justice liaison team in police cells after he was arrested for breaching a court order by harassing his ex-girlfriend. Mr E was subsequently detained in prison after his suspended sentence order was revoked. Mr E informed prison health staff on 19 November that he was known to the community mental health team. No contact was made by the prison health service with the community mental health team until 7 December. The community mental health team consultant provided information about Mr E on 11 December and Mr E was seen by

prison health staff just prior to being released from prison the following day. Notification of Mr E's release was given to the community health team via email, the day prior to Mr E's release.

1.15 The community mental health team attempted to contact Mr E on the day he was released from prison but was seen only briefly when he attended the community mental health team base for the Christmas party on 13 December. Staff were unsuccessful in meeting with Mr E despite attempts to contact him on his mobile and by joint visits to his home. The community mental health team attempted to refer Mr E to the home treatment team but the referral was not accepted on the basis that community mental health team had not reviewed Mr E since he had been released from prison and he had therefore not agreed to the referral.

1.16 Mr E was not seen again for review of his mental state until after he was arrested for the death of Miss A.

Accommodation

1.17 Until April 2006 Mr E had lived mostly with his mother since arriving in the UK in 1999, originally living in London, and then moving to Romsey in October 2005.

1.18 In April 2006 Mr E was homeless after he moved back to London. He was in temporary accommodation in Southwark before returning to Lambeth.

1.19 At the time of the offence Mr E had recently been released from HMP Belmarsh where he had served four weeks of a 12-week sentence. Mr E returned to his flat on 12 December. Support workers from the Single Homelessness Project saw him on 17 December. A woman was present during this visit, whom the support workers assumed was his girlfriend.

Relationship with the victim

1.20 Mr E and Miss A first met in summer 2012 when Miss A was on holiday from her home country of Russia. Miss A returned to London on 10 December 2012 and attempted to see Mr E at his home address. Mr E was not at home so Miss A called other friends in London to find somewhere to stay.

1.21 On 16 December a mutual friend of Miss A and Mr E saw Miss A, who was still alone. It was reported that she was unhappy, as she was still unable to locate Mr E. Between this sighting and 18 December Miss A found Mr E.

1.22 On 18 December the police were called to Mr E's address following complaints of a disturbance. Mr E and Miss A were both spoken to by police, but neither of them made an allegation against the other and no injuries were noted by police. Miss A indicated to police that she was Mr E's wife.

1.23 On 28 December the police were again called to Mr E's address, this time following a call made by Mr E who claimed that Miss A was attacking him. Miss A gave false details to the police and Mr E left the address with the police.

1.24 On 29 December Miss A sent a text to Mr E asking him to return home. Between this date and 7 January 2013 Mr E killed Miss A during a violent attack on her at his home.

Offence

1.25 On 6 January 2013 a mutual friend saw Mr E in central London. The mutual friend asked where Miss A was. The mutual friend reported that Mr E was very dismissive, said that Miss A had left and that he hadn't seen her for a month. The mutual friend was concerned at Mr E's response; it is believed that he had tried to contact Miss A as well as her brother in Russia to find out whether he had heard from Miss A. The mutual friend reported Miss A as a missing person. Police officers went to Mr E's home address to look for her but there was no reply and the police officers did not force entry to the property.

1.26 In the early hours of 7 January police returned to Mr E's address and forced entry where they found Miss A's body.

1.27 Intelligence gathered by the police during the investigation that followed led police to believe that Mr E killed Miss A between 4:00pm on 30 December and 7:00am on 31 December. Miss A had been beaten and sexually assaulted.

Sentence

1.28 In November 2013 Mr E admitted manslaughter on grounds of diminished responsibility. The judge ordered that Mr E serve a minimum of seven years and three months. The judge also made a hospital order under Section 45a of the Mental Health Act[4]. In sentencing Judge Richard Marks said:

"The ferocity of your sustained attack on your defenceless and naked victim, who was in bed at the time the attack started, is as shocking as it is abhorrent…You are a large man and she was 5ft 2in and seven stone in weight…You bear a significant responsibility for what you did in particular having regard to the fact you ceased taking your medication, knowing what effect that would have on you."

Internal investigation

1.29 South London and Maudsley 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:

- Consultant Psychiatrist;
- Consultant Nurse;

[4] *Section 45A of the Mental Health Act is an order which the Crown Court can make at the same time as imposing a prison sentence upon an offender who suffers from mental disorder.*

- Trust Investigation Facilitator.

1.30 The key concerns were:

- *"There was a lack of an appropriate risk assessment and regular updates of this. There was also a lack of sharing of risk information with relevant staff in the CMHT and in other supporting services.*

- *Regular mental state examinations were not carried out.*

- *Mr E's alcohol and drug use were not assessed (which may have had a bearing on his mental state and the risks he posed) and therefore the risk assessment was not adjusted accordingly.*

- *Important information from daily MDT planning meetings were not recorded in the ePJS record.*

- *There did not appear to be a gauge of Mr E's level of risk to women and information about his social networks were not explored.*

- *There was a lack of communication between in-reach prison staff and CMHT staff.*

- *There was a lack of communication between the CMHT and the probation service (for example, CMHT staff were unaware that they may have been able to obtain support from the probation service).*

- *There was a lack of communication of accurate risk to the Home Treatment Team.*

- *Options to invoke MAPPA or consider an assessment from forensic mental health services did not appear to have been explored by the CMHT.*

- *Potential child safeguarding risks were not identified, assessed and referred appropriately."*

1.31 Five recommendations were made by the internal investigation team:

- *"The Trust to commission a piece of work to address interfaces between services within AMH and non-AMH CAG services.*

- *All Trust community teams to meet with the SLAM forensic services to learn and develop and protocol for management when patients are discharged from prison.*

- *The psychosis community service (Lambeth South) team manager and team consultants to work together to ensure mandatory training in the team is completed and up to date. This will include the following and should be audited to ensure learning is embedded:*

    - *their responsibilities in relation to safeguarding children and adults;*

- *risk assessment and escalation of concerns for complex patients with a history of violence, in particular domestic violence, drug and alcohol use and psychosis.*

- *The psychosis CAG senior manager team to take up the following areas across the CAG in relation to AMH model work. This will include:*

  - *mental health assessments including history, mental state examinations, formulation and resulting care plans;*

  - *drug and alcohol and the use of questionnaires available on ePJS, urinary drug screens, hepatitis B and C and HIV status;*

  - *commissioning SLAM partners to work with the psychosis community services (Lambeth South) team to facilitate team members to work together and develop a vision for the service.*

  - *adherence to NICE Guideline 120: psychosis with co-existing substance misuse, March 2011. This includes the provision of the Care Programme Approach to deliver care."*

1.32 We agree with the findings of the internal investigation.

Domestic Homicide Review

1.33 We have also reviewed those recommendations made by the Domestic Homicide Review that are applicable to the Trust. All the recommendations made by the Trust internal investigation team were included, however there were an additional three recommendations made by the Domestic Homicide Review. These were:

- "*The Trust audits its clinical staff to establish the understanding of the extent, impact and risk of Domestic Violence and addresses the findings accordingly.*

- *The Trust reviews its physical communication systems at community team bases and puts in place contingency arrangements in case of failure.*

- *The Trust works with the London Probation Trust to develop a working protocol for putting in place and managing Community Order "Mental Health Requirements.*"

1.34 There was also a recommendation for the Chair of Safer Lambeth Partnership to "*forward a copy of the Domestic Homicide Review to the Chair and Chief Executive of the Trust for the information of the Board. For the Board to consider any further actions required to augment the internal review already presented to them and any necessary additions to their current plan."*

1.35 The implementation of these recommendations was reviewed as part of the review of the internal investigation action plan.

Independent investigation

1.36 This independent investigation has drawn upon the internal process and has studied clinical information, witness statements, interview transcripts and policies. The team has also interviewed Trust staff who had been in contact with Mr E or who had attempted to meet with him. We have also interviewed staff who are now managing teams that provided services to Mr E, to understand how the recommendations have been embedded and what change there has been to service delivery.

Conclusions

1.37 It is our view that a further violent assault by Mr E was entirely predictable by mental health services. In addition we consider that if the mental health care and treatment had been provided in an appropriate and timely fashion it is possible that Mr E's mental health would have been sufficiently stable that the violent attack on Miss A might have been avoided.

Recommendations

1.38 The independent investigation supports the recommendations made by the Trust internal investigation team, and has not repeated them here. However where we feel that further work is required in providing assurance of the completion and effectiveness of recommendations from the internal investigation we have included our own recommendation. This is in addition to a focus on improvements that we consider should be made to service delivery now.

1.39 We have made a number of recommendations to improve practice. These have been given one of two 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.

1.40 The following list shows the recommendations in priority order.

Priority One Recommendations

Recommendation 1

The Trust must undertake an audit of the effectiveness of the final protocols that have been developed:

- management of patient care when patients are discharged from prison.
- working protocol for putting in place and managing Community Order "Mental Health Requirements".

Recommendation 2

The Trust must implement a process of monitoring the effectiveness of case note audits and individual supervision, implemented following the internal investigation, with regard to care plans and risk assessments.

Recommendation 3

The Trust must undertake an audit against the standards in the relevant policy/ies to identify how effective the new systems are in providing assurances about the completion of documentation by team members.

Recommendation 4

The Trust must ensure that all staff are clear about the process and timeframe to follow when there are concerns about the welfare of a service user who is not engaging with services. The Trust must also implement a system to monitor this and address any issues of non-compliance.

Recommendation 5

The Trust must ensure that services are configured to allow for best practice in risk assessment to be implemented in all services.

Recommendation 6

The Trust must ensure that care co-ordinators have the opportunity to review a service user's history and risk factors when a service user is first allocated to them. The Trust must also implement a system to monitor this and address any issues of service non-compliance through appropriate routes.

Recommendation 7

The Trust must ensure that clinical staff are clear about the escalation processes when they are unable to secure a mental health act assessment in a timely fashion. The Trust must also monitor the use of those escalation processes in order to be assured of their effectiveness.

Recommendation 8

The Trust must ensure that section 117 aftercare needs are formally considered and liaise with the relevant organisations in order to ensure that identified needs are met.

Recommendation 9

The Trust must ensure that staff are clear about when information should be shared with other agencies (usually probation or the police) about a service user breaching bail conditions. The Trust must also ensure that staff comply with the guidance on when to share information.

Recommendation 10

Commissioners of prison health services must ensure that providers take appropriate and timely action to obtain relevant details about detained prisoners' care plans and risk assessments when they are made aware that the prisoner is known to a community mental health team.

Priority Two Recommendations

Recommendation 11

The Trust must ensure that when teams are disbanded and the functions absorbed into other teams (eg the assertive outreach function being absorbed into the community mental health team) the operating requirements of the new team function is clear to everyone.

Recommendation 12

The Trust must provide clearer guidance to staff on obtaining information from family members when there is no consent from the service user, but the service user is presenting with behaviour that is a risk to themselves or others. The Trust must also provide guidance to staff on obtaining collateral information from other individuals known to service users when the service user is presenting with behaviour that poses a risk to the other individual.

Recommendation 13

The Trust must undertake an audit of the timeliness of entries into clinical records following clinical team or zoning meetings. When the scale of the problem is understood, the Trust must put into place measures to rectify any problems identified and implement a system to monitor compliance on a longer term basis.

Recommendation 14

The Trust must ensure communications with GPs are sent in a timely fashion and that when an action is requested of the GP, this is followed up by the relevant psychiatry medical team.

Recommendation 15

The Trust must ensure that when a carer's assessment is recommended, appropriate actions are taken to ensure that this is offered to the carer in a timely fashion.

Good practice

1.41 In 2005 after Mr E had been detained for treatment his mother moved to Romsey. Trust staff ensured not only that onward referral to the relevant clinical team was done, but also wrote to the local GP practice requesting that they register Mr E in order that he could access appropriate community services.

2 Independent investigation

Approach to the investigation

2.1 The independent investigation follows the NHS England Serious Incident Framework (March 2015) and Department of Health guidance[5] guidance on Article 2 of the European Convention on Human Rights, the investigation of serious incidents in mental health services.

2.2 . The terms of reference for this investigation are given in full in Appendix A.

2.3 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 occurring.

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

2.5 The investigation was carried out by Naomi Ibbs, Senior Independent Investigator for Niche, with expert advice provided by:

- Dr Afzal Javed, Consultant Psychiatrist;
- Sue Salas, advisor on culture and mental health;
- Carol Dudley, advisor on safeguarding;
- Christopher Gill, lay person and critical friend;
- John Kelly, retired Detective Chief Superintendent and advisor on interagency communications;
- Liz Ostrowski, Domestic Violence Intervention Project.

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

2.7 The report was peer reviewed by Carol Rooney, Deputy Director, Niche.

2.8 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[6]

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

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

2.9 Mr E did not respond to the request from NHS England for Mr E to consent for access to relevant records in order to conduct this investigation. Therefore access to all records was obtained through seeking consent from the relevant Caldicott Guardian[7].

2.10 We used information from Mr E's clinical records provided by the Trust and Mr E's GP records. We also reviewed the Domestic Homicide Review report and spoke to the Family Liaison Officer from the Metropolitan Police.

2.11 We also reviewed the medical records from HMP Belmarsh where mental healthcare was provided by Oxleas NHS Foundation Trust. These were requested on a number of occasions and it took many months for these to arrive from Oxleas NHS Foundation Trust.

2.12 As part of our investigation we interviewed the following staff from the Trust (South London and Maudsley NHS Foundation Trust):

- Care co-ordinator, Recovery Team;
- Consultant psychiatrist, Recovery Team;
- Care co-ordinator, Lambeth Early Onset Team;
- Manager, Lambeth Home Treatment Team;
- Dual Diagnosis Lead, Lambeth;
- Team leader who had recently received RCA[8] training;
- Head of Patient Safety;
- Director of Nursing.

2.13 Contact for the victim's family was with Miss A's brother. NHS England, wrote to him using an email address provided to us by the police. The letters were translated into Russian and invited Miss A's brother to contribute to the investigation, however we did not receive a response.

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

2.15 Appendix C details information provided by the Trust about the demographic profile in Lambeth; the function and composition of the Lambeth South Promoting Recovery Team (referred to as the community mental health team in this report); and the process for staff redeployment.

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[7] Caldicott Guardian – a senior person responsible for protecting the confidentiality of patient and service user information and enabling appropriate information sharing. Each NHS organisation is required to have a Caldicott Guiadian; this was mandated in 1999 by Health Service Circular HSC 1999/012. Caldicott Guardians were subsequently introduced into social care in 2002, mandated by Local Authority Circular LAC 2002/2.

[8] Root Cause Analysis (RCA) – is a method of problem solving used for identifying the root causes of faults or problems.

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

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

2.17 We received no further comments from staff as part of this process.

2.18 The draft report was shared with the following organisations prior to publication:

- NHS England;
- the Trust;
- Oxleas NHS Foundation Trust;
- Palace Road GP Surgery.

2.19 This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Interview with Mr E

2.20 We wrote to Mr E at the start of the investigation, explained the purpose of the investigation and asked to meet him. Mr E did not respond to our letter so we also wrote to the prison governor and to the manager of the prison healthcare service to ask for their assistance in ensuring that Mr E understood the purpose of the investigation.

2.21 Mr E did eventually agree to meet with us and we visited him in prison to discuss the investigation process and give him an opportunity to provide information to our investigation.

2.22 We met with Mr E again prior to the publication of the report.

2.23 Mr E did not agree to us reporting our discussion with him and therefore we have not provided any commentary in this report.

Structure of the report

2.24 Section 3 sets out Mr E's personal history and the details of the care and treatment provided to Mr E. We have included a full chronology of his care at Appendix D in order to provide the context in which he was known to services in London.

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

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

2.27 Section 6 sets out our overall analysis and recommendations.

2.28 Appendix C has been included at the request of the Trust, to enable the reader to understand the demographics of the population being served by the team and the policy for redeployment of staff.

3 The care and treatment of Mr E

Personal history

3.1 Mr E was born in Portugal in 1985 and came to the UK in November 1998 at the age of 13. We understand that Mr E's English was poor at that time and that he was educated at home initially. However he studied hard as he was keen for his English to be good and he entered mainstream school a year after arriving in the UK.

3.2 It is reported that Mr E's mother had a difficult pregnancy and that Mr E "*cried all the time in his first year*" but after that he was "*fine*". Mr E developed normal milestones and had a '*normal primary school*' experience in Portugal, but Mr E suffered racial bullying at secondary school (we believe this to have been in the UK) and at times would retaliate. Mr E had problems with teachers and left school at the age of 15 with no qualifications.

3.3 Mr E is the eldest of two sons, his brother being five years younger than Mr E. His parents separated when he was nine years old. Mr E had a difficult relationship with his father and paternal grandmother due to the belief that she had put a spell on Mr E and his father when Mr E was young. It was reported that Mr E's family believed this to be true as both Mr E and his father became unwell at the same time.

3.4 In 2005 Mr E's parents were involved in a fight during which his mother threatened his father with a knife. Mr E's mother was subsequently arrested and spent time in a police cell. It is reported that this affected Mr E badly.

3.5 Mr E had a difficult relationship with his father with whom he would often argue and fight. Mr E's father called Mr E names and "*never showed affection unlike the treatment shown to Mr E's younger brother*".

3.6 Prior to the index offence, Mr E had worked in various jobs for short periods. Mr E had also experienced periods of unemployment, during which time he claimed benefits and also lived in a council property.

3.7 It was reported in 2011 that Mr E had a dog for company; something that the care co-ordinator considered was a protective factor.

Forensic history

3.8 Mr E has a notable forensic history only some of which we believe was known to the Trust during the time that they were responsible for his care and treatment.

3.9 The forensic history noted below is taken from information provided in the Domestic Homicide Review report published by Safer Lambeth Partnership.

3.10 In 2007 Mr E was arrested for causing actual bodily harm to a man in a café. He was subsequently detained under the Mental Health Act.

3.11 On 6 September 2008 Mr E was given a caution for criminal damage. This followed an incident where he had attended Miss M's address and forced his way in through the back door. He argued with Miss M about the breakdown of their relationship, smashed her phone and held a knife against her throat.

3.12 On 11 September 2008 Mr E was arrested for assault and criminal damage for head-butting Miss M and breaking her car windscreen. On 21 September Mr E was charged with common assault after he had head-butted Miss M again and refused to allow her to leave his property. Mr E was prosecuted only for the offence on 21 September because the Crown Prosecution Service did not consider it was in the public interest to proceed with charging Mr E for offence on 11 September.

3.13 On 14 October 2008 Mr E appeared at Camberwell Green Magistrate's Court and was sentenced to:

- a two year community order subject to probation supervision;
- 120 hours of unpaid work;
- participation in an Integrated Domestic Violence Programme (IDVP).

3.14 On 21 October 2008 Mr E was arrested at Miss M's university campus where he had assaulted her and smashed the window of her car. Mr E was cautioned for assault and criminal damage.

3.15 On 25 December 2008 Mr E again assaulted Miss M whilst she was asleep by slapping and punching her face, biting her chest, punching and kicking her, pulling her by the hair and hitting her with a belt. Miss M also reported that Mr E had been holding a knife. Mr E was charged with assault and criminal damage and appeared in court on 29 December. Mr E was bailed until February with conditions that required him to have no contact (direct or indirect) with Miss M.

3.16 In January 2009 Mr E appeared in court for breaching the community order conditions. Mr E was given a Mental Health Treatment Requirement[9] to run alongside his community order.

3.17 In November 2009 Mr E attended crown court for breaching his bail conditions by having contact with Miss M. Mr E was given a suspended sentence order of 18 months, custody was suspended for 24 weeks and an 18 month Mental Health Treatment Requirement was made.

3.18 On 25 April 2012 Mr E was arrested for assault and threats to kill on different girlfriend (referred to in the Domestic Homicide Review report as Ms Y). Ms Y had been asleep and was woken by Mr E shouting that he was going to kill her. Mr E punched her in the face and kicked her, Ms Y also reported that Mr E had cut her finger with a knife. Mr E was released on police bail.

3.19 On 1 May 2012 Mr E was again arrested, this time for breaching his bail conditions by contacting Ms Y. Mr E was charged with harassment and remanded in custody.

3.20 On 4 July 2012 Mr E appeared in court and was given a six month prison sentence, suspended for 12 months, with a restraining order and a requirement to undertake 25 days of one-to-one support with probation.

3.21 In October 2012 Mr E was arrested for breaching the court order preventing him from having contact with Ms Y. Mr E appeared in court in relation to this matter on 19 November 2012 when his suspended sentence was activated and he was detained. When Mr E was released from prison the requirement for him to undertake one-to-one support with probation lapsed .

3.22 On 20 December 2012 Mr E was arrested for shoplifting. He appeared at court on 21 December and was fined £100.

4 Psychiatric history

4.1 Records indicate that Mr E was first seen by mental health services in 1998 for depression following his parents' divorce. It is reported that he was treated with anti-depressants for one month and that he recovered quickly. We have not seen any evidence of this treatment. We have sought to clarify whether this treatment was provided in Portugal or the UK, however, we have been unable to do so.

[9] *The Mental Health Treatment Requirement (MHTR) is one of three possible treatment requirements which may be made part of a Community Order. The MHTR is intended for the sentencing of offenders convicted of an offence(s) which is below the threshold for a custodial sentence and who have a mental health problem which does not require secure inpatient treatment. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/391162/Mental_Health_Treatment_Requirement_-_A_Guide_to_Integrated_Delivery.pdf*

2005

4.2 In early to mid-2005 Mr E was involved in a mugging incident when he was hit on the head. Examination at hospital included a CT scan,[10] this ruled out any serious injury and Mr E was discharged from hospital.

4.3 In August 2005 Mr E was admitted to Lambeth Hospital under Section 2 of the Mental Health Act[11] after he was found wandering in Gatwick airport having gone through the departure lounge. Assessors found that he was disorientated, confused and seeing images and it was determined that Mr E was too unwell to consent to treatment, therefore he was detained.

4.4 At that time it was reported that Mr E was born in the UK to Portuguese parents and that his parents spoke very little English. A telephone conversation between his mother and clinical staff was interpreted by Mr E's brother, who was on holiday in Portugal with their mother.

4.5 Mr E's mother had travelled to Portugal a week prior to Mr E's detention and since that time Mr E had been acting bizarrely, was confused and was responding to voices in his head. Mr E's father reported that Mr E had left his father's home (where he had been staying since his mother and brother had gone to Portugal) and had been wandering around and sleeping rough.

4.6 Mr E reported that he had a girlfriend who had left him for another man and that he had four girlfriends and that he was cheating on all of them. He also said that one of them had had a miscarriage and was repeating: "*she lost my baby and left me*". He expressed anger against his father saying that he did "*not give me love because of my mother*". Mr E stated that he believed his father couldn't love him as he (Mr E) had "*committed sins in the past four years*" referring to smoking cannabis which had "*destroyed my brain cells*". Mr E reported that he had seen the devil as he was in his left side and that he had the good in his right side. He also stated that his paternal grandmother put a spell on him when he was young, and that he was waiting for his grandmother to die so that his father could love him.

4.7 Mr E remained an inpatient at Lambeth Hospital until October 2005. At a Care Programme Approach meeting on 15 September 2005 it was decided to refer Mr E to services in Romsey, where his mother was planning to live with his younger brother. This was done on 26 September but there is no evidence of any written response from the Romsey team, however an entry on 30 September indicated that a clinician from Southampton would be able to see Mr E at his mother's home the following Wednesday, 5 October.

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[10] A computerised tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body. CT scans are sometimes referred to as CAT scans or computed tomography scans.

[11] Section 2 of the Mental Health Act is used to detain a person in hospital for assessment of their mental health and to provide any treatment that they might need. Section 2 is used if a person has not been assessed in hospital before or if they have not been assessed in hospital for a long time.

4.8 On 18 September Trust staff also wrote to the local GP practice in Romsey to ask that they register Mr E "*in order for him to receive community mental health services follow up*".

4.9 Mr E was discharged on 12 October 2005 into his mother's care in Romsey.

2006

4.10 In April 2006 Mr E returned to London, as he was unable to continue living with his mother who was living in a property provided by her employer. Mr E initially lived in Southwark and then moved to Lambeth. He had not been taking his medication and presented to the Lambeth Early Onset CMHT on 21 April where it was noted that he "*had not been taking medications and appeared to be relapsing*".

4.11 In June Mr E was reviewed and he reported that he had been taking olanzapine[12] and lithium[13] for the previous few days and that he had felt much better as a result. Mr E's concern at that time was sorting out his benefits: he had been unable to make a claim during the previous month, as paperwork had been lost. Mr E also said that he had been busy studying Islam and attending the mosque every day and that as a consequence of converting to Islam he had split up with his girlfriend and had stopped drinking and smoking.

4.12 On 3 July Mr E was admitted to the Lambeth Early Onset inpatient unit due to a relapse of his mental illness. It was reported that Mr E had become progressively more chaotic, psychotic, disorganised and paranoid with increased auditory hallucinations. Mr E had not been taking his medication, had been using cannabis and had experienced stressful social circumstances. It was Mr E's opinion at that time that he had been admitted to the inpatient unit because he was homeless and that he needed help to sort out his accommodation and benefits.

4.13 Mr E made a relatively quick but partial recovery whilst on the ward, he continued to be paranoid despite the lessening of auditory hallucinations. He had little insight and considered that his only problem was being homeless. This problem was addressed following a visit to the Homeless Persons Unit on 7 July when he was given six months' temporary accommodation in a bed and breakfast. Mr E was very happy about this and requested overnight leave. As Mr E was an informal patient and had been taking his mediation staff agreed to his request. A plan was made for extended leave to continue with daily, supervised medication administration until Mr E had found accommodation in the Lambeth area.

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[12] *Olanzapine is an antipsychotic medication that affects chemicals in the brain. It is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic depression).*

[13] *Lithium is use to treat the manic episodes of manic depression. Lithium affects the flow of sodium through nerve and muscle cells in the body. Sodium affects excitation or mania. Manic symptoms include hyperactivity, rushed speech, poor judgement, reduced need for sleep, aggression and anger.*

4.14 At a ward round meeting on 18 July it was agreed that as it would take some time for Mr E to secure permanent accommodation Mr E would be discharged from the ward. Mr E's care co-ordinator agreed to provide follow up work with him, despite Mr E being temporarily outside of the care co-ordinator's catchment area.

4.15 On 20 July Mr E, accompanied by a girlfriend, attended a Care Programme Approach meeting with his care co-ordinator. Mr E reported things were going well and he had not heard any voices since re-starting his medication. Despite this statement he said that still felt that people were talking about him everywhere he went but that he could cope with this. Mr E said that he recognised that he suffered from a mental illness and that his symptoms were the TV talking to him. Mr E reported that was willing to take his medication as he recognised the benefits of doing so. Mr E said that he had no side effects, although admitted he did feel tired and drowsy occasionally but was able to cope with this. Mr E denied any regular cannabis use, and said that he was trying to give it up and believed he could achieve this without the help of any support groups.

4.16 Mr E was offered follow up appointments on 18 and 25 September and 6 December but there is no evidence that he attended these. He did attend an appointment on 13 December when Dr C reviewed Mr E at the Lambeth Early Onset team base. Mr E did not describe any symptoms of concern, however Dr C noted that Mr E was "*low in mood with flat effect and psychomotor retardation"*[14]. Mr E reported that he had not taken any medication for a number of weeks and had not relapsed. He denied taking cannabis or other illicit drugs but reported that he had continuing problems with accommodation, which was not helping his mental state. Mr E felt that he had too much medication and considered that he only needed an anti-psychotic medication given his paranoia. A compromise was reached and Mr E was prescribed 10mg of olanzapine to be taken every evening.

2007

4.17 On 23 January 2007 Dr P reviewed Mr E at the Lambeth Early Onset team base. Mr E reported that he had been compliant with his prescription of 10mg olanzapine every evening and Dr P noted that Mr E was at a significant risk of relapse if he were to stop his medication during the following two years. Dr P felt that Mr E did not require intensive input at this time and could therefore be managed by his GP, with a contingency plan for rapid referral back to mental health services if he were to relapse. Dr P recorded that in preparation for this, "*Mr E's care coordinator would complete a relapse prevention plan and organise a handover CPA to the new GP in Lewisham*". Dr P provided Mr E a list of GPs near to his address in Lewisham and asked Mr E to register with one of them in the following week so that the process of transferring his care to a GP could be started. Dr P also recorded that he would contact the

[14] *Psychomotor skills are the skills in which the brain and body must work together. A common example is hand-eye co-ordination tasks such as making a drink, folding laundry, or catching a ball. Psychomotor retardation is a slowing down of psychomotor movements…including slowed speech, slowed movement and impaired thinking.*

Lewisham Early Intervention Team so that they were aware of Mr E's case, should there be any problems or a relapse.

4.18 On 11 April Mr E was assessed under the Mental Health Act and detained under Section 2. He was psychotic, having disturbed thoughts, experiencing auditory hallucinations and his speech was very difficult to follow. Mr E had assaulted a stranger in a café after what appeared to have been a homophobic attack. Mr E reported a long term relationship with a woman which had started since his first contact with the Lambeth Early Onset service. However staff noted that the status of that relationship was unclear after admission as Mr E referred to his "*evil*" girlfriend and "*wifey*" stating that they had not broken up but were having a break "*because of the wedding*". Staff had difficulty identifying the Nearest Relative[15] as there were no details on the records held by the Trust and Mr E declined to give any contact details. At this time Mr E had no convictions, although he had been arrested three times in the week prior to his previous admission in 2005.

4.19 Two of Mr E's friends visited him in hospital and were present for an interview with Mr E. On the matter of the assault in the café, Mr E reported that he had attacked a Portuguese man whom at the time he thought to be gay. Mr E reported that the man "*wanted to eat Halal food, he may not, he thinks bad about Muslims*". Mr E's two friends stated that this was incorrect and that Mr E had attacked the man because Mr E suspected he was to blame for the breakdown in the relationship with Mr E's girlfriend four weeks prior to his admission to hospital. Mr E then agreed with this statement and elaborated on what the man had said prior to Mr E assaulting him.

4.20 On 17 April Mr E was transferred to a Psychiatric Intensive Care Unit (PICU) after he had been aggressive and abusive, and "*presented a significant risk to others*" by concealing knives and forks in his room. Mr E's father visited him in the PICU, but despite this staff were still unable to obtain any information in order to identify a Nearest Relative. Mr E remained in the PICU until 4 May when he was transferred back to the ward.

4.21 On 30 April, whilst Mr E was being treated in the PICU, a Mental Health Review Tribunal was held. The recommendation put forward by Mr E's medical team from the ward was that a Section 3[16] Mental Health Act assessment should be started and that Mr E should remain in hospital. Specific concerns were the implementation of relapse prevention strategies, relapse prevention counselling and supervision of medication compliance. It was also felt that Mr E needed counselling on the dangers of drug use and a

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[15] The Nearest Relative is a legal term used in the Mental Health Act. It is not the same as the next of kin – the next of kin has no rights under the Mental Health Act. The general rule is that the Nearest Relative will be the person that comes highest on the list defined in Section 26 of the Act. That list is: husband, wife or civil partner; son or daughter; father or mother; brother or sister; grandparent; grandchild; uncle or aunt; niece or nephew. If there are two or more people in the same category the eldest person will be the Nearest Relative. The Approved Mental Health Professional should try to identify who the Nearest Relative is during a mental health assessment.

[16] Section 3 of the Mental Health Act allows for a person to be detained for treatment for up to six months. A person can be detained under Section 3 if they are well known to mental health services and there is no need for them to be assessed under Section 2. A person can also be detained under Section 3 following an admission for assessment under Section 2.

reassessment of the risks. The Tribunal Panel considered that Mr E was sufficiently unwell to require hospital treatment, and that if Mr E were not required to remain in hospital he would wish to leave. Therefore the Panel found that Mr E should remain detained under the Mental Health Act. Mr E's diagnosis at this time was acute and transient psychotic disorder; the report to the tribunal noted that Mr E's diagnosis in July 2006 had been schizoaffective disorder.

4.22 On 8 May doctors reviewed Mr E and decided that Mr E no longer needed to be detained and rescinded the Section 2 detention. Mr E remained in hospital as an informal patient for a further five weeks until 12 June when he was discharged from the ward. The plan on discharge was for a seven-day follow up appointment on 18 June, regular lithium level monitoring, a medical appointment to be arranged by Mr E's care co-ordinator and long term follow up to be provided by the Lambeth Early Onset community mental health team.

4.23 In mid July Mr E was reviewed by Dr C, a specialist registrar and his care co-ordinator Mr B. Mr E reported that he was living in his own one-bedroom flat in Streatham and that he was living with his girlfriend. It was noted that Mr E "*looked very well, in fact the best I have seen him*". Mr E did not report any hallucinations or delusions and it was noted that his insight was good, that he had not been taking any illicit drugs and had been fully compliant with his medication. Mr E reported that two weeks prior to the appointment somebody had shot a number of bullets through his front door at 2:30 in the morning. Staff who had visited Mr E at home on 4 July had noted bullet holes in his front door and had asked Mr E about it. Mr E had given them the same information as he provided to Dr C. Mr E said that he had not been harmed and had managed to deal with the stress. Mr E also said that did not know who had done it and that he was continuing to live in his flat. Dr C provided Mr E with two weeks' supply of olanzapine 20mg once daily, and lithium 1500mg once daily. A plan was made for Mr E to see his care co-ordinator two weeks later, prior to going on holiday to Portugal for a fortnight. We have found no evidence that staff offered any support beyond asking him about the bullet holes. Neither have we found evidence that they took any other action to ensure his safety.

4.24 On 3 August Mr E's Mr K, Mr E's new care co-ordinator attempted to contact him "to see if he has returned from Portugal". The call went straight to voicemail and Mr K noted that he would try calling again the following week.

4.25 On 10 August Mr K met with Mr E and Dr C. Mr E reported that he had returned from Portugal the previous Wednesday and that he was very bored. He was unable to identify anything that excited him apart from driving and that although he had been playing computer games he also found these boring. It was noted that his mood appeared flat and that his thoughts were focussed on getting a job. Mr E agreed to see a vocational worker the following week.

4.26 In early September staff left numerous messages for Mr E to contact the clinic to arrange an appointment to see the doctor. Mr E arrived at the clinic and told staff that he had not answered his phone as he knew who was calling him and he was already on his way to the clinic. There was very brief contact with

him as he arrived close to 5:00pm; medication was provided and an appointment was arranged for the following Tuesday, 5 September. Mr E did not attend this appointment. There were further attempts to contact Mr E and eventually on 20 September Mr E attended the clinic. It was noted that he had not been seen for more than two weeks and that he had missed his medication for the previous three to five days. This fact did not appear to staff to be of concern to Mr E. Mr E had also missed a number of appointments with a work placements officer. Mr K helped Mr E contact the housing office to organise for repairs to his front door that had been shot at a few months' previously and Mr K recorded that he felt that Mr E's mental health remained unchanged. The plan at this time was to continue to meet Mr E every two weeks, although Mr K noted that he was concerned that Mr E may become socially isolated as his girlfriend had gone to Spain to study and would be gone for a year.

4.27 In late October, after Mr E had not attended appointments or answered messages left on his phone, the clinical team discussed Mr E's case. The decision was made to place Mr E in the 'red zone' due to poor compliance with medication and non-attendance at appointments. It was also agreed that Mr K would contact Mr E's mother to find out more information about Mr E's wellbeing. Mr E's mother reported that she had had no contact with Mr E for more than five weeks. Contact with Mr E's GP established that there had been no contact since February. When staff attempted an unannounced home visit, they got no response from the front door and staff could hear Mr E's mobile ringing inside the flat when they tried calling him. The decision was then made to contact the police who agreed to arrange a welfare check. A call was subsequently received from a friend of Mr E who had responded to a message left by Mr K. The friend of Mr E said that he had spoken to Mr E three days' previously; he agreed to contact Mr E and provide some feedback to Mr K. On 26 October Mr E attended an appointment with Dr L. It was noted that Mr E had been without medication for at least two weeks. Mr E presented with his arm in plaster having fractured his wrist after a fall. Dr L noted that Mr E appeared to be co-operative during the appointment but his answers were guarded and cautious. Mr E reported that the reason he had not attended appointments was because his girlfriend had gone to Spain for a year. Dr L recorded that his impression was that Mr E was not unwell, but that Mr E placed himself at high risk of relapse, preventing a full recovery due to his poor engagement with the service and intermittent compliance with his medication. Mr E's case was subsequently discussed in a case review meeting when it was decided that contact should increase from every two weeks to every week.

4.28 In early November Mr K went on holiday for three weeks. Mr E's case was temporarily managed by Mr A who called Mr E to introduce himself and explain his role. Mr A offered to meet with Mr E that week but Mr E declined saying that he was due to see Dr L the following week. Mr A suggested that he call Mr E the following Monday to check how he was – this Mr A did but Mr E did not answer the call and he did not attend to collect his medication. There was a further clinical discussion in mid November when it was noted that Mr E had not been seen for two to three weeks, had declined opportunities to collect his medication and was not returning calls from staff. It

was therefore agreed that Dr L and Mr A would attempt a home visit to re-establish contact. The home visit took place the day after the clinical discussion. Dr L and a medical student successfully saw Mr E who denied feeling paranoid or in low mood, but admitted missing doses of medication. Dr L noted that Mr E no longer had a cast on his wrist and Mr E told Dr L that the cast had been removed as he was feeling better. Dr L established that the fracture was one that often had complications with the healing process and stressed the importance of attending follow up appointments to Mr E. At this time the decision was made to move Mr E from the red zone to the amber zone. In late November Mr A received a text message from Mr E asking Mr A to contact him as he was concerned his wrist may not have been healing properly. Mr A tried calling Mr E but did not get a response, Mr A then sent Mr E a text asking him to attend the clinic. At the end of November Mr E attended the clinic and collected his medication. He was seen by the duty worker and asked to see Mr A as he said something had happened and he needed to talk to Mr A. The duty worker told Mr E that Mr A had left and that he didn't know who had been allocated as Mr E's new care co-ordinator. Mr E was frustrated that "*everybody he saw kept leaving*" but declined the offer of an appointment. Mr E said that he would return the following week to find out who his new care co-ordinator would be and the duty worker noted this information in the diary, along with an instruction that if staff did not hear from Mr E, a welfare check should be done.

4.29 In early December Mr E attended the clinic at lunchtime without an appointment and outside of usual appointment slots. He was seen by Dr L and his new care co-ordinator Ms H. Mr E presented in an animated state and was pre-occupied by delusional beliefs that his upstairs neighbour had been spying on him by pulling up the floorboards. Mr E was certain that what he was reporting was fact and said a number of times that he was not mentally unwell. Mr E was distressed and angry about his experiences and wanted the team to help him to lodge a case against his neighbour. Dr L expressed concern that Mr E appeared not to recognise that he would be culpable if he were to act violently towards his neighbour. Mr E assured staff that he had been taking his medication but Dr L noted in the records that staff knew from experience that Mr E's compliance with his treatment was poor. In addition Mr E admitted to smoking cannabis a few days' previously and saw no link between this and his mental state at that time. Dr L noted that Mr E appeared to be relapsing and recorded risks to both Mr E and Mr E's neighbour. Mr E was again placed in the 'red zone' and plans were made for a home visit and to consider a referral to the home treatment team. Dr L also noted that if Mr E would not agree to input from the home treatment team, then assessment for detention under Section 3 of the Mental Health Act should be arranged.

4.30 The following day Mr E did not attend his appointment and therefore given the risk of violence towards his neighbour Dr L made the first recommendation for Mr E to be detained under Section 3. Ms H and a social worker attempted to visit Mr E at home but got no response, so they put a letter through Mr E's letterbox. A further home visit was attempted the following day by Ms H and the home treatment team. Again there was no response "*despite the bathroom light being switched on*". Ms H noted that Mr E had already indicated he was not interested in working with the home treatment team,

therefore Ms H continued with plans to assess Mr E under Section 3 of the Mental Health Act. Ms H made the necessary referral to the social worker but was told that the social work team had been "*inundated with referrals and the admission process would not be able to be started until the following week*". Later in the day Mr E arrived at the clinic to let the team know he was fine and to "*apologise for not being in*". Ms H gave Mr E "*several hours*" to talk and noted that he appeared less pre-occupied by his neighbour. When Ms H asked about what contact Mr E had had with his family, Mr E reported that he had seen his father the previous day and his mother a few weeks' previously. Ms H noted that she would discuss the course of action with Dr P, however we have not been able to identify whether this discussion took place or what the outcome was.

4.31 In mid December after Mr E had failed to attend an appointment with Ms H and Dr L, they made a successful home visit to Mr E. The records show that Mr E seemed calmer but still pre-occupied by his neighbour, and that Mr E reported that he planned to visit his girlfriend in Spain in the new year.

4.32 Mr E missed a number of appointments and did not respond to calls from staff. He eventually attended the clinic at the end of December and was given his medication. Mr E's girlfriend was with him and said that he was happy to see her. Mr E also asked to see the doctor as he was complaining of side effects; an appointment was arranged with Dr L the following day. Mr E did not attend the planned appointment with Dr L the following day.

2008

4.33 Mr E attended the clinic in early January with no appointment arranged. He said he hoped staff would help him to complete an incapacity benefit form and make arrangements to be re-housed, given the shooting incident the previous year. Mr E was seen by Dr L and his new care co-ordinator Mr J. Mr E continued to report that "*his neighbour upstairs was watching him*" and that he "*hears him talking about Mr E and commentating on his actions on a daily basis*". Mr E reported no problems when he was outside his flat and maintained that he was not mentally ill. Mr E said that he had had a good couple of weeks with his girlfriend who had come over from Spain and that he was planning to go out to visit her. Mr E was calm and jovial but Dr L noted a "slight air of irritability", that Mr E posed a low to medium risk of harm to others, and that he remained inconsistently engaged in treatment. Two days later Mr E collected two weeks' supply of medication prior to leaving for Spain to visit his girlfriend.

4.34 In mid January Mr E attended early for his appointment and stated he did not have much time, as he was due at another appointment. Mr J helped Mr E to complete a form and recorded that "*no overt psychotic symptoms noted and none reported*". Mr E said that he had enjoyed his holiday but expressed concern that he had been sleepwalking. Mr J advised Mr E to discuss this with Dr L two days later. Mr E did not attend this appointment and did not respond to the call made by Dr L.

4.35 The following day Mr E arrived at the team base and apologised for not attending the previous day. Mr J was unable to spend any time with Mr E as he was going out on a crisis visit. Mr E was given medication and an appointment the following day to see Mr J and Dr L. Mr E did not attend this appointment, but did answer his phone when Dr L called him. Mr E was apologetic and agreed to see Dr L the following week. This appointment was subsequently cancelled due to staff sickness.

4.36 In late January Mr E attended the clinic to collect his medication and reported that he had run out as he had lent tablets to a fellow client. Arrangements were made for Mr E to see Dr L; Mr E reported that his neighbour had stopped spying on him and that he couldn't hear his neighbour's voice commentating on his (Mr E's) actions. Mr E remained convinced that this experience had been real and not part of his mental illness. Dr L tried to encourage Mr E to make a link between cannabis use, non-compliance with medication and increased psychotic symptoms but Mr E was unable to do so. Mr E stated he was always compliant with his medication and denied ever using cannabis.

4.37 In mid February Mr E asked Mr J to help him complete a GP registration form. Mr J noted some superficial scratches to Mr E's forehead and right hand, when Mr J questioned Mr E about this Mr E was evasive saying "*it was a misunderstanding and that it was resolved*". Mr E continued to express an interest in a painting and decorating course and agreed to attend an appointment with a vocational worker. This appointment was organised for a fortnight later but Mr E did not attend, neither did he attend his appointment with Dr L the following day. However Mr E arrived at the clinic some time after his scheduled appointment and asked for medication. Two weeks' supply was provided by the duty worker.

4.38 In late March Mr E arrived at the clinic after 5:00pm, the duty worker informed him that the clinic was closed but agreed to hand over two weeks' supply of medication. It was recorded that "*no problems observed in his interactions*".

4.39 In early April Mr E missed two appointments with Mr J. In mid April Mr E attended to collect his medication, Mr J was unable to see him properly but gave him two weeks' supply of medication and offered an appointment two days later. Mr E did not attend this appointment or an appointment in late April.

4.40 In late May Mr E was the subject of a clinical discussion. It was noted that Mr E had frequently missed planned appointments, subsequently making unscheduled visits to collect his medication. Mr J noted that as a result it had been difficult to assess Mr E's mental state. Mr E had not provided contact details for his new GP, which were required to facilitate transfer to the appropriate CMHT. When staff had spoken to Mr E about his mental state, Mr E continued to report no concerns and focussed the discussion on social issues. The team agreed to discuss Mr E's case again at the next clinical review.

4.41 In late June Mr E was offered an appointment for early July, but Mr E made an unscheduled visit to collect his medication, nearly three weeks prior to the

appointment offered. The duty worker gave Mr E two weeks' supply of medication and Mr E asked for help in renewing his freedom pass. Mr E was advised to return with his expired pass and proof of residency.

4.42 At the beginning of July Mr E attended the clinic after staff called him to remind him he needed to attend. Mr E brought the proof of residency and a letter in order to renew his freedom pass. A week later he attended to collect his medication and reported that he was compliant with his medication and that he had no symptoms of paranoia whilst at home. Mr E was unable to provide details of the GP surgery but believed it might have been Palace Road Surgery. It was noted at this time that Mr E was aware he was due to be discharged from the team and that his care would either be managed by another team (Recovery and Support) or by his GP.

4.43 In mid August Mr E attended an appointment with Mr J who noted that Mr E appeared "*well kempt with reasonable rapport*". Although Mr J also noted that at times Mr E appeared vague with glazed eyes. Mr E denied any drug use and said that he had no concerns about his mental health. Mr J gave Mr E two weeks' supply of medication and agreed to another referral to vocational support services. Mr J noted that the plan was to transfer responsibility for Mr E's care to the south west community team.

4.44 In early September Mr E presented at the clinic dressed in what staff described as an Islamic kameez. He informed staff that he had converted to Islam two years previously. Mr E presented as quite fatuous but denied any cannabis use or relapse indicators. The plan was for Mr E to be reviewed by Dr G two weeks later. It appears that Mr E did not attend this appointment.

4.45 In late September Mr E was interviewed in the presence of an Appropriate Adult[17] after he had assaulted his girlfriend. The Appropriate Adult Form indicates that Mr E was charged with abduction and actual bodily harm after he had hit his girlfriend in the face whilst holding her against a wall. A week after this incident Mr E made an unscheduled visit to the clinic. Mr E was seen by the duty worker regarding medication and calls to the council. Mr J returned from a visit and met briefly with Mr E. Mr E reported that he was concerned that he had split up with his girlfriend two weeks previously and admitted that they had had an altercation. Mr E was vague about the details of the offence, but Mr J noted that Mr E had "*slapped/punched her*". Mr E was quick to add that the offence was nothing to do with his illness and that he and his girlfriend had been having relationship difficulties for some time. Mr E said that his girlfriend found out that he had been out with someone else and that his girlfriend would regularly go out clubbing with her friends whilst he was at home worrying about her. Mr J noted that Mr E had been seen by the duty worker the previous week but that this had not been documented. Mr E asked for more medication as a friend had borrowed some of his (Mr E's) medication. Mr J advised Mr E to ask his friend to return the medication.

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[17] *An Appropriate Adult is a parent, guardian or social worker required to be present at a police interview of a vulnerable adult.*

4.46 In October Mr E had two unscheduled attendances at the clinic and was seen by the duty worker on one occasion. Mr E sought support from staff in dealing with the housing office regarding a water leak and later advised Mr J that although he had a job in Primark he had received a bailiff's letter regarding debts of £3000. Mr J advised Mr E to return in two days when Mr J would be able to facilitate a call with the bailiffs. Mr J also advised Mr E to contact the Citizen's Advice Bureau. There is no record that Mr E attended.

4.47 In November Mr E missed appointments with Mr J and with his probation officer. Mr E made two unscheduled attendances at the clinic, on both occasions appearing to have been under the influence of drugs. Mr E told Mr J that he had received a letter from probation informing him that he had breached the conditions of his order and that he was going to be recalled to court, as he had not been attending his community service. Mr E asked Mr J to write to his probation officer to say that Mr E had missed his probation appointment as he had been at an appointment with Mr J. When Mr J refused to do so, as it was untrue, Mr E became annoyed. Mr J subsequently spoke with the probation officer and was informed that Mr E had told probation that he was late for appointments as his girlfriend had been keeping him up and he had had little sleep. Mr E also accused his girlfriend of "*stealing his sperm*" and refused to disclose her new address to the probation officer. Concerns were expressed by the probation officer about Mr E, as there had been two further incidents since Mr E's initial assault on his girlfriend. There were sufficient concerns about the risk to Mr E's ex-girlfriend that Mr J, the probation officer and the police agreed that the police would contact Mr E's ex-girlfriend to advise her to avoid contact with Mr E.

4.48 On 28 November Mr J made a request for an urgent assessment under the Mental Health Act because of concerns about Mr E's behaviour towards his girlfriend. Mr J was advised by the Emergency Duty Team in social care that they would not set up an assessment and would only respond if Mr E was brought to their attention by the police or through attendance at A&E. Mr J informed the police community support unit of this information and was told of Mr E's assault history against his girlfriend:

- 6 September - Mr E had kicked in the back door of the family home and had been charged with criminal damage;
- 11 September – Mr E had head-butted his girlfriend and had been charged and bailed;
- 21 September – Mr E had headbutted his girlfriend.

The entry made by Mr J states "*please see attached risk assessment*" however we have been unable to locate the document in order to review the content.

4.49 On 2 December Mr J met with Mr E who apologised for his behaviour the previous week but was reluctant to discuss his presentation any further. Mr E continued to express anger towards his girlfriend regarding his lack of employment. Mr E was inconsistent in his references to the woman,

occasionally referring to her as his ex-partner, friend and later his girlfriend. Mr J offered for the home treatment team to provide input and support to Mr E but Mr E refused this as be believed he was well and "*appeared offended that staff had suggested otherwise*". Mr E also denied he was stressed and became annoyed that staff were discussing his private life which he felt was not their concern. Mr J recorded that clinical staff considered that "*Mr E would not be detainable and therefore decided not to continue with a mental health act assessment as this could have adversely affected the therapeutic relationship*".

4.50 The following day Mr E arrived four hours late for his appointment, he was unwilling to stay for long and only wanted contact details for housing repairs. Mr J noted that Mr E was due to attend court the following day regarding his breach of licence.

4.51 On 18 December Mr E did not attend his scheduled appointment with Dr G and Mr J and did not respond to a telephone call on 19 December. Mr J later attempted a home visit and spoke to Mr E through the window. Mr E stated he didn't want to come down as he was with someone. Mr E did agree to go to the clinic the following Monday to collect his medication, when he attended Mr J noted that there were no signs of agitation or hostility and Mr E talked in a calm manner about his ex-girlfriend. Mr E remained in the red zone. On 30 December staff attempted to contact Mr E to remind him of his appointment with Dr G. These attempts were unsuccessful and Mr E did not attend his appointment.

2009

4.52 Dr P and Mr J met with Mr E on 5 January and noted that Mr E had been arrested and charged with domestic violence on 27 December. Mr E said that he had not seen his ex-girlfriend since before Christmas, the claims were vexatious and that he had not assaulted her recently. Mr E said he wanted to avoid her as she was a bad influence on him, bringing him drugs and forcing him to have sex with her. Mr E also said that he was concerned she was stealing from him when she stayed and he was asleep. Mr E claimed that he hadn't used drugs since Christmas and that he was compliant with his medication. He reported that he was seeing his family regularly and getting on well with them.

4.53 Mr E attended two further scheduled appointments and made an unscheduled visit to the clinic throughout January. His presentation was suspicious and paranoid and he had bruising to his head and fist and a bloodshot eye but denied being in an altercation. Mr E was anxious about a letter and a cheque for a cold weather payment that he had received. Mr E complained that the "*letter was not written on real paper, that it didn't taste right from touching it*" and didn't believe that he could pay the cheque into his bank account. Mr E was also significantly concerned about the barcode on the letter. He denied smoking cannabis but then said that cannabis had been posted through his letterbox. It was noted that the plan was to call Mr E the following day to remind him of his medical review. This was done and despite offering two appointments, Mr E did not attend either of them.

4.54 On Friday 16 January Dr G noted that given Mr E's presentation at the appointment with the duty worker a mental health act assessment was required, with assistance from the police. Dr G contacted the social work duty team but they were unable to accept the referral and stated that Dr G should call back on Monday.

4.55 On Monday 19 January Mr J attempted to call Mr E but did not receive an answer. The plan was to discuss Mr E at the clinical review meeting the following day. This was done and the outcome was that the first recommendation for a mental health act assessment would be initiated. Mr J also spoke to Mr E's probation officer who informed Mr J that Mr E had been seen that day and had presented as paranoid, thought disordered and intimidating. When Mr J made the referral to the approved mental health professional[18] (AMHP) team he was informed that the AMHP team would not act on the referral until a first medical recommendation had been completed. Mr J explained the potential difficulty in this as Mr E would frequently not attend appointments and assessing Mr E at home without support was considered too risky.

4.56 On 21 January Mr J called Mr E and he agreed to attend the clinic to see Dr P and Mr J. Mr E appeared dishevelled and had notable bruising to his left eye, he stated this was a result of falling out of bed during a nightmare. Mr E presented with paranoid ideas towards his ex-girlfriend stating that she had "*got someone to steal his national insurance card and other documents and there was someone 'out there' pretending to be him*". Mr E continued to state that his ex-girlfriend was entirely responsible for his admissions to hospital and that she had drugged him to cause this. He denied that he had plans to see her again and was aware that he was not to see her, but reported that she had recently called him as she had left a jumper at his flat. He also denied plans to retaliate stating that he "*loved her and wanted to marry her*". Mr E refused to have his medication increased and would not agree to intervention from the home treatment team or admission to hospital. Dr P noted that Mr E was likely to require admission to a psychiatric intensive care unit for two or three weeks. Mr J informed the AMHP team that the first medical recommendation for detention had been completed. The AMHP team advised that they had nine other assessments to carry out and therefore there would be a delay in them being able to do Mr E's assessment.

4.57 Also on 21 January Mr J attended a MARAC[19] meeting when he informed the meeting of the plans for the mental health act assessment. The MARAC panel felt that the mental health act assessment should be done as a matter of priority given the risks to Mr E's ex-partner. The police representative at the

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[18] Approved Mental Health Professional (AMHP) is a role that required specialist training and can be undertaken by social workers, community psychiatric nurses, occupational therapists and psychologists. It is the duty of the AMHP, when two medical recommendations have been made, to decide whether or not to make an application to a named hospital for the detention of the person who has been assessed.

[19] MARAC (Multi-Agency Risk Assessment Conference) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.

meeting offered to assist in arranging police attendance to facilitate the assessment soonest.

4.58 On 22 January Mr J informed the AMHP team that the first medical recommendation had been completed. Mr J was informed that there were nine other assessments to do and that there would be a delay in completing Mr E's assessment. Mr J informed the Independent Domestic Violence Advisor (IDVA)[20] and the community support unit officer of the situation. A week later Mr J was informed that the assessment would not take place on 29 January as the AMHP team was having difficulty obtaining a warrant due to funding issues. Mr J escalated the issue and requested that the AMHP office liaise directly with Dr G.

4.59 On 30 January a Mental Health Act assessment was attempted, in attendance were the AMHP, police, student social worker, Section 12 doctor[21], locksmith. A male answered the door and said he wasn't Mr E but had been living in the property for several months. The male allowed professionals to enter and expressed his concerns about Mr E. The male said that Mr E had been abusing his girlfriend, cutting her hair with scissors and then threatening to stab her. The male reported that Mr E had been abusing his girlfriend for no reason and that Mr E was only sleeping for about two hours per night – talking to himself throughout the night. The male was happy to give his mobile details and to inform the team when Mr E returned to the flat. It does appear that at least one of the professionals in attendance knew Mr E, and therefore would have been able to verify that the male present was not Mr E. We found no evidence that the Mental Health Act assessment was pursued.

4.60 Also on 30 January Mr E's probation officer contacted Mr J to inform him that Mr E's "*breach hearing*" had taken place the previous day. Mr E had been given an "*18 month mental health treatment requirement to run alongside the community order*". The probation officer advised that if Mr E failed to comply with his mental health appointments she would "*be able to breach him*".

4.61 On 3 February Mr E attended the clinic and was seen by Dr G and Mr J. Mr E admitted to feeling stressed and became tearful during the appointment, he admitted to feeling paranoid and believing that he was being followed. Mr E also claimed to have received threatening telephone calls from male friends of his ex-girlfriend, demanding money. Mr E agreed to an informal admission to the Lambeth Early Onset inpatient unit and was warned that any aggressive behaviour may lead to him being detained and/or moved to a PICU.

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[20] Independent Domestic Violence Advisors (IDVAs) provide support to victims of domestic abuse who are the highest risk of serious injury or homicide.

[21] A doctor who is 'approved' under Section 12 of the Mental Health Act is approved on behalf of the Secretary of State as having special expertise in the diagnosis and treatment of 'mental disorders'. Doctors who are approved clinicians are automatically also approved under Section 12.

4.62 Mr E's presentation was chaotic during the first week of admission and he was initially detained on Section 5(2)[22] on 8 February and then on Section 3 on 9 February. Mr E was nursed on 1:1 observations from 8 February. On 16 February Mr E was transferred to a PICU after he was abusive and made threats towards staff and other patients. His paranoia led to increasingly confrontational and disruptive behaviour and he had started to hoard knives and cutlery in his room.

4.63 On 12 March Mr E was transferred back to the Lambeth Early Onset ward from the PICU. The discharge report indicated that Mr E's mental state had been variable and that he had stolen mobile phones and an ipod from ward staff. He used his belt to threaten staff and was verbally aggressive and threatened violence towards staff. Mr E settled after three weeks and he was transferred back to the Lambeth Early Onset ward after a further week. He remained on Section 3 of the Mental Health Act.

4.64 On 17 April a Mental Health Review Tribunal was held. Reports submitted by clinical staff indicated that Mr E had a "*fair degree of insight into his mental state, he recognises that he was unwell and realises the impact of stress on his mental state*". It was also noted that Mr E declined the opportunity to see the Lambeth Early Onset drug worker, stating he "*will be able to abstain from cannabis*" yet at the time of writing the clinician stated that Mr J had been unable to achieve this, citing a urine sample taken on 26 March tested positive for cannabis, suggesting that Mr E had smoked whilst on leave from the ward.

4.65 An occupational therapist's report submitted to the Tribunal hearing, dated April 2009 noted that Mr E had a "*court case pending following an assault on an ex-girlfriend. They have a court order forbidding them from seeing each other until this has been resolved*". It further stated that "*his sister visits regularly on the ward and they appear to have a good relationship*" and that "*although there is a court order preventing them from having contact, she [the ex-girlfriend] regularly comes to the ward in an attempt to see him, and [Mr E] states that they do still have contact*". We have found no evidence that Mr E had a sister and therefore we believe that it was his girlfriend/ex-girlfriend who was visiting him. The report also notes that he had a "*friend who is staying in the main bedroom, while* [Mr E] *occupies the main living room*". A statement that appears to give further credence to the claims of the male present in Mr E's flat at the end of January 2009.

4.66 The medical report submitted to the Tribunal hearing indicated that "*without the restrictions of the current inpatient compulsion and a future supervised community treatment order, we are very likely to see a repeat of previously established patterns…*". We have found no documents indicating the outcome of the Tribunal hearing nor any further discussion about a community treatment order.

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[22] *Section 5 allows for a doctor or nurse to stop a client from leaving hospital. A section 5(2) is known as the doctor's holding power. The doctor in charge of a patient at the time must write a report explaining why a patient needs to be detained and why informal treatment is inappropriate. Under Section 5(2) a patient can be held for up to 72 hours and is not renewable.*

4.67 On 18 April a member of the ward staff saw Mr E and a female patient enter the garden. The member of staff went out to the garden but was unable to see anyone. On walking to the far end of the garden that was in darkness the member of staff found "*Mr E and the female patient holding each other very close and with their trousers down*". Mr E and the female patient were instructed to return to the ward, at which point they both panicked, pulled up their trousers and slowly walked inside without saying anything. The incident was investigated by the nurse in charge but Mr E and the female patient refused to explain their actions and were very abusive and threatening towards staff. Both patients were placed on 1:1 observations, Mr E's leave was cancelled, and the duty doctor was informed. On 19 April the senior nurse informed the police of the incident. Feedback to the ward staff indicated that the police would take no action.

4.68 Nursing staff spoke with Mr E again on 19 April regarding the incident in the garden. Mr E did admit that he had been in the garden with a female patient and that they had both taken down their trousers. Mr E said that it was the female patient that had led him into the garden and denied that any penetrative sex had taken place. Mr E was tearful and apologetic and said that he had lied because he didn't want to jeopardise his discharge from the ward.

4.69 On 20 April a discharge meeting was held and it was noted that Mr E "*appeared very stable and calm with good insight*". Mr E was keen to be discharged and said that he would "*try not to do what would bring him back into the hospital*". Dr P noted that Mr E had made a "*good recovery*" and was now well for discharge. There was no further mention of the community treatment order. A seven day follow up appointment was arranged with the Lambeth Early Onset community team for 28 April.

4.70 Mr E attended the appointment on 28 April with Mr C and reported that things had been going well since discharge from hospital. Mr E reported that he had been spending time with his friends and that he had been avoiding people who use cannabis. Mr E reported that "*unfortunately his ex-girlfriend had called to his house and he had contact with her*". Mr E said that he was unsure about what would happen with the relationship in the future or what his feelings for her were.

4.71 In May Mr C saw Mr E on three occasions, one of which was a joint appointment with probation. Mr E reported to Mr C that he had had contact with his ex-girlfriend but subsequently denied this during the meeting with probation. At a later meeting with Mr C, Mr E said that his relationship with his ex-girlfriend had re-started and that she had moved into his flat as she had had an argument with her mother. Mr E denied that there had been any arguments or physical violence between him and his girlfriend. Mr E said that he was afraid to tell probation, as he was concerned he would have to go back to court or would be jailed. Mr C advised Mr E to be honest with probation but it appears he took no other action such as informing Mr E's probation officer.

4.72 In June Mr C accompanied Mr E to a Camberwell Magistrates' Court where they met with Mr E's barrister for a committal hearing. Mr E's bail conditions

remained the same: for him to have no contact with his ex-girlfriend. Approximately a week later Mr E attended an appointment with Mr C and reported that things were going well and that his girlfriend was living with him. Mr C reminded Mr E of his bail conditions and Mr E responded by saying that he understood this and the possible consequences. Mr E also reported that he had been attending a course regarding domestic violence with probation and said that he had found it helpful.

4.73 In July Mr E did not attend his medical appointment with Dr G and there was no contact with Mr C or any one else from the community mental health team during the month.

4.74 In early August Mr C contacted the assessment and treatment team to request an update on the referral made to them two months previously. Mr C was told that the team had no record of the referral and asked Mr C to resend it. On 5 August Mr C met with Mr E who reported that his girlfriend had moved out; Mr C noted that Mr E appeared "*bright in mood and well kempt*". Two weeks later Mr C called Mr E to arrange an appointment for Mr E to collect his medication; there was no response and Mr C left a message. Mr C also noted that he had tried calling twice the previous day.

4.75 The following day (21 August) the team duty worker attempted to call Mr E but again was unsuccessful in contacting him. A further message was left for Mr E to contact the team. The same day the team received a call from Mr E's probation officer asking for an update on Mr E. The probation officer was advised that the last contact with Mr E was on 5 August and that he had not responded to calls and messages about appointments and medication. The probation officer advised that Mr E was due in court on 9 or 10 September and that there was the possibility of a custodial sentence. Mr E was aware of this but hadn't appeared overly concerned about it when the probation officer had seen Mr E earlier in the week.

4.76 On 26 August Mr C made a visit to Mr E's home, as the team had not been successful in contacting Mr E via telephone. Mr E was not at home so Mr C left a letter for Mr E asking him to contact the team. When Mr C returned to the team base he saw Mr E who was waiting and reported that he didn't feel well and that he was sleeping excessively. Mr E again said that his girlfriend was no longer living with him and denied feeling depressed or having paranoid thoughts. Mr E reported that he was compliant with his medication but Mr C noted that Mr E was a week late collecting the most recent prescription. Mr C advised Mr E that he would be leaving his job and that Mr E would be allocated a new care co-ordinator. Mr E was given an appointment to see Dr P on 7 September.

4.77 In September Mr E did not attend his appointment with Dr P, despite a reminder message being left earlier in the day. There was no response to the three attempts by staff to contact Mr E during the month, although Mr E presented at the team base on two occasions to collect his medication. On one occasion staff noted that Mr E appeared well and on the other occasion staff noted that Mr E appeared to have taken cannabis prior to attending but denied use of recreational drugs when challenged. It was recorded that staff

should consider a urine drug screen, but we can find no evidence that this was followed up.

4.78 In November Mr E attended regularly every fortnight to collect his medication. No concerns were reported by Mr E or noted by staff.

2010

4.79 In February 2010 a letter was sent to the community team referring Mr E's case for transfer. The letter advised that Mr E:

- attended the team base regularly to collect his medication;
- mental state remained stable;
- was in contact with probation services regarding domestic violence towards his ex-girlfriend and that he attended psycho-education groups at a probation centre in an attempt to address this issue;
- lived alone and had a reasonable level of functioning;
- been made aware of the referral in August 2009 and that he was looking forward to meeting his new care co-ordinator.

4.80 In March Ms L wrote to the early onset team to introduce herself as Mr E's new care co-ordinator and requested FACS (Fair Access to Care Services)[23] assessment, care plan and up-to-date Care Programme Approach paperwork. At the end of the month Ms L and Mr C met with Mr E to discuss the plan to hand over care co-ordination responsibility from the early onset team to the Lambeth South West Support and Recovery Team. A plan was made for a Care Programme Approach meeting to be held with both teams on 6 April and it was reported that Mr E was happy with this plan.

4.81 On 6 April Dr S, the specialist registrar for the recovery and support team, wrote to Mr E's GP to advise that Mr E had been transferred to the care of their team following a joint review with Mr E and the early onset team. It was noted that Mr E's last relapse had been in February 2009 and that "*he had maintained progress for a whole year without issues of non-compliance or heavy drug use*." Dr S provided Mr E with some leaflets on bipolar affective disorder as well as information about Mr E's medication, as he appeared to be unaware of those. Dr S arranged for Mr E to have his first blood test with the team, after which Dr S asked Dr P to arrange a 12-hour post dose lithium level every 90 days, a thyroid function test and kidney function test every six months. Dr S further advised that Mr E would need annual blood tests for metabolic syndrome due to the two neuroleptic medications he was being prescribed. Dr S informed the GP that Mr E had been at risk of causing harm to others in the past, especially to his ex-girlfriend, and that much of the aggression was due to poor mental health wherein he was convinced that

23 FACS is a national framework setting out the eligibility for receiving social care support from a local authority

others meant harm to him. Dr S advised that Mr E had reported that he was no longer in contact with his ex-girlfriend but that he continued to be under probation (Ms R) at least until the following year. Dr S informed the GP that the plan was for Mr E to continue to collect his medication from the team and that he would be reviewed every three months.

4.82 Between 9 April and 8 June Mr E attended the team base regularly to collect his medication. During this time no concerns were recorded by staff. On 8 June Mr E collected additional medication as he was going on holiday to Manchester but did not attend to collect his medication on return. On 24 June Ms L called and left messages for Mr E but did not receive a response.

4.83 On 7 July Mr E responded to messages advising him that his medication was available for collection and was advised to contact Ms L urgently as she was concerned about his welfare. A week later on 14 July, Mr E collected his medication and expressed concern about his housing benefit as he didn't think he was entitled to it as he had started working on a full time basis. Ms L advised him to contact the benefit office and made an appointment for Mr E to see the team benefit advisor. Ms L noted that Mr E looked well and advised him to maintain the progress he had made.

4.84 Two days later, on 16 July, Mr E arrived at the team base in an anxious state and informed Ms L that he had lost the medication he had collected two days previously. Replacement medication was provided.

4.85 On 23 August Mr E attended an appointment with Ms L and reported that he had lost his job as his employer wasn't satisfied with his work. Ms L provided reassurance and advice and suggested it would be good to meet Mr E's mother at the next medical review. Mr E "*quickly asked why should his mum attend*".

4.86 Between 8 September and 28 October Mr E attended every two weeks to collect his medication. During this time no concerns were noted by staff.

4.87 On 13 September 2010 Mr E's GP received a discharge summary report relating to an admission in early 2009. The report notes the date of discharge as 20 April 2009, appears to have been typed on 8 September 2010 and is stamped as being received at Palace Road Surgery on 13 September 2010. The report provided details of Mr E's care and treatment during the period of admission, including the transfer to PICU, and provided a discharge diagnosis of "*acute and transient psychotic disorders*".

4.88 On 16 November Mr E attended a medical review with Ms L and Dr F. Mr E arrived late but "*presented well and stable in his mental state*". He complained of sleeping too much (up to 12 hours per night) and felt that he was taking too much sodium valproate. Mr E denied taking drugs or alcohol and stated he "*would not be involved with it*" after his previous experience and said that he had a brother with a mental illness who hadn't taken medication. Mr E told staff that his flat was in good order, his girlfriend visited occasionally and that he maintained contact with his mother who was his main carer. The plan was to arrange for blood tests to be done, refer to SHARP (Social Inclusion, Hope

and Recovery Project)[24] team, and for Mr E to collect his medication fortnightly.

4.89 When Mr E collected his medication on 1 December he was informed that the clinical team had decided to step down his care to be provided by the GP for both collection of medication and review of mental state. Mr E was advised that if he needed CMHT services within a year of being discharged the team could see him again. Ms L noted that he looked well and did not express any concerns about the plan.

4.90 On 7 December Mr E's case was discussed in the clinical meeting. The team decided, based on Mr E's history of non-compliance and substance misuse, it would be wise to keep him within the medication clinic but ask the GP to prescribe medication whilst Mr E's mental state was being monitored by the medication clinic. It was noted that Mr E had always stopped professionals from entering his flat, however the team planned to make an unannounced joint visit to assess the environment and find out if Mr E was up to date with his rent. The team noted that as Mr E's mother was listed as his main carer she should be offered a carer's assessment and that if Mr E was unhappy for information to be shared with his mother, he should put that in writing. Ms L was to ask for a current contact number for his mother at next meeting with Mr E. We found no evidence of written confirmation from Mr E that clinical staff should not share information with his mother.

4.91 Between 20 December 2010 and 26 January 2011 Mr E collected his medication every two weeks and it was recorded that no concerns were noted.

4.92 On 24 December Mr E's GP received a letter from the Recovery and Support Team doctor, Dr F, following Mr E's appointment on 16 November. The letter was noted as having been typed on 10 December. Dr F advised that Mr E had been seen along with his care co-ordinator Ms L for a medical review. Mr E had presented as stable and had said that he had not used drugs or alcohol and accounted for how this could potentially exacerbate his mental state. Mr E wanted to know for how long he needed to take medication and was advised that he would need to be compliant with his mood stabiliser and anti-psychotic medication for a considerable time before a reduction could be considered. Mr E advised that he maintained an active day, kept his flat in good order and maintained contact with his girlfriend and his mother. Mr E was advised to discuss any potential work with his care co-ordinator as there were concerns about anything that would interrupt his sleep cycle. Mr E said he would prefer to attend his GP rather than the community mental health team in order for relevant blood tests to be completed. Dr F advised that Ms L would continue to monitor Mr E fortnightly and supply his medication. Medication was noted as: olanzapine 20mg nocte; sodium valproate chrono 1700mg nocte.

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[24] *SHARP Team: The Social inclusion, Hope and Recovery Project (SHARP) is an innovative*, forward thinking service that *offers a range of psychosocial interventions, to people using South London and Maudsley NHS Foundation Trust mental health services.*

2011

4.93 On 28 January Ms L received a call from Mr E's probation officer advising that Mr E had attended a meeting with her but had appeared unkempt, had grown a beard and had admitted that he wasn't taking his medication. Ms L said that she had seen Mr E two days previously when he had presented as stable and well apart from the beard, which he joked about. Ms L agreed to do a 'random' joint visit to assess Mr E's home environment and monitor his mental state.

4.94 On 31 January Ms L attempted to make a home visit to Mr E, accompanied by another member of staff. There was no response at his door and his mobile phone went straight to voicemail. Ms L left a message for Mr E to call her - he did not do so.

4.95 On 1 February Mr E was discussed at the clinical review meeting. The information from Mr E's probation officer advising that Mr E was not taking his medication was noted and the team decided to arrange another medical review and respond to the letter from probation to advise of the action planned.

4.96 On 9 February Mr E attended the clinic to collect his medication where he was seen by the duty worker, who noted that Mr E appeared to be in a hurry. Mr E was on the phone and waited in the corridor, when he eventually went into the clinic room the duty worker asked how he had been, he responded "*yeah cool*". Two weeks' medication was provided.

4.97 Between 11 and 21 February several calls were made to Mr E. There was no response and no indication in the notes that a message was left.

4.98 On 22 February Ms L received a call from Mr E's probation officer expressing concern about his presentation that day at his probation appointment. Ms L gave reassurance that Mr E was due a medical review the following day and Ms L would update her. The probation officer suggested a joint visit with Ms L to Mr E's home address as soon as possible as she was not certain that things were going well at home. Ms L discussed Mr E's relationship with his mother, with the probation officer who confirmed that she was aware that Mr E really didn't want his mother involved.

4.99 The following day Mr E did not attend his medical review despite text messages being sent by staff reminding him. A further appointment was arranged for 2 March.

4.100 On 28 February Ms L received an email from Mr E's probation officer advising that Mr E had been placed "*on notice*" and that a home visit would be arranged when both Ms L and the probation officer would attend. If Mr E was not there at the time of the home visit, he would automatically be in breach because his order required treatment and supervision with probation. The probation officer advised that Ms L and the probation officer attending would count as two visits so if he wasn't at home he could be immediately breached. The probation officer said that Mr E was very clear about this and that she

would text him to remind him in advance. It appears that the plan was for the joint visit to take place on 9 March.

4.101 Later that day Mr E attended to collect his medication. He was provided with two weeks of olanzapine and sodium valproate. Ms L recorded that Mr E was withdrawn, guarded and slow when answering direct questions and noted that although Mr E would usually smile when she entered the room, Mr E seemed to have lost interest in anything. Mr E was dressed shabbily and appeared to have lost weight; he said he was going to the gym often. Ms L asked how he had been and why he had not attended so many appointments with the SHARP team and medical review. Mr E said that he needed a job; Ms L advised him that the SHARP team would be able to help him. Mr E agreed to attend the SHARP team to arrange an appointment and to attend a medical review. Mr E again confided that he had not been taking his medication because he felt the dose was too high. Ms L advised him to attend for a blood test.

4.102 On 9 March Ms L and Mr E's probation officer met at Mr E's flat. Mr E was at home and let the professionals in. The dog was tied up in the kitchen and was barking. The flat appeared reasonably clean although there was no carpet and his bed was in the living room. The bedroom appeared to be being used by a lodger, Mr E denied this but said a friend used to stay with him and was no longer doing so. Mr E appeared pale and Ms L felt that he had not been eating properly, however Mr E refused to let them see the fridge as he hadn't cleaned it for some time. Mr E said that he had been going to the gym and that he liked the way he looked. Mr E appeared relaxed and was coherent with no psychotic symptoms observed. Mr E was reluctant to speak about his family but said that he had seen his mother the previous week and that she was happy with his progress. Mr E maintained he did not want staff to contact his mother and bother her with his problems and became irritable when Ms L continued to probe him on the matter; he also refused to provide his mother's contact number. Mr E said that he was only taking olanzapine as the sodium valproate wasn't doing him any good and caused him to put on weight. He agreed to attend the medical review that Friday and to attend for a blood test the following Monday.

4.103 The following day Mr E attended to discuss his medication with a doctor, however his appointment wasn't until the following day. He was advised to return for his appointment, which he was willing to do because he was not taking sodium valproate and wanted the olanzapine reduced. Mr E appeared to have been under the influence of drugs or alcohol but denied this. Ms L informed him that next time staff may have to carry out a drug screening test.

4.104 We cannot find any evidence that he did attend the following day, nor that any follow up action was discussed by the team, nor actioned by Ms L.

4.105 On 21 Mr E attended for a sodium valproate level blood test. The record notes that he was calm in mood and pleasant on approach but Mr E "*could not wait to see his care co-ordinator who was keen to see him for his medication*".

4.106 On 24 March Mr E attended to collect his medication when he presented as restless and thought disordered. He stated that his medication had been changed without prior notice. Ms L advised that this would not happen without his knowledge and that he was on the same medication as he had always been. Mr E stated that the olanzapine had changed colour; it now had pink stripes rather than purple and was oval shaped rather than round. Ms L contacted the pharmacy to reassure Mr E; pharmacy staff confirmed that the medication had been the same since the previous November when the prescription had been changed from two 10mg tablets to one 20mg tablet. Mr E said that he felt different, he was "*no longer able to get hold of himself*" and he blamed this on these changes. Ms L advised him that he had not been taking the medication as prescribed and that this was why he was feeling this way. Mr E got very angry, calling Ms L a liar for saying that he wasn't taking his medication. Ms L offered to ask the crisis doctor to see Mr E which he agreed to, however when Ms L tried to arrange this she was informed that "*he should be given an appointment with his regular doctor, rather than just turning up to inform the team that he had stopped taking his medication*". Ms L offered to contact Mr E as soon as his regular doctor returned from leave. Mr E was angry when he left and said that he would only take what was good for his body.

4.107 On 30 March Mr E was referred to the crisis and home treatment team by the psychiatric liaison team at St George's hospital. "*Due to his mental health, ie psychosis, poor eye contact, poor concentration, not being able to engage in conversation, wandering in A&E and picking up bits from the floor, thinking he can't speak English but can, it was felt that it was inappropriate for HTT input*". However Mr E was not taken on by the crisis and home treatment team.

4.108 On 31 March Mr E was admitted to a psychiatric inpatient ward (Ladywell Unit) following an attendance at A&E at St George's Hospital, where he had arrived via ambulance and escorted by police. He presented having cut his hand while trying to repair a window (his arm had gone through the window). Following assessment Mr E was detained under Section 2 of the Mental Health Act. Prior to being taken to A&E Mr E's neighbours had called 999; he appeared overtly disturbed by auditory and visual hallucination. A urine drug screen was completed as Mr E was found with a sachet of cannabis. Mr E said he was *'crazy'* because he opened the window too far and it broke. He was very aggressive towards staff and was anxious about his dog, wanting to know who would feed it. Risks were noted as a history of assaults and hiding knives in his room when previously an inpatient, also a previous admission to a PICU was noted as a risk. Staff escorted Mr E around the ward due to his risks. Mr E was placed in the red zone and remained there until 6 April as his presentation continued to be unpredictable.

4.109 On 6 April at 16:30 Mr E was moved to the amber zone. He presented as calm but quite demanding, and continued to go to the office to request different things. Mr E complied with his medication and used garden leave for cigarette breaks. However at 20:30 the records show that he had been moved back to the red zone; we have not seen any information to indicate a change in the way his care should be managed.

4.110 On 7 April he was reported as being both in the red zone and the amber zone. Again it is unclear how Mr E's presentation had changed for the zones to be changed.

4.111 On 9 April Mr E was visited by a friend who appeared to have passed him lighters. Staff described Mr E as labile in mood but sometimes aggressive, with a fixed stare and shouting at staff and patients. Mr E was overly familiar with female staff, saying that he loved them.

4.112 On 10 April, staff noted that Mr E had spent time with his girlfriend during "*protected time*".

4.113 On 11 April Ms L called Mr E's probation officer, Ms R, and informed her that Mr E was in hospital and that Ms L would contact her again as soon as Mr E was discharged. The probation officer stated that his probation was due to expire on 24 April and that she was due to see him at some point before his probation expired. Ms L advised Ms R to wait until the next ward round when Ms L would know more about his discharge date.

4.114 On 12 April Mr E was given leave from the ward and so contacted his ex-girlfriend to drive him home. The ex-girlfriend arrived at the ward and staff contacted the police to clarify how Mr E was to enter his flat - Mr E had planned to break off the padlock and put on another one. The police provided staff with a code and advised that Mr E had to attend Streatham police station with some identification in order to collect the keys to the padlock. Mr E went to the police station with his ex-girlfriend to collect the keys and make arrangements to get the window fixed. Mr E was advised by staff "*how to behave whilst on leave from hospital*". On return from leave Mr E appeared calm, bright and pleasant and said that he had eaten supper with his ex-girlfriend. Mr E reported that he had sorted everything in his flat and that he was now not worried about his flat. Staff asked him Mr E to provide a urine sample so that a urine drug screen could be conducted. Mr E responded by saying that he had done a urine sample in the morning and that it had been positive.

4.115 The following day, 13 April, Mr E was found to be ready for discharge from the ward. Ward staff discussed the discharge with the home treatment team who refused to accept Mr E due to his risk history. It was therefore agreed that support would be provided by the community mental health team, noting "*and will re-refer to LHTT* [Lambeth Home Treatment Team] *if required*". Staff informed Mr E's probation officer Ms R of Mr E's discharge, Ms R said that Mr E had already contacted her.

4.116 On 18 April Mr E was seen by a duty worker for his seven day follow up appointment. The staff member noted that Mr E appeared to be making a good recovery, and that no issues were raised.

4.117 On 20 April Mr E collected his medication and staff explained why the dose of sodium valproate had been reduced. An appointment was arranged for 16 May for a blood test. Mr E's mental state appeared to be stable, staff noting

that he was engaging and had talked about his desire to stop smoking, asking for help from staff with this issue.

4.118 On 5 May (although not entered into the records until 10 May) Mr E was observed in the reception area of the community mental health team base and appeared restless and very thin. Mr E said that he was now eating healthily having eaten a lot of takeaways previously. He appeared very distracted and wanted to collect his medication, but his prescription was not due until 18 May. Mr E said that he needed to talk to someone to get help with issues with his flat; the duty worker offered to help. Mr E approached her face closely and said "*look at my eyes*". Mr E said he couldn't see properly and that he needed glasses; he was advised to visit an optician. Mr E said he had lost his flat keys, after some probing he told the duty worker that he had another set of keys but that he would have to change the locks. He then changed subject and said that he had a window in his flat that was boarded and needed fixing - he was paranoid that different people were going into his flat when he left the window open near the roof. Mr E said that things had gone missing but he wasn't able to describe what, he stated he would report it to the police but appeared unsure what he would be reporting. The duty worker contacted Lambeth Living and asked for the broken window to be fixed, Lambeth Living advised that contractors had reported that Mr E had been walking round with a screwdriver so they didn't feel safe to carry out the work. The duty worker also reported that Mr E had no hot water or heating and asked for this to be rectified. The duty worker updated Mr E and advised him to remain in the flat that evening to wait for the plumbing contractor. Mr E refused to provide his mobile number to Lambeth Living.

4.119 On 9 May (but not entered until 10 May) Ms L met with Mr E who was complaining of toothache, Ms L advised him to see his GP for the toothache. Mr E was "*distracted, pressured in speech and jumping*" between subjects. He wanted Ms L to go to his flat with him to see what repairs needed to be done. Mr E wanted to know when the team would be discharging him to the GP, as this was the plan before he was detained to hospital. Ms L advised this would be done when his mental state was stable. Mr E appeared drowsy and intoxicated and Ms L advised him to go home whilst she arranged for a medical review. The plan was for a joint home visit on Wednesday to view the state of his flat; and a medical appointment with Dr F. Mr E returned to the team base later to use the phone to call Lambeth Living regarding the repair of his boiler, the duty worker advised him to wait for Ms L but he did not wait to see her. This was a missed opportunity to see Mr E in his home environment; a rare occasion when he invited staff to his home.

4.120 On 11 May Ms L was informed by reception staff that Mr E was in reception but by the time she got there he had gone. Ms L had arranged a medical appointment with Dr F for the following day, as Mr E had been unstable since discharge from hospital, presenting at the team base, seeking assistance unnecessarily, looking unkempt, weight loss, and intimidating when approaching staff. Mr E confirmed he would attend.

4.121 The following day Mr E attended for his medical appointment with Dr F. Mr E appeared calm, coherent and pleasant; his main worry was his flat as there

was a hole in the wall and Mr E said he didn't feel safe and wanted to be moved. Dr F asked if Mr E felt that someone could look through the hole but Mr E didn't answer. Dr F asked if Mr E was taking his medication and he admitted he wasn't taking it as prescribed. Dr F arranged for a blood test and urine drug screen to be done the following Monday. Mr E left in a hurry as he had a dental appointment.

4.122 On 16 May Mr E attended the community mental health team base for blood tests and saw Ms L. Mr E told her that his dog had been returned to him but he was not happy that the dog had lost weight. Ms L encouraged Mr E to look after the dog now that they had been reunited.

4.123 On 18 May Mr E presented asking for help with reporting housing repairs as none had been completed. Mr E said he believed people were climbing in through the window. Mr E "*went on and on about repairs in the flat*" and said that his neighbour had a new heating system whilst Mr E still had the old one. Mr E got agitated when Ms L tried to explain why his neighbour might be entitled to something that Mr E was not. Ms L described Mr E's presentation to be paranoid and suspicious and constantly falling asleep between his conversations with her. Mr E admitted to drinking alcohol but denied illicit substances, he was offered a urine drug screen but he declined. Ms L noted that she planned to conduct a joint home visit in the morning to assess Mr E's mental state, however we can find no evidence that this took place.

4.124 On 23 May Mr E collected his medication and was informed that his blood test indicated he had been compliant with his medication. Mr E said that contractors were at his flat to repair the holes in the wall, but Mr E had reported more holes in the floor.

4.125 On 26 May Mr E saw Ms L with a letter he had received from the council regarding rent arrears. He was very agitated and the only way Ms L could reassure him was to contact the housing department. They advised that the housing benefit had been stopped on 6 May 2011. Ms L then contacted the benefit office and was advised that they didn't believe that Mr E was still at the address and so wanted confirmation of his residency via a utility bill. Ms L advised Mr E to take a bill to the office to enable payments to be recommenced.

4.126 On 1 June Mr E attended the team base to apologise for missing the appointment the previous day. Ms L noted that he appeared drunk and could hardly open his eyes. Ms L asked if he had been taking cannabis but he said he had been drinking all weekend. He wanted to know how he could get a job so Ms L advised him to work with the SHARP team. Ms L recorded "*he was practically sleeping during our meeting, I advised him to go home and get some rest*".

4.127 On 6 June Mr E attended the team base to discuss a crisis loan as he had nothing to eat until his benefit arrived on that Friday. Ms L suggested he attended SPIRES on Tuesday where he could get a cooked meal and also offered him a food voucher. Ms L advised him to manage his money more wisely and save some for emergencies; she noted his mental state was

"*reasonably stable*". Mr E said he would be contacting the dog house to ask them to collect his dog as he was unable to feed him. Ms L provided Mr E with information about Lambeth Vocational matrix and offered to accompany him to the session; as he had not engaged with the SHARP team despite several reminders of his appointment.

4.128 On 9 June Mr E attended the team base to discuss his housing situation. He told Ms L that he had gone to the council to find out why contractors hadn't attended and had lost his temper when council staff had asked the "*same question over and over again*". Ms L contacted Lambeth Living who confirmed that the work was still outstanding and promised to follow it up. Mr E was reassured by this but stated that he no longer felt comfortable in his flat. Ms L suggested he apply for rehousing. Mr E collected two weeks' supply of sodium valproate 1500mg and olanzapine 20mg.

4.129 On 17 June Mr E attended the team base and asked to see Ms L, he appeared anxious and stated he wasn't sure what to do with himself. He said he was bored as his girlfriend had broken up with him. He had gone to Croydon shopping centre to shoplift and had been caught by the security team but they had not called the police. Mr E was unsure what he wanted - initially he wanted to be admitted to hospital, then said it was not the best place, but he did want the company of other people. Ms L suggested supported accommodation but Mr E said he didn't want to live in a hostel. Ms L advised that he visit his family but Mr E said that his mum didn't work and he didn't want to bother her. He said he had been living on mashed potatoes as he wasn't able to cook and Ms L noted that Mr E had lost weight. Mr E reported that he owed £400 in rent and that he had refused to take a proof of address to confirm he was still living at the address. Ms L encouraged Mr E to attend A&E over the weekend if his symptoms became worse. Mr E said he was going straight to the benefit office. Ms L noted that she would increase the contact with Mr E to resolve the crisis, arrange a urine drug screen, and organise for Mr E to be assessed for input by the home treatment team.

4.130 Three days later, Ms L received a call from Mr E stating that his window had not been repaired and asking to be rehoused. Ms L suggested Mr E attended the team base but he said he had other things to do. Ms L tried contacting Lambeth Living but they wouldn't respond to Ms L's questions, as Mr E was not present with her. Ms L tried to explain the situation but the person she was talking with wouldn't cooperate. Ms L requested the address of the tenancy officer to arrange for a consent form to be sent so that she could make enquiries on Mr E's behalf. Ms L arranged a joint home visit (although it is unclear with whom) in order to assess Mr E's mental state. On arrival at his flat, the front door was padlocked and the letterbox and keyhole had been blocked up. Ms L noted this as evidence of Mr E's paranoia. Ms L then discussed Mr E's case at the team review meeting when it was agreed that Dr F would see Mr E as an urgent appointment on the Friday, 25 June (five days hence).

4.131 The following day, 21 June, Mr E attended the community mental health team base to be seen by the crisis doctor and Ms L, Mr E appeared unkempt and tired and said that he had been drinking and that he hadn't taken his

medication. Mr E denied breaking up with his girlfriend and said he had lots of girlfriends. Mr E said that he had seen his father recently as he had nothing to live on and had been visiting his father at weekends. Ms L noted that it was well documented that Mr E did not have a good relationship with his father and that Mr E reported that he did not know where his mother was at that time. Dr F noted that Mr E displayed an underlying "irritable affect" and although Mr E denied any acute risks Dr F recorded that he appeared preoccupied, guarded and paranoid. Mr E reported that he was bored, Ms L reminded him of the appointments with the SHARP team that he hadn't attended. Mr E became irritable saying "*why all the questions, you are not doing anything to help me. I come here for my medication and I have asked for a housing transfer and nothing has happened*". Dr F intervened but "*Mr E went on and on*". Dr F asked what help Mr E wanted but Mr E was unable to be specific and kept jumping between subjects. Ms L noted he was obviously hungry and irritable. Dr F noted that it was clear that Mr E was relapsing and that his medication compliance was questionable but that he was not detainable as he was willing to attend appointments. It was agreed that Ms L would speak to the home treatment team to assess Mr E in light of relapsing mental state and medication compliance concerns. Ms L also noted she planned to contact Mr E's mother for an update.

4.132 The following day Ms L discussed Mr E's case with the home treatment team who recorded that input from their team appeared "*unlikely especially due to the drinking issue*". However the home treatment team did agree to accompany Ms L on a joint home visit the next day. The joint home visit took place on 23 June, but on arrival Mr E would not allow staff access as he said he had a friend with her baby in his flat and it was not a convenient time to talk. Mr E promised to attend the team base that afternoon, but there is no record that he did so.

4.133 On 28 June Mr E arrived to collect his medication, but it had not been provided by the pharmacy as Mr E's prescription card needed to be updated. Ms L suggested Mr E return the following day, to which he agreed. Ms L noted that Mr E presented as suspicious and that he complained of sweating too much and attributed this to his medication.

4.134 The following day Mr E did attend and collected four weeks' supply of medication. Ms L noted that he presented as "fairly stable" in mental state.

4.135 Throughout July Mr E did not engage with the SHARP team, despite attempts to contact him. Ms L did see him on 18 July (but entry not made until 25 July) when she attempted a home visit. Mr E was standing outside his door, but was pleasant and his mental state appeared to be stable. Mr E promised to see Ms L at the team base before the weekend. There is no indication that Mr E did so.

4.136 On 25 July Mr E attended the team base to discuss issues with his medication and to inform Ms L that he had found a job for two hours a day, cleaning offices. Mr E reported feeling sedated by his medication and that the dose of sodium valproate was too high and wanted it reduced. Ms L "*promised to inform the doctors*" and noted that Mr E presented as fairly settled, less

chaotic, and apprehensive - he was able to stay focussed throughout the meeting.

4.137 On 12 August Mr E attended to collect his medication and was seen by the duty worker. He was observed to be stable in mental state and was informed that medication was not due until 15 August. Mr E argued that he needed the medication because he had run out, but he denied taking more medication than was prescribed. He was advised that he must take his medication as prescribed and was given two weeks' supply of medication; olanzapine 20mg and sodium valproate 1500mg.

4.138 At the beginning of August, after not attending three appointments with the SHARP team, it was suggested that Mr E should be discharged from their caseload. There is no indication of Ms L's response in the records. However, on 17 August Mr E arrived at the team base to ask Ms L to accompany him to the SHARP team for support with getting a job. Ms L advised him that he had no appointment but that she was happy to re-refer him if he was willing to engage with them. There is no indication of Mr E's response to this, only that he expressed anger and frustration waiting for his door and windows to be fixed.

4.139 On 19 August Mr E attended the team base asking to use the phone as he had received a letter from a debt collecting agency who had advised that he owed £3000 to a phone company. Ms L was called by administration staff as Mr E lost his temper and started shouting down the phone. Ms L established that Mr E was trying to arrange repairs to his property but Lambeth Living had advised they had not received a surveyor's report. Mr E said he was upset because the repairs had been outstanding for a long time and he felt unsafe with the windows boarded and the door half broken. Mr E stated that he felt unwell due to the draught coming through the window; he had not been able to go to work and had lost his job as a result. He became tearful, but calmed down with reassurance from Ms L. Ms L agreed to refer him back to the SHARP team. Mr E also asked for help applying for another flat as he didn't feel safe at his address; he described an experience when he felt someone was trying to get into his flat during the night and required a lot of reassurance from Ms L, asking if she believed his story. Ms L suggested that Mr E requested a transfer form and offered to help him complete it. Ms L agreed that Mr E could use the office phone for 20 minutes maximum until he was able to replace his mobile phone.

4.140 On 26 August Mr E approached a duty worker who was about to see another client, and asked to be seen first as he was in a hurry. Staff noted that when Mr E first attended he was observed to be pulling bizarre faces and then started pacing up and down the room, invading other patients' personal space. He appeared irritable and impatient but his medication was provided.

4.141 On 31 August Mr E arrived at the SHARP team looking for support in finding work. He did not have an appointment and staff advised him that as he had not attended the appointments offered to him previously they had returned the referral to Ms L. Staff suggested that Mr E could be re-referred if required.

4.142 During September Mr E collected his medication as planned and asked for some condoms, which were provided. He also reported that he was doing voluntary work in an animal farm in Battersea whilst looking for paid work. Ms L noted that he appeared to have lost weight but Mr E claimed he liked how he looked and said that he was eating well. Mr E reported that he was taking only 1000mg of the 1500mg sodium valproate and Ms L encouraged him to take it as prescribed.

4.143 During October Mr E attended twice to collect his medication. At the first appointment Ms L noted that he looked tired and Mr E said that he had not had much sleep the previous night as his "*girlfriend was around*". Mr E asked for a review of his medication and Ms L agreed to let him have an appointment date when he next collected his medication. There is no indication that Ms L followed up on this during October.

4.144 On 9 November Mr E was seen by a duty worker as he wanted to collect his medication but staff advised him that it was not due until the following day. Mr E also asked that Ms L contact him.

4.145 On 14 November Mr E attended for an appointment with Ms L. Ms L noted that he presented as cheerful, pleasant and coherent, and although his pupils were dilated Mr E denied any illicit drug use. Mr E said that he had not returned the previous week as he had a job interview, which had been successful. Mr E again requested a medical review, as he was not happy with the dose of sodium valproate. Ms L encouraged Mr E to continue with the prescribed dose until he was seen by the consultant.

4.146 On 22 November Mr E attended to collect his medication but was advised that they were not due until 28 November. He was advised to return then as he was also due to be reviewed by the consultant on the same day. His mental state was noted to have been stable.

4.147 On 28 November Mr E attended a Care Programme Approach review with Ms L and Dr A (her first meeting with Mr E as his consultant). Mr E reported that he had a new job and was proud of his efforts in securing and maintaining this. There were no reports of negative symptoms and his risk when well was assessed as low, however when unwell it was noted that there was an increased risk to others of aggression and assault, and he had been known to carry weapons. However during the meeting, Mr E minimised his risk of relapse and risk to others when unwell. Mr E felt that medication helped with feelings of being too active, losing his temper and feeling stressed. He said he had reduced his medication because it made him feel too drowsy and he had gained weight, but agreed to comply with the current dose. A discussion took place about the triggers to previous relapses, including substance use, stress and non-compliance. Mr E said that since his last admission to hospital in April 2011 he had been abstinent of cannabis, including skunk, and cited financial implications and feeling slowed down as reasons. Ms L agreed to update the Care Programme Approach documents and send a copy to Mr E's GP; Dr A did not agree to reduce Mr E's medication and Mr E would continue to collect it fortnightly from the team base. A blood test would be arranged and a home visit by Ms L when appropriate. Mr E said that he had recently

split up with his girlfriend but said that he was close to a few friends he could trust and confide in. Mr E refused any psychological intervention but agreed to support to deal with his freedom pass and inform the team of any changes.

4.148 Between 9 December 2011 and 11 April 2012 Mr E attended to collect his medication regularly every two weeks and staff recorded a stable mental state.

2012

4.149 On 25 April (although not entered into the records until 4 May) Mr E reported that he had lost his wallet and therefore his freedom pass and asked Ms L to help him to complete the paperwork to sort it out. Mr E said that he was taking his medication regularly and talked about his father who had travelled to Portugal for his grandmother's birthday. Mr E said he would have loved to have gone as he missed his grandmother, but was unable to afford the ticket.

4.150 On 3 May Mr E was assessed by the criminal justice mental health services in the custody suite at West End Central Police Station. The following day Ms L received a call to advise that Mr E had been detained. On 25 April he had assaulted his ex-girlfriend by cutting her with a razor blade and on 4 May had subsequently breached the conditions of his bail by approaching her again. Police had arrived at his flat and found boxes of olanzapine and sodium valproate, despite this Mr E maintained that he had been taking his medication. Mr E presented to the criminal justice mental health team as irritable and hyperactive, but with no evidence of psychosis.

4.151 On 14 May Ms L recorded that Mr E had not collected his medication the previous week. He was also expected to attend for assessment after he had been detained for assaulting his ex-girlfriend. Mr E's case was discussed at the team review meeting and it was agreed that he needed to be seen as soon as possible to monitor his mental state and encourage him to return any unused medication. It was also agreed that Dr A would see him two days later.

4.152 The following day Ms L made a home visit to monitor mental, physical and social wellbeing as Mr E had not arrived to collect his medication. There was no response from his door, so Ms L left Mr E a note to inform him of the appointment with Dr A the next day.

4.153 Mr E did not attend his appointment with Dr A on 16 May and Ms L recorded that the team was concerned that his mental health was relapsing and that he posed a risk to others, as it had been reported that he had cut his ex-girlfriend with a razor. It was agreed that Ms L would carry out a joint visit and arrange a welfare check if she was unable to meet with Mr E. Dr A noted that if Mr E presented to A&E due to his mental state, staff should consider admission to hospital to re-start treatment. Dr A also noted his diagnosis of affective psychosis and that when Mr E relapsed his risk of violence was high.

4.154 On 18 May Ms L attempted a joint home visit (it is unclear with whom) to Mr E but there was no answer at his door. Ms L left a note asking Mr E to make contact with the team.

4.155 On 21 May Mr E's case was discussed at the team review meeting. It was decided that he posed a risk to the public, given his recent assault on his ex-girlfriend. It was agreed that his details should be circulated to the police and an alert put on the system for appropriate response should he present at A&E.

4.156 The following day Ms L contacted the police to ask them to conduct a welfare check. Two days later (24 May) Ms L received a message from the police to advise that Mr E had attended a court hearing two days previously (22 May) and had been detained in prison. Ms L noted that there had been no contact from any of Mr E's relatives.

4.157 Ms L sent an email to the Prison Location Service on 31 May, as she had not received any information about where Mr E was being held. Ms L noted that Mr E had never wanted staff to involve his family and therefore she had not contacted them.

4.158 By 26 June Ms L had not received a response from the Prison Location Service and Mr E's case was discussed at the team meeting. It was agreed to ask another member of staff to assist and this resulted in Ms L receiving confirmation that Mr E was being held at HMP Thameside. Ms L noted that she would make contact with the prison to find out how Mr E was.

4.159 On 3 July Ms L received a call from Ms N, probation officer advising that Mr E was due in court the following day. Ms N said that it was possible he would be released back into the community and confirmed that the charges were assault by punching and biting his girlfriend. Ms N reported that Mr E became tearful during an interview and that he maintained that he was taking his medication prior to the incident. Ms N asked whether Mr E had considered receiving his medication via depot as an alternative to oral medication, Mr E said he this had been suggested but he had not agreed to it. Ms L noted that if Mr E were released he would be under supervision of probation and would remain in the care of the community team. Mr E would need to be considered for depot medication and that contact would need to be increased through joint visits.

4.160 The following day Ms L contacted Ms N for the outcome of the court hearing. Ms N advised that Mr E was in the community under supervision from that day and that he had been given a six month prison sentence, suspended for 12 months, and an indefinite restraining order to never have contact with the girlfriend that he assaulted. Ms N said that the plan was for Mr E to be inducted for probation the following day.

4.161 On 5 July Mr E attended for monitoring; he was cheerful and said he had been "*on holiday at the Thames*". Ms L noted that his mental state was stable and that his speech was coherent and behaviour was appropriate. Mr E asked to use the phone as he needed to reinstate his benefits as he thought they had been stopped whilst he was in prison. Mr E spoke about the incident that led to his arrest and confirmed he had been drunk, got involved in a fight and got himself into trouble. Mr E wanted his medication and Ms L suggested that he had a review before starting on medication again but Mr E said he had been on the same medication whilst in prison. Ms L arranged for Mr E to see Dr A

the following Monday for a medication review. Ms L noted that Mr E should be considered for depot treatment, as he was not compliant with oral treatment.

4.162 On 9 July Dr A started an entry but there is no text.

4.163 On 11 July Mr E attended the team base and was seen by Ms S-J and the duty worker. He was given two weeks' medication, staff noted that he appeared restless but was polite and claimed he hadn't taken his medication since the previous day. Mr E took that day's medication whilst supervised. Mr E said that he had to attend the police station to collect his identification from when he was arrested but that he couldn't find the crime reference number, which he needed, and said this was why he felt restless. No other concerns were reported or observed.

4.164 On 14 July the community mental health team received a call from liaison psychiatry at St George's. Mr E had presented with a shoulder injury (fractured collar bone) but had been unable to give an account of how he received the injury. Additional St George's staff were concerned that he was taking no notice of the injury. St George's staff asked for information about recent reviews and were advised that the community mental health team had no current concerns.

4.165 On 18 July Mr E's GP, Dr P, received a call from Mr E's key worker at the community health team. Dr P was advised to provide a sick note for three months from 4 July. Dr P provided the sick note as requested.

4.166 The following day Mr E attended the community mental health team asking to use the phone to "*sort out his benefits*". He was escorted into a room and a member of staff (Ms M) stayed with him briefly, however Mr E's body language and tone indicated he was agitated. Ms M asked for support from a colleague, E, who sat with Mr E whilst he made some calls. Staff agreed that Mr E could use the team fax machine to receive some correspondence from the prison where he had recently been detained.

4.167 On 24 July Mr E was seen by the duty worker who noted that Mr E looked anxious but fairly settled. Mr E stated that somebody from the team had recently helped him complete a housing benefit form but had forgotten to sign it. Eventually Mr E said that there were some mistakes on the form and as such he wanted a new application completed. A crisis slot was offered for Mr E to see the benefits advisor the following day.

4.168 The following day Mr E attended the team base and asked to use the phone to call his electricity supplier, as he believed he was in credit. Mr E said that he had not used much electricity and had been away for about two months. Mr E also had a housing benefit form and asked for the person who helped him complete the form to sign it. Mr E had not attended the appointment with the benefit advisor that morning, and was invited to make another appointment but Mr E left the building.

4.169 On 1 August Dr A completed a document to advise that Mr E was not able to drive, given his medical condition, and in accordance with DVLA Medical

Standards of Fitness to Drive. Mr E was informed in writing, and this was copied to his GP and care co-ordinator, Ms L.

4.170 On 9 August Mr E presented at the team base and reported that his benefits had been stopped for over a month. Mr E asked for a doctor's certificate for him to take to the job centre and said he had no money to buy food and that the job centre would not give him a crisis loan without a medical certificate. The duty worker called Dr A who said that she wanted to see Mr E before she would provide a certificate. It was noted that Dr A and Ms L would be in on the following Monday and Ms L would be asked to call Mr E to offer him an urgent appointment. The duty worker gave Mr E a requisition for food which he could collect the next day.

4.171 On 13 August Mr E attended the team base to collect a sick note for the job centre in order to reinstate his benefits. His mental state was assessed by Dr A and a sick note given for six months. Mr E assured staff that he was taking his medication as prescribed. Mr E was advised to make an appointment with the GP for a physical health check. Mr E advised that he was considering going back to college as he enjoyed art classes in prison. Dr A said that a medical review should be planned for the following month.

4.172 Mr E collected his medication twice more during August and although he was offered a food voucher in response to a request, he then said that he didn't have time to wait for the voucher.

4.173 On 3 September Mr E attended a medical review with Dr D (who was covering for Dr A) and Ms L. Mr E told Dr D that he felt stressed and that he might "*lose it and do something*" because nobody was helping him. Mr E's current difficulties were noted as:

- benefits not reinstated since he left prison;
- in arrears with rent;
- wants to get another job – he had previously worked for a few hours as a cleaner;
- wants to move house as doesn't like the neighbours;
- he was given another puppy the previous week, it became injured when it trapped it's foot in the door and was given treatment by the emergency medical centre;
- he had run out of money for food, having spent it on dog food,
- he was collecting vouchers from the team base but was not eligible for another crisis loan;
- he had been caught shoplifting (sugar) and was on probation;
- he had lost his freedom pass.

4.174 Mr E said he had got angry at the weekend and had "*trashed his flat*". He was vague about the details but said it lasted minutes not hours. He admitted that he got angry easily sometimes but denied recent violence to others. Mr E said that he had been given cannabis and cocaine over the weekend but was unclear about the quantities. Mr E said that he owed people money and that they would come to his flat to collect it. Consequently he didn't feel safe in his home, and Mr E said if they threatened him he would defend himself and might harm someone. Mr E acknowledged that he had been unwell and needed hospital treatment in the past, also said "*I'm a bit naughty sometimes*". He agreed that illicit substances and alcohol generally made his mental state worse but said "*I'm not addicted, don't buy it, don't use it often*". He agreed that medication helped him and said that in the past he had missed tablets when drinking alcohol. He said that he had not missed any tablets in the previous week but Dr D noted a history of non-compliance. Mr E said that he didn't want to go to hospital; a particular concern was that he had to look after his dog and follow up on its injury. Dr D found no signs of mania or psychosis, but noted some paranoia re neighbours. She also noted that based on his history, Mr E did present a risk to others, but at that time his presentation appeared to relate to personality difficulties and substance use rather than manic psychosis, although the risks would further increase if his mental state deteriorated. Dr D agreed that the community mental health team would increase their contact with Mr E and monitor his beliefs in relation to paranoia; Mr E should continue taking his medication, avoiding illicit substances and alcohol; and that Mr E should contact police or attend A&E if feels threatened by neighbours. Ms L would discuss the situation with Mr E's probation officer and that if Mr E deteriorated further, home treatment team intervention or hospital treatment should be considered.

4.175 On 21 September Ms L saw Mr E with Ms N, his probation officer. Initially Mr E presented as stable and engaged, although Mr E said that he had toothache and had taken paracetamol. He reported that his dog was better and said that he wanted to keep it as a companion. Mr E confirmed he was collecting and taking his medication and was looking forward to returning back to work as soon as possible. Mr E was encouraged to get involved in activities that would prepare him for work. Mr E gave verbal consent for Ms L to share information with Ms N. Ms N described the expectations of Mr E whilst on probation and reminded him that the aim was to support him with his difficulties with relationships, in particular with women as he had recently assaulted his partner. However Mr E did not want to address the issue. Ms N reported that Mr E had been punctual in his attendance with probation, however the sessions appeared to be a struggle, as Mr E got defensive when talking about the incidents that led to his detention. Mr E denied drug use and any issues relating to his current bail condition. He did not want to discuss his current relationship but did disclose that he had had a relationship that lasted two days. Mr E became agitated and "*turned away from the meeting*" when the conversation about the relationship intensified, he stated that he didn't want to discuss it as *"they always leave me anyway*". Mr E said he would rather go back to prison than talk about the incident that led to his last arrest. Ms N confirmed that Mr E had actually cried during sessions when the issues had arisen and that he sometimes had become agitated. Ms N planned to seek

help from colleagues who were experienced in this area and from male staff if possible.

4.176 On 2 October Mr E collected 2 weeks' supply of medication; staff did not record their assessment of his mental state. However Mr E did not take up the offer of passing a message to Ms L. The following day Mr E arrived at the team base in crisis. He had not received any benefit since leaving prison in July 2012 despite submitting the document requested. Ms L supported Mr E by contacting the job centre to find out what had happened. Ms L was informed that Mr E was not entitled to ESA[25] as he did not meet the requirements for the right to reside and therefore was not considered to be habitually resident in the UK. Mr E confirmed that his passport had expired and that he had no money to apply for a new one. Ms L offered Mr E some food items donated by staff and a voucher to collect from the food bank.

4.177 Two days later, on 5 October Mr E attended the team base to discuss the outcome of the ESA application. Mr E advised that he was in arrears with his rent and council tax and feared he might lose his flat as his housing benefit had stopped until he had proven that he was in receipt of benefits. Mr E was also concerned that somebody else may have used his details to claim other benefits. Ms L contacted the job centre and was told that their decision was based on the fact that Mr E failed the habitual residency test. Ms L attempted to clarify Mr E's situation and the job centre advised him to appeal against the decision.

4.178 On 8 October Mr E attended the office with his appeal form. He was supported in completing the document and staff noted that he appeared brighter in mood and more positive in approach to his current financial difficulties. Mr E reported that he now had a phone and that his father had given him some money over the weekend. Mr E realised that it was easier to seek help from family than borrowing money from friends. Mr E said he was fearful of his friend to whom he owed money and was concerned that his friend was going to increase the amount of money Mr E owed.

4.179 On 16 October Ms L called the office to request a home visit for Mr E as Ms L was off sick that day. Mr M and Ms W knocked on Mr E's door for a while but "*he was either out or was refusing to let them in*".

4.180 Two days later Mr E met with Ms L and his probation officer Ms N for a review. Ms N reported a slight improvement in her working with Mr E as he had demonstrated insight to his problem and had agreed to a different approach towards his life and setting some realistic goals. Mr E said he would rather go back to prison as he was able to gain some skills when inside, which he had not been able to do in the community. It was noted that Mr E was struggling financially due to the delay in getting his benefit, as the job centre had not received the paperwork. Mr E wanted to find a job as soon as possible to

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[25] *Employment and Support Allowance (ESA) is a benefit for people who are unable to work due to illness or disability. There are 2 types of ESA, and you may be entitled to one or both of them:* ***Contribution-based ESA*** *- you can get this if you've paid enough National Insurance contributions. It's taxable.* ***Income-related ESA*** *- you can get this if you have no income or a low income. You don't have to have paid National Insurance contributions and it isn't taxable. www.ageuk.org.uk*

support himself. Ms L suggested a referral to First Step Trust[26] but Mr E declined. Ms L and Ms N asked Mr E to consider engaging with the employment worker to help him with writing a CV. Two weeks' supply of medication was given to Mr E.

4.181 On 26 October Ms J-B contacted the benefits office to correct Mr E's mobile number and was able to get a face to face appointment for him on 30 October. Ms L called Mr E to inform him about the interview, importance of attending and proof of identification that he would have to take. Mr E was made aware that if he missed the appointment his benefits would be affected. Mr E was advised to go to A&E if he became unwell over the weekend.

4.182 On 30 October Mr E attended the team base after his appointment at the benefits' office. He appeared vague and incoherent and did not maintain good eye contact during the meeting. Ms L noted "*it was obvious that he had smoked cannabis*", which Mr E confirmed. Mr E revealed that he had not been taking his medication since July and that he was beginning to feel unwell. Mr E expressed difficulties with no income and agreed to attend Spires for food, a change of clothing and to have a shower. Mr E felt this was becoming his routine, he was not happy to live like that and he constantly had urges to commit crimes and return to prison. Mr E was engaged with probation but said he would rather not attend. Mr E reported that he was being charged with a driving offence that he had committed in March 2012 and would have to appear at Bromley Magistrates Court. He said he was pleading guilty because he had no road tax or insurance at the time. Ms L helped Mr E to complete the form to enable him to pay the fine and avoid going to prison and noted that Mr E would see his consultant the following day for a review.

4.183 The same day Ms L received an email Ms N, Probation advising that Mr E had attended that day and had been "*quite incoherent*". He had claimed not to have taken his medication as he had no food, and his medication made him hungry. Ms N reiterated the importance of taking his medication however he got very annoyed about this and the fact that he continued to have no benefits. Mr E had decided to sign up to JSA[27] and he had an appointment at the job centre on Thursday at 11:30. Ms N suggested a home visit, however Mr E got very defensive and asked why Ms N needed to do this. Ms N said she would raise it again the following week, however she was unable to make unannounced home visits so there was nothing she could do if Mr E declined to meet her.

4.184 On 31 October Mr E attended an urgent review with Ms L, a student nurse Ms C and Dr A. There were concerns about Mr E's mental health due to non-compliance with medication and threats of harm to others after Mr E received a letter that his appeal for benefits had failed. Ms L noted that a court case on

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[26] First Step Trust is a charity that runs social enterprises to provide work and training opportunities for people excluded from work because of mental health issues or other disadvantages, including drug and alcohol recovery problems and a history of offending. http://firststeptrust.org.uk/about/

[27] Job Seekers Allowance (JSA) is an unemployment benefit that can be claimed whilst looking for work. Eligibility criteria apply and the type of allowance paid is dependent upon what the claimant is entitled to. https://www.gov.uk/jobseekers-allowance

that matter was scheduled for 20 December. Mr E reported feeling distressed, upset, frustrated and angry. He said he did not think it was fair that for the past six months he had received no benefits (since release from prison) and that nothing had happened despite his efforts. Mr E said that he was getting into debt with rent arrears and that friends had lent him £200 for food. It was noted that Mr E received food vouchers from the team and that he had attended Spires day centre, however Mr E felt ashamed of his current situation. It was recorded that Mr E was clear that there was a part of him that wanted to get through this period of difficulty with support as he had attended appointments and had responded to calls and letters. However it was also recorded that part of Mr E felt angry and thought "*why should he be taking his medication*" that "*makes him angry and I don't need so much anyway*". Mr E acknowledged his mental health condition and that if he was non-compliant for a period he could relapse. The team explained the longer-term effects of having several episodes and his condition becoming more difficult to treat. Mr E said that he had considered breaching his probation by not attending a few appointments so that he could be back in prison and have food and vocational activities. The team recorded that their emphasis was on hoping that things would resolve. A referral to the home treatment team was considered but Mr E was reluctant about this approach and said he would attend the team base on average twice per week. It was therefore agreed that if there were any further deterioration in his mental health, or if he stopped collecting his medication, or stopped attending the team base that Mr E would be referred to the home treatment team so that staff could monitor his compliance with medication and provide additional support from services to prevent an admission under the Mental Health Act.

4.185 On 7 November Mr A, Benefits Advisor advised Ms L that Mr E had been into the community mental health team base the previous Wednesday seeking reassurance about his benefit. Mr A encouraged Mr E to proceed with his application for JSA whilst waiting for the decision of his appeal for ESA. Mr A reported that he did not observe any psychotic symptoms at that time and that Mr E engaged well. The outcome of the meeting resulted in the need for Mr E's doctor to write a letter to support his ESA claim.

4.186 On 9 November Ms C, student nurse recorded that Ms L had received an email from Ms N requesting that a mental health nurse be present at her next meeting with Mr E at his home address on 22 November. The purpose of this would be to monitor Mr E's mental health, review his living environment and assess his current needs. Attempts by Ms C to contact Mr E on his mobile were unsuccessful. Mr E had previously told Ms C and Ms H that he wanted to sell his phone as he didn’t have enough money to support himself. Mr E was discouraged from doing so as it would limit the ability for him to receive calls regarding his benefit queries and limit his ability to engage with the community mental health team. It was agreed that Ms L would attend the home visit with Ms N on 22 November, and follow up on the consultant letter to support Mr E's application for benefits.

4.187 On 12 November Mr E met with Ms L and Ms C to inform them of the new development in his claim for Job Seekers' Allowance (JSA) and Employment Support Allowance (ESA). Mr E appeared bright, pleasant and engaged well.

He was appropriately dressed for the weather, reported that he had been compliant with his medication and denied any sleeping problems. Mr E handed in a letter he had received from the job centre in response to his appeal against the decision to disallow income related ESA. The letter stated that Mr E was not a qualifying person, as he did not satisfy any of the categories prescribed in Regulation 6 of the Immigration Policy[28]. It further stated that Mr E was not treated as habitually resident in the UK because he did not have a right to reside in the UK, unless he could provide evidence that he was seeking employment in the UK and had a genuine chance of being engaged. Ms C advised that Mr E's consultant would write a supporting letter to accompany Mr E's appeal. Ms L planned to continue to support Mr E with his benefit claim, and offer weekly reassurance. The next planned appointment would be the home visit with the probation officer on 22 November.

4.188 On 17 November (but not recorded until 19 November) Mr H (role unknown) attempted to conduct a mental health screening assessment at West End Central Police station. Mr E had been arrested for breach of a court order issued on 4 July 2012 in relation to harassment of a female. The arrest following an argument Mr E was having with the same female. Mr E attended for interview but did not engage meaningfully with the assessment, often presenting in a surly manner, however there were no obvious florid or acute mental health symptoms that would indicate admission to hospital. Mr E denied many symptoms, although admitted to some stress linked to financial problems. Mr H reported that Mr E appeared to be engaging with the community mental health team and that he had reporting being compliant with his medication.

4.189 On 19 November Ms H recorded that she had received information from a Ms B, forensic mental health practitioner that Mr E had been out drinking with his ex-partner. Mr E had clearly been intoxicated and he was reported to have pushed his ex-partner resulting in police involvement and Mr E being taken into custody. Ms B gathered from Mr E that he had some psychological

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[28] *"Qualified person"*

6.—(1) In these Regulations, "qualified person" means a person who is an EEA national and in the United Kingdom a

(a) a jobseeker; (b) a worker; (c) a self-employed person; (d) a self-sufficient person; or (e) a student.

(2) A person who is no longer working shall not cease to be treated as a worker for the purpose of paragraph (1)(b) if

(a) he is temporarily unable to work as the result of an illness or accident; (b) he is in duly recorded involuntary unemployment after having been employed in the United Kingdom, provided that he has registered as a jobseeker with the relevant employment office and (i) he was employed for one year or more before becoming unemployed; (ii) he has been unemployed for no more than six months; or (iii) he can provide evidence that he is seeking employment in the United Kingdom and has a genuine chance of being engaged; (c) he is involuntarily unemployed and has embarked on vocational training; or (d) he has voluntarily ceased working and embarked on vocational training that is related to his previous employment. (3) A person who is no longer in self-employment shall not cease to be treated as a self-employed person for the purpose of paragraph (1)(c) if he is temporarily unable to pursue his activity as a self-employed person as the result of an illness or accident. (4) For the purpose of paragraph (1)(a), "jobseeker" means a person who enters the United Kingdom in order to seek employment and can provide evidence that he is seeking employment and has a genuine chance of being engaged.
http://www.legislation.gov.uk/uksi/2006/1003/made

problems that he needed help dealing with but that he was not accepting the help available to him.

4.190 A report completed by Ms B dated 19 November highlighted that during interview Mr E was unclear when his community order started, whether he was on a suspended sentence order, or whether there were additional requirements on his order. Ms B described Mr E's engagement as "*superficial*" and indicated that it was her view that he required ongoing intervention around managing the emotional difficulties within intimate relationships. It is not clear whether this report was shared with the Trust community mental health team. We found the report in the clinical records provided by Oxleas NHS Trust.

4.191 Also on 19 November HMP Belmarsh health records indicate that Mr E disclosed that he was in receipt of medication for mental health problems and that he was known to the community mental health team in Streatham. Mr E was prescribed olanzapine 20mg and valproate sodium 1000mg. There is no indication that staff had confirmed the details of Mr E's prescription with either the community mental health team or Mr E's GP prior to issuing the prescription.

4.192 The following day, 20 November, Ms L received an email from Mr E's Probation Officer, Ms N advising that she had managed to get confirmation from the court system that Mr E's suspended sentence order had been activated the previous day and that he had been sentenced to 24 weeks in custody, this took into account the 60 days he had served on remand for the previous offence. Ms N advised that Mr E would be released in 12 weeks' time with no order and no supervision and Ms L noted that Mr E was currently in HMP Belmarsh. Ms N advised Ms L that the home visit planned for Thursday would no longer go ahead and that she would leave it to the discretion of Ms L regarding informing the housing department. Ms K further advised that the offence had been committed against the same victim and that she was planning to contact the police to get new contact details for the victim. There is no evidence that Ms L took any action to inform mental health services at HMP Belmarsh of Mr E's current care plan and risk assessments.

4.193 On 27 November Dr A sent a letter supporting Mr E's appeal against the decision to disallow his income related ESA from and including 4 July 2012.

4.194 On 30 November Mr E received a first hepatitis B vaccination, administered by health staff at HMP Belmarsh. Staff noted that the next vaccination was due on 7 December, however we can find no evidence that this was followed up.

4.195 On 6 December Mr E, social care manager at HMP Belmarsh, spoke to someone from the Streatham community mental health team who confirmed that Mr E was known to the team. Mr E was not able to speak to Ms L as she was not on duty, however Mr E was advised to call again the following day.

4.196 On 7 December Ms L received an email from Mr E at HMP Belmarsh confirming an earlier telephone conversation. Mr E advised that Mr E had reported to the Inreach Mental Health Team at HMP Belmarsh that he had

mental health problems and was under the care of Ms L. Mr E requested that Ms L forward information about Mr E's psychiatric history, reports, medications and any other relevant information so that Mr E could be appropriately managed whilst in prison. Ms L forwarded the email to Dr A for her to respond, which she did on 11 December. Dr A advised that Mr E was being prescribed olanzapine 20mg and sodium valproate 1000mg. Dr A also advised that Mr E had a "*significant forensic history*" with arrests prior to 2007 and thereafter convictions of assault on his girlfriend/ex-girlfriend on three separate occasions; assault on a stranger, and criminal damage.

4.197 On 11 December Mr E attempted to speak to Ms L to inform her of Mr E's release, however Ms L was not available. There is no record of the conversation between Mr E and the member of staff from the community mental health team in Trust records.

4.198 On 12 December Ms L received an email from Mr E at HMP Belmarsh that he had sent the previous day. The email stated that Mr E was being released the following day (12 December) and that Mr E had left several messages for Ms L to contact him but he had not heard from her. Mr E stated that Mr E would be released from HMP Belmarsh the following day and that his mental state appeared settled, he had been given a week's supply of medication and that Mr E's GP would be notified. Mr E said that that he would see Mr E just prior to release and advise him to report to Ms L. As Mr E had been released from prison by this time, Ms L immediately contacted Mr E to arrange an assessment for the following day and recorded that Mr E sounded cheerful and coherent in his speech. Mr E advised that he would be attending the job centre the following morning to sort out his benefits and that he would attend the community mental health team afterwards. Ms L planned to meet with Mr E the following day, encourage him to stay for the Christmas dinner, and arrange a medical review and a joint home visit as soon as possible.

4.199 The following day staff saw Mr E briefly when he came for the Christmas party, but he left before Ms L could engage with him. It was reported that he sounded incoherent in his speech and appeared confused about being there. He was leaving the building as Ms L approached him but promised to come back on Friday. Ms L planned to see Mr E on the Friday when he came to collect his medication and would arrange a medical review with his consultant.

4.200 On 17 December Mr E's case was discussed at the team review meeting. It was suggested that if Mr E did not attend for monitoring, he should be referred to the home treatment team. Mr E did not attend and so a referral to the home treatment team was made at the end of the day. Ms L from the home treatment team suggested that it would be practical for the community team to meet with Mr E and assess him properly before making a referral if necessary; the referral was not accepted. The home treatment team said that they would only accept a referral if the client had given consent. Given that the community mental health team had been unable to contact Mr E, he had not consented and therefore the referral was rejected.

4.201 On 20 December it was reported to Ms L by a colleague that Mr E was seen coming into the community mental health team base. Mr E was gone by the

time Ms L got down to see him. Ms L recorded that Mr E's mobile number was no longer working when she tried to call him. Ms L planned to carry out a home visit as soon as possible and to deliver Mr E's medication before the weekend.

4.202 On 24 December Mr E did not attend to collect his medication and for staff to monitor his mental state. Mr E's case was discussed at the team review and it was agreed to carry out a joint visit to deliver his medication. Ms L went to Mr E's flat that day with a colleague but there was no sign of Mr E so the medication couldn't be delivered. A crisis information leaflet was posted through Mr E's letterbox and information that Spires[29] would be open on Christmas Day for him to spend the day with others and where he could get a cooked meal. Ms L noted that she planned to make contact with Mr E by the end of the week.

4.203 On 28 December Ms L received a call from Ms D at the Single Homeless Unit to advise that Mr E had been referred to them as he was about to be evicted for non-payment of rent. Ms D stated that she had already met with Mr E whose behaviour had been inappropriate during the meeting and therefore Ms D wanted more information about Mr E's mental health. Ms L advised that Mr E was not engaging and that staff were unsure how he was at that time.

2013

4.204 On 4 January Ms N advised Ms L that she had not heard from Mr E. Mr E had not attended his appointment with Ms L that day. Ms N thought it likely that his flat had been repossessed during his sentence but Ms N had not heard anything from the housing department.

4.205 On 7 January Ms L discussed Mr E's case at the clinical review meeting. The plan was to carry out another joint visit to try and supply his medication. Later Ms L received a call from Streatham Police Station asking for contact details for Mr E, as there had been a murder at his flat and he was a suspect.

4.206 On 9 January Dr P, Mr E's GP, wrote to the community mental health team to advise that no recent Care Programme Approach information had been received. Dr P requested an update on Mr E's mental health state, current medication and care co-ordinator details.

4.207 On 14 February Dr P wrote to the Trust internal investigation team to advise that he had not seen Mr E since 23 April 2012 and that the last correspondence he had received from Streatham community mental health team had been 28 November 2011. Dr P had requested an update on Mr E's care plan on 9 January 2013 and as at 14 February he was still waiting for it to arrive.

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[29] *Spires is a South London based charity that helps hundreds of homeless and disadvantaged people all year round. We work to improve the quality of life of people who are homeless, insecurely housed, unemployed or suffering from the effects of poverty, mental ill health and loneliness.http://lambethandsouthwarkmind.org.uk/directory/spires-centre/*

5 Arising issues, comment and analysis

5.1 Mr E had been in the care of the Lambeth early onset team from April 2006 until March 2010. During this time Mr E had three admissions; one of which was an informal admission; one was under Section 2 and the third was under Section 3. On both occasions he was admitted under section he was transferred to a PICU bed elsewhere.

5.2 Mr E often maintained a distance from clinical teams and was reluctant to have any discussion about his offending behaviour, either with clinical staff or his probation officer. Mr E's refusal to engage with clinical teams worsened to the point that he was only happy to discuss his housing or benefit issues, nothing else. This pattern of contact continued and the community mental health team did not intervene to change it. If there were discussions about how to more effectively manage him, these were not documented in his clinical record, and any actions made no change to Mr E's lack of engagement.

5.3 Mr E's care co-ordinator from April 2010 until the time of the offence had no previous experience in working with adults with a forensic history or with drug and alcohol issues. The team had been newly reconfigured and had an increased caseload.

Engagement with clinical teams

5.4 A common pattern appeared in February 2008 of Mr E not attending scheduled appointments but arriving at the community mental health team base at another time in order to collect his medication. A consequence of this was that he was usually then seen by the duty worker. When staff sought to understand his mental state, Mr E would often leave the building and not engage with the clinician.

5.5 The Trust Care Programme Approach Policy addresses poor engagement with services under the sections "*Loss of contact with services*" and "*Refusal to maintain contact*". These sections state:

"Loss of contact with services

14.1 New CPA *If it becomes clear that contact with a service user has been lost, a review meeting should be held to consider the next steps. Each member of the team should make every reason- able effort to re-establish contact. Consideration should be given to contacting the following: carer/family, service user's GP, local A&E departments and community teams in other Trusts. The Care Co-ordinator will take responsibility for co-ordinating this. "*

"14.3 *If contact is lost with a service user who, it is judged will pose a serious risk to themselves, or others, then immediate consideration should be given to informing the police."*

"Refusal to maintain contact

15.1 *This procedure applies to service users under the care whose whereabouts and physical wellbeing is known and who have made it clear that they refuse to engage with services.*

15.2 *Refusal of engagement should rapidly be discussed within the MDT and communicated to the GP. An assessment of the risks that the service user presents to him/her self (including risks of self-neglect), or others, should be undertaken and plans made accordingly. Such individuals should be on (New) CPA.*

15.3 *In some circumstances consultation with the Forensic Psychiatric Services may be advisable. The Clinical Director should also be consulted.*

15.4 *Consideration should be given to carrying out a mental health assessment with a view to compulsory admission to hospital.*

15.5 *Where there are serious concerns regarding the safety of children, family members or the public, consideration should be made as to whether the police should be informed of the situation / child or adult protection referral.*

15.6 *In all cases, an action plan should be set out following discussion within the team and where appropriate family members and other carer (s). The action plan should be clearly documented in EPJS. This action plan is likely to include the following elements:*

- *A formal review during the initial six months following attempts to engage the service user in services.*
- *Prior to this review there should be a wide-ranging consultation of people involved in the service user's care/support, which might include some or all of the following: team members, GP, carer (s) and family members and other relevant agencies as appropriate i.e. housing associations, housing officers and voluntary sector agencies.*
- *A team decision on the minimum type of contact with the service user, for example, an attempt to visit, an offer of outpatient appointments once every three months, or support/monitoring via a third party such as a housing support worker."*

5.6 Mr E's refusal to engage with services was not communicated to his GP and we have found little evidence of discussion within the multi-disciplinary team about how to manage Mr E's reluctance to engage with the community mental health team in managing his mental illness. We can find no evidence of any discussion about a referral to the forensic service.

5.7 The only intervention by a forensic service practitioner we have found documented was after Mr E was arrested in November and an assessment was conducted in the police cells.

5.8 A referral to the home treatment team after Mr E was released from prison was rejected. When we spoke to the manager of the home treatment team

she told us that the process for referral into the team is to gain the consent of the client. As the community mental health team had not been able to meet with Mr E, his consent had not been given and therefore the referral was not accepted. The home treatment team manager told us that the team did not provide an outreach service, although the Trust used to have assertive outreach teams but this function had been absorbed into community mental health teams in "*around 2010*". During interview Ms L told us that the team "*thought that the home treatment team would work with him intensively to make sure that he took his medication*".

5.9 Despite an unsuccessful home visit on 24 December, and concerns that Mr E had not had any medication since release from prison on 12 December, there was no escalation of Mr E's lack of contact with services.

5.10 During the internal investigation the team leader told the internal investigation team that if the team had concerns and they hadn't seen the patient, they escalated the issue by asking the police to do a welfare check. However, this did not happen when the team was unable to assess Mr E following his release from prison.

Risk assessment and third party information

5.11 The Trust Clinical Risk Assessment and Management of Harm framework identifies that:

"Service users moving into or out of prison is another key area where clinicians must ensure that risk and essential clinical information is passed on to the relevant professionals."

"A Full Risk Assessment (FRA) must be completed for service users:

- *Where completion of the Brief Risk Screen indicates that further more detailed (assessment (Full Risk Assessment) is required*
- *At the first and every subsequent CPA review*
- *When there is a significant change of circumstances for example:*
    - *On admission;*
    - *When moving between services;*
    - *When commencing shared care;*
    - *When granting leave;*
    - *On discharge.*
- *At the request of another agency e.g. a day centre, or housing association*
- *At times of known high-risk for example:*
    - *During the post discharge period following a depressive episode;*

- *When facing new personal or family responsibilities or challenges;*
- *Following disclosure by the service user about something of concern (e.g. domestic violence or abuse);*
- *Whenever there are concerns."*

5.12 The policy encourages staff to consider all possible sources of information but is unclear about how information could be obtained from family members when there is no consent from the service user.

5.13 In Appendix 3 of the policy it states:

"It is acknowledged that currently the pressure of working within busy inner city urban mental health centres compromises best practice in risk assessment. There are a number of implications for resources, most notably staff time. A full detailed risk assessment means close scrutiny of notes, seeking information from other services, interviews with the service user and carers, MDT meetings and time to document and share the information with those who need to know. Teams should look at systems for determining priorities for service users who need a more detailed risk assessment, including how this could be built into current working practices (for example via case presentations or reviews). Team leaders may need to look at allocating time to staff to achieve this objective and at setting realistic time-scales for completing more thorough risk assessments. If teams feel they cannot meet the standards as set out in this document due to lack of time or resources this should be discussed with their Service Manager."

5.14 It is of great concern that the Trust identifies that best practice in risk assessment is compromised by the pressure of inner city urban mental health centres. It appears that this statement provides a rationale for delivering sub-standard care and places the responsibility for dealing with the problem with team leaders.

5.15 Ms L told us that there was not a consistent approach by staff in assessing Mr E's mental state. Ms L was not able to clarify this further other than to say that some information that her team had about Mr E was incorrect (such as his mother's telephone number). Ms L also indicated that this (inconsistent approach) had changed and that there is a more structured approach when assessing clients now, however she said that the team now relied more upon information from friends and family members, neither of which was engaged with the team in the case of Mr E.

5.16 During interview Ms L told us that Mr E was someone who "*usually came out in a red/amber zone…because he was not picking up his medication on his usual pick up, or he has not attended a CPA or medical review appointment*". Ms L told us that there were discussions about Mr E at zoning meetings but that these records were held separately from the clinical records. We asked whether any information from the zoning meetings was recorded in the relevant clinical record and Ms L told us that at the time this was not the case, but now individual clinicians were expected to add the relevant information to clinical records. However Ms L also told us that although this was what was

expected, clinicians did not always input the information into client records in a timely fashion and that sometimes records were updated retrospectively.

5.17 The community mental health team operational policy provides information about identifying which zone clients should be categorised in and how to manage care, treatment and clinical discussions for each zone (red, amber and green). The operational policy states that the administrator will be responsible for recording the clinical discussions and for ensuring that a copy of the relevant discussion is present in the clinical records for each client discussed.

5.18 Ms L told us that she felt there was a short period of time when the majority of the team knew Mr E "*very well*", but that following a team restructure this changed, and it became only Ms L that knew Mr E. Ms L told us that the only time concerns were so significant that the team reported Mr E as a missing person, was when they then found out that he was in prison for having had contact with his ex-girlfriend.

5.19 As we have said previously, Mr E appeared to engage with the clinical team only when it suited him to do so and even then only on a superficial level. We asked Ms L whether the absence of third party information about Mr E impacted upon her assessment of his risk. Ms L told us that it did not.

5.20 Ms L told us that at the time the "*information was not available for her to know who [Mr E] was*" and that she would meet with him "*on the grounds that he was a likeable person*" and usually on her own. Ms L told us that "*what scares me now is that if I had his information now I would have done things differently*". We found these statements particularly concerning because all of Mr E's risk information was available to read in the electronic client records that Ms L had access to.

5.21 Dr A told us that as Mr E's engagement with the team was difficult, it would have been useful to have "*collateral information*" but the team did not have any contact details for Mr E's family and did not have his permission to speak to them. However she acknowledged that having information from Mr E's family would have been useful, particularly in understanding his early history and whether Mr E had been witness to any violence. Dr A was clear that the only way the team could override Mr E's wishes for them to have contact with his family was "*if there was a particular risk to those individuals*".

5.22 It is our view that further guidance should be provided to staff on how to respond to situations where a client is refusing to engage with clinical teams and there is a known and documented risk to others. Community mental health team staff were reluctant to make contact with Mr E's mother as he had stated he did not want her involved in managing his care. Clinical team staff could also have considered talking with Mr E's girlfriend/ex-friend about how he presented when he was with her. Although Mr E had not provided consent for this, the presence of the risk to the girlfriend/ex-girlfriend was known by staff. It would have been entirely appropriate for staff to obtain relevant information from either of these collateral sources without divulging any clinical information about Mr E.

Drug and alcohol use

5.23 There is clear evidence of Mr E's significant drug and alcohol use over a long period of time. Dr A told us that although Mr E was reluctant to talk it didn't mean that "*we can't continue to ask the question, so I think we would use every opportunity to bring the topic up in a way that doesn't seem judgmental or punitive*". Dr A was clear that the therapeutic relationship would "in time" allow the person to be honest with the team.

5.24 Dr A also described the team seeing the whole picture, including risks and treatment options, and continuing to offer solutions on site, rather than sending Mr E to another team which might create a missed opportunity. Dr A also described bringing a range of expertise into the team so that there is an individual particularly skilled in (for example) dual diagnosis. However this was what was happening in 2016 rather than in 2012.

5.25 Dr A said that "*there was an awareness that we didn't know enough*" and described that there would have been an escalation way and a pathway that the team could discuss in a more multidisciplinary way. However we have not found evidence of these discussions impacting positively on the way that the community mental health team was able to engage with Mr E.

5.26 We discussed with Dr A the issue of a urine drug screen (UDS) being used to help to managing Mr E's drug use. Dr A told us that community mental health teams had access to a UDS if requested but that the team also needed to have expertise in managing the consequences of the UDS results in working with the client.

5.27 Dr A told us that Mr E had been offered a UDS on numerous occasions, including in inpatient settings, and he had always refused. Dr A was clear that in order to use a UDS constructively in a community setting would be to help clients to engage in tackling their drug and alcohol use in a collaborative way. This is in accordance with the Trust policy on the Care and Treatment of Service Users with Dual Diagnosis.

5.28 That same policy states:

"A range of physical, psychiatric/psychological and social risks are associated with dual diagnosis (see for example Banerjee et al 2002, DH 2002a, University of Manchester 2006, DH England and the devolved administrations 2007, DH/National Treatment Agency 2011). These may result in harm to the person themselves and/or to others (eg carers/family, children, staff, wider community). Thorough risk assessment and management are essential when working with this group."

"Risk assessment must identify the risks associated with mental health, substance use and the interaction of the two, and include risks posed to service users, their family and carers, children, staff (on and off Trust premises eg in service users' homes) and others in the wider community. The risk to children, including the unborn, and young carers must be assessed. The possibility of the service user posing a risk to 'adults at risk' (vulnerable

adults) or being an 'adult at risk' themselves must also be considered. Where required the relevant child or adult Safeguarding procedures must be initiated (NICE 2011a)."

"When people are unable to provide information about their substance use (eg due to poor mental state), are reluctant to do so, or it is thought that they are not giving an accurate account, observations and information that is known (even if incomplete) and the sources of this information should be recorded in the EPJ drug and alcohol assessment fields. Engagement is key to good assessment and should be a priority."

"All service users who are currently or have recently used substances must have a care plan(s) which addresses substance use. This may include support and recovery plans, risk management plans, crisis and contingency plans. Given the risk of relapse, consideration should also be given to developing a plan for those that have had past problems."

5.29 We have not found evidence of robust risk assessment and management of Mr E, particularly in the months leading to the death of Miss A. Mr E's care plan, crisis plan and summary of need documents include very brief references to his drug and alcohol use:

- "*He is well known to be participating in long term use of cannabis*" – September 2010;
- "*[Mr E] uses cannabis daily but says he wants to give up. There is a query about crack cocaine use.*" – April 2011;
- "*Early warning signs/relapse indicators: when [Mr E] smokes cannabis he will be come restless; irritability…stop taking medication; …turn up at the [team base] for unnecessary appointments; display hostility*" – December 2011;
- "*denied recent use of illicit substances but admits to drinking beer socially*" – December 2011.

5.30 The team was aware that Mr E was abusing substances but staff did not properly assess the degree of substance misuse or the impact of this on his mental health.

5.31 Inpatient staff did not pursue the use of a UDS when Mr E did not agree to a screening test being done. Staff across both inpatient and community services did not follow the dual diagnosis policy in recording their observations and formulating a care plan to address Mr E's substance use. Teams should have continued to try to obtain a UDS and implemented the dual diagnosis policy.

5.32 Finally, there are no care plan, summary of need or crisis plan documents after December 2011.

Mental Health Act assessment

5.33 Between April 2006 and March 2010 Trust staff requested a Mental Health Act assessment on four occasions. On two occasions the request was denied and not follow up by Trust staff and on the third occasion it took two weeks for the local authority to respond.

- December 2007: following a failed home visit by Trust staff, due to concerns about Mr E's relapsing mental state, the care co-ordinator made a referral to the social work team for an assessment. She was told that the social work team had been inundated with referrals and the process would not be able to be started until the following week;

- November 2008: following two incidents of assault on his girlfriend, Trust staff requested an urgent assessment be undertaken by the Emergency Duty Team. The Emergency Duty Team advised they would not organise this and would only respond to a request for assessment for Mr E he if was brought to their attention by the police or attending A&E;

- 16 January 2009: following attendance at the community mental health team when Mr E presented as suspicious and paranoid, Trust staff contacted the social work duty team to request an assessment, with assistance from the police. The social work team said that they were unable to accept the referral and Dr G should call back on Monday (three days hence);

- 19 January 2009: after Trust staff had not been able to contact Mr E and his case had been discussed by the multi-disciplinary team, Mr E's care co-ordinator contacted with social work team. The social work team said that they would not act on the request for assessment until a first medical recommendation had been completed;

- 22 January 2009: following discussion at a MARAC meeting when the panel felt that an assessment should be completed as a matter of urgency, Mr E's care co-ordinator contacted the social work team again. The social work team advised that they had nine other assessments to complete and there would be a delay in completing Mr E's assessment.

- 29 January 2009: Mr E's care co-ordinator was advised by the social work team that they were having difficulty obtaining a warrant due to funding issues;

- 30 January 2009: an assessment was attempted at Mr E's home address but was unsuccessful as he was not at home.

5.34 Trust staff did not escalate the lack of an AMHP in:

- December 2007: because Mr E arrived at the community mental health team clinic later and his care co-ordinator spent several hours with him, after which she noted she would discuss the course of action with a doctor.

We have not been able to identify whether this discussion took place or what the outcome was;

- November 2008: because when Mr E met with his care co-ordinator his care co-ordinator recorded that clinical staff considered that Mr E would not be detainable and therefore decided not to continue with a Mental Health Act assessment;

- at the end of January 2009: appropriately so, because Mr E agreed to an informal admission. He was later detained on Section 5(2) and then Section 3.

5.35 The Mental Health Act Code of Practice[30] sets out the responsibilities on local authorities to provide AMHPs at paragraph 14.35:

"Local authorities are responsible for ensuring that sufficient AMHPs are available to carry out their roles under the Act, including assessing patients to decide whether an application for detention should be made. To fulfil their statutory duty, local authorities should have arrangements in place in their area to provide a 24-hour service that can respond to patients' needs."

5.36 And at paragraph 14.45 specifies:

"*Unless there is good reason for undertaking separate assessments, patients should, where possible, be seen jointly by the AMHP and at least one of the two doctors involved in the assessment.*"

5.37 It is clear from the delays on four occasions that the responsibilities under the Act to ensure that sufficient AMHPs were available were not fulfilled. As a result a full assessment did not take place.

5.38 At the time the local authority and the Trust had a Section 31 agreement[31] in place. This agreement delegated the responsibility for all mental health social care staff and their associated functions to the Trust. At the time the most senior mental health social worker also worked within the Trust. This meant that the Trust had day-to-day management of all AMHPs and therefore the responsibility to ensure that assessments were undertaken in a timely fashion. The local authority could not delegate the accountability for ensuring that its responsibilities were met, but it lacked the means in which to fulfil those responsibilities because they had 'given' their staff to the Trust.

5.39 It is not clear why staff did not escalate the issue to managers when they were told that an AMHP was not available to respond to the request for an

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[30] *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF*

31 *Section 31 of the Health Act 1999 made provision for Health Authorities or Primary Care Trust and local authority departments to delegate functions to one another. In the case of health and social care, this will allow, for example, one of the partner bodies to commission all mental health or learning disability services locally. It is expected that this will also reduce the costs associated with having two authorities commissioning services for the same group* of people;

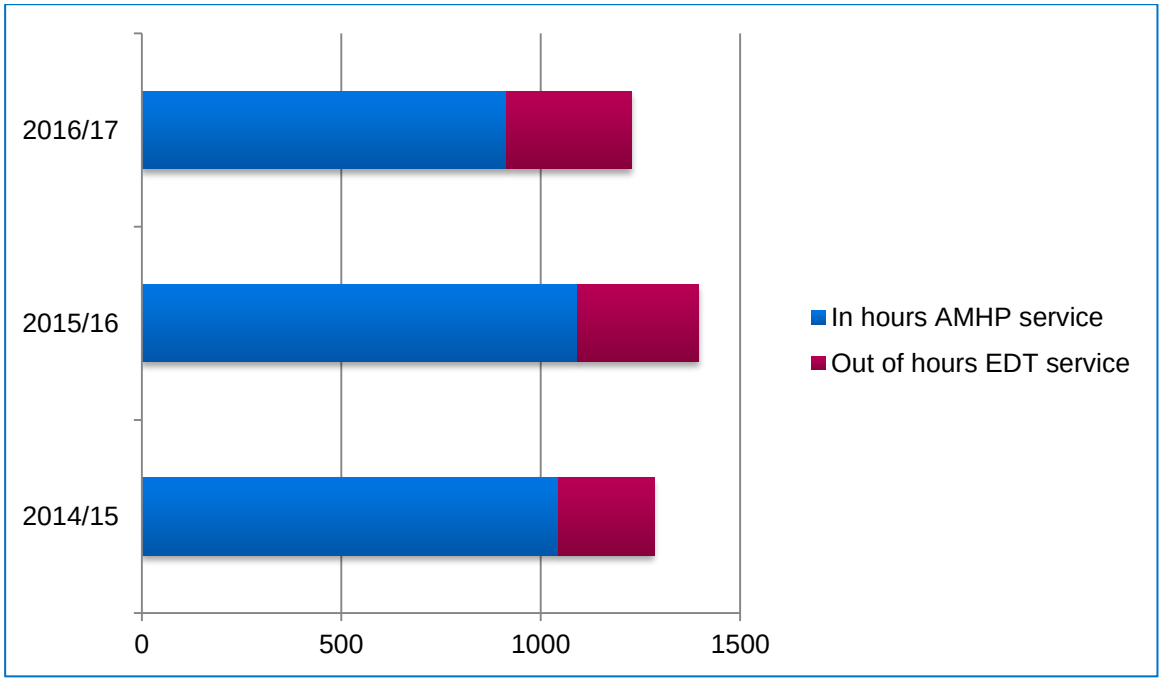
assessment under the Mental Health Act. The Trust should have escalated the matter to the local authority if there were issues of capacity within the social work functions that had been delegated to them.

5.40 The local authority has since withdrawn the delegation of its responsibilities to the Trust in regards to the provision of AMHP staff. Operational control of this staff group now rests with the local authority. There is a mix of staff that are permanently located with teams within the Trust who are supported by a rotating AMHP. We have therefore not made a recommendation regarding this issue.

5.41 There are now regular meetings between the Trust and the local authority and any issues are escalated to the local authority Head of Service and Service Director. We understand that there are currently no issues of assessments not being undertaken due to the lack of capacity of AHMP staff.

5.42 Lambeth Council provided us with information about Mental Health Act assessment activity for the three years to 2017. This shows that the number of assessments completed spiked in 2015/16 but in 2016/17 reduced to lower than in 2014/15.

Figure 1 Number of Mental Health Act assessments undertaken by Lambeth Council



5.43 We understand that the number of referrals to the Centralised Lambeth AMHP service in 2016/17 was actually 1,135. This means that there were 221 referrals that did not progress to assessment. We understand that in most of these cases the AMHP service would have worked with the referrer in identifying a "*least restrictive approach first*".

5.44 We have been provided with sufficient evidence that accessing an AMHP in a timely fashion no longer appears to be a problem.

Section 117 aftercare

5.45 Although some of Mr E's Care Programme Approach review documents indicate that he was entitled to Section 117 aftercare, we have not found evidence of his aftercare needs being formally considered. This was also an issue raised in the Domestic Homicide Report where it is stated "*it could be argued that the lack of holistic care planning and implementation particularly from April 2010 was a breach of* [Mr E's] *entitlement* [to aftercare services]".

5.46 The Mental Health Act Code of Practice provides a definition of aftercare services in Section 33:

> *"33.3 The After-care services mean services which have the purposes of meeting a need arising from or related to the patient's mental disorder and reducing the risk of a deterioration of the patient's mental condition (and, accordingly, reducing the risk of the patient requiring admission)*
>
> *33.4 CCGs and local authorities should interpret the definition of after-care services broadly. For example, after-care can encompass healthcare, social care and employment services, supported accommodation and services to meet the person's wider social, cultural and spiritual needs, if these services meet a need that arises directly from or is related to the particular patient's mental disorder, and help to reduce the risk of a deterioration in the patient's mental condition.*
>
> *33.5 After-care is a vital component in patients' overall treatment and care. As well as meeting their immediate needs for health and social care, after-care should aim to support them in regaining or enhancing their skills, or learning new skills, in order to cope with life outside hospital."*

5.47 This could have been a useful tool for the community mental health team to consider how they could have supported Mr E in managing his mental needs more effectively.

5.48 Community mental health team staff were very supportive to Mr E in managing housing problems and benefits but there was little day to day focus on monitoring his mental state. Ms L told the internal investigation that there was not a consistent approach to assessing Mr E's mental state. We asked Ms L how she would conduct a mental state examination for Mr E, however she was unable to provide a description. Ms L talked about having "*information from the individual, their friends and family members, or nearest relatives*" and that information would be formulated into "*family history, personal history and past medical history*" with information being documented as a progress note in the client record.

Cultural issues

5.49 There is scant information in Mr E's clinical records about his cultural background. Mr E is from Portugal. He visited Portugal whilst under the care of the Trust. Some clinical records state that Mr E came to the UK aged 7 years, others state aged 12 or 13 years and others state he was born in the UK. One entry states his mother was interviewed with an interpreter and that

she said Mr E came to the UK aged 12. It is unclear why the family migrated to the UK or to London.

5.50 In the clinical records reference is made to Mr E having experienced racial bullying at school. It would have been appropriate for staff to have explored with Mr E whether or not he was experiencing racial bullying as an adult. In addition the clinical records also refer to how Mr E had a difficult relationship with his father and paternal grandmother due to the belief that she had put a spell on Mr E and his father when Mr E was young. It was reported that Mr E's family believed this to be true as both Mr E and his father became unwell at the same time. In 2005 Mr E stated that his paternal grandmother put a spell on him when he was young, and that he was waiting for his grandmother to die so that his father could love him. It would have been helpful if the community mental health team staff had explored this issue further with him to clarify whether or not he still held this view about what caused him to become unwell.

5.51 Mr E attended one appointment in 2008 dressed in an "*Islamic kameez*" and stated he had converted to Islam two years previously. This was not explored further by staff at this time or subsequently. Given that Mr E was under the care of a community mental health team in London, which is one of the most diverse in London, we would expect that staff would have the skills and experience to do so and would have explored this matter further with him. Staff could have explored with Mr E what led to him converting to Islam and the circumstances and reasons for him doing so. This could quite possibly have given staff greater insight into his mental state at that time and subsequently. The staff needed to consider whether his reasons for converting to Islam seemed genuine and appropriate or whether this was possibly a cause for concern. It should be noted that at that time only 5% of the population of Lambeth were Muslim, which is small in comparison to other London boroughs. It is important to consider how common it is for an individual to convert to Islam. In 2013 The Economist reported that the number of converts in the UK to Islam per year was 5,200. The team should have talked to him about his reasons for converting to Islam and sought to understand the impact this may have had on his own understanding of his mental illness.

5.52 The Royal College of Psychiatry guidance regarding "*Good Psychiatric Practice: Code of Ethics*[32]" (RCP 2014) states that a psychiatrist must be sensitive to issues of gender, ethnicity, colour, culture, lifestyle, beliefs, sexual orientation, age and disability". As we stated above we feel that there is more that the team should have done to understand Mr E's cultural beliefs.

5.53 In addition it is unclear whether anyone explored in detail with Mr E if he intended to reside in the UK for the foreseeable future and what connections he retained in Portugal.

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[32] *http://www.rcpsych.ac.uk/files/pdfversion/CR186.pdf*

Communicating with and transferring care to the GP

5.54 There were two occasions that the mental health team advised that Mr E's care was going to be transferred to his GP:

- January 2007: the early onset team recorded that they felt that Mr E did not require intensive input at that time and could be managed by his GP with a contingency plan for rapid re-referral if required. We can find no evidence of attempts to transfer the care, nor a record of an alternative decision later being made by the clinical team.

- December 2010: the community mental health team advised Mr E that a clinical decision had been taken to step down his care to be provided by his GP. On this occasion Mr E's case was discussed at the clinical team meeting a week later, when it was decided, based on his history of non-compliance and substance misuse, that the Mr E should remain within the medication clinic but his GP would be asked to prescribe his medication. We can find no evidence of the GP being informed of this decision and therefore are unclear how Mr E's medication was prescribed.

5.55 In September 2010 Mr E's GP received a discharge summary report relating to Mr E's admission in early 2009. The report was typed and sent 17 months after Mr E was discharged and therefore the GP had no information about his patient's mental state or that he had been discharged from hospital, until Mr E presented to him.

5.56 In November 2012 Dr A wrote to Mr E's GP with a summary of the meeting held with Mr E, Dr A and Ms L on 31 October. Dr A advised the GP that she had asked Mr E to attend the GP surgery so that he could receive a physical health check and asked that the GP inform her of the results of the specific checks. Mr E's GP never received this letter. We know this as in the GP records we found a letter from Mr E's GP to the community mental health team consultant psychiatrist dated 9 January 2013 advising that no recent Care Programme Approach review had been received.

Liaison with the probation service

5.57 Liaison with the probation service was not consistent and the evidence indicates that nearly all contacts between that service and mental health services were initiated by the probation service. There are a number of occasions when Mr E's probation officer had made contact with the mental health team because of concerns about Mr E's mental state. However, there are a number of occasions when mental health staff were aware that Mr E was in breach of bail conditions and that a member of the public was at risk, but the probation service (nor any other agency) was informed.

5.58 Liaison between mental health services and the probation service started in November 2008 after Mr E had been charged in September with abduction and actual bodily harm (ABH) in relation to his girlfriend. The probation officer expressed concerns to the mental health team as Mr E had assaulted his girlfriend on two further occasions since the assault with which Mr E had been

charged in September. At this time the probation officer was so concerned about the risk to Mr E's now ex-girlfriend that it was agreed the police would be asked to trace the ex-girlfriend to advise her to avoid contact with Mr E.

5.59 In May 2009 there was one joint appointment between the mental health team, the probation officer and Mr E. Mr E had previously told mental health staff that he had had contact with his ex-girlfriend but subsequently denied this during the meeting with probation. Later that month Mr E told mental health staff that his girlfriend had moved into his flat. Other than advising Mr E to be honest with probation, there is no evidence that mental health staff took any action regarding the risk now present to Mr E's girlfriend/ex-girlfriend. When we spoke with Mr C we asked him what actions he took other than giving Mr E advice. Mr C told us that he was "*pretty sure, but couldn't find it documented*" that he would have discussed the issue with the multi-disciplinary team. Mr C said that he could only assume that the recommendation from that discussion was to continue to encourage Mr E to inform probation himself. When we asked Mr C what consideration he gave to the risks Mr E posed to his girlfriend/ex-girlfriend he responded only from memory, as there was nothing in the records to help him. Mr C told us that he recalled that "*it was the girlfriend/ex-girlfriend who was initiating contact and it was difficult to protect her in those circumstances".*

5.60 The community mental health team should have shared this information with probation and acted in the interests of protecting Mr E's girlfriend and the public. The Trust should have included contact with probation into Mr E's care plan, including what information would be shared and when. This would have ensured all staff (not just his care coordinator at the time) were clear when to escalate concerns.

5.61 In June 2009, mental health staff accompanied Mr E to a committal hearing where it was noted that Mr E's bail conditions remained the same: no contact with the girlfriend/ex-girlfriend. A week after this hearing Mr E told mental health staff that his girlfriend was living with him. The response from staff was to remind Mr E of his bail conditions; we can find no evidence that any action was taken to reduce the risk to the girlfriend/ex-girlfriend, nor that Mr E's probation officer was informed. Mr C knew that Mr E was in serious breach of his bail conditions but did not share the information with any other agency. When we spoke with Mr C we asked him what actions he took with this information. Mr C told us that he was "*pretty sure, but couldn't find it documented*" that he would have discussed the issue with the multi-disciplinary team. Mr C said that he could only assume that the recommendation from that discussion was to continue to encourage Mr E to inform probation himself. When we asked Mr C what consideration he gave to the risks Mr E posed to his girlfriend/ex-girlfriend he responded only from memory, as there was nothing in the records to help him. Mr C told us that he recalled that "*it was the girlfriend/ex-girlfriend who was initiating contact and it was difficult to protect her in those circumstances".*

5.62 In mid August 2009 the probation officer contacted mental health services asking for an update on Mr E. The probation officer was informed that the last time the team had seen Mr E was on 5 August and that he had not responded

to recent calls and messages about appointments and medication. This was an opportunity for staff to inform the probation officer that Mr E had been living with his girlfriend/ex-girlfriend, but this did not happen.

5.63 We can find no evidence of any contact with probation for 17 months, until January 2011 when mental health staff received a call from Mr E's probation officer expressing concern that he had admitted he wasn't taking his medication. The probation officer was advised that staff had seen Mr E two days previously when he had presented as stable and well. It was agreed that a joint home visit by mental health staff and probation would be arranged to assess Mr E's home environment and his mental state. There is no record that Ms L shared information with the probation officer about the contact that Mr E had been having with his girlfriend/ex-girlfriend.

5.64 The following month mental health staff again received a call from Mr E's probation officer expressing concern about how he had presented at his appointment that day. Ms L provided reassurance that Mr E was due a medical review the following day, but made no mention that mental health staff had not been able to conduct a mental health assessment since the probation officer had raised concerns the previous month. However Ms L did discuss Mr E's relationship with his mother; both Ms L and the probation officer acknowledged that Mr E did not want his mother involved in his care and treatment.

5.65 At the end of February 2011 Mr E's probation officer advised mental health staff that he had been placed "on notice" and that Ms L and she (the probation officer) should arrange a home visit as a last chance before Mr E would be in breach of his treatment and supervision order. Again there is no evidence that Ms L shared information with the probation officer about Mr E's lack of contact with the mental health team. The joint visit did take place and Ms L and the probation officer met with Mr E at his flat.

5.66 We can find no further contact between mental health services and the probation service until July 2012. This followed Mr E's detention and subsequent release from HMP Thameside for assaulting his girlfriend/ex-girlfriend with a razor blade. By now Mr E also had an indefinite restraining order placed on him in relation to the girlfriend/ex-girlfriend.

5.67 In September 2012 there was a joint meeting between mental health services, the probation service and Mr E. During this meeting it was clear that Mr E did not want to discuss relationships with women and the probation officer reported her sessions with Mr E as being a struggle.

5.68 In October 2012 during a joint meeting with mental health services and the probation service Mr E reported that he would rather go back to prison as he was unable to gain skills in the community. Later that month Ms L received an email from the probation officer reporting that Mr E had appeared "*quite incoherent*" during his meeting with her and that Mr E had reported that he was not taking his medication.

5.69 In early November 2012 the probation officer requested that a mental health nurse be present at her next meeting with Mr E at his home address later that month. The probation officer wanted Mr E's mental state assessed and to review his living environment. This meeting never took place as Mr E was detained in HMP Belmarsh on 17 November for breach of the restraining order in relation to his girlfriend/ex-girlfriend.

5.70 The probation officer notified the mental health team of Mr E's detention on 20 November. At this time the probation officer also noted that when Mr E was released 12 weeks later, there would be no order and no supervision required from probation.

5.71 There were numerous missed opportunities to alert other agencies, specifically the probation service, about

- Mr E's breach of court orders and bail conditions;
- Mr E's lack of engagement with the community mental health team.

5.72 Dr A told us that she felt that Mr E's pattern of domestic violence is something that "*possibly required more joint thinking with probation services, because he did have a substance misuse problem, he did have a psychotic illness, but I think it was his personality that…could have been more discussed around…this escalating in violence towards women".*

5.73 It is clear from talking to staff and from information in Trust records that Trust staff were aware of Mr E's forensic history and the nature of his assaults on his girlfriend/ex-girlfriends but they failed to grasp the degree of the continuing risk to women. It is our view that some staff viewed Mr E solely as a vulnerable adult and therefore focussed any interventions on his housing and benefit needs. In summary it is our view that the Trust was aware of his forensic history but failed to recognise the ongoing risks that he presented. This is because staff did not respond assertively when they were unable to see Mr E for long enough to conduct a thorough mental state examination.

5.74 It is our view that the Trust should have considered Mr E's risks to women when determining whether he was allocated a male or female care coordinator. This should have been viewed as part of overall care planning and risk assessment and management. The Trust should also have considered the complexity of Mr E's presentation when identifying a care coordinator. Ms L told us that at the time she did not receive regular supervision and as such felt ill equipped to manage a complex client such as Mr E.

5.75 We acknowledge that it appears that community mental health staff had no knowledge of the presence of Miss A in Mr E's life, either at the time of the offence or in the preceding summer.

Domestic violence and risk of harm to others

5.76 Staff documented on numerous occasions that Mr E posed a risk to others, in particular females with whom he had a relationship. However we can find little evidence of information being shared with other agencies when it was clear that Mr E's girlfriend/ex-girlfriend was at risk:

- January 2009: Mr E stated on more than one occasion that his girlfriend/ex-girlfriend was responsible for his admissions to hospital. Mr E denied he had plans to see her again but said his girlfriend/ex-girlfriend had recently called him as she had left an item of clothing at his flat.

- April 2009: an occupational therapy report prepared for a Mental Health Review Tribunal identified that "*although there is a court order preventing them [Mr E and the girlfriend/ex-girlfriend] having contact, she regularly comes to the ward in an attempt to see him and Mr E states that they do still have contact*".

- May 2009: Mr E informed his care co-ordinator that his relationship with his girlfriend had re-started.

- November 2010: Mr E informed his care co-ordinator that his girlfriend visited occasionally.

- December 2010: Mr E again informed his care co-ordinator that he maintained contact with his girlfriend.

- April 2011: staff reported that Mr E had spent time with his girlfriend whilst on an inpatient ward and later escorted Mr E to collect his flat keys from the police station.

- October 2011: Mr E told staff that he had not had much sleep the previous night as his "*girlfriend was around*".

5.77 Staff took Mr E's case to a MARAC meeting on only one occasion and we have not been able to identify that staff properly considered the risks to Mr E's girlfriend/ex-girlfriend when he talked about her to staff.

5.78 As we have previously stated, Dr A told us that she felt that more joint work could have been done with the probation service in managing Mr E's substance misuse, psychotic illness, personality and escalating violence. It appeared to us that Dr A had spent notable time reflecting on Mr E's case and on occasions was clear that she was speaking "*with the benefit of hindsight*". Dr A said that she felt the team would have benefitted from more thinking about Mr E's case, in particular the different aspects that can contribute to domestic violence in somebody who re-offends with the type of violence that Mr E used. Dr A said she felt the team would also have benefitted from input from the police.

Capacity and capability issues

5.79 The internal investigation identified concerns about the way that the community health team functioned:

- Medical staff and care co-ordinators worked in isolation from each other;
- Three community mental health teams had merged to create two community health teams resulting in larger caseloads;
- High turnover of staff, high levels of sickness and vacant posts;
- One care co-ordinator allocated to manage a complex service user (Mr E) without having received specific training for working with clients with a forensic history or drug and alcohol problems.

5.80 The impact of these changes meant that staff had more clients to care co-ordinate, and some of those clients were more complex. The new team had also taken the responsibility for the assertive outreach function that had previously been provided by a separate team. The assertive outreach function requires staff to work more intensively with the clients on their caseload. This in itself means that staff time becomes more pressured. Add to these factors, a team with fewer experienced staff and a high turnover, and the risks of issues being missed by staff increases significantly.

5.81 Ms L told us that following one service restructuring she and a couple of others were the only staff members who knew Mr E's case and history. The consequence of this was that when she raised concerns it took a long time for other team members to understand what she was talking about.

5.82 Ms L also told us that team meeting used to be minuted by administrative staff, but that information about the discussions was held only in those minutes, it was not transcribed into relevant client records. Ms L told us that process had now changed and individual clinicians were expected to update client records following team meetings and that these records are held in addition to the minutes taken by the administrator. Ms L told us that sometimes clinicians don't have time to make these entries and then entries are either forgotten about or made retrospectively.

5.83 We asked Ms L to clarify the statement she made to the internal investigation team that she "*worked blindly with [Mr E] as a mental health nurse*". Ms L told us that she had been a mental health nurse in the older adults team for many years prior to joining the adult community team in March 2010. Mr E was allocated to Ms L in April 2010. Ms L told us that she had not received training to be a community nurse and that she felt she had a knowledge gap in identifying individuals' needs and developing a plan to meet those needs. However she said that she now has the knowledge and experience to be able to conduct assessments and care planning appropriately.

5.84 Ms L told us that after she had been working in the older adults service for 11 or 12 years she developed a significant health problem and she was told she

"*wasn't to have patient contact and it was a service need to find [her] a suitable place to work because [she] was still employable*". The Trust has clarified that this does not reflect the facts of the case and we have therefore left the matter with the Trust for them to resolve with Ms L.

5.85 Ms L told us that when she first started working for the community mental health team she did not have regular supervision. However she now receives supervision every four weeks as a minimum, with the option to ask for more supervision if she had a case that was particularly challenging.

5.86 As a qualified nurse Ms L was required, via the Nursing and Midwifery Council, to ensure that she worked within the limits of her competence. The Code of Conduct has since been revised and is much clearer about expectations. The Code of Conduct that was valid at the time of this incident in 2012 that Ms L needed to adhere to stated:

Management of risk

- "*You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk*"

Keeping your skills and knowledge up to date

- "*You must have the knowledge and skills for safe and effective practice when working without direct supervision"*
- *"You must recognise and work within the limits of your competence"*
- *"You must keep your knowledge and skills up to date throughout your working life"*
- *"You must take part in appropriate learning and practice activities that maintain and develop your competence and performance"*

Dealing with problems

- *"You must act immediately to put matters right if someone in your care has suffered harm for any reason".*

5.87 This final bullet point is relevant to the time in July 2007 when Mr E had bullet holes in his front door, indicating he was at risk. Although we acknowledge that Ms L was not Mr E's care co-ordinator at that time, it was Mr C.

5.88 It is our view that Mr E should not have been allocated a female care co-ordinator, given the risks that were evident by the time he was allocated to Ms L. In addition Ms L lacked experience in adult mental health and had no experience of managing the type of risk that Mr E presented.

5.89 There are a number of occasions when Mr E was presenting as a risk to others and when he appeared to be at risk himself, when more action could have been taken by the mental health team treating him, as discussed in the

sections above on domestic violence and risks to others, and liaison with probation service.

5.90 We were given conflicting responses about the consideration of referring Mr E to the forensic team. However we can find no evidence that this was properly explored. Had Mr E been assessed by the forensic team, it is possible that a more assertive and robust approach to managing his care and treatment could have been in place.

Carer's assessment

5.91 In December 2010 the early onset team noted that Mr E's mother was listed as his main carer and that as such she should be offered a carer's assessment. It appears that staff did not have a current contact number for Mr E's mother at that time as Ms L was tasked with obtaining that information from Mr E at her next meeting with him.

5.92 We can find no evidence that Ms L followed up on the task to obtain Mr E's mother's contact details or offering her a carer's assessment.

6 Review of Trust domestic violence policy

6.1 We have reviewed the Trust domestic violence policy and in doing so have drawn upon the following documents:

- Department of Health's publication: *"Responding to Domestic Abuse: A handbook for health professionals".* This document is available online and although it was published in 2005 it remains relevant and a very helpful resource for all health practitioners, Trust managers and policy makers. It references a sample domestic violence policy, which is likely to be a useful template, but this is only available via an accompanying CD ROM which we have not accessed.

- *NICE Quality Standard (QS116) Domestic Violence and Abuse – February 2016.* https://www.nice.org.uk/guidance/QS116/chapter/Introduction

6.2 We have previously provided this same review in a report for another investigation that was commissioned by NHS England at the same time as this investigation. We therefore ask readers to be mindful that the Trust may have already made progress on recommendations arising from this review.

6.3 Overall the content of the policy provides a comprehensive and constructive overview for Trust staff in domestic violence awareness that relates to their direct work with patients. It gives helpful and clear processes and pathways for frontline staff to follow regarding the identification and response to disclosures of domestic violence by patients. However, there is insufficient clarity regarding what the Trust management's responsibility or commitment is in providing the working environment and the comprehensive domestic violence training required in order that practitioners can carry out their obligations safely and effectively.

6.4 The bulk of the document takes the form of a practitioner handbook rather than a policy, and as such duplicates similar documents such as the Department of Health 2005 handbook. A more useful format for a domestic violence policy would comprise a shorter, clear policy focussed on obligations and tasks to be carried out by each grade of staff within the Trust in various situations where domestic violence is an issue. This should also include specifically what training and clinical supervision or support should be provided and what senior managers will commit to do to ensure the policy is achievable. It is our view that there should also be a separate handbook accompanying the training which can then be used as an ongoing guide to good practice and professional development.

6.5 Within the above Department of Health 2005 handbook, there is useful guidance for policy makers and Trust managers, including the following in relation to writing a domestic violence policy.

"What should be included in domestic abuse policy? As a bare minimum, policy should include:

a) a description of the principles underpinning the policy;

b) a definition of domestic abuse;

c) information on the national and local context;

d) an outline of expectations of policy;

e) the Authority's or Trust's approach – to include reference to who has responsibility for asking a woman about domestic abuse. By saying that everybody needs to take responsibility for asking about domestic abuse, you might risk nobody doing so. The main responsibility should lie with the person with primary responsibility for a woman's care. It is of paramount importance that your policy is underpinned with education and training, supervision and support for staff."

6.6 We know that a third of domestic violence victims are men[33], and therefore where the handbook specifically references female victims, the Trust should not make a gender differentiation.

6.7 The Trust domestic violence policy reflects the minimum inclusions referenced in the Department of Health 2005 handbook in the following ways:

a) Section 4.4 states the principles underpinning interventions around domestic violence, which incorporate those given in the handbook. The principle stating that practitioners should not attempt specialist interventions themselves but refer to local agencies is missing from the

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[33] The Home Office Statistical Bulletin of 2009/10 estimates that among adults (aged between 16 and 59) 15.8% of men and 29.4% of women have been victims of domestic violence since the age of 16. It estimates that this represents around 2.6 million men and around 4.8 million women. Looking at the numbers of victims in the last year, 4.2% of men and 7.5% of women are estimated to have experienced domestic violence equating to around 677,000 men and 1,207,000 women. So on both of these measures about one third of victims are men.

Trust's stated underpinning principles, however there is considerable reference in the body of the policy to the need to refer to other services where appropriate and a good list of local and national domestic violence services.

b) There is a comprehensive section on the definition of domestic violence in Sec 4.3.1. Whilst there is interesting and helpful information here, a shorter clearer summary of what the Trust intends to use as its definition, would have been preferable, with the additional external links and research findings included in a separate training handbook.

c) Sections 4.5 – 4.9 outline issues around the prevalence of domestic violence and its effects, including links to mental health issues. Whether this can be viewed as a summary of the national and local context, within which the Trust policy has been written, is arguable. As with much of this Policy, this section contains a lot of interesting and useful information around domestic violence, which would be better contained within a separate handbook.

d) Section 4.3.2 gives a good list of the aims of the Trust policy, and these points do reflect what the document goes on to deliver. It is also clear to whom the policy is targeted and whom it affects.

e) Section 4.3.3 states all Trust staff *"have a role in identifying and responding to disclosures of domestic violence."* The explicit direction that the main responsibility should lie with the person with primary responsibility for the relevant patient's care is missing from this policy. There is therefore a risk in situations where practitioners are covering for absences, or dealing with high caseloads, that the lack of an explicit policy instruction on responsibility for this task, could lead to oversights or misunderstandings over responsibilities. There is also a very clear expectation that this work requires a good level of training, to which we make reference later.

6.8 The NICE Quality Standard (QS116) Domestic Violence and Abuse document has recently been published and contains four key quality statements:

Statement 1 People presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion.

Statement 2 People experiencing domestic violence and abuse receive a response from level 1 or 2 trained staff.

Statement 3 People experiencing domestic violence or abuse are offered referral to specialist support services.

Statement 4 People who disclose that they are perpetrating domestic violence or abuse are offered referral to specialist services.

6.9 Each of the above comprises details of what the statement means for service providers, practitioners and service users. There is therefore an expectation that the Trust has a responsibility to ensure that its frontline staff are equipped

to undertake their stated tasks. The Trust policy reflects these four statements in the following ways:

Statement 1 There are clear references in Section 5.2 regarding the need for the practitioner to find a private space where they can interview the patient alone about any potential experiences of domestic violence. There is also reference to the need to allow time for disclosure to be made. Furthermore, there is detailed guidance within the policy to assist practitioners in identifying and asking patients about potential domestic violence.

The onus for creating and finding this space and time appears to sit with the practitioner; there is no reference to Trust responsibilities in ensuring that on a strategic level they plan for suitable space to be created and available at all reasonable times for this purpose, or that workloads are within manageable limits to enable time to be spent by practitioners in gathering disclosure in a safe and sensitive way with patients.

Similarly, in relation to how effectively staff are trained in identifying and asking questions around domestic violence, there is a strong assumption that the staff members will absorb the learning within this document and seek out further locally provided training or online learning and guidance tools. Only basic reference is made in Section 14.3 to the responsibility of senior managers and clinicians in ensuring staff members are aware of the Policy document and have access to local training events.

Statement 2 This follows on from Statement 1 in that it requires training to be provided for practitioners that can enable them to safely and effectively identify and ask questions around domestic violence.

We would strongly advise against reliance solely upon written information (such as the handbook-style guidance within this policy), or the standard local Safeguarding Board DV training events. These will be insufficient for staff who are tasked with directly questioning and responding to patient disclosure from either victims or perpetrators. Local Safeguarding Board training events are usually basic generic awareness courses and rarely tailored to the specific service delivery issues experienced by mental health professionals. This policy does not give any indication of what depth and quality of training is required for SLAM practitioners in this context.

Handbook-style guidance which makes up the bulk of the policy document, is an excellent resource but only when accompanied with specialist, tailored training that includes plenty of: experiential components; skills practice and reflective discussions around victims' experience of domestic violence; the additional complexities and risk factors linked to mental health issues; and a patient's potential experiences of further

powerlessness in carrying a “mental illness” label, as well as strategies for professionals to adopt around their own self-care.

There is very little reference in the policy to what constitutes adequate and effective training, clinical supervision or ongoing professional development in domestic violence for mental health workers, and no reference to the Trust’s obligation under the policy to provide this training or ensure the time and budget is provided to enable it to be obtained externally. There is no reference in the policy to the level 1 and 2 training requirements that are explicitly mentioned in the NICE Standards.

Statement 3 This relates to the referral pathways into local specialist services when domestic violence has been identified. The Trust care pathway flowchart in Section 6 is useful and easy to follow, with reference to a range of local support agencies and further services detailed in a later Appendix.

Section 14.2 states the responsibility of senior clinicians and managers to make visible in the workplace the contact details of local support services, which is positive.

Statement 4 This relates to the referral pathways into appropriate interventions for people disclosing or identified as being the perpetrator of domestic violence. Section 9 of the policy responds to this reasonably well, outlining a process of identification and risk assessment, as well as giving the national Respect Phone-line details. However it does not recognise the significant level of anxiety that this process can create for practitioners who are generally not trained or confident in engaging with domestic violence perpetrators directly around their use of violence or abuse.

6.10 It is sometimes difficult and potentially intimidating for frontline staff to approach potential perpetrators regarding their behaviours. This is reflected in the lack of referrals (made by general health or mental health practitioners) of abusers into local domestic violence perpetrator services. Less than 1% of DVIPs’ annual perpetrator referrals are via health professionals.

7 Internal investigation and action plan

7.1 The Trust was notified on 7 January 2013 that Mr E was the suspected offender involved in the death of Ms A. The Trust notified with Clinical Commissioning Group on 10 January and commissioned an internal investigation. However the police did not allow the Trust to interview their own staff until 12 March 2013. This placed a delay of 61 days into the process that was not within the control of the Trust.

7.2 The timeline for managing investigations is stated in the Trust Policy for the Investigation of Incidents, Claims and Complaints version 2.2 dated September 2011. Section 5.1 of the policy details timescales to be met for

incidents of varying severity. For incidents with a severity classed as A or B the policy states:

- "Investigation commissioned outside CAG/s involved at Level 2 as soon as possible but in any event 10 working days of the notification of the incident."

- "□□□□□□□red investigation* completed within 60 working days from date of notification to completion of the investigation, report and Trust BLI. Investigation to be completed by the Team Leader or other senior manager not directly involved in the event."

- "* A structured investigation incorporates a root cause analysis".

7.3 The final report was presented to commissioners by 22 May 2013 but was subsequently amended following discussion at a Board Level Inquiry meeting on 27 June 2013.

7.4 The internal investigation report identifies that some recommendations put forward by the investigation team were amended at the Board Level Inquiry. We asked the Director of Nursing why amendments would be made and were told recommendations are sometimes amended during the "*fit for purpose*" check.

7.5 The internal investigation team comprised:

- a consultant psychiatrist, Addictions Clinical Advisory Group;

- a consultant nurse, Child and Adolescent Mental Health Clinical Advisory Group;

- a Trust investigation facilitator.

7.6 The report states that Mr E "*came to the UK in 1999 at the age of twelve years*". Given that Mr E was born in September 1985 if he had come to the UK in 1999 he would have been either 13 or 14 years old.

7.7 The internal investigation found ten areas of concern:

- There was a lack of an appropriate risk assessment and regular updates of this. There was also a lack of sharing of risk information with relevant staff in the CMHT [community mental health team] and in other supporting services.

- Regular mental state examinations were not carried out.

- Mr [F's] alcohol and drug user were not assessed (which may have had a bearing on his mental state and the risks he posed) and therefore the risk assessment was not adjusted accordingly.

- Important information from daily MDT [multi disciplinary team] planning meetings were not recorded in the ePJS [electronic patient] record.

- There did not appear to be a gauge of Mr [F's] level of risk to women and information about his social networks were not explored.

- There was a lack of communication between in-reach prison staff and CMHT staff.

- There was a lack of communication between the CMHT and the probation service (for example, CMHT staff were unaware that they may have been able to obtain support from the probation service.

- There was a lack of communication of accurate risk to the Home Treatment Team.

- Options to involve MAPPA or consider an assessment from forensic mental health services did not appear to have been explored by the CMHT.

- Potential child safeguarding risks were not identified, assessed and referred appropriately.

7.8 There were six associated recommendations made by the internal investigation team. These were:

1. *"The Trust to commission a piece of work to address interfaces between services within AMH and non-AMH CAG services.*

2. *All Trust community teams to meet with the SLAM Forensic services to learn and develop a protocol for management when patients are discharged from prison.*

3. *The Psychosis Community Services (Lambeth South) team manager and team consultants to work together to ensure mandatory training in the team is completed and up to date. This will include the following and should be audited to ensure learning is embedded:*

    a. *Their responsibilities in relation to safeguarding children and adults.*

    b. *Risk assessment and escalation of concerns for complex patients with a history of violence, in particular domestic violence, drugs and alcohol use and psychosis.*

    c. *Clinical documentation, including ePJS, meeting minutes, correspondence between SLAM teams and external agencies.*

4. *The Psychosis CAG senior manager team to take up the following areas across the CAG in relation to AMH model work. This will include:*

    a. *Mental health assessments including history, mental state examinations, formulation and resulting care plans.*

    b. *Drug and alcohol and the use of questionnaires available on ePJS, urinary drug screens, hepatitis B and C and HIV status.*

c. *Commissioning SLaM partners to work with the Psychosis Community Service (Lambeth South) team to facilitate team members to work together to develop a vision for the service.*

d. *Adherence to NICE Guideline 120: Psychosis with co-existing substance misuse, March 2011. This includes Care Programme Approach to deliver care."*

5. *Oversight is required to monitor the progress of any service where significant concerns (or patient safety issues) had been raised and/or where assurance was required on improvement to service delivery. (Additional BLI recommendation)*

6. *The investigation report highlighted that the team had been under a lot of pressure due to organisational change and increased workloads. The organisational chance had impacted upon service delivery and there had been other incidents which had also identified organisation change as a contributory factors. (Additional BLI recommendation)*

7.9 We support the findings and recommendations made by the internal investigation team.

7.10 An additional three recommendations were identified by the Domestic Homicide Review:

7. *The Trust audits its clinical staff to understand the extent and impact of Domestic Violence training and addresses the findings accordingly. (Additional BLI recommendation)*

8. *The Trust reviews its physical communication systems at Community Team bases and puts in place contingency arrangements in case of failure. (Additional DHR recommendation)*

9. *The Trust works with the London Probation Trust to develop a working protocol for putting in place and managing Community Order "Mental Health Requirements". (Additional DHR recommendation)*

7.11 At the time of reviewing the Trust action plan (May 2016) recommendations two and nine remained incomplete. We discussed the reasons for this with the Director of Nursing and were told that the piece of work was due to be completed the following week. We understand that despite the lack of progress being escalated within the organisation on a number of occasions, timely action had not been taken. We understand that the lack of progress was being addressed as a performance management issue. As this work was incomplete we recommend that the Trust undertakes an audit of the effectiveness of the final protocols that have been developed.

7.12 We have seen evidence of actions for all other recommendations and are satisfied that they have been completed. In particular, we have seen evidence of an intensive programme of work with the community mental health team to address issues of managing clients in the red zone, reviewing the way in which clients are allocated to care co-ordinators, improving take up of training

for child and adult safeguarding, improvements in mental state, domestic violence and substance misuse assessments.

7.13 However we feel that further work could be done in providing assurance in the following areas:

- **Recommendation 3, action 2.** We note that case note audits had been completed in January 2014 and that a process has now been established through individual supervision to monitor the requirement to review and update risk assessments. It is our recommendation that the Trust has a process of monitoring the effectiveness of addressing this issue through supervision.

- **Recommendation 3, action 3.** The Trust has advised that systems are in place to provide assurances about documentation by team members. However no details have been provided about what those systems are so we are unable to comment upon the effectiveness of them. It is our recommendation that the Trust undertakes an audit to identify how effective the new systems are.

8 Overall analysis and recommendations

Predictability and preventability

8.1 Predictability is '*the quality of being regarded as likely to happen, as behaviour or an event*'.[34] 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.[35]

8.2 Prevention[36] 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.

8.3 It is our view that a further violent assault by Mr E was entirely predictable by mental health services. In considering the issue of preventability we have made our assessment based upon the information known to health services only.

- There was clear evidence of Mr E's history of violent behaviour, particularly towards female partners.

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

[35] *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*

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

- The risk of violence increased when Mr E became unwell and was disengaged with services.

- Risks always increase at a time of transition from one service to another, and particularly on release from prison.

8.4 We acknowledge that Mr E's convictions were no more serious than battery and assault and given this, mental health staff could not have predicted that any future assault would result in the death of Miss A. In making this statement we do not wish to minimise the impact of Mr E's assaults on Miss M and Ms Y. We want merely to draw attention to the fact that he had not been charged with causing injuries that the criminal justice system considered to be "*serious*".

8.5 Given that the community mental health team were not aware of the existence of Miss A, it is difficult to say that there were specific risks that the team knew about that should have been managed. However, it is our view that had:

- Mr E's treatment been managed more assertively by the community mental health team; and

- there been a quicker response to Mr E's mental health needs in prison; and

- the community mental health team undertaken a full assessment of Mr E's mental state on release from prison; and

- a discussion about community treatment order been properly followed up;

it is possible that Mr E's mental health would have been sufficiently stable that the violent attack on Miss A might have been avoided.

8.6 We are also mindful that Mr E's financial position contributed significantly to his mental state. This was an important focus for Mr E, particularly when all of his benefits were withdrawn and he faced the possibility of being evicted from his flat. Although Dr B wrote to the benefits office and community mental health team staff were supportive of Mr E in trying to resolve his benefit problems, we can find no evidence that anyone gave proper consideration to Mr E's Section 117 aftercare needs.

Recommendations for NHS organisations

8.7 We have made a number of recommendations to improve practice. These have been given one of two 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.

8.8 The following list shows the recommendations in priority order.

Priority One Recommendations

Recommendation 1

The Trust must undertake an audit of the effectiveness of the final protocols that have been developed:

- management of patient care when patients are discharged from prison.
- working protocol for putting in place and managing Community Order "Mental Health Requirements".

Recommendation 2

The Trust must implement a process of monitoring the effectiveness of case note audits and individual supervision, implemented following the internal investigation with regard to care plans and risk assessments.

Recommendation 3

The Trust must undertake an audit against the standards in the relevant policy/ies to identify how effective the new systems are in providing assurances about the completion of documentation by team members.

Recommendation 4

The Trust must ensure that all staff are clear about the process and timeframe to follow when there are concerns about the welfare of a service user who is not engaging with services. The Trust must also implement a system to monitor this and address any issues of non-compliance.

Recommendation 5

The Trust must ensure that services are configured to allow for best practice in risk assessment to be implemented in all services, including those in inner city urban mental health centres.

Recommendation 6

The Trust must ensure that care co-ordinators have the opportunity to review a service user's history and risk factors when a service user is first allocated to them. The Trust must also implement a system to monitor this and address any issues of service non-compliance through appropriate routes.

Recommendation 7

The Trust must ensure that clinical staff are clear about the escalation processes when they are unable to secure a mental health act assessment in a timely fashion. The Trust must also monitor the use of those escalation processes in order to be assured of their effectiveness.

Recommendation 8

The Trust must ensure that section 117 aftercare needs are formally considered and liaise with the relevant organisations in order to ensure that identified needs are met.

Recommendation 9

The Trust must ensure that staff are clear about when information should be shared with other agencies (usually probation or the police) about a service user breaching bail conditions. The Trust must also ensure that staff comply with the guidance on when to share information.

Recommendation 10

Commissioners of prison health services must ensure that providers take appropriate and timely action to obtain relevant details about detained prisoners' care plans and risk assessments when they are made aware that the prisoner is known to a community mental health team.

Priority Two Recommendations

Recommendation 11

The Trust must ensure that when teams are disbanded and the functions absorbed into other teams (eg the assertive outreach function being absorbed into the community mental health team) the operating requirements of the new team function is clear to everyone.

Recommendation 12

The Trust must provide clearer guidance to staff on obtaining information from family members when there is no consent from the service user, but the service user is presenting with behaviour that is a risk to themselves or others. The Trust must also provide guidance to staff on obtaining collateral information from other individuals known to service users when the service user is presenting with behaviour that poses a risk to the other individual.

Recommendation 13

The Trust must undertake an audit of the timeliness of entries into clinical records following clinical team or zoning meetings. When the scale of the problem is understood, the Trust must put into place measures to rectify any problems identified and implement a system to monitor compliance on a longer term basis.

Recommendation 14

The Trust must ensure communications with GPs are sent in a timely fashion. The Trust must also ensure that when a request is made for a GP to take some specific action, that this is followed up by the relevant Trust medical team.

Recommendation 15

The Trust must ensure that when a carer's assessment is recommended, appropriate actions are taken to ensure that this is offered to the carer in a timely fashion.

Appendix A – Terms of reference

Core 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 findings if relevant from any additional report such as Domestic Homicide Review (DHR) and the Trust's progress in implementing any recommendations.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from [Mr E's] first contact with services to the time of his offence.
- Review the appropriateness of the treatment of [Mr E] 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 E] harming himself or others.
- Examine the effectiveness of [Mr E'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

- Review why there was a delay in starting the internal investigation
- Assess the extent to which the Trust understood [Mr E's] drug taking and its impact on his mental health and behaviour
- Assess why the Trust did not fully appreciate [Mr E's] forensic history and the risk he posed to women
- Review and assess if the Trust could have done more to engage and communicate with [Mr E's] known friends and family during his admissions in hospital and after the incident, referencing any cultural and social issues
- Assess the capacity and capability issues and workload concerns raised by the internal report

Appendix B – Documents reviewed

South London and Maudsley NHS Foundation Trust documents

- Clinical records for Mr E
- Internal investigation report dated June 2013
- Action plan
- Notes from internal investigation interviews
- Investigation of Incidents, Complaints and Claims Policy v2.3 August 2012
- Incident Policy v3.1 July 2015
- Lambeth Early Onset CMHT Operational Policy October 2014
- Operational Policy Lambert PRT Logo latest Version June 2015
- SHARP (Social Inclusion, Hope and Recovery Project) Operational Policy November 2011
- Home Treatment Team Operational Policy v3.1 October 2015
- Care Programme Approach Policy v2 2011
- Care Programme Approach Policy v2.1 April 2015
- Supervision Policy v3 October 2011
- Supervision Policy v4 September 2014
- Safeguarding Children Policy and Procedures June 2008
- Safeguarding Children Policy August 2015
- Domestic Violence Policy - Final v9 March 2013
- Clinical Risk Assessment and Management of Harm Framework v6.1 October 2011
- Clinical Risk Assessment and Management of Harm Policy v7 August 2015
- Care and Treatment of service users with Dual Diagnosis July 2015
- Forensic Pathway Protocol July 2014
- Referral Guidelines 2015-2016

Other Documents

- GP records
- Oxleas NHS Trust records (prison healthcare)

Appendix C

Demographic details for Lambeth

The local population has needs related to a high level of social deprivation such as unemployment, poor social housing and child poverty. Lambeth is one of 13 Boroughs that make up inner London. It is the second largest inner London Borough with an official population of 272,000 (2006 mid-year estimate)

It is suggested that there are higher rates of mental disorder in south London compared with other parts of the country. This highlights the importance of accurate local assessment of levels of mental disorder and effective community based treatments.

Compared with national figures, it appears that incident rates for psychosis are 61% higher in south London. Compared with national rates, levels of anxiety or depression are 7% higher in Croydon, 27% higher in Lambeth, 20% higher in Lewisham and 20% higher in Southwark.

Compared with the national average (2.47/1000), use of mental health services is higher in Croydon (3.35/1000), Lambeth (4.1/1000), Lewisham (3.5/1000) and Southwark (3.3/1000) with similarly increased proportions of the population on Care Programme Approach.

Lambeth South Promoting Recovery Team

Lambeth South is one of four Promoting Recovery teams in Lambeth split across two sectors, with each one relating to a defined group of GP practices. The teams work closely with other community teams in the Psychosis CAG. A key element of the service is improved access with 'easy in and easy out' so that secondary care services are able to respond rapidly and flexibly when needed and also encourage patients to move on to primary care once active interventions are completed.

The teams promote earlier interventions, informed by proactively working with service users to:

- identify their strengths and their recovery goals across different domains in their lives;
- understand the course of their psychosis, and their relapse pattern to improve the recovery, social and clinical outcomes of service users in the teams.

The Promoting Recovery teams have systems in place to allow the recovery practitioners to focus on planned intervention work which is not crisis driven for set times in the week and at other times they will be actively managing patients in crisis or entering the 'amber' zone. Crisis work slots will involve work across the team so the patients are held by the team as well as having input from individual recovery practitioners. A small group of service users in each team receive daily supervised medication either through their attendance at the team base or via daily visits.

For teams to carry out systematic recovery and relapse focused work they will need to ensure that all patients have a comprehensive assessment of their medical, social, psychological, and occupational/skills/vocational needs. This will inform a multidisciplinary bio-psychosocial formulation, which helps to identify the focused interventions that will comprise the care plan.

The South Lambeth Promoting Recovery Teams comprise of a multi-disciplinary team and include the following team members:

- Team Leader
- Psychiatrists (Consultant +/- ST4-6; CT1-3; SAS doctors)
- Clinical Psychologists (B7, B8)
- Nurse Practitioners (B6,B7)
- Social Workers
- Occupational Therapists (B6, B7)
- Peer Support (STR3) workers
- Team Admin (B4)
- Locality Admin (B5 managers, B3 receptionists

Process for redeploying staff (taken from Trust Job Protection Policy)

Once staff have been sent a formal 'at risk' letter, all vacancies will be reviewed by the Human Resources Case Worker and those which may be suitable for staff at risk will be identified. These vacancies will be made available for 'at risk staff' first before open competition by other staff.

Unions will be consulted in accordance with the restructuring procedure and staff informed of the redeployment process and any potential redundancies.

Where necessary and if appropriate Management and Staff Side will seek to agree the criteria for selection for redundancy.

As part of the restructuring process all staff at risk will be interviewed to discuss job options and the wishes of the individual. The employee's line management as appropriate and a member of Human Resources will conduct this meeting.

At the end of the restructuring process a meeting will be arranged between the employee, their Head of Department (or other senior manager with authority to dismiss) and a member of Human Resources, who will be the Human Resources Case Worker for the redeployment, to officially notify the employee that they are being given notice of redundancy. At this meeting, staff will be advised that their

redeployment period and due notice period run concurrently. Staff may be accompanied to the meeting by a work colleague or a union representative.

If two or more members of staff in the 'at risk category are suitable for any vacancy they will be interviewed in competition with other redeployees only. Medical staff interviews will be held in accordance with national regulations.

Suitable vacancies exist where the staff member has the qualifications (nationally recognised) deemed essential for competent performance in the job and is broadly comparable and similar to the core requirements of the person specification.

(As a guide, unless a member of 'at risk' staff meets 80% of the core requirements of a post, including any specific qualifications required, it is unlikely to be deemed as suitable alternative employment. Any training requirements should be training that can be undertaken in a specified time limited period, either on the job training or specific courses).

Recruitment to Posts

All suitable redeployees, meeting at least 80% of the essential criteria for the role, will be interviewed for the position prior to open recruitment. It should be noted however that all qualifications/certificates required for the role must be met. The manager has the right to decline to accept the member of staff if they do not meet the requirements for the post and for justifiable business reasons. If the manager declines to accept a member of staff, the member of staff can appeal to the Director of Human Resources, who will convene a panel to consider the decision. The decision of the Appeal panel is final.

Refusal to co-operate with the Redeployment Policy or rejection of a post that is deemed suitable alternative employment by the Trust will lose the right to a redundancy payment.

Staff offered an alternative post will be inducted into their new job and there will be a 4-week trial period. This period may be extended by up to a further 4 weeks at the agreement of the manager, the budget holder and the member of staff where appropriate.

Line management, in consultation with Human Resources, may reserve the right to terminate a trial prior to the completion of a 4 week trial period where it is identified that the person is clearly unsuitable within the post, in order to allow the redeployee to maximise the redeployment/notice period available to maximise opportunity elsewhere. High levels of absence through any trial period may be used as an indicator that the post is not suitable alternative work.

Staff offered permanent alternative employment on a lower grade (only one band lower would be deemed suitable permanent alternative employment) or who otherwise suffer a loss of earnings will have their conditions of service protected in accordance with the Trust's Pay Protection Policy. They will also be given a ring-fenced opportunity for subsequent vacancies of their original grade, and for which they are suitable, for a period of 6 months following redeployment. During the six-month period it will be the responsibility of the redeployee to identify any potential

post within this timeframe. Human Resources will not be actively seeking posts at the higher grade following substantive redeployment into the lower graded post.

The Trust will work with staff formally put at risk for the duration of their notice period to redeploy them to avoid, if possible, redundancy. Should no suitable vacancy have been found at the end of the redeployment/notice period the staff member will be advised in a formal meeting that their contract of employment is terminated on the grounds of redundancy. Staff may be accompanied to the meeting by a trade union or professional association representative or a work colleague. This meeting will take place at least one week prior to the redeployment/notice period end date.

The Trust reserves the right to extend the length of the redeployment period where necessary

Appendix D - Chronology of Mr E's contacts with the Trust, his GP, and the prison healthcare provider

Date	Source	Event	Information
Tue 20/06/05	SLAM records	Reported information	Father reported to SLAM that Mr E went to see a psychiatrist for depression following his parents' divorce: Mr E took antidepressants for a month and recovered very quickly.
Tue 16/08/05	SLAM records	Admission - detained S2	Admitted on S2 following bizarre behaviours in the community. Mother on holiday in Portugal, history obtained over the telephone with Mr E's younger brother acting as interpreter.
Wed 12/10/05	SLAM records	Discharge	Discharged to Romsey Community Mental Health Team, Southampton as his mother had moved to Southampton and Mr E went with her as a temporary arrangement.
Sat 01/04/06	SLAM records	Moved house	Moved back to London from Romsey. Initially lived in Southwark then moved to Lambeth.
Fri 21/04/06	SLAM records	Appointment	Follow up by LEO CMHT - Mr E had not been taking medications and appeared to be relapsing.
Thu 01/06/06	SLAM records	Appointment	Reviewed by a Specialist Registrar and a care co-ordinator. Mr E told staff that he had been taking olanzapine 15mg and lithium 400mg nocte for the previous few days and had felt much better as a result. Mr E said in the previous week when he hadn't been taking his medication he was "mad, his thoughts were all over the place and that he was irritable". His concern at that time was sorting out his benefits as he had been unable to claim any for the last month due to the paperwork being lost. He had spent most of his time trying to sort this out and studying Islam and visiting the mosque on a daily basis. Mr E said as a consequence of converting to Islam he had split up with his girlfriend and had stopped drinking and smoking.
Mon 03/07/06	SLAM records	Admitted	Admitted 3/7/06; discharged 20/7/07. Informal admission. Mr E felt he had been admitted as he was homeless and needed help to sort out his accommodation and benefits. Mr E reported that "*a few people in the area wanted to harm him*" but wouldn't elaborate and denied hearing voices. Quick but partial recovery made whilst on the ward, auditory hallucinations settled but he continued to be paranoid.

Date	Source	Event	Information
Fri 07/07/06	SLAM records	Visit to HPU	Visit to HPU - given six months' temporary accommodation at a B&B in Forest Hill. Appeared very happy about this and wanted overnight leave. Plan made to continue extended leave with daily supervised medication until accommodation could be found in the Lambeth area.
Tue 18/07/06	SLAM records	Ward round	Discussed length of time anticipated before Mr E could secure permanent accommodation. Noted that Mr E was compliant with medication and therefore a decision was made to discharge him from the ward. Care co-ordinator happy to follow him in the Forest Hill area.
Thu 20/07/06	SLAM records	Care Programme Approach meeting	Attended by Mr E, his girlfriend and care co-ordinator. Mr E reported things were going well, he ad not heard any voices since re-starting his medication. Continued to feel that people were talking about him everywhere he went but stated he could cope with this. Recognised that he suffered from a mental illness and that his symptoms were the TV talking to him. Mr E was willing to take his medication as he recognised the benefits of doing so and reported no side effects, although admitted he did feel tired and drowsy occasionally but was able to cope with this. Mr E denied regular cannabis use, stated he was trying to give it up completed and believed he could achieve this without the help of any support groups. Denied any risk of harm to self or others.
Mon 21/08/06	SLAM records	Letter sent	From Dr P, unclear to whom. Dr P had reviewed Mr E on 21/8. Mr E had been attending the service for the previous year since his first episode of manic psychosis. Variable compliance with medication but in recent weeks this had improved and his accommodation was more settled. Mr E had also cut down on his drug use and was only using cannabis occasionally. Medication continued as olanzapine 15mg nocte and lithium 40mg nocte. Appointment for 3/52 time.
Tue 19/09/06	SLAM records	Letter sent	To Mr E offering an appointment on 25/9/06 @ 4:00pm as he had missed the appointment on 18/9.
Wed 29/11/06	SLAM records	Letter sent	To Mr E offering an appointment on 6/12/06 @ 1:30pm.

Date	Source	Event	Information
Fri 22/12/06	SLAM records	Letter sent	From Dr C, unclear to whom. Dr C had reviewed Mr E on 13/12 at the LEO team. Mr E did not describe any psychotic or manic features, in particular paranoia, which he had found distressing in the past. Low in mood with flat affect and psychomotor retardation. Mr E had been on no medication for a number of weeks and had not relapsed. He denied taking cannabis or other illicit drugs but continued to have problems with accommodation, which was not helping his mental state. Dr C discovered that a possible reason for non-compliance was a side effect of drowsiness. Mr E said he felt his medication was too much and that he only needed an anti-psychotic given that paranoia had been a major issue. A compromise was reached of olanzapine 10mg nocte. Four weeks' supply provided.
Tue 23/01/07	SLAM records	Letter sent	From Dr P, unclear to whom. Dr P had reviewed Mr E on 23/1 at the LEO team base where Mr E had been attending for the previous 18 months since his first episode of manic psychosis. In that time Mr E had spent some time in Southampton where services followed him up but he returned early in 2006 and had not been followed up by the LEO team since then. Mr E had been placed in accommodation in Lewisham and was not intending to return to Lambeth. The plan was for his care to be transferred to the local service in Lewisham as he was having difficulty maintaining contact in Lambeth. The relapse appeared to have been caused by non-compliance with his prescribed medication and difficulties with homelessness. He had settled into accommodation six months earlier and had been compliant with medication, as a result his mental state appeared to have been stable with no further signs of psychosis or mood swings. He was prescribed olanzapine 10mg nocte and reported that he was compliant with this. It was noted that Mr E was at significant risk of relapse if he were to stop his medication in the following two years. He did not require intensive input at that time and could have been managed in primary care with a contingency for rapid referral to mental health services if he started to relapse. In preparation for this, Mr E's care coordinator would complete a relapse prevention plan and organise a handover CPA to the new GP in Lewisham. Dr P would also contact with Lewisham EIT so that they were aware of Mr E's case should there be any problems or relapse. Mr E given a list of GPs near to his address in Lewisham and Dr P asked him to register with one of them in the following week so that the process of transfer could be started.

Date	Source	Event	Information
Wed 11/04/07	SLAM records	Admission - detained S2	Admitted on S2 following unprovoked assault on a stranger in a café. Questions about who is legally the Nearest Relative - possible Mr E's mother, but no details for her at that time.
Tue 17/04/07	SLAM records	Transfer to PICU	Transferred to PICU after being aggressive and abusive and presenting a significant risk to others by concealing knives and forks. A social circumstances report dated 27/4 stated that Mr E's father visited him whilst he was in PICU but there were no contact details on file and Mr E refused to provide any information.
Mon 30/04/07	SLAM records	MHRT	MHRT found that Mr E should continue to be detained as he was suffering from a mental disorder, diagnosed as schizo-affective disorder with prominent manic features. The panel were satisfied on the evidence that, when unwell, the patient could represent a risk to others. Treating team planning to move to S3 for treatment.
Fri 04/05/07	SLAM records	Transfer to ward	Transferred from PICU back to the ward.
Tue 08/05/07	SLAM records	Discharge from S2	Discharge notification of S2 patient, S2 ended 10am 8/5.
Mon 04/06/07	SLAM records	Letter sent	To Mr E from MHA Office advising him that he was no longer detained under S2.
Tue 12/06/07	SLAM records	Discharge	Admitted on S 2 on 11/4/07, transferred to PICU 17/4/07, returned to acute unit 4/5/07 and discharged 12/6/07. Detention rescinded on 8/5/07. Admitted following arrest for causing ABH to a stranger in a café. Diagnosis of acute and transient disorder. Presentation on day of admission was Mr E expressing paranoid ideas about people in the cafe saying he was gay, and delusions of reference. Displayed strange behaviour in the cell by trying to wash his clothes down the toilet. Mr E had been transferred to a PICU in order to manage his risks to others, after he had been aggresive and abusive to others, and had concealed knives and forks in his room. DISCHARGE PLAN: seven day follow up 18/6; regular lithium level monitoring; medical appointment with LEO to be arranged by care co-ordinator; psycho-education, relapse prevention and counselling around drug misuse; continue long term follow up by LEO CMHT; Mr E to contact LEO CMHT, or A&E if any concerns.

Date	Source	Event	Information
Fri 13/07/07	SLAM records	Letter sent	To Dr W, Jenner Health Centre from Dr C, Specialist Registrar. Mr E was reviewed with his care co-ordinator Mr BG approximately four weeks after discharge from hospital following a schizomanic relapse that required compulsory admission. Mr E was now living with his girlfriend. Dr B reported that Mr E looked very well, the best he had seen him. About two weeks previously somebody had shot a number of bullets through his front door at 2:30 am. Mr E was unharmed and had managed to deal with the stress. Dr B noted a slight fine lithium tremor to Mr E's hands but advised him to continue with the current dosage. Mr E given two weeks' supply of medication and was to be seen again by his new care co-ordinator prior to going on holiday to Portugal.
Fri 10/08/07	SLAM records	Letter sent	To Dr W, Jenner Health Centre from Dr B, Specialist Registrar. Mr E was reviewed with his care co-ordinator KD. Mr E had returned from a two week holiday in Portugal and appeared well and tanned, he said no problems during this time and denied being non-compliant with medication. Mr E complained of being bored and desperate to find a job. He lived in a flat with a long-term girlfriend who worked in a bookshop. Mr E had a flat affect with slow and monotonous speech and depressed affect. Denied problems with sleep, appetite, concentration or feeling suicidal. Medication: olanzapine 20mg nocte; lithium 1500mg od. Mr E given two weeks' supply with a further review in two weeks.
Thu 16/08/07	SLAM records	Telephone call	Received from the pathology lab - lithium levels reported as 1.63, twice Mr E's normal levels. Recommended that test be repeated ASAP and preferably 24 hours after taking the dose.
Mon 20/08/07	SLAM records	Telephone call	Message left for Mr E to call the clinic to arrange for a repeat blood test.
Thu 23/08/07	SLAM records	Telephone call	Message left for Mr E to call the clinic to arrange for a repeat blood test. Mr E to attend the following day before 2pm. Mr E unhappy that test had to be repeated.
Mon 03/09/07	SLAM records	Appointment	Messages left for Mr E to contact the clinic to arrange an appointment with the doctor. Mr E arrived at the clinic and said that he had not answered his telephone as he knew who was calling him and he was already on his way to the clinic. Very brief contact as nearly 5pm, medication provided and appointment arranged for the following Tuesday.
Wed 05/09/07	SLAM records	Appointment	DNA - further appointment to be arranged.

Date	Source	Event	Information
Wed 19/09/07	SLAM records	Telephone call	Call to Mr E after he had not attended for an appointment. Second attempt to contact Mr E that day. Mr E informed that his medication was due - agreed to meet at the clinic the following day.
Thu 20/09/07	SLAM records	Appointment	Mr E attended the clinic - he had not been seen for more than two weeks and had missed his medication for at least 3-5 days. Mr E appeared brighter and was not concerned at having missed appointments or medication. Mr E had missed a number of appointments with a work placements officer but agreed to attend the following week. Mr K helped Mr E contact Lambeth housing associated regarding his unrepaired door that had been shot at a few months' previously. Mr K recorded that he felt Mr E's mental health remained unchanged, no concerns about his presentation. Mr K was concerned about the lack of motivation to pursue things that Mr E had identified as being important to him. Mr E told Mr K that his girlfriend had gone to Spain to study and would be gone for a year. Mr K was concerned that this would further isolate Mr E and discussed this with Mr E. PLAN: continue to meet every two weeks.
Fri 05/10/07	SLAM records	Appointment	DNA - medication now due, not answering mobile phone.
Tue 09/10/07	SLAM records	Telephone call	Message left for Mr E to collect his medication.
Mon 22/10/07	SLAM records	Telephone call	Message left for Mr E to collect his medication.
Tue 23/10/07	SLAM records	Clinical discussion	Mr E placed in red zone as had not been seen for four weeks, no medication since 20/9/07. PLAN: contact his mother to find out current concerns and advise about missing person if she doesn't know where he is.
Wed 24/10/07	SLAM records	Telephone call	Call to Mr E's mother, phone passed to someone else due to language barrier. She reported not having had any contact with Mr E for more than five weeks. Contact made with GP in Lewisham, no contact with Mr E since February. Home visit attempted (two members of staff) no response from the door and staff could hear his mobile ringing in his flat. Contact with police who agreed to do a welfare check. Call received from Mr E's friend who returned Mr K's call. Friend had spoken with Mr E three days' previously - agreed to call Mr E and provide feedback to Mr K.

Date	Source	Event	Information
Fri 26/10/07	SLAM records	Appointment	DNA vocational appointment. Discharged from vocational caseload due to persistent DNAs.
Fri 26/10/07	SLAM records	Appointment	Not entered until 8/11/07. Dr L reviewed Mr E who continued to engage poorly with the service. Mr E had been without medication for at least two weeks. Mr E attended with his arm in plaster having fractured his wrist after a fall. Mr E appeared to be cooperative during the appointment but his answers were cautious and guarded. Mr E said that the reason he had not attended appointments was because his girlfriend had gone to Spain for a year. Dr L's impression was that Mr E was not unwell, but that he placed himself at high risk of relapse and prevented full recovery due to poor engagement with the service and intermittent compliance with medication.
Tue 30/10/07	SLAM records	Clinical discussion	Case discussed in clinical review. Partial compliance with medication, fragile mental state. PLAN: weekly contact.
Thu 01/11/07	SLAM records	Telephone call	Mr A called Mr E to introduce himself as covering Mr K for three weeks as he had left. Mr E declined the offer to meet that week saying that he was meeting Dr C the following week and that Mr A could meet him then. Mr A agreed a welfare call on Monday. Mr E expressed no concerns and said that he had been taking his medication.
Tue 06/11/07	SLAM records	Clinical discussion	PLAN: telephone call the following day.
Fri 09/11/07	SLAM records	Telephone call	Mr A called Mr E to do a general welfare check and remind him to collect his medication. No reply. DNA for medication. PLAN: contact again on Monday.
Thu 08/11/07	SLAM records	Letter sent	To Dr W, Jenner Health Centre from Dr L, Specialist Registrar. Mr E had been reviewed on 26/10 - content of letter as per entry below on 14/11.
Mon 12/11/07	SLAM records	Telephone call	Mr A called Mr E regarding collecting his medication. No answer, message left.
Tue 13/11/07	SLAM records	Clinical discussion	Mr E not been seen for 2-3 weeks, declined opportunities to collect medication on Friday. Medication now overdue, not returning calls. PLAN: Dr L and Mr A to do home visit to try to re-establish contact.

Date	Source	Event	Information
Wed 14/11/07	GP records	Letter received	Letter dated 8/11/07 To Dr W, Jenner Health Centre from Dr C, Specialist Registrar. Mr E had been reviewed on 26/10/07. He continued to engage quite poorly with the service and staff were aware that he had been without medication for at least two weeks. Mr E had attended his appointment with his left arm in plaster after fracturing his wrist, which Mr E said he suffered during a fall. Mr E appeared cooperative during interview although some of his answers appeared guarded and cautious. Mr E said that his girlfriend had gone to Spain to study for a year and cited this as the reason that he had been unable to attend appointments during the previous two weeks. Mr E had been making use of the vocational support although his engagement had been patchy. Mr E was reminded of the importance of being compliant with his medication. Dr C reported that his impression was that Mr E was not unwell but that he continued to place himself at high risk of relapse and preventing a full recovery due to his poor engagement and intermittent compliance with medication.
Wed 14/11/07	SLAM records	Home visit	Home visit by Dr L and medical student. Mr E denied feeling paranoid or experiencing low mood. Admitted missing doses of medication. Dr L noted that Mr E no longer had a cast on his wrist. Mr E said it was removed because he felt it was better. Dr L questioned further and established that it was a scaphoid fracture. Mr E had missed two follow up appointments with outpatients, Dr L stressed the importance of reviewing the fracture due to potential complications with recovery. Mr E confirmed he would make an appointment asap as he didn't realise the implications of his actions. PLAN: move from red to amber zone, welfare call on Monday, medical review 23/11/7.
Wed 21/11/07	SLAM records	Text message	Received by Mr A from Mr E asking for contact from the team as he thought his recently fractured wrist might not have been recovering properly. Mr A tried calling Mr E with no response. Text sent to Mr E asking him to go to the clinic.
Fri 23/11/07	SLAM records	Appointment	Mr E did not attend his appointment. Dr L tried calling Mr E with no response,, message left asking Mr E to contact the clinic. Dr L noted concerns as: Mr E scaphoid fracture, medication due to be collected that day, lithium bloods needed.

Date	Source	Event	Information
Fri 30/11/07	SLAM records	Appointment	Mr E attended the clinic and collected his medication - he was seen by the duty worker. Mr E asked to see Mr A - Mr E said something had happened and he needed to talk. The duty worker told Mr E that Mr A had left and that the duty worker didn't now who had been allocated as his new care co-ordinator. Mr E expressed frustration that everybody he saw kept leaving. The duty worker expressed sympathy and offered an appointment but Mr E declined saying he would return the following week to find out about his new care co-ordinator. Duty worker noted in the clinic diary that Mr E would return the following week and that a welfare check should be done if the clinic staff did not hear from Mr E.
Tue 04/12/07	SLAM records	Appointment	Mr E attended the clinic at lunchtime, outside of any appointments. He was seen by Dr L and his new care co-ordinator Ms H. Mr E presented in an animated state and was pre-occupied with delusional beliefs that his upstairs neighbour had been spying on him by pulling up the floorboards. Mr E was certain that he was reporting fact and said a number of times that the was not mentally unwell. Mr E was distressed and angered by his experiences and said that he was not depressed or suicidal. Mr E wanted the team to help take his case forward against his neighbour and said that although he wanted to "slap him" he denied any confrontation with his neighbour. Dr L was concerned that Mr E did not seem to appreciate that he would be fully culpable should he act violently towards his neighbour, saying "yea, but he's been doing all this to me, so it's not right!". Mr E was also convinced that his neighbour was responsible for the burglary in his flat the previous time that Mr E had been in hospital. Mr E had been banging on the ceiling with a broom handle. Mr E assured staff that he had been taking his medication, but Dr L noted that staff knew from experience that Mr E's compliance with treatment was poor. Mr E admitted to smoking cannabis 2-3 days previously and saw no link between this and his current mental state. Dr L noted that Mr E appeared to have a relapse of his psychotic illness, secondary to poor compliance with his medication, and cannabis use. Risks to Mr E's neighbour were noted, as well as self-neglect. PLAN: Mr E to be placed in red zone, home visit with Ms H and Dr L or duty worker, to discuss with HTT if Mr E presented in a similar way again - if Mr E would not agree to treatment then consider detention under S3 which Dr L was willing to recommend.

Date	Source	Event	Information
Wed 05/12/07	SLAM records	Appointment	Mr E did not attend his appointment, in view of this and the high risk of violence, especially towards his neighbour, Dr L made the first recommendation for admission under S3 MHA. Mr E to be given further opportunity to engage with HTT the following day, via a home visit by Ms H and HTT.
Wed 05/12/07	SLAM records	Home visit	Ms H and a social worker attempted to visit Mr E at home but got no response. Message posted through Mr E's letterbox. Ms H then referred Mr E to the HTT and arranged a further home visit for the following day.
Thu 06/12/07	SLAM records	Home visit	Ms H and HTT attempted to visit Mr E at home but there was no reply despite there being a light on in the bathroom. Mr E had already indicated to the community team that he was not interested in working with the HTT. Ms H to continue with plans for admission. Ms H referred Mr E to the social worker for assessment and was told that the social work team had been inundated with referrals and the admission process would not be able to be started until the following week. Later in the day Mr E arrived at the clinic to let the team know he was fine and apologise for not being in. Ms H gave Mr E several hours to talk and noted that he appeared less pre-occupied by his neighbour. Ms H helped Mr E arrange for his front door to be changed and Mr E asked about being re-housed. Ms H asked what contact Mr E had had with his family - Mr E said that he had seen his father the previous day and his mother a few weeks' previously. PLAN: discuss with Dr P and agree course of action.
Wed 12/12/07	SLAM records	Appointment	Mr E did not attend his appointment with Ms H and Dr L.
Fri 14/12/07	SLAM records	Appointment	Ms H and Dr L made a home visit to Mr E as he did not attend his appointment the previous day. Mr E let them in when they knocked on the door. Noted that he seemed calmer but still pre-occupied with his neighbour. Mr E said that he planned to visit his girlfriend in Spain in the new year and asked for medication.

Date	Source	Event	Information
19/12/7 - 26/12/7	SLAM records	Appointment	Several appointments provided by Mr E did not attend them and did not respond to any calls from staff.
Thu 27/12/07	SLAM records	Unscheduled attendance	Mr E attended the clinic and was given his medication. He asked to see the doctor as he complained of side effects. Appointment arranged with Dr L for the following day. Mr E had his girlfriend with him and said he was happy to see her.
Fri 28/12/07	SLAM records	Appointment	Mr E did not attend his appointment with Dr L. PLAN: call Mr E on 31/12 to encourage him to see Dr L.
Wed 02/01/08	SLAM records	Unscheduled attendance	Mr E attended the clinic with no appointment arranged. Mr E was hoping to have help from the staff in completing an incapacity benefit form and making calls to the police and housing to get re-housed in view of the incident that led to gunshots in his front door. Seen by Dr L and his new care co-ordinator Mr J. Mr E continued to report that his upstairs neighbour was watching him and that he "hears him talking about Mr E and commentating on his actions on a daily basis". Mr E said there were no problems when he was outside his flat and maintained that he was not mentally ill. Mr E said that he had had a good couple of weeks with his girlfriend who had come over from Spain and that he was planning to visit her for a week. Mr E was calm and jovial but Dr L noted a "slight air of irritability". Mr E denied any psychotic experiences other than those noted above and said he had been fully compliant with his medication, despite maintaining that he was not mentally unwell. Dr L noted a low to medium risk of harm to others and that Mr E remained inconsistently engaged in treatment. PLAN: bloods taken, meeting with Mr J re incapacity forms and phone calls, meet with Dr L in two weeks after holiday to Spain.
Fri 04/01/08	SLAM records	Unscheduled attendance	Mr E collected two weeks supply of medication as he was travelling to Spain with his girlfriend. Call to incapacity benefit to request another form as the previous one was lost.
Wed 09/01/08	SLAM records	Letter sent	To Dr W, Jenner Health Centre from Dr L, Specialist Registrar. Content as per entry below on 11/2.

Date	Source	Event	Information
Mon 14/01/08	SLAM records	Unscheduled attendance	Mr E attended early for his appointment and stated he did not have much time as he had another appointment to attend. Mr J helped Mr E complete the DWP form, no overt psychotic symptoms noted and none reported. Mr E said he enjoyed his holiday but expressed concern that he had been sleep walking. Mr J advised Mr E to discuss this with Dr L.
Wed 16/01/08	SLAM records	Appointment	Mr E did not attend his appointment with Dr L. Call to Mr E's mobile - no answer and message left.
Thu 17/01/08	SLAM records	Unscheduled attendance	Mr E arrived at the team base and apologised for not attending the previous day. Mr J was unable to spend time with Mr E as Mr J was going out on a crisis visit. Mr E was given medication and an appointment the following day to see Mr J and Dr L.
Fri 18/01/08	SLAM records	Appointment	Mr E did not attend his appointment with Dr L. Dr L called Mr E who was apologetic and agreed to see Dr L the following week 23/1.
Wed 23/01/08	SLAM records	Text message	Text message sent to Mr E to cancel his appointment with Dr L due to sickness.
Mon 28/01/08	SLAM records	Unscheduled attendance	Mr E attended the clinic and collected his medication. He reported that he had run out of olanzapine as he had 'lent' tablets to a fellow client. Appointment arranged to see Dr L 29/1.
Tue 29/01/08	SLAM records	Appointment	Dr L saw Mr E who attended alone. Mr E reported that his neighbour had stopped spying on him and said he couldn't hear his voice commentating on his (Mr E's) actions. Mr E remained convinced that this experience had been real and not part of a mental illness. Mr E was unable to make a link between cannabis use and increased psychotic symptoms, or use of olanzapine reducing his symptoms. Mr E said he was always compliant with his medication and denied using cannabis, looking confused when Dr L mentioned Mr E's cannabis use prior to Christmas.
Mon 11/02/08	SLAM records	Unscheduled attendance	Mr E asked Mr J to help him complete a GP registration form. Mr J noted some superficial scratches to Mr E's forehead and right hand. Mr E was evasive when Mr J questioned how these had been sustained, saying that "it was a misunderstanding and that it was resolved". Mr E continued to express an interest in a painting and decorating course and agreed to attend an appointment with a vocational worker.

Date	Source	Event	Information
Mon 11/02/08	GP records	Letter received	Letter dated 9/1/08 To Dr W, Jenner Health Centre from Dr C, Specialist Registrar. Mr E had been reviewed on 29/1 and appeared to be upbeat. He reported that his neighbour appeared to have stopped spying on him and that he had not heard his neighbour's voice commenting on his actions. Mr E was open to the idea of exploring those experiences as part of a mental illness, however Dr C felt that Mr E was more convinced that they had been real experiences. Mr E was unable to make a link between cannabis use exacerbating his psychotic symptoms and his olanzapine medication in reducing the symptoms. Although Mr E reported that he was always compliant with his prescribed medication and denied using cannabis Dr C reported that he had a degree of scepticism with regard to these reports. Dr C noted a mild lithium tremor and that Mr E's lithium level was 0.8 which was within the therapeutic range. Dr C made plans to withdraw the lithium over the coming six weeks and told Mr E that if he remained compliant with the olanzapine during the period and there was no evidence of psychosis or affective disturbance, Dr C may be able to support Mr E's application to renew his driving licence. However, Dr C felt that Mr E was not stable or sufficiently engaged in treatment at that time and told Mr E that he should not be driving.
Mon 25/02/08	SLAM records	Appointment	Mr E did not attend his appointment with the vocational worker. Mr J left a message for Mr E reminding him of his appointment with Dr L the following day.
Tue 26/02/08	SLAM records	Unscheduled attendance	**13:00** - Mr E did not attend his appointment with Dr L. PLAN: continue follow up with care co-ordinator and book again with Dr L in one month. **14:30** - Mr E attended the clinic unexpectedly asking for medication. Two weeks supply of olanzapine provided by duty worker.

Date	Source	Event	Information
Wed 12/03/08	SLAM records	Letter sent	To Dr W, Jenner Health Centre from Dr L, Specialist Registrar. Mr E was reviewed on 12/3. Since stopping lithium a couple of weeks previously Mr E had been feeling slightly better physically, and no worse mentally. He had fairly unstructured days but did not seem to be socially isolated, seeing friends and remaining in contact with his parents who were divorced. Mr E had seen the Vocational Advisor for a shore while and college course or part time work was discussed with him. Mr E continued to express concern about the neighbour upstairs from him but no longer seemed convinced that his neighbour had been spying on him. Mr E told Dr L that he tended to ignore thoughts about the neighbour so it no longer had an effect on his life. No other psychotic symptoms noted. Mr E to continue on olanzapine 20mg once daily. As he was well over the two-year time period for treatment with LEO he would be transferred to his locality Recovery and Support Team for ongoing care as soon as they were able to accommodate him.
Mon 24/03/08	SLAM records	Unscheduled attendance	Mr E arrived at the team base after 5pm and the duty worker informed him that the clinic was closed. Duty worker agreed to hand over two weeks' supply of medication - no problems observed in his interactions.
Thu 03/04/08	SLAM records	Appointment	Mr E did not attend his appointment with Mr J. Called and offered another appointment for 7/4.
Mon 07/04/08	SLAM records	Appointment	Mr E did not attend his appointment with Mr J.
Mon 14/04/08	SLAM records	Unscheduled attendance	Mr E attended to collect his medication - Mr J was unable to see him properly, but gave him his medication and offered an appointment.
Wed 16/04/08	SLAM records	Appointment	Mr E did not attend his appointment with Mr J - another appointment given for 25/4.
Fri 25/04/08	SLAM records	Appointment	Mr E did not attend his appointment with Mr J.

Date	Source	Event	Information
Wed 28/05/08	SLAM records	Clinical discussion	Mr J noted that Mr E had frequently DNA'd planned appointments and had made unscheduled visits to collect medication and enquire about application for a freedom pass. Mr J noted it had been difficult to assess him because of his adhoc engagement. Mr E had not provided contact details for his new GP - required to facilitate transfer to the appropriate CMHT. Mr E continued to report no concerns with his mental state - focussing on social issues. PLAN: discuss at next clinical review.
Fri 20/06/08	SLAM records	Letter sent	To Mr E offering an appointment on 8/7/08 @ 12pm.
Tue 24/06/08	SLAM records	Unscheduled attendance	Mr E attended the clinic and requested his medication. Two weeks' supply was given. Mr E informed the duty worker that his freedom pass had expired and that he needed assistance to complete the new application form. Advised to bring in two proof of residency and expired pass - Mr E agreed to come in the following day.
Wed 25/06/08	SLAM records	Letter sent	To Accessible Transport Unit requesting that Mr E's freedom pass be renewed. His previous pass had expired in March 2008 and it had not been renewed since then for reasons unknown.
Tue 01/07/08	SLAM records	Appointment	Mr E attended after staff called him. Mr E brought in proof of residency and a letter for his freedom pass.
Wed 09/07/08	SLAM records	Unscheduled attendance	Mr E attended to collect medication. Mental state appeared stable with no current concerns - Mr E denied paranoia at home and being compliant with medication. Mr E unable to provide details of GP but believed it might have been Palace Road Surgery. Mr E aware that he was to be discharged but would need to be represented to the team to decide if discharge would be to R&S or GP. Two weeks' medication given, appointment offered on 14/7.
Mon 11/08/08	SLAM records	Letter sent	To Mr E offering an appointment on 18/8/08 @ 4pm.
Mon 18/08/08	SLAM records	Appointment	Mr J met with Mr E who appeared well kempt with reasonable rapport. Appeared vague at times and eyes glazed - denied cannabis or drug use or any current concerns. Given two weeks' medication. Agreed to referral for vocational support. PLAN: transfer to SW CMHT.

Date	Source	Event	Information
Fri 05/09/08	SLAM records	Unscheduled attendance	Mr E arrived at the clinic dressed in what appeared to be an Islamic Kameez. Informed staff that he had converted to Islam two years previously. Presented as quite fatuous but denied cannabis use or any relapse indicators. PLAN: review with Dr G in two weeks.
Fri 05/09/08	SLAM records	Letter sent	To Mr E offering an appointment on 12/9/08 @ 3pm.
Sun 07/09/08	GP records	Letter received	From St George's Healthcare. Mr E had attended A&E on 7/9 at 04:28 complaining of abdominal pain. Diagnosis: femoral hernia. Advised to wear underpants rather than boxer shorts to provide more support. For review and follow up by GP. Advised to return to A&E if groin swelling becomes irreducible.
Sat 20/09/08	GP records	Letter sent	From Palace Road Surgery to Mr E. Blood test results had been received and Dr H wanted to discuss those with Mr E. Mr E to contact the surgery to make a routine appointment.
Mon 22/09/08	SLAM records	Appropriate Adult (PACE 1984) Form	Mr E was interviewed in by police in the presence of an Appropriate Adult after he had assaulted his girlfriend. Form indicates that Mr E was charged with abduction and ABH after he had held his girlfriend against a wall and hit her face whilst she was being held.
Mon 29/09/08	SLAM records	Unscheduled attendance	Mr J happened to see Mr E on return from a visit. Mr J was being dealt with by the duty worker regarding medication and calls to the council. Mr J met with Mr E briefly - no overt manic or psychotic symptoms noted. Mr E was concerned that he had split up with his girlfriend two weeks' previously and admitted that they had a physical altercation. Mr E was vague about the details but Mr J noted that Mr E had "slapped/punched her". Mr E was quick to add that it was nothing to do with his illness and that they had been having relationship difficulties for some time. Mr E's girlfriend had found out that he had been with someone else and she would go clubbing with her friends regularly, returning home late at night while he had been at home worrying about her. Mr J noted that the police were involved and Mr E was due in court the following month. Mr J noted that Mr E had apparently seen by duty worker the previous week and given medication, however this had not been documented. Mr E asked for more medication as his friend had borrowed some of Mr E's medication - Mr J advised Mr E to ask his friend to return the medication.
Thu 09/10/08	SLAM records	Letter sent	To Dr P from Dr G. Content as entry below on 3/11/08.

Date	Source	Event	Information
Thu 16/10/08	SLAM records	Unscheduled attendance	Mr E attended the clinic to use the phone regarding a housing repair - water damage in his bathroom. Seen by duty worker.
Wed 29/10/08	SLAM records	Unscheduled attendance	Mr E arrived late for his appointment and could only be seen briefly. Mr E had started a work placement in Primark which he reported was going well. Mr E was in receipt of a bailiff's letter dated 2007 which had been sent to his previous address, regarding debts of £3000. Mr J advised Mr E to return on Friday and Mr J would facilitate a phone call with the bailiffs and also suggested Mr E contact CAB.
Mon 03/11/08	GP records	Letter received	Letter dated: 9/10/08 To Dr P from Dr G, Specialist Registrar LEO Community Team. Mr E was reviewed by Dr G with his care co-ordinator Mr J. Since discharge from hospital 16 months previously, Mr E had been largely well. Although Dr G's predecessor, Dr C, had commented that Mr E had reported some grumbling feelings of paranoia Mr E was reported that he had not had any such experiences. Mr E had a meeting planned with the owners of a restaurant later that day - he planned to work there as a kitchen assistant, starting on 16 hours per week. Three weeks previously Mr E was arrested after a violent incident with his now ex-girlfriend. He was initially charged with ABH but this was later changed to common assault. Mr E was in touch with probation services and was on conditional bail. Mr E was clear that the incident did not relate to any symptoms of mental illness and may have been explained as an episode of domestic violence. Mr E continued to use cannabis every few weeks. Plan: continue with current doses of medication; Mr E to continue with medication for approximately three years after recovery (up to summer 2010); Mr E to take omega 3 fish oils; fasting glucose test to be done by GP; as Mr E is beyond the two years that the LEO Team takes on clients, transfer to the South West Lambeth Recovery and Support Team to be planned.
Mon 03/11/08	GP records	Letter sent	From Palace Road Surgery to Mr E. Urine test results had been received and Dr P wanted to discuss those with Mr E. Mr E to contact the surgery to make a routine appointment.
Thu 06/11/08	SLAM records	Appointment	Mr E did not attend his appointment with Mr J.

Date	Source	Event	Information
Wed 12/11/08	SLAM records	Unscheduled attendance	Mr E collected two weeks' supply of medication and reported that he had not received the rent card that he had ordered several weeks previously. Duty worker called Lambeth Council and ordered a new rent card. Later entry by Mr J: "Given medication by duty. Appeared stoned with glazed eyes and difficulty concentrating, denied cannabis use. Wanted to call debt collectors but did not have letter/contact details, advised to come in on Friday with the relevant letters".
Thu 13/11/08	SLAM records	Telephone call	Received by Mr J from Mr E's probation officer who expressed concern that Mr E had missed appointments and during the previous meeting seemed to have trouble concentrating, appearing under the influence of drugs. Mr J advised that he was due to meet Mr E the following day, he would also arrange and CPA and send the probation officer an invitation.
Fri 14/11/08	SLAM records	Appointment	Mr E did not attend his appointment with Mr J.
Mon 24/11/08	SLAM records	Unscheduled attendance	Mr E attended the clinic appearing aroused and agitated. Mr E informed Mr J that he had received a letter from probation informing him that he had breached the conditions of his order and was going to be recalled to court as he had not been attending his community service. Mr E wanted Mr J to write to probation stating that Mr E had an appointment at the clinic at the time of his last appointment with probation. Mr J informed Mr E that he could not do this as it wasn't true. Mr E became annoyed at this stating that Mr J didn't want to help him and that he didn't mind going to prison anyway. Mr E's reason for missing community service was that it was too early and that he preferred to stay in bed. Mr J advised Mr E that his behaviour appeared to be agitated - Mr E said that he had eaten too much chocolate the previous night and had a sore stomach - he maintained that he was compliant with his medication. Mr J was unable to carry out a more detailed assessment as Mr E left. Mr J informed the vocational worker and vocational worker of the situation and placed Mr E in the red zone.

Date	Source	Event	Information
Thu 27/11/08	SLAM records	Telephone call	Mr J called Mr E's probation officer. Mr E had told the probation officer that he had written proof as to why he had been missing appointments and community work. This had been proven not to be valid and Mr E had admitted that he had been oversleeping. Mr E had arrived two hours late for his probation appointment, appeared dishevelled and agitated and gave the excuse that he had little sleep as his girlfriend had been keeping him up. Mr E accused his girlfriend of stealing his sperm and would not disclose her new address to his probation officer. Concerns were expressed as there had been two further incidents since Mr E's initial assault on his girlfriend. The probation officer informed Mr J that she had 'breached' Mr E for missing appointments and would be submitted a report to court requesting a mental health requirement.
Fri 28/11/08	SLAM records	MHAA request	Request for urgent MHAA due to signs of relapse. The degree of hostility meant that the team was unable to fully assess his mental state compliance or discuss informal admission. Concerns expressed about risks to ex-girlfriend. CMHT had informed Mr E's probation officer and the police who had agreed to call his ex girlfriend to advise her to avoid contact with him.
Fri 28/11/08	SLAM records	Telephone call	Telephone call to EDT regarding the referral for MHA. Advised that the EDT will not set up an assessment and will only respond if Mr E is brought to their attention ie via A&E or police. Telephone call to CSU to update on feedback from EDT, girlfriend had been contacted and she would be spending the week out of London in her student accommodation. CSU had put a 'special scheme' on the girlfriend's family home in Lambeth so officers would respond accordingly should Mr E go there. Mr E's assault history against his girlfriend noted as: 6/9 kicked in back door of family home and charged with criminal damage; 11/9 head-butted girlfriend, charged and bailed; 21/9 head-butted girlfriend. PLAN: if not admitted over the weekend, urgent home visit and MHA assessment.

Date	Source	Event	Information
Tue 02/12/08	SLAM records	Appointment	Mr J met with Mr E who apologised for his behaviour the previous week but was reluctant to discuss his presentation further. Mr E continued to voice some anger towards his girlfriend regarding his lack of employment citing the reason as his probation and community service following his domestic violence towards her. Mr E gave inconsistent information, occasionally referring to her as his ex-partner, friend and later his girlfriend. Mr E said that she was trying to get him beaten up and have fights with others. Mr E was offered input from the HTT but he refused this as he believed himself to be well and appeared offended that staff had suggested otherwise. Mr E denied he was stressed and became annoyed that staff were discussing his private life, which he felt was not their concern. PLAN: staff considered Mr E would not be detainable and therefore decided not to continue with a MHA as this could have adversely affected the therapeutic relationship.
Wed 03/12/08	SLAM records	Unscheduled attendance	Mr J saw Mr E who arrived four hours later than his appointment. Mr E was not willing to stay for long and wanted contact details of housing repairs. Mr J noted that Mr E had a court appearance the following day regarding his breach - report sent to probation requesting that it not be shared with Mr J as it would adversely impact the therapeutic relationship.
Wed 03/12/08	SLAM records	Letter sent	To probation officer providing a psychiatric report for the courts. Report describes admission in 2005, 2007 and progress in the community since discharge in June 2007. Report described signs of relapse over the preceding three weeks with increased agitation, suspiciousness and paranoid thoughts towards his ex girlfriend. On 28/11 Mr E presented at the CMHT as extremely hostile and agitated. Due to this presentation a referral was made to the out of hours duty team and the following Monday 1/12 a referral was made for a MHAA. Mr E presented on Tuesday 2/12 and it appeared that his mental health had improved in that he demonstrated a greater degree of emotional control, however it was felt that he still showed signs of relapse. Therefore the MHAA had been 'suspended' and the CMHT would attempt to see Mr E at least weekly.
Thu 18/12/08	SLAM records	Appointment	Mr E did not attend his appointment with Dr G and Mr J.

Date	Source	Event	Information
Fri 19/12/08	SLAM records	Telephone call	Mr J attempted to contact Mr E - no answer from his mobile. Mr J later did a home visit - Mr E spoke to him from his window, did not want to come down as he was with someone. Mr E agreed to go to the clinic on Monday to collect his medication.
Mon 22/12/08	SLAM records	Appointment	Mr J met with Mr E who appeared well kempt with no signs of agitation or hostility. Mr E talked in a calm manner about his ex-girlfriend stating that they should remain friends. Remain in red zone.

Date	Source	Event	Information
Wed 24/12/08	GP records	Letter received	Letter dated: 8/12/08 To Dr P from Dr PP, Consultant Psychiatrist, LEO Community Team. Mr E was reviewed on 8/12. Dr PP advised that Mr E had been followed up by the LEO Community Team for the previous 2½ years following his first episode of manic psychosis. Dr PP reported that Mr E had been difficult to engage partly because of poor compliance with medication, drug use and repeated relapses, and that there were again concerns about relapse and a section assessment had been considered the previous week. This was still being planned, despite a slight improvement. Mr E had not agreed to any increase in his medication or to the involvement of the Home Treatment Team. Mr E attended his appointment that day, only with prompting after he failed to attend his booked appointment earlier that afternoon. Mr E reported that he had attended court the previous week for a case of domestic violence: he received 120 hours of community service and had been ordered to attend for counselling. Mr E was already attending probation and said that he had another court case in early January 2009. Mr E reported that he had been receiving prank calls from friends of his ex-partner, threatening him to give back her belongings and money that he owed her. Mr E also reported that his ex-partner had come to his flat and had sex with him, after which he became upset with her, called the police and got her to leave. Mr E said that she left him with £10 worth of skunk which he smoked over the previous couple of days. Dr PP reported that Mr E appeared stoned. Dr PP advised that the team would liaise with probation and the police to ascertain exactly what had happened in order to identify the risks and organise a section assessment if appropriate. Appointment arranged with Dr G the following week 18/12 and Mr E would remain in the red zone of alert and in daily contact with the team.

Date	Source	Event	Information
Mon 29/12/08	SLAM records	Unscheduled attendance	Mr E attended the clinic without an appointment. Mr J could only see him briefly as he had another client to see. Mr E reported that his ex-girlfriend had called the police the previous week due to an argument and Mr E had been arrested - he had attended court that day and been bailed. Mr J sought confirmation of the incident from the CSU. They confirmed that police had been called on 26/12 by the ambulance service who had been treating Mr E's ex-girlfriend. She told police that Mr E had had some alcohol and cannabis and that he had assaulted her, punching and slapping her, biting her breast, dragged her by the hair, hit her with a belt and drawn a knife (which he didn't use).
Tue 30/12/08	SLAM records	Appointment	Staff attempted to contact Mr E to remind him of his appointment that day. Mr E did not arrive for his appointment with Dr G.
Mon 05/01/09	SLAM records	Appointment	Dr P and Mr J met with Mr E. Noted that Mr E had been arrested and charged with domestic violence on 27/12. Mr E said that he had not seen his ex-girlfriend since before Christmas and that the claims were vexatious and that he had not assaulted her recently. Mr E said that he wanted to avoid her as she was a bad influence on him, bringing him drugs and forcing him to have sex with her. Mr E said he was also concerned that she was stealing from him when she stayed with him and he was sleeping. Mr E said that otherwise he was okay - he had not used drugs since Christmas and that he was compliant with his medication. He said he was seeing his family regularly and getting on well with them - his mother was back in London with his younger brother and that he had seen his father intermittently.
Wed 07/01/09	SLAM records	Appointment	Mr J saw Mr E who appeared reasonably well kempt with good rapport and eye contact. Mr E continued to identify his ex-girlfriend as the cause of his problems and presented as mildly paranoid.
Thu 08/01/09	SLAM records	Unscheduled attendance	Mr E arrived at the clinic and informed Mr J that he had just been to court regarding breaching his community order. He was also due in court on 9/2 regarding the assault on his ex-girlfriend - Mr E continued to deny the allegation stating that she made it all up to get back at him. Mr E reported that he was compliant with his medication and that he felt more himself and wasn't as stressed.

Date	Source	Event	Information
Wed 14/01/09	SLAM records	Appointment	Mr E requested his medication and whilst waiting was engrossed in colouring in a leaflet. When the duty worker spoke to him, he didn't acknowledge him. The left side of Mr E's head was bruised, and he had a bloodshot eye and it appeared that his right fist was also bruised. He denied having been in an altercation. Mr E said he had not seen his ex-girlfriend since before Christmas. Mr E produced two letters; one confirming he was on the electoral role and the other (which caused him distress) was a £25 cold weather payment from Job Centre Plus. Mr E complained that "the letter was not written on real paper, that it didn't taste right from touching it". Mr E didn't believe he could pay the cheque into his bank account so the duty worker kept it for safe keeping. Mr E was significantly concerned about the barcode on the letter. Duty worker asked Mr E if he had smoked cannabis recently - Mr E was hostile in his denial then said that cannabis had been posted through his letterbox. Mr E said that he had bought a dog and had had it for a few days before selling it. PLAN: call Mr E the following day to remind him of his medical review.
Wed 21/01/09	GP records	Letter received	Letter to Dr P from Dr P, Lambeth Early Onset Community Team (LEO) to advise that Mr E had been of particular concern during previous weeks. An assessment for detention under section had been started that day and it was likely that Mr E would be assessed by the second opinion doctor in the coming 2-3 days. Mr E appeared acutely psychotic, quite paranoid, thought disordered and experiencing intermittent hallucinations. He described a widespread conspiracy involving his ex-girlfriend and believed people had been taking shots at him and might have come to harm him with knives. On-going concerns about Mr E's relationship with his ex-girlfriend who appeared to be quite vulnerable and despite the existence of a restraining order had been repeatedly seeing him, putting herself at risk. Mr E's care co-ordinator Mr J attended a MARAC meeting that day for a domestic violence review. The police had offered their assistance to promptly process the section assessment so that Mr E's risk to his ex-girlfriend and others could be minimised. Mr E was likely to be admitted to a PICU for 2-3 weeks and Dr P advised that the clinical team would be looking to prescribe depot medication whilst Mr E was in hospital, and then discharge him on a Community Treatment Order.

Date	Source	Event	Information
Wed 21/01/09	SLAM records	MARAC meeting	Mr J attended a MARAC meeting for Mr E's ex-partner. MARAC meeting informed of plans for MHAA - panel felt this should be done ASAP given the risks to the ex-partner. The police representative offered to assist in arranging police attendance to facilitate the assessment asap.
Thu 22/01/09	SLAM records	Telephone call	Mr J called the SW AMHP team to inform them that the first medical recommendation had been completed. Mr J was informed that there were nine other assessments to do and there would be a delay. Mr J informed the IDVA and CSU officer of the situation.
Fri 23/01/09	SLAM records	Unscheduled attendance	Mr E called into the clinic to check the time of his appointment on the following Monday. Presented as slightly elated and continued to express ideas that his identity had been stolen. No aggression exhibited but remained over-familiar, telling staff that he loved them.
Fri 23/01/09	SLAM records	Telephone call	Mr J received a call from social work staff, discussed the possibility of social care visiting with S12 doctor to complete second medical recommendation as the first recommendation would expire over the weekend. Mr J advised that he felt uncomfortable attending as Mr E's mood was unpredictable, and reported that Mr E had commented that if he felt threatened by anyone he would stab them.
Mon 26/01/09	SLAM records	Appointment	Mr E arrived an hour early for his appointment. Continued to present with some elation and suspiciousness, particularly when he was given his medication. No aggression displayed but this remained changeable.
Wed 28/01/09	SLAM records	Email	Mr J emailed the AMHP team to advise that Dr G would be available to attend the MHAA at 10 that Friday. Mr J reiterated the urgency of the assessment and that the clinical team, probation and the community support team felt that Mr E was a high risk towards others, particularly his ex-partner. Mr J also spoke to the AMHP team who advised that the assessment had not been confirmed for Friday and that they were yet to obtain a warrant.
Thu 29/01/09	SLAM records	Telephone call	Mr J called the AMHP team and was informed by a student social worker that the assessment of Mr E would take place as the AMHP team were having difficulty obtaining a warrant due to funding issues. Mr J escalated the issue to various staff for the matter to be resolved.

Date	Source	Event	Information
Fri 30/01/09	SLAM records	MHA assessment	MHAA attempted at Mr E's home address. In attending the AMHP, student AMHP, S12 doctor, police, locksmith. The police briefed those present about the planned procedure. A male answered the door and said he wasn't Mr E but had been living in the property for several months. The male allowed professionals to enter and expressed his concerns about Mr E. The male said Mr E had been abusing his girlfriend, cutting her hair with scissors and threatening to stab her with the scissors. The male reported that Mr E had beaten the girlfriend for no reason and that Mr E was only sleeping for about two hours per night - talking to himself throughout the night. The male was happy to give his mobile details and to inform the team when Mr E returned to the flat.
Tue 03/02/09	SLAM records	Appointment	Mr E attended the clinic and was seen by Dr G and Mr J. Mr E admitted to feeling stressed and became tearful during the appointment. He identified his stressors as the pending court case for common assault and criminal damage and he continued to believe that someone had stolen his identity and was pretending to be him. Mr E admitted to feeling paranoid believing that he was being followed and claimed to have received threatening phone calls from male friends of his ex-girlfriend, demanding money. Mr E agreed to an informal admission to the LEO ward. He was warned that any aggressive behaviour may lead to being detained and moved to a PICU.
Sun 08/02/09	SLAM records	MHAA - Section 5(2)	After a number of days of being chaotic whilst on the ward Mr E was detained on Section 5(2) and placed on 1:1 observations.
Mon 09/02/09	SLAM records	MHAA - Section 3	Mr E was found not to have been taking his medication, despite staff administering it to him. He was assessed for detention under Section 3 and remained on 1:1 observations.
Mon 16/02/09	SLAM records	Transfer to PICU	Mr E was transferred to PICU after he was abusive and made threats towards staff and other patients. Paranoia led to increasing confrontational and disruptive behaviour. Started to hoard knives and cutlery in his room, two Stanley knives were also found in his room.
Mon 16/02/09	GP records	Letter received	Letter to Dr P from CW Approved Social Worker advising that Mr E had been assessed on 10/2 when he had appeared agitated, restless and chaotic. Mr E refused informal admission and was detained under Section 3 of the MHA.
Thu 12/03/09	SLAM records	Transfer to ward	Transferred from PICU back to the ward. On return he was settled, calmer and not under the influence of psychotic phenomena.

Date	Source	Event	Information
Thu 12/03/09	SLAM records	Inpatient with leave	CTO considered given serious risks of violence. Increasing periods of leave tried, including unescorted. Staff believed that he had smoked cannabis again during one period of leave as he was irritable, suspicious and mildly elated on return. Leave suspended. When leave tried again it is reported that he again smoked cannabis and deteriorated. Mr E refused a UDS but staff felt it was obvious from his presentation that drugs were involved. Settled again after a period without leave. Due to some incidents with female patients on the ward and Mr E not changing his behaviour, despite repeated warnings, he was discharged from the ward to the care of the LEO CMHT.
Mon 16/03/09	SLAM records	Discharge summary	Admitted on following assault on a member of the public in a café. Expressing paranoid ideas, known illicit drug use, odd behaviour displayed in police cell - tried to flush clothes down the toilet. Non compliant with medication regime. Concerns raised from various sources about deterioration in mental state over the previous weeks. Mr E refused attempts to increase his medication, HTT intervention or informal admission until 3/2.
Fri 17/04/09	SLAM records	MHRT	Tribunal found that Mr E had previously been successfully treated in hospital as an informal patient and rescinded the detention.
Mon 20/04/09	SLAM records	S23 - Rescindment of detention	Rescindment notification completed by RC. Notification incorrectly identifies Mr E as the RC.
Thu 30/04/09	SLAM records	OT report	OT report recommended a short term placement in supported housing to enable Mr E to build up his skills and to focus on more meaningful and productive activities. The plan being for Mr E to return to more independent living relatively quickly. Observed that when unwell Mr E would fear for his safety, have difficulty concentrating, decision making and problem solving. The report also noted that his sister had been visiting him on the ward and that they appeared to have a good relationship.
Tue 28/04/09	SLAM records	Appointment	Mr E attended an appointment with Mr C - reported that things were going well. Said that his ex-girlfriend had been to see him and that he was unsure what his feelings were.
Fri 01/05/09	SLAM records	Appointment	Mr E attended an appointment with Mr C and Dr S. Appeared well although he had a scratch on his face - said he hit his face on a cupboard and denied any altercations. Admitted some contact with ex-girlfriend but refused to discuss details.

Date	Source	Event	Information
Mon 11/05/09	GP records	Letter received	Letter dated 1/5/09 to Dr P received 11/5 from Dr G, LEO Services. Mr E had been reviewed on 1/5 with his care co-ordinator Mr C. Most recent admission was on 3/2/09 and although initially an information admission, he was detained under Section 3 after a week, and a week later was transferred to the PICU. He was discharged on 20/4 following rescindment of the section by the MHRT and having been found to have engaged in sexually inappropriate behaviour with a vulnerable female patient. Reported that Mr E's illness was complicated by a recurrent pattern of non-adherence with psychotropic medication and cannabis use. History of aggressive and violent behaviour when unwell, in 2007 assaulted a stranger in a cafe and several violent offences towards his ex-girlfriend. Medication: olanzapine 20mg nocte and sodium valproate 1.7g nocte. Mr E reported that since discharge 11 days previously, he had been well, denied symptoms of mood disturbance or emergence of psychotic symptoms. Mr E admitted he had been in contact with his ex-girlfriend Ms E, despite the court injunction preventing him from doing so. Court case for charge of common assault/ABH to be heard on 12/5/09 which Mr E was not obliged to attend. Staff had not been asked to prepare a psychiatric report for the case at the time of writing. Mr E reported that he was not taking cannabis and despite Dr G's efforts to engage Mr E with the Dual Diagnosis Worker, Mr E was adamant that he would tackle this on his own. Mr E was last in paid employment about two years previously, as a pizza delivery driver. Mr E was keen to restart employment in the form of an apprentice electrician. Staff to set up another meeting with Vocational Workers. Plan: continue with olanzapine 20mg nocte and sodium valproate chrono 1.7g nocte; continue to encourage Mr E to meet with Vocational Workers and Dual Diagnosis Specialist; referral offered to Metropolitan Housing Support (refused by Mr E); as Mr E was well beyond the two years with which clients remained under the care of LEO services, to be referred to South West Lambeth Recovery and Support Team; to be reviewed by Dr G in one month, continue to meet with Mr C, care co-ordinator on a regular basis.
Fri 15/05/09	SLAM records	Appointment	Mr E met with his probation officer and Mr C. Mr E was late and appeared calm and relaxed. The probation officer informed Mr E that he would be required to attend an IDAP group and attend probation weekly. Mr E denied having any contact with his ex-girlfriend.

Date	Source	Event	Information
Thu 21/05/09	SLAM records	Appointment	Mr E met with Mr C. Mr C spoke about the relationship and Mr E's lack of openness with probation. Mr E said he was concerned he would be in trouble and then informed Mr C that the girlfriend had moved back into Mr E's flat following an argument with her mother. Mr E denied any arguments or physical violence had taken place.
Tue 09/06/09	SLAM records	Appointment	Mr C accompanied Mr E to Camberwell magistrates court where they met Mr E's barrister for a committal hearing. Mr E's bail conditions remained the same - no contact with his ex-girlfriend.
Tue 16/06/09	SLAM records	Appointment	Mr E attended an appointment with Mr C - reported that things were going well but that he hadn't been doing much. Also reported that his girlfriend was living with him. Mr C reminded Mr E of his bail conditions - Mr E said he understood this and that possible consequences. Said that he had been attending a course regarding domestic violence with probation which he found helpful.
Thu 09/07/09	SLAM records	Letter sent	To Mr E advising that he was no longer detained under S3 MHA. Section was rescinded on 20/4/09.
Fri 17/07/09	SLAM records	DNA	Mr E did not attend his medical appointment with Dr G.
Thu 23/07/09	GP records	Letter received	To Dr P from Tooting NHS Walk-in Centre. Mr E had attended on 22/7 at 21:07 complaining of back pain: boil lower back. Medication prescribed.
Thu 23/07/09	GP records	Letter received	To Dr P from Tooting NHS Walk-in Centre. Mr E had attended on 22/7 at 17:08 complaining of back pain: he did not wait to be seen.
Sat 25/07/09	GP records	Letter received	To Dr P from St George's Healthcare A&E. Mr E had attended on 24/7 at 22:30 complaining of feeling unwell. Diagnosis: pilonidal abscess not yet ready for I&D. Medication prescribed.
Tue 04/08/09	SLAM records	Telephone call	Mr C called assessment and treatment team to request an update on the referral made two months' previously. No record of referral received - Mr C to resend.
Wed 05/08/09	SLAM records	Appointment	Mr E attended an appointment with Mr C - appeared bright in mood and well kempt. Mr E reported that his girlfriend had moved out into her own flat.
Thu 20/08/09	SLAM records	Telephone call	Mr C called Mr E to arrange an appointment and for Mr E to collect his medication. No response, message left, x2 calls also the previous day.

Date	Source	Event	Information
Fri 21/08/09	SLAM records	Telephone call	Duty worker called Mr E, no response, message left to call the team.
Fri 21/08/09	SLAM records	Telephone call	Call received from probation officer asking for update on Mr E. Advised that last contact was 5/8 and that he had not responded to calls that week to arrange an appointment and medication. Probation officer stated Mr E was due in court on 9 or 10 September - possibility of custodial sentence, Mr E was aware of this but didn't seem too stressed. Probation officer saw Mr E earlier in the week and he seemed okay.
Thu 26/08/10	SLAM records	Home visit	Mr C made a visit to Mr E's home as telephone contact unsuccessful over last seven days. Nobody home - Mr C left a letter asking Mr E to get in touch. When Mr C returned from the visit Mr E was at the clinic, he reported he didn't feel well and that he was sleeping excessively - if he didn't have to get up he would sleep til 3pm or 4pm. Mr E reported that his girlfriend was no longer living with him, in accordance with his bail conditions. Mr E denied feeling depressed, objectively appear euthymic, no evidence or irritability or agitation, denied paranoid ideas. Said he was compliant with medication although Mr C noted he was a week late to collect the supply given that day. Mr C informed Mr E that he would be leaving and that Mr E would be allocated a new care co-ordinator. Appointment given to see Dr P on 7/9.
Mon 07/09/09	SLAM records	DNA	Mr E did not attend his appointment with Dr P, despite a reminder message left earlier in the day.
Tue 08/09/09	SLAM records	Telephone call	Staff attempted to contact Mr E but no response and unable to leave a message. SMS sent.
Mon 14/09/09	SLAM records	Unscheduled attendance	Mr E attended the team base to request his medication - not available in the building, Mr E to return the following day. Appeared subdued but was pleasant. Mr E said that court case adjourned pending psychiatric reports. Overdue a medical review - Dr M to see Mr E that day.
Mon 14/09/09	SLAM records	DNA	Mr E did not attend his appointment with Dr M. Dr M to discuss with Mr S to arrange another appointment.
Tue 15/09/09	SLAM records	Unscheduled attendance	Mr E attended to collect his medication. "*No management presented as he told me that he cannot wait to get back to work. Looking well and stable and nothing to suggest any signs of relapse."* . Two weeks medication given, next due 29/9.

Date	Source	Event	Information
Tue 29/09/09	SLAM records	Telephone call	Ms C called Mr E to arrange an appointment - no response. Text sent with appointment on 1/10.
Sat 10/10/09	SLAM records	Community care services assessment of need	Assessment completed by Ms C. Provided history of Mr E's presentation and care but noted he was stable at the time the assessment was completed. It was noted that "during the current admission he introduced a girl as his girlfriend and invited her to the CPA meeting". Later in the assessment it is noted that Mr E was on bail after having seriously assaulted his girlfriend. His bail conditions required that Mr E did not contact her but she had been attending the ward asking to see him.
Tue 13/10/09	SLAM records	Appointment	Mr E was seen by Ms C. *"Has been attending for meds and appointments with CC, but DNA'd appointment with vocational advisor."* Appeared to have taken cannabis prior to appointment, but denied use of recreational drugs. No evidence of psychosis, mood euthymic, reasonable insight into need to continue medications. PLAN: needs bloods, medication from LEO "*next week",* consider UDS.
Thu 22/10/09	SLAM records	Appointment	Mr E attended fairly regularly, every two weeks to collect his medication. No concerns noted by staff or Mr E.
Tue 09/02/10	SLAM records	Case transfer letter	Letter from LEO Services to CMHT referring Mr E's case for transfer. Letter advised that he attended the team base regularly to collect medication without prompting and that his mental state remained stable. Letter also advised that he was in contact with probation services regarding domestic violence towards his ex-girlfriend and that he attended psycho education groups at one of their centres in an attempt to address this issue. The letter advised that Mr E lived alone and had a reasonable level of functioning. It was noted that Mr E had been made aware of the referral in August 2009 and that he was looking forward to meeting his new care co-ordinator.
Mon 15/03/10	SLAM records	Letter sent	Letter from Ms L to LEO Services introducing herself as Mr E's new care co-ordinator. Ms L requested FACS Assessment and Care Plan and an up to date Care Programme Approach.
Wed 31/03/10	SLAM records	Appointment	Mr E was seen by Ms C and Ms L as part of transition plan to Lambeth SW Recovery and Support Team. Ms L would be Mr E's new care co-ordinator. Plan for final Care Programme Approach on 6/4 with both teams. Mr E was happy with the plan and had no concerns about his mental state.

Date	Source	Event	Information
Tue 06/04/10	GP records	Letter received	To Dr P from Dr S, Specialist Registrar, Lambeth SW Recovery and Support Team. Advised that Mr E had been transferred to their team and that Dr S had reviewed Mr E with his previous care co-ordinator Ms T and his new care co-ordinator Ms H. Noted that his last relapse was in February 2009 and that he had maintained progress for a whole year without issues of non-compliance or heavy drug use. Mr E remained stable, was seeking part time work and wanted to pursue a mechanical engineering course through First Step Trust. Dr S provided some leaflets on bipolar affective disorder as well as information about Mr E's medication, as he appeared to be unaware of those. Dr S arranged for Mr E to have his first blood test with the team, after which Dr S asked Dr P to arrange a 12-hour post dose lithium level every 90 days, and a TFT, U&E every six months. In addition Mr E would need annual bloods for metabolic syndrome due to the two neuroleptics that he was on. Mr E had been at risk of causing harm to others in the past, especially to his ex-girlfriend. Much of the aggression was due to poor mental health wherein he was convinced that others meant harm to him. Mr E told Dr S that he was no longer in contact with his ex-girlfriend but that he continued to be under probation (Ms R) at least until the following year. Plan: Mr E to continue to collect medication from the team, reviewed every 3 months, blood tests for Li levels, TFT, U&E, LFT and fasting glucose.
Fri 09/04/10	SLAM records	Appointment	Mr E attended fairly regularly, every two weeks to collect his medication. No concerns noted by staff or Mr E.
Tue 08/06/10	SLAM records	Appointment	Mr E attended to collect extra medication to cover him whilst on holiday in Manchester.
Thu 24/06/10	SLAM records	DNA	Mr E did not attend to collect his medication, Ms L called and left messages - no response.
Wed 07/07/10	SLAM records	Telephone call	Call from Mr E returned to confirm medication was available for collection. Mr E advised to contact Ms L urgently as she was concerned about his welfare.
Tue 14/07/09	SLAM records	Appointment	Mr E attended to collect his medication. Mr E expressed concerns about his housing benefit as he didn't think he was entitled to it now he was working full time. Ms L advised him to contact the benefit office, and made an appointment with the team benefit advisor. Ms L noted that Mr E looked well and was advised to maintain it.

Date	Source	Event	Information
Fri 16/07/10	SLAM records	Unscheduled attendance	Mr E arrived and appeared anxious. He informed Ms L that he had lost his medication that he had collected. Replacement medication provided.
Mon 23/08/10	SLAM records	Appointment	Mr E met with Ms L - Mr E had lost his job as they weren't satisfied with his work. Ms L provided reassurance and advice. Ms L discussed the next medical review and suggested it would be good to meet Mr E's mother. Mr E "quickly asked why should his mum attend".
Wed 08/09/10	SLAM records	Appointment	Mr E attended fairly regularly, every two weeks to collect his medication. No concerns noted by staff or Mr E.
Mon 13/09/10	GP records	Discharge summary received	Date of admission: 3/2/09; Date of discharge: 20/4/09; Report appears to have been typed 8/9/10 and is stamped as received by Palace Road Surgery on 13/09/10. Mr E admitted to LEO Unit from Kennington Police Station, under Section 2 MHA. He presented as agitated and restless and although settled on the ward initially, soon spoke about people stealing his identity, that his house was neither safe nor legal and that there were many threatening people in the community. Mr E said he felt safe on the ward. He was maintained on 1:1 and his medication was given in liquid form to ensure compliance, Mr E was very unhappy about this. As a result of his paranoid he started to hoard knives and cutlery in his room. When two Stanley knives were found in his room, he was assessed and transferred to Eden PICU on 16/2/09. He was returned to the LEO Unit on 12/3/09. On his return he was calmer and not under the influence of psychotic phenomena. He was tried on increasing periods o leave and this moved to unescorted leave. He smoked cannabis on at least two leave occasions and refused a UDS however it was obvious to staff that drugs were involved. Due to some incidents with female patients on the ward, and Mr E not changing his behaviour despite repeated warnings, Mr E was discharged off the ward into the care of the LEO CMHT. Discharge diagnosis: F23 acute and transient psychotic disorders Discharge medication: olanzapine 10mg nocte; omacor capsules 2tabs bd Follow up: 2 weeks supply of medication given, medical appointment to be made within two weeks with LEO CMHT SpR; 7 day follow up with LEO Care Co-ordinator; continue follow up with LEO community team until transfer to sector team.

Date	Source	Event	Information
Tue 16/11/10	SLAM records	Appointment	Mr E attended a medical review with Ms L and Dr F - Mr E was late but presented well and stable in his mental state. He complained of sleeping too much - up to 12 hours per night and felt that he was taking too much sodium valproate. Denied taking drugs or alcohol and stated he would not be involved with it after his previous experience. Mr E said that he had a brother with a mental illness who hadn't taken medication. Mr E said that his flat was in good order, his girlfriend visited occasionally and that he maintained contact with his mother who was his main carer. PLAN: arrange bloods, refer to SHARP team, collect medication fortnightly.
Wed 01/12/10	SLAM records	Appointment	Mr E collected his medication and was informed that the clinical team had decided to step down his care to be provided by the GP for both collection of medication and review of mental state. If he needed CMHT services within a year of being discharged, he could be seen again. Ms L noted that he looked well and did not express any concerns. Mr E said he was okay with the plan.
Tue 07/12/10	SLAM records	Clinical discussion	Mr E was discussed in the clinical review meeting. The team decided, based on Mr E's history of non-compliance and substance misuse, it would be wise to keep him within the medication clinic but ask the GP to prescribe medication whilst Mr E's mental state was being monitored by the medication clinic. It was noted that Mr E had always stopped professionals from entering his flat, plan to do an unannounced joint visit to assess the environment and find out if he was up to date with his rent. Agreed that as mother was main carer she should be offered a carer's assessment. If Mr E was unhappy for information to be shared with his mother, he should put that in writing. Ms L to ask for a current contact number for mother at next meeting with Mr E.
Mon 20/12/10	SLAM records	Appointment	Mr E attended regularly to collect his medication every two weeks. No concerns noted.

Date	Source	Event	Information
Fri 24/12/10	GP records	Letter received	Clinic date: 16/11/10; Typed date: 10/12/10; Received: 24/12/10 To Dr P from Dr F, Specialist Registrar, Lambeth SW Recovery and Support Team. Advised that Mr E had been seen along with his care co-ordinator Ms H for medical review. Mr E presented a stable and euthymic in mood and said that he had not used drugs or alcohol and accounted for how this could potentially exacerbate his mental state. Mr E wanted to know for how long he needed to take medication and was advised that he would need to be compliant with his mood stabiliser and anti-psychotic medication for a considerable time before a reduction could be considered. Dr F noted no overt features of psychosis. Mr E maintained an active day, kept his flat in good order and maintained contact with his girlfriend and his mother. Mr E was advised to discuss any potential work with his care co-ordinator as there were concerns about anything that would interrupt his sleep cycle. Mr E said he would prefer to attend his GP rather than the CMHT in order to obtain a valproate level on him. Ms H would continue to monitor him fortnightly and supply his medication. Ms H to refer Mr E to the SHARP team for vocational activities. Medication: olanzapine 20mg nocte; sodium valproate chrono 1700mg nocte.
Fri 28/01/11	SLAM records	Telephone call	Ms L received a call from Mr E's probation officer advising that Mr E had attended a meeting with her but had appeared unkempt, had grown a beard and had admitted that he wasn't taking his medication. Ms L said that she had seen Mr E two days previously when he had presented as stable and well apart from the beard which he joked about . Ms L agreed to do a 'random' joint visit to assess Mr E's home environment and monitor his mental state.
Mon 31/01/11	SLAM records	Home visit	Ms L attempted a home visit with another member of staff. No response and mobile phone went straight to answer. Ms L left a message for Mr E to call her - he did not do so.
Tue 01/02/11	SLAM records	Clinical discussion	Ms F was discussed at the clinical review meeting. Information from probation officer advising that Mr E was not taking his medication was noted. Decided to arrange another medical review and respond to the letter from probation to advise of action planned.
Wed 09/02/11	SLAM records	Unscheduled attendance	Mr E attended the clinic to collect his medication - see by the duty worker who noted that Mr E appeared to be in a hurry. Mr E was on the phone and waited in the corridor, when he eventually went into the clinic room the duty worker asked how he had been, he responded "*yeah cool*". Two weeks' medication provided - next due 23/2.

Date	Source	Event	Information
Fri 11/02/11	SLAM records	Telephone call	Several calls made to Mr E - noted on 11/2, 15/2 and 21/2. No response and no indication that message left.
Tue 22/02/11	SLAM records	Telephone call	Ms L received a call from Mr E's probation officer expressing concern about his presentation that day at his probation appointment. Ms L gave reassurance that Mr E was due a medical review the following day and Ms L would update her. The probation officer suggested a joint visit with Ms L to Mr E's home address as soon as possible as she was not certain that things were going well at home. Ms L discussed Mr E's relationship with his mother, with the probation officer who confirmed that she was aware that Mr E really didn't' want his mother involved.
Wed 23/02/11	SLAM records	DNA	Mr E did not attend his medical review despite text messages reminding him. Further appointment arranged for 2/3.
Mon 28/02/11	SLAM records	Unscheduled attendance	Mr E attended to collect his medication. Provided with two weeks of olanzapine and sodium valproate. Ms L recorded that Mr E was withdrawn, guarded and slow when answering direct questions. Ms L noted that although Mr E would usually smile when she entered the room, Mr E seemed to have lost interest in anything. Mr E was dressed shabbily and appeared to have lost weight, he said he was going to the gym often. Ms L asked how he had been and why he had DNA'd so many appointments with the SHARP team and medical review. Mr E said that he needed a job - Ms L advised him that the SHARP team would be able to help him. Mr E agreed to attend the SHARP team to arrange an appointment and to attend a medical review. Mr E again confided that he had not been taking his medication because he felt the dose was too high. Ms L advised him to attend for a blood test.
Mon 28/02/11	SLAM records	Email	Ms L received an email from Mr E's probation officer advising that Mr E had been placed "on notice" and the letter indicated that a home visit would be arranged when both Ms L and the probation officer would attend. If Mr E wasn't there at the time of the home visit, he would automatically be in breach because his order required treatment and supervision with probation. Ms L and the probation officer attending would count as two visits so if he wasn't at home he could be immediately breached. The probation officer said that Mr E was very clear about this and that she would text him to remind him in advance.

Date	Source	Event	Information
Wed 09/03/11	SLAM records	Home visit	Ms L and Mr E's probation officer met at Mr E's flat. Mr E was at home and let the professionals in. The dog was tied up in the kitchen and was barking. The flat appeared reasonably clean - no carpet, bed in living room. The bedroom appeared to be being used by a lodger, Mr E denied this but said a friend used to stay with him and was no longer doing so. Mr E appeared pale and Ms L felt that he had not been eating properly, however Mr E refused to let them see the fridge as he hadn't cleaned it for some time. Mr E said that he had been going to the gym and that he like the way he looked. Mr E appeared relaxed and was coherent with no psychotic symptoms observed. Mr E was reluctant to speak about his family but said that he had seen his mother the previous week and that she was happy with his progress. Mr E maintained he did not want staff to contact his mother and bother her with his problems and became irritable when staff continued to probe him on the matter - he refused to provide his mother's contact number. Mr E said that he was only taking olanzapine as the sodium valproate wasn't doing him any good and caused him to put on weight. He agreed to attend the medical review that Friday and to attend for a blood test the following Monday.
Thu 10/03/11	SLAM records	Unscheduled attendance	Mr E attended to discuss his medication with a doctor, however his appointment wasn't until the following day. He was advised to return for his appointment, he was willing to because he was not taking sodium valproate and wanted the olanzapine reduced. Mr E appeared to have been under the influence of drugs/alcohol but denied this. Ms L informed him that next time staff may have to carry out a drug screening test.
Mon 21/03/11	SLAM records	Appointment	Mr E attended for a sodium valproate level blood test. He was calm in mood and pleasant on approach. Mr E "*could not wait to see his care co-ordinator who was keen to see him for his medication*".

Date	Source	Event	Information
Thu 24/03/11	SLAM records	Appointment	MR E attended to collect his medication. Presented as restless and thought disordered. He stated that his medication had been changed without prior notice. Ms L advised that this would not happen without his knowledge and that he was on the same medication as he had always been. Mr E stated that the olanzapine had changed colour - now with pink stripes rather than purple and oval shaped rather than round. Ms L contacted the pharmacy to reassure Mr E. Mr E said that he felt different, he was no longer able to get hold of himself and he blamed this on these changes. Ms L advised him that he had not been taking the medication as prescribed and that this was why he was feeling this way. Mr E got very angry, calling Ms L a liar for saying that he wasn't taking his medication. Ms L offered to ask the crisis doctor to see Mr E which he agreed to, however when Ms L tried to arrange this she was informed that "*he should be given an appointment with his regular doctor, rather than just turning up to inform the team that he had stopped taking his medication*". Ms L offered to contact Mr E as soon as his regular doctor returned from leave - Mr E was angry when he left and said that he would only take what was good for his body.
Wed 30/03/11	SLAM records	Referral	Mr E was referred to the crisis team by the psychiatric liaison team at St George's hospital. "*Due to his mental health, ie psychosis, poor eye contact, poor concentration, not being able to engage in conversation, wandering in A&E and picking up bits from the floor, thinking he can't speak English but can, it was felt that it was inappropriate for HTT input. NOT TAKEN ON BY HTT*."
Thu 31/03/11	SLAM records	Admission - detained S2	Admitted from A&E at St George's - presented having cut his hand while trying to repair a window. Neighbours called 999. Overtly disturbed by auditory and visual hallucinations, thought disordered. UDS completed as was found with a sachet of cannabis. Mr E said he was 'crazy' because he opened the window too far and it broke. Very aggressive with staff. Anxious about his dog - wanted to know who would feed it. Mr E escorted around the ward due to high risk of violence towards others. Mr E was placed in the red zone and remained there until 6/4.
Thu 31/03/11	GP records	SLAM admission	Copy of SLAM form advising of admission to Triage ward under Section 2 MHA.

Date	Source	Event	Information
Wed 06/04/11	SLAM records	Nursing note	16:30 moved to amber zone. Presented as calm but quite demanding, continued to go to the office to request different things. Spent part of the day with peers and staff, complied with medication and used garden leave for cigarette breaks. At 20:30 he was moved back to the red zone.
Fri 08/04/11	SLAM records	MHRT	MHRT application to First Tier Tribunal.
Sat 09/04/11	SLAM records	Nursing note	Mr E was visited by a friend who appeared to have passed him lighters. Labile in mood but sometimes aggressive, fixed stare and shouted at staff and patients. Overly familiar with female staff - said that he loved them.
Mon 11/04/11	SLAM records	Telephone call	Ms L called Mr E's probation officer and informed her that he was in hospital and that Ms L would contact her again as soon as Mr E was discharged. The probation officer stated that his probation was due to expire on 24/4 and was due to see him at some point before his probation expired. Ms L advised the probation officer to wait until the next ward round when Ms L would know more about his discharge date.
Tue 12/04/11	SLAM records	Nursing note	Mr E was given leave and contacted his ex-girlfriend to drive him home. The ex-girlfriend arrived at the ward and staff contacted the police to identify how Mr E was to enter his flat. Mr E had planned to break off the padlock and put on another one. The police provided staff with a code and advised that Mr E had to attend Streatham police station with some ID to collect the keys. Mr E went to the police station with his ex-girlfriend to collect the keys and get the window fixed. Mr E advised by staff how to behave whilst on leave from hospital. On return from leave Mr E appeared calm, bright and pleasant and said that he had eaten supper with his ex-girlfriend. Mr E reported that he had sorted everything in his flat and said that he had done a urine sample in the morning and that it had been positive.
Wed 13/04/11	SLAM records	Nursing note	Mr E identified as appropriate for discharge from ward. Discussion with home treatment team resulted in them refusing to accept him due to his risk history. Support to be provided by CMHT "*and will re-refer to LHTT if required*". Staff informed Mr E's probation officer of Mr E's discharge - she said that Mr E had already contacted her.
Thu 14/04/11	SLAM records	MHRT	Outcome of MHRT recorded as cancelled.

Date	Source	Event	Information
Mon 18/04/11	SLAM records	Unscheduled attendance	Mr E seen by duty worker for his seven day follow up. Appeared to be making a good recovery, no issues raised.
Wed 20/04/11	SLAM records	Appointment	Mr E collected his medication and staff explained why the dose of sodium valproate had been reduced. Appointment on 16/5 for blood test. Mental state appeared to be stable. Mr E was engaging and talked about desire to stop smoking - asked for help from staff with this.
Thu 05/05/11	SLAM records	Unscheduled attendance	Mr E observed in the reception area and appeared restless and very thin. Mr E said that he was now eating healthily having eaten a lot of takeaways previously. Appeared very distracted and wanted to collect medication - not due until 18/5. Stated that he needed to talk to someone to get help with issues with his flat - duty worker offered to help. Mr E approached her face closely and said "look at my eyes". Mr E said he couldn't see properly and that he needed glasses - advised to visit an optician. Mr E said he had lost his flat keys, after some probing told duty worker that he had another set of keys but that he would have to change the locks. He then changed subject and said that he had a window in his flat that was boarded and needed fixing - he was paranoid that different people were going into his flat when he left the window open near the roof. He said that things had gone missing but wasn't able to describe what. Stated he would report it to the police but appeared unsure what he would be reporting. Duty worker contacted Lambeth Living and asked for the broken window to be fixed - LL advised that contractors had reported that Mr E had been walking round with a screwdriver so didn't feel safe to carry out the work. Duty worker also reported that Mr E had no hot water or heating and asked for this to be rectified. Duty worker updated Mr E and advised him to remain in the flat that evening to wait for plumbing contractor. Mr E refused to provide mobile number to LL.

Date	Source	Event	Information
Mon 09/05/11	SLAM records	Appointment	Ms L met with Mr E who was complaining of toothache - Ms L advised him to see his GP for the toothache. Mr E was distracted, pressured in speech and jumping between subjects. He wanted Ms L to go to his flat with him to see what repairs needed to be done. Mr E wanted to know when the team would be discharging him to the GP as this was the plan before he was detained to hospital. Ms L advised this would be done when his mental state was stable. Mr E appeared drowsy and intoxicated and Ms L advised him to go home whilst she arranged for a medical review. PLAN: joint home visit on Wednesday to view state of flat; medical appointment with Dr F. Mr E returned to the team base six hours later to use the phone to call LL regarding the repair of his boiler. Duty worker advised him to wait for Ms L but he did not wait to see her.
Wed 11/05/11	SLAM records	Unscheduled attendance	Ms L was informed by reception staff that Mr E was in reception but by the time she got there he had gone. Medical appointment offered for the following day - Mr E confirmed he would attend.
Thu 12/05/11	SLAM records	Medical review	Dr F reviewed Mr E who appeared calm, coherent and pleasant. His main worry was his flat - there was a hole in the wall and Mr E said he didn't feel safe and wanted to be moved. Dr F asked if Mr E felt that someone could look through the hole - Mr E didn't answer. Dr F asked if Mr E was taking his medication - he admitted he wasn't taking it as prescribed. Blood test arranged for the Monday - and UDS to be done then too. Mr E left in a hurry as he had a dental appointment.
Mon 16/05/11	SLAM records	Appointment	Mr E attended for bood tests and saw Ms L. Mr E said that his dog had been returned to him but he was not happy that the dog had lost weight.
Wed 18/05/11	SLAM records	Unscheduled attendance	Mr E presented asking for help with reporting housing repairs as none had been completed. Mr E said he believed people were climbing in through the window. Mr E *"went on and on about repairs in the flat*" and said that his neighbour had a new heating system whilst Mr E still had the old one. Mr E got agitated when Ms L tried to explain how the system worked. Mr E observed to be paranoid and suspicious and constantly falling asleep between his conversation with Ms L. Admitted to taking alcohol but denied illicit substances. Offered a UDS but declined. PLAN: joint home visit in the morning to assess mental state.

Date	Source	Event	Information
Mon 23/05/11	SLAM records	Appointment	Mr E collected his medication - informed that his blood test indicated he had been compliant with his medication. Mr E said that contractors were at his flat to repair the holes in the wall, but Mr E had reported more holes in the floor.
Thu 26/05/11	SLAM records	Unscheduled attendance	Mr E saw Ms L with a letter he had received from the council regarding rent arrears. He was very agitated and the only way Ms L could reassure him was to contact the housing department. They advised that the housing benefit had been stopped on 6/5/11 - Ms L contacted the benefit office and was advised that they didn't believe that Mr E was still at the address and wanted confirmation via a utility bill. Ms L advised Mr E to take a bill to the office to enable payments to be recommenced.
Wed 01/06/11	SLAM records	Nursing note	Mr E attended the team base to apologise for missing the appointment the previous day. He appeared drunk and could hardly open his eyes. Ms L asked if he had been taking cannabis but he said he had been drinking all weekend. He wanted to know how he could get a job - Ms L advised him to work with the SHARP team. Ms L recorded "*he was practically sleeping during our meeting, I advised him to go home and get some rest*".
Mon 06/06/11	SLAM records	Unscheduled attendance	Mr E attended the team base to discuss a crisis loan as he had nothing to eat until his benefit arrived on that Friday. Ms L suggested he attended SPIRES on Tuesday where he could get a cooked meal. Ms L offered him a food voucher. Ms L advised him to manage his money more wisely and save some for emergencies. Mental state reasonably stable. Mr E said he would be contacting the dog house to ask them to collect his dog as he was unable to feed him - Ms L supported this plan.

Date	Source	Event	Information
Fri 17/06/11	SLAM records	Unscheduled attendance	Mr E attended the team base and asked to see Ms L. He appeared anxious and stated he wasn't sure what to do with himself. He said he was bored as his girlfriend had broken up with him. He had gone to Croydon shopping centre to shoplift - he was caught by the security team but they had not called the police. Mr E was unsure what he wanted - initially he wanted to be admitted to hospital, then said it was not the best place, but he did want company of others. Ms L suggested supported accommodation - Mr E said he didn't want to live in a hostel. Ms L advised that he visit his family - Mr E said that his mum didn't work and he didn't want to bother her. Said he had been living on mashed potatoes as he wasn't able to cook. Mr E had lost weight. Mr E reported that he owed £400 in rent and that he had refused to take a proof of address to confirm he was still living at the address. Ms L encouraged Mr E to attend A&E over the weekend if his symptoms became worse. Mr E said he was going straight to the benefit office. PLAN: increase contact to resolve crisis, to be assessed for HTT input, do UDS.
Mon 20/06/11	SLAM records	Telephone call	Ms L received a call from Mr E stating that his window had not been repaired and asking to be rehoused. Ms L suggested Mr E attended the team base but he said he had other things to do. Ms L tried contacting LL but they wouldn't respond to Ms L's questions - Ms L tried to explain the situation but the person she was talking with wouldn't cooperate. Ms L requested the address of the tenancy officer to arrange for a consent form to be sent so that she could make enquiries on Mr E's behalf. PLAN: carry out joint home visit, appointment to see crisis doctor asap. Home visit conducted same day - Mr E was not at home and there was a padlock on the front door. Staff noted evidence of paranoia and suspicion - the letterbox and keyhole were blocked. Mr E was discussed as a current problem at the team reviews. Decided that he would need to be seen by crisis team.

Date	Source	Event	Information
Tue 21/06/11	SLAM records	Appointment	Mr E attended to be seen by the crisis doctor - he appeared unkempt and tired. Mr E said he had been drinking and that he hadn't taken his medication. Denied breaking up with his girlfriend and said he had lots of girlfriends. Said that he had seen his father recently as he had nothing to live on and had been visiting his father at weekends. Noted that records show that Mr E didn't have a good relationship with his father. Said he didn't know where his mum was at that time but was guarded about this. Mr E said he was bored, Ms L reminded him of the appointments with the SHARP team that he hadn't attended. Mr E became irritable saying "why all the questions, you are not doing anything to help me. I come here for my medication and I have asked for a housing transfer and nothing has happened". Dr F intervened but Mr E went on and on. Dr F asked what help Mr E wanted but he couldn't be specific and kept jumping between subjects. Ms L noted he was obviously hungry and irritable. Dr F noted that it was clear that Mr E was relapsing and that his medication compliance was questionable but that he was not sectionable. PLAN: refer to HTT, joint visit to offer appointment with HTT, contact mum for update.
Thu 23/06/11	SLAM records	Home visit	Ms L attempted a home visit with member of staff from HTT. Mr E opened his door but would not allow staff access as he said he had a friend with her baby in the flat and it wasn't a convenient time to talk. Mr E promised to attend the team base that afternoon. PLAN: Mr E to attend the clinic that afternoon, Ms L to facilitate calls to LL to arrange date for repairs, NO ROLE FOR HTT.
Tue 28/06/11	SLAM records	Appointment	Mr E attended for his medication but it had not been provided by pharmacy. Ms L suggested he returned the following day. Mr E presented as suspicious, complained of sweating too much and blamed his medication for it, then said it was the weather.
Wed 29/06/11	SLAM records	Appointment	Mr E attended the clinic and collected four weeks' supply of medication. Presented as fairly stable in mental state. Next due 27/7.
Mon 28/11/11	SLAM records	Nursing notes	Mr E collected his medication every fortnight, appeared well and sought assistance in getting his benefits paid. He was supported over the Christmas period by his family as he was unable to access a crisis loan and he left the team base before Ms L could get him a food bank voucher.

Date	Source	Event	Information
Fri 01/07/11	SLAM records	Telephone call	Ms L tried to call Mr E to arrange another appointment but his mobile didn't appear to be working. Letter sent offering appointment on 14/7.
Thu 14/07/11	SLAM records	Appointment	Mr E did not attend his appointment with the SHARP team.
Mon 18/07/11	SLAM records	Home visit	Ms L attempted a home visit as he had not attended for a mental health assessment. Mr E was standing outside his front door, pleasant on approach and stable mental state. Mr E "*promised to see*" Ms L at team base before the weekend.
Mon 25/07/11	SLAM records	Unscheduled attendance	Mr E attended to discuss issues about his medication and to inform Ms L that he had found a job. Mr E reported being sedated by his medication and felt that the dose of sodium valproate was too high and wanted it reduced. Ms L "*promised to inform the drs*". Mr E presented as fairly settled, less chaotic, and apprehensive - he was able to stay focussed throughout the meeting. Mr E said that he had found a cleaning job in the city - two hours every day.
Mon 01/08/11	SLAM records	Unscheduled attendance	Mr E attended to collect his medication - he had forgotten about his appointment at the SHARP team and was apologetic but unsure that he wanted to engage with them as he had found a job. Two weeks' supply of medication given.
Fri 12/08/11	SLAM records	Appointment	Mr E attended to collect his medication and was seen by the duty worker. Observed to be stable in mental state and was informed that medication was due on 15/8. Mr E argued that he needed the medication because he had run out - he denied taking more medication than was prescribed. Two weeks' supply of medication provided.

Date	Source	Event	Information
Fri 19/08/11	SLAM records	Unscheduled attendance	Mr E attended the team base asking to use the phone as he had received a letter from a debt collecting agency - he owed £3000 to a phone company. Ms L was called by admin staff as Mr E lost his temper and started shouting down the phone - Ms L established that Mr E was trying to arrange repairs to his property but LL had advised they had not received a surveyor's report yet. Mr E stated that he felt unwell due to the draught, he had not been able to go to work and had lost his job as a result. He became tearful, but settled with reassurance. Ms L agreed to refer him back to the SHARP team. Mr E asked for help applying for another flat as he didn't feel safe at his address - described an experience when he felt someone was trying to get into his flat during the night. PLAN: Mr E to use the phone for 20 minutes maximum until he is able to replace his mobile phone, medication due 26/8.
Fri 26/08/11	SLAM records	Unscheduled attendance	Mr E approached a duty worker and asked to be seen as he was in a hurry. When he first attended he was observed to be pulling faces and then started pacing up and down the room, invading other patients' personal space. Appeared irritable and impatient. Medication provided.
Wed 31/08/11	SLAM records	Unscheduled attendance	Mr E attended the SHARP team with no appointment - he wanted help to find part time work. Signposted to STATUS EMPLOYMENT and advised that if he had additional needs he wanted support for, Ms L could refer him.
Fri 09/09/11	SLAM records	Appointment	Mr E collected his medication - two weeks' supply.
Mon 26/09/11	SLAM records	Appointment	Mr E attended for his medication and was given two weeks' supply. Mr E reported that he was doing voluntary work at an animal farm in Battersea and was enjoying it. Mr E appeared to have lost weight but claimed to like it that way and reported that he was taking 1000mg sodium valproate rather than 1500mg as prescribed. Ms L reminded him of the importance of taking medication as prescribed.
Tue 11/10/11	SLAM records	Appointment	Mr E attended to collect his medication. Ms L noted that he look tired and Mr E said that he had not slept much the previous night as his girlfriend was round. He also said that he had had a job interview and was waiting confirmation of the outcome.
Tue 25/10/11	SLAM records	Appointment	Mr E collected two weeks' supply of medication - appeared stable in mental health. Eating and sleeping okay.

Date	Source	Event	Information
Wed 09/11/11	SLAM records	Unscheduled attendance	Mr E was seen by the duty worker and requested medication - not due until the following day. Mental state appeared settled. Requested contact with Ms L - duty worker to ask Ms L to contact Mr E.
Mon 14/11/11	SLAM records	Appointment	Mr E attended the clinic and presented as cheerful, pleasant and coherent - pupils were dilated but he denied illicit drug use. Mr E said he had not returned the previous week to collect his medication as he had a job interview. He had started a job for a few hours per week. Mr E requested a medical review as he was not happy to continue with his current dose of sodium valproate 1500mg - Ms L encouraged him to continue with what he was taking until he was seen by the consultant.
Tue 22/11/11	SLAM records	Unscheduled attendance	Mr E attempted to collect his medication which was not due until 28/11. Mr E appeared to be pleased with the extra income from his job and spending time away from home. Stable improvement maintained in mental state.
Mon 28/11/11	SLAM records	Medical note	Care Programme Approach review with Ms L and Dr A (her first meeting with Mr E as his consultant). Mr E had a new job and was proud of his efforts in securing and maintaining this. There were no reports of negative symptoms. Risk when well assessed as low, however when unwell increased risk to others of aggression and assault, has been known to carry weapons. However during the meeting Mr E minimised his risk of relapse and risk to others when unwell. Mr E felt that medication helped with feelings of being too active, losing his temper and feeling stressed. He said he had reduced his medication because it made him feel too drowsy and he had gained weight, but agreed to comply with the current dose. Discussion about the triggers to previous relapses, including substance use, stress and non-compliance. Mr E said that since his last admission to hospital in April 2011 he had been abstinent of cannabis, including skunk, and cited financial implications and feeling slowed down as reasons. PLAN: Ms L to update CPA documents and send copy to GP; medication unchanged - to remain on current dose, collected fortnightly from team base; blood test to be arranged; home visit by Ms L when appropriate; Mr E to deal with freedom pass and inform CMHT of any changes; declined psychological interventions at present - focus on work.

Date	Source	Event	Information
Mon 28/11/11	SLAM records	Nursing note	Medical review with Dr A and Ms L. Mr E attended early for the review, engaged very well and maintained good eye contact. Mr E was quite honest and coherent in his response. Mr E recalled being admitted to hospital on several occasions. He reported that there were as a result of him not being stable in life. He stated that he had moved on and did want any of those things to recur. Mr E said that talking to friends and family about it did help him to deal with things. Mr E admitted smoking cannabis in the past but denied recent use. He admitted drinking alcohol socially when he was stressed. Mr E saw his parents regularly and it was noted that he had a younger brother. He was sleeping well 8-9 hours and his appetite was reasonably good. Mr E denied every having felt depressed or suicidal. Mr E reported that he had started a job for 3 hours per week which he secured through the internet. Mr E felt valued being able to work and expected to get more hours as soon as they were available. Mr E did not disclose his mental health to his employer and said he wanted to stay well. Mr E blamed his previous admission to hospital on services picking on him. Mr E reported being taken to the hospital because he had cut his hand and was then taken to a psychiatric hospital on a [MHA] section. Mr E reported that he only saw his GP for physical health issues and that he had recently been to the surgery for pain in his stomach, he had been given some tablets and he felt much better. Mr E said that he had always felt that 1500mg of sodium valproate was too much for him and he had decided to reduce the dose by taking just 1g daily instead. Dr A agreed f to continue with 1g until he had had a blood test to determine whether this was an appropriate dose. Mr E was happy to take 20mg olanzapine. Dr A suggested psychological input but Mr E refused saying that he didn't feel comfortable talking about the past as this had been buried. Mr E said that he wouldn't attend SHARP for an assessment despite his request to be re-referred for activities. He said he wanted to see if they could help him with his CV but now that he had a job he was no longer interested. PLAN: Mr E to attend blood clinic for valproate level; Mr E to continue with 1g sodium valproate until advised otherwise; Mr E to re-consider psychological input.
Mon 28/11/11	GP records	Letter received	Letter to Dr P from SLAM CMHT. Advised that Dr A saw Mr E with his care co-ordinator Ms L. Diagnosis: Bipolar Affective Disorder (with psychotic symptoms). Medication: psychotropic medication dispensed fortnightly at the team base, sodium valproate MR 1gr od (progressively reduced from 1.7gr since April 2011); olanzapine 20mg od.

Date	Source	Event	Information
Fri 09/12/11	SLAM records	Nursing note	**12:42** Mr E attended the base and collected two weeks medication. He was coherent and pleasant. Mr E asked to use the phone to call the benefit office because his money hadn't been paid that day, however the phone lines weren't working. Ms L came in and took over. **17:08** Mr E could not use the phone as it wasn't working. He was advised to go to the job centre in Brixton as he wanted to enquire why he had not been paid on Friday. Ms L helped Mr E to completed the DLA form. Mr E did not express any other worries.
Fri 23/12/11	SLAM records	Nursing note	Mr E attended to collect his medication. Ms L checked the cupboards but Mr E's medication was not there. Mr E was asked to return on Wednesday as he said he had some medication left at home. Mr E asked to use the telephone as his benefit had not been paid. Contact with the job centre confirmed that this was because Mr E had reported that he was working. Ms L informed the job centre that Mr E only worked three days a week and that he should still get some support. Mr E was advised to apply for a crisis loan to sustain him through Christmas. Ms L and Mr E tried to apply for the loan but were told that it was too late and there was nothing that could be done in short time. Mr E left before Ms L could get him the food bank voucher. Ms L called his phone but Mr E didn't answer. PLAN: Ms L to contact Mr E after the holiday and chase his medication/FP10.
Wed 28/12/11	SLAM records	Nursing note	Mr E attended the team base to collect his medication but staff noted that it was not due until 6/1/12. Staff asked him to return the following day to see his care co-ordinator.
Thu 29/12/11	SLAM records	Nursing note	Mr E attended the team base to use the phone and collect his medication. Ms L noted that Mr E remained stable in his mental state and reported to have depended on family at Christmas. Mr E said he was off work until 3/1/12. He was allowed to use the telephone "*which is taking a long time*" but did not give any feedback regarding the outcome of his conversation.
Tue 03/01/12	GP records	Letter sent	From the GP Practice Co-ordinator to Mr E asking him to make a routine appointment with Dr P to discuss the Job Cente Plus form received by the practice.

Date	Source	Event	Information
Fri 13/01/12	SLAM records	Other	Mr E attended the team base to collect his medication. His mental state appeared settled and he reported that he was okay. No concerns expressed. Given two weeks' supply of medication - next due 27/1. Plan to feed back to care co-ordinator
Fri 27/01/12	SLAM records	Nursing note	Ms L saw Mr E at the team base. Mr E continued to maintain stable improvement in his mental state but needed some support with speaking to the benefit agency. Mr E used the phone and seemed satisfied. Mr E handed in a housing transfer form to be completed - Ms L offered to help him with this and to hand it over for him to sign and submit by himself.
Tue 07/02/12	SLAM records	Nursing note	Mr E attended to collect a housing transfer form which was completed for him to sign and send off. Ms L noted that Mr E remained stable in his mental state. Due to collect his medication the following week.
Mon 13/02/12	SLAM records	CC/Main contact note	Mr E was seen on duty and collected two weeks' medication. Medication collected four weeks' late - Mr E stated that he had a small amount of medication at home until that day. Mr E appeared settled in mental state, no concerns reported/observed. Next meds due 27/2.
Tue 28/02/12	SLAM records	Nursing note	Mr E attended for his medication. Mr E continued to maintain stable improvement in his mental state and reported that his hours had increased from 3-5 hours per week. Mr E explained the flexibility of his work as he was allowed to go in at any time after 5pm for an hour Monday to Friday. Ms L advised him not to stress himself too much. Mr E also complained that he was receiving less money for his income support. He was due to attend a review of his benefit soon and this would be addressed. Ms L asked him to collect a supporting letter to support his claim.
Tue 13/03/12	SLAM records	CC/Main contact note	Mr E attended the team base and presented as stable in mental state. According to Mr E he confirmed that everything was fine. Two week medication was given as TTA's. No issue reported or observed.
Wed 28/03/12	SLAM records	CC/Main contact note	Mr E attended the team base to collect two weeks' supply of medication. Mr E appeared well, stable in mental health, smiled and gave good eye contact. No concerns to report.

Date	Source	Event	Information
Wed 11/04/12	SLAM records	Nursing note	Mr E attended for his medication - no side effects reported and he continued to maintain stable improvement in his mental state. He reported that he was working for five hours and was actively trying to see if that could be increased by his employer.
Sat 21/04/12	GP records	OOH contact	Mr E contacted the GP OOH service complaining of severe rectal pain during the previous few days. Referred to Primary Care Service.
Sun 22/04/12	GP records	Letter received	From King's College Hospital advising that Mr E had attended the Emergency Department on 21/4/12 complaining of a lump to the perineum. Intermittent scrotal swelling caused by cough, spontaneously reducible. No evidence of obstruction. Needs a referral to surgeons.
Mon 23/04/12	GP records	Consultation	Attended complaining of swelling in the testicles for one month, no swelling or inguinal hernia found on examination. Ultrasound scan requested.
Wed 25/04/12	SLAM records	Nursing note	RETROSPECTIVE ENTRY Mr E attended for his medication and presented as stable, rational in his speech and pleasant on approach. Mr E reported that he was finding it difficult to get a replacement for his freedom pass which he lost when he lost his purse. Mr E said that he had been taking his medication as prescribed. He talked about his family as his father had travelled to Portugal for Mr E's grandmother's birthday - Mr E had wanted to go as he missed his grandmother but couldn't afford the ticket. Two weeks' medication given.
Thu 03/05/12	SLAM records	Nursing note	Mr E had been assessed by the Criminal Justice Mental Health Service in the custody suite at West End Central Police Station. Copy of the report to the Custody Sergeant outlining the assessment was placed in the correspondence section. Letter to Custody Sergeant stated Mr E presented as slighted elevated in mood, annoyed and irritated due to being in custody. NO signs of any acute mental deterioration. Mr E had good insight, denied any suicidal ideation plans or thoughts. Advice given to comply with medication every night as prescribed - Mr E understood and took on board. Recommendations: in the absence of any severe deterioration it did not appear he would benefit from hospital admission under section; if released from custody he was due to meet with his CMHT on Tuesday 8/5.

Date	Source	Event	Information
Fri 04/05/12	SLAM records	Nursing note	Telephone call received by Ms L advising that Mr E had been detained for assaulting his ex-girlfriend on 25/4 - he had cut her with a razor blade. That day he had breached his bail conditions by approaching this ex-partner. Police arrived at his home and found boxes of olanzapine and sodium valproate - he had not been taking his medication as prescribed. Mr E had been assessed by Mr K - he was appropriately dressed, slightly irritable, hyperactive, said he was frustrated for being in detention. No evidence of psychosis noted.
Mon 14/05/12	SLAM records	Nursing note	Ms L recorded that Mr E had not collected his medication the previous week. He was also expected to attend for assessment after he had been detained for assaulting his ex-girlfriend. Discussed at the team review meeting. PLAN: to be seen ASAP to monitor mental state; encourage him to return unused medication; Dr A to see him on Wednesday.
Tue 15/05/12	SLAM records	Nursing note	Home visit by Ms L to monitor mental, physical and social wellbeing as Mr E had not arrived to collect his medication. No response from his door, note left to inform him of appointment with Dr A on Wednesday.
Wed 16/05/12	SLAM records	Nursing note	Mr E DNA'd his medical review despite a reminder letter being sent. Ms L recorded that the team is now concerned that his mental health was relapsing and that he posed a risk to others, as it had been reported that he had cut his ex-girlfriend with a razor blade. Mr E had not collected his medication. PLAN: carry out a joint visit, arrange a welfare check if not seen.
Wed 16/05/12	SLAM records	Medical note	Dr A recorded that an urgent medical review had been arranged due to concerns about non compliance, deterioration in mental health and increased risk to others. Mr E DNA'd appointment and no contact had been made with the team. Dr A emailed Ms L to try to contact him that week as he was at high risk of relapse. CRISIS PLAN: if presents to A&E about his mental health, consider admission to hospital to re-start treatment as evidence of non-compliance (police found boxes at home); diagnosis of affective psychosis and when relapsing has high risk of violence - recent charge of attacking ex-girlfriend with razor blade and breaching bail condition; last admission April 2011 been well and stable in community since; last review by CMHT 20/4 when he presented as stable. Seen by Criminal Justice Mental Health Service on 4/5 with signs of hypomania.

Date	Source	Event	Information
Fri 18/05/12	SLAM records	Nursing note	Ms L recorded a joint home visit to engage with Mr E. No answer at front door. Note left for him to make contact.
Mon 21/05/12	SLAM records	Nursing note	Mr E discussed at the team review meeting. Decided that he poses a risk to the public as he cut his girlfriend with a razor. Not seen on last home visit to assess his mental state. Details to be circulated to the police as soon as possible. Alert to be put onto the system for when he presents at A&E.
Tue 22/05/12	SLAM records	Nursing note	Ms L contacted the police to carry out a welfare check as Mr E had not contacted the CMHT since he left custody the previous week, and he had DNA'd his medical review.
Thu 24/05/12	SLAM records	Nursing note	Information received by Ms L from the police to say that Mr E had attended a court hearing and had been detained.
Fri 25/05/12	GP records	DNA	Mr E did not attend his ultra sound scan appointment at King's College Hospital.
Wed 30/05/12	GP records	Letter received	Letter to Dr P from King's College Hospital. Advising that Mr E did not attend for the booked ultrasound scan on 25/5/12.
Thu 31/05/12	SLAM records	Nursing note	Ms L sent an email to Prison Location Service to locate Mr E as the CMHT staff had not had any correspondence to indicate where he was being held. Mr E has never wanted staff to involve his family so Ms L had not contacted them.
Mon 25/06/12	SLAM records	Nursing note	Mr E discussed at the team review meeting. No response received from MoJ to confirm which prison he was in. Suggested that further email be sent to Mr SJ to assist with the search.
Thu 28/06/12	SLAM records	Nursing note	Ms L reported that a colleague had approached staff at Brixton prison. It was confirmed that Mr E was in custody at HMP Thameside. PLAN: to make contact with prison and find out how he is.

Date	Source	Event	Information
Tue 03/07/12	SLAM records	Nursing note	Ms L received a call from Ms N, probation officer advising that Mr E was due in court that Wednesday. Ms N said that it was possible he would be released back into the community - the charges were assault by punching and biting his girlfriend. Ms N reported that Mr E became tearful during an interview - he maintains he was taking his medication prior to the incident and did not agree to accept depot as an alternative. PLAN: if released Mr E would be under supervision of probation; remain in care of CMHT and to be considered for depot; increased contact on a joint visit.
Wed 04/07/12	SLAM records	Nursing note	Ms L contacted Ms N for the outcome of the court hearing. Informed that Mr E was in the community under supervision from that day. Mr E was given a suspended sentence and restraining order (indefinite) to never have contact with the girlfriend that he assaulted. Mr E to be inducted for probation the following day.
Wed 04/07/12	SLAM records	Suspended sentence order	Sentenced to 6 months' imprisonment, suspended for 12 months. Activity requirement: present to the Domestic Abuse Activity as directed by probation, for 25 days.
Thu 05/07/12	SLAM records	Nursing note	Mr E attended for monitoring. He was cheerful and said he had been on holiday. Mental state was stable. Coherent in speech and appropriate in behaviour. Asked to use the phone as he needed to reinstate his benefits as he thought they had been stopped whilst he was in prison. Mr E spoke about the incident that led to his arrest - he confirmed he had been drunk, got involved in a fight and got himself into trouble. Mr E wanted his medication and Ms L suggested that he had a review before starting on medication again - Mr E said he had been on the same medication whilst in prison. Ms L arranged for Mr E to see Dr A the following Monday for a medication review. PLAN: review on Monday 1:00pm to bring current medication; to be considered for depot treatment as he is not compliant with oral treatment; referrals for vocation, exercise and social inclusion.
Mon 09/07/12	SLAM records	Medical note	No text but entered by Dr A.

Date	Source	Event	Information
Wed 11/07/12	SLAM records	Nursing note	Mr E attended the team base and was seen by Ms S-J and B. He was given two weeks' medication - appeared restless but polite and claimed he hadn't taken his medication since the previous day. Mr E took that day's medication whilst supervised. Mr E said that he had to attend the police station to collect his ID from when he was arrested but that he couldn't find the crime reference number, which he needed - this was why he felt restless. No other concerns reported or observed.
Sat 14/07/12	SLAM records	Liaison note	Call from liaison psychiatry at St George's. Mr E had presented with a shoulder injury (fractured collar bone) but unable to give an account of how he received it - staff concerned that he was not taking due notice of the injury. Asked for information about recent reviews - no concerns expressed by CMHT. No obvious relapse indicators whilst at St George's.
Wed 18/07/12	GP records	Telephone call	Dr P received a call from Mr E's key worker at Streatham CMHT; advised to provide a sick note for 3 months from 4/7/12. Sick note provided as requested.
Thu 19/07/12	SLAM records	Social work note	Mr E attended unannounced asking to use the phone to 'sort out his benefits'. He was escorted into a room and Ms M stayed with him briefly, however Mr E's body language and tone indicated he was agitated. Ms M asked for support from a colleague E, who sat with Mr E whilst he made calls. Mr E asked if a prison could fax some information for him to the team base. As at 15:30 no fax had been received.
Tue 24/07/12	SLAM records	CC/Main contact note	Mr E seen by duty worker. Looked anxious but fairly settled. Mr E stated that somebody from the team had recently helped in him complete a housing benefit form but had forgotten to sign it. Eventually Mr E said that there were some mistakes on the form and as such he wanted a new application completed. Crisis slot offered to see benefits advisor the following day.
Wed 25/07/12	SLAM records	CC/Main contact note	Attended the team base and requested to use the phone to call his electricity supplier as he believed he was in credit. Mr E said that he had not used much electricity and had been away for about 2 months. Mr E also had a housing benefit form and asked for the person who helped him complete the form to sign it. Mr E DNA'd the appointment with the benefit advisor that morning, invited to make another appointment but Mr E left the building.
Wed 25/07/12	GP records	A&E attendance	Mr E attended St George's Hospital A&E with a fracture to the shoulder blade after falling off a bicycle.

Date	Source	Event	Information
Wed 25/07/12	GP records	Letter received	Letter to Palace Road Surgery from St George's Healthcare. Diagnosis: minimally displaced right mid shaft clavicle. Mr E was vague about how he obtained the injury. Talked about falling off his bicycle on 14/7/12. Complained of right shoulder pain at that time and he had a further injury when lifting a table which appeared to have aggravated his symptoms. Mr E appeared a little vacant during the consultation and although admitted to smoking tobacco, denied smoking cannabis or taking drugs. Mr E given some exercises, advised to take regular paracetamol and given a follow up appointments for four weeks.
Wed 01/08/12	SLAM records	Medical note	Freedom pass application - medical fitness to drive. Dr A advised Mr E that he was not able to drive as his medical condition meant that he didn't comply with the DVLA Medical Standards of Fitness to Drive. Mr E was informed in writing, copied to his GP and care co-ordinator.
Thu 09/08/12	SLAM records	CC/Main contact note	Mr E presented at the team base and reported that his benefits had been stopped for over a month. Requested a doctor certificate for him to take to the job centre. Said he had no money to buy food and job centre will not give him a crisis loan without a medical certificate. Ms A called Dr A who said that she wanted to see Mr E before should would provide a certificate. Dr A and Ms L would be in on the following Monday and Ms L would be asked to call Mr E to offer him an urgent appointment. Ms A gave Mr E a requisition for food which he could collect the next day.
Mon 13/08/12	SLAM records	Nursing note	Mr E attended the team base for a sick note for the job centre to reinstate his benefits. Mental state assessed by Dr A and sick note given for 6 months. Mr E assured staff that he was taking his medication as prescribed. Staff advised Mr E to make an appointment with the GP for a physical health check. Mr E considering going back to college as he enjoyed art classes in prison. PLAN: book a review for September; Mr E to arrange a physical health check with his GP; medication due on Friday
Fri 17/08/12	SLAM records	CC/Main contact note	Mr E collected 2 weeks' medication, said he was 'good' but complained of toothache - advised to see a dentist.
Fri 31/08/12	SLAM records	Nursing note	Mr E collected medication, became irritable when he had to wait - said that he had an appointment to get to. Collected 2 weeks' medication but didn't have time to wait for food voucher that he said he needed.

Date	Source	Event	Information
Mon 03/09/12	SLAM records	Nursing note	Mr E told Dr D that he felt stressed and that he might lose it and do something because nobody was helping him. Current difficulties: * benefits not reinstated since he left prison; * in arrears with rent; * wants to get another job - previously worked for a few hours as a cleaner; * wants to move house as doesn't like the neighbours; * given another puppy the previous week, injured when it trapped it's foot in the door, treatment given by emergency medical centre; * run out of money for food, spent it on dog food, collecting vouchers from team base but not eligible for another crisis loan; * caught shoplifting (sugar) and is on probation; * lost his freedom pass Mr E said he got angry and trashed his flat over the weekend. He was vague about the details but said it lasted minutes not hours. Said he got angry easily sometimes but denied recent violence to others. Mr E said that he had been given cannabis and cocaine over the weekend but was unclear about the quantities. Mr E said that he owed people money and that they would come to his flat to collect it - he didn't feel safe in his home, if they threatened him he would defend himself and might harm someone. He was prone to losing his temper. Mr E acknowledged that he had been unwell and needed hospital treatment in the past, also said "I'm a bit naughty sometimes". He agreed that illicit substances and alcohol generally made his mental state worse but said "I'm not addicted, don't buy it, don't use it often". He agreed that medication helps and said that in the past he had missed tablets when drinking alcohol. He said that he'd not missed any tablets in the previous week and Dr D noted history of non-compliance. Mr E said that he didn't want to go to hospital - a particular concern was that he had to look after his dog and follow up on it's injury. No florid signs of mania or psychosis, some paranoia re neighbours. Based on history did present a risk to others but at that time seemed to relate to personality difficulties and substance use rather than manic psychosis - risks would further increase if mental state deteriorated. PLAN: increase contact with CMHT and monitor beliefs in relation to paranoia; continue medication; avoid illicit substances and alcohol; contact police or attend A&E if feels threatened by neighbours; Ms L to discuss with probation officer; if further deterioration, HTT or hospital treatment.
Thu 20/09/12	GP records	DNA	Letter to Palace Road Surgery from St George's Healthcare to advise that Mr E did not attend his appointment on 19/9/12.

Date	Source	Event	Information
Fri 21/09/12	SLAM records	Nursing note	Mr E was seen with Ms N his probation officer. Initially presented as stable and engaged. Mr E said that he had toothache and had taken paracetamol and reported that the dog was better - he wanted to keep it as a companion. Mr E confirmed he was collecting and taking medication and was looking forward to returning back to work as soon as possible. Mr E encouraged to get involved in activities that would prepare him for work. Mr E gave verbal consent for Ms L to share information with Ms N. Ms N described the expectations of Mr E whilst on probation and that the aim was to support him with his difficulties with relationships, particularly women as he had recently assaulted his partner but did not want to address the issue. Ms N reported that Mr E had been punctual in his attendance with probation but this seemed to be a struggle as he got defensive when talking about the incidents that led to his detention. Mr E denied drug use and any issues relating to his current bail condition. He did not want to discuss his current relationship but disclosed that he had had a relationship that lasted two days. Mr E became agitated and turned away from the meeting when the conversation about the relationship intensified - he stated that he didn't want to discuss it as 'they always leave me anyway'. Mr E said he would rather go back to prison than talk about the incident that led to his last arrest. Ms N confirmed that Mr E had actually cried during sessions when the issues had arisen and that he sometimes had become agitated. Ms N planned to seek help from colleagues who are experienced in this area and from male staff if possible.
Tue 02/10/12	SLAM records	Contact	Mr E collected 2 weeks' supply of medication - next due on 16/10. He was asked how he was and whether he had a message for his care co-ordinator. Mr E said he had no freedom pass and no benefits.
Wed 03/10/12	SLAM records	Nursing note	Mr E arrived at the team base in crisis. He had not received any benefit since he let prison in July 2012 despite submitting the document requested. Mr O supported Mr E by contacting the job centre to find out what had happened. Ms L was informed that Mr E was not entitled to ESA as he did not meet the requirements for the right to reside and therefore not considered to be habitually resident in the UK. Mr E confirmed that his passport had expired and that he had no money to apply for a new one. Ms L offered Mr E some food items donated by staff and a voucher to collect from the food bank.

Date	Source	Event	Information
Fri 05/10/12	SLAM records	Nursing note	Mr E attended the team base to discuss the outcome of the ESA. Mr E was in arrears with his rent and council tax and feared he might lose his flat as his housing benefit had stopped until he had proven that he was in receipt of benefits. Mr E was concerned that somebody else may have used his details to claim other benefits. Ms L contacted the job centre and was told that their decision was based on the fact that Mr E failed the habitual residency test. Ms L attempted to clarify Mr E's situation and the job centre advised him to appeal against the decision.
Mon 08/10/12	SLAM records	Nursing note	Mr E attended the office with his appeal form. He was supported in completing the document. He appeared brighter in mood and more positive in approach to his current financial difficulties. Mr E reported that he now had a phone and that his father had given him some money over the weekend. Mr E realised that it was easier to seek help from family than borrowing money from friends. Mr E said he was fearful of his friend to whom he owed money - he was concerned that his friend was going to increase the amount of money Mr E owed.
Tue 16/10/12	SLAM records	Social work note	Ms L called the office to request a home visit for Mr E as Ms L was off sick that day. Mr M and Ms W knocked on Mr E's door for a while but he was either out or was refusing to let them in.
Thu 18/10/12	SLAM records	Nursing note	Mr E met with Ms L and his probation officer Ms N for review. Ms N reported slight improvement in her working with Mr E as he had demonstrated insight to his problem and agreed to a different approach towards his life and set some realistic goals. Mr E said he would rather go back to prison as he was able to gain some skills when inside, rather than in the community. Mr E was struggling financially due to the delay in his benefit - the job centre had not received the paperwork. Mr E wanted to find a job as soon as possible to support himself. Ms L suggested a referral to First Step Trust but Mr E declined. Ms L and Ms N asked Mr E to consider engaging with the employment worker to help him with writing a CV. 2 weeks medication given as per prescription - next due 1/11/12

Date	Source	Event	Information
Fri 26/10/12	SLAM records	Nursing note	Ms J-B contacted JSA to rectify Mr E's mobile number and managed to get a direct appointment for him on 30/10. Ms L called Mr E to inform him about the interview, importance of attending and proof of ID that he would have to take. Mr E was aware that if he missed the appointment his benefits would be affected. Mr E was advised to go to A&E if he became unwell over the weekend.
Tue 30/10/12	SLAM records	Nursing note	Mr E attended the team base after his JSA sign up. Appeared vague and incoherent. Did not maintain good eye contact during the meeting - it was obvious that he had smoked cannabis, Mr E confirmed this. Mr E revealed that he had not been taking his medication since July and that he was beginning to feel unwell. Mr E expressed difficulties with no income and agreed to attend Spires for food, change of clothing and to have a shower. Mr E felt this was becoming his routine, he was not pleased to live like that and he constantly had urges to commit crimes and return to prison. Mr E was engaged with probation which he said he would rather not attend. Mr E reported that he was being charged with a driving offence committed in March 2012 - Bromley Magistrates Court. He said he was pleading guilty because he had no road tax and insurance at the time. He was support with the form to enable him to pay the fine and avoid going to prison. Mr E will see his consultant the next day for a review.
Tue 30/10/12	SLAM records	Email	Email from Ms N, Probation to Ms L advising that Mr E attended that day and was quite incoherent. Claimed not to have taken his medication as he had no food and his medication made him hungry. Ms N reiterated the importance of taking his medication however he got very annoyed about this and the fact that he continued to have no benefits. Mr E had decided to sign up to JSA and he had an appointment at the job centre on Thursday at 11:30. Ms N suggested a home visit, however Mr E got very defensive and asked why Ms N needed to do this. Ms N said she would raise it again the following week, however she was unable to make unannounced home visits so there was nothing she could do if Mr E declined to meet her.

Date	Source	Event	Information
Wed 31/10/12	SLAM records	Medical note	Urgent review attended by Mr E, care co-ordinator Ms H, student nurse Ms C and Dr A. Review held due to raised concerns about Mr E's mental health due to non compliance with medication, threats of harm to others after Mr E received a letter that his appeal for benefits had failed. Court case on this matter on 20/12. Mr E reported feeling distressed, upset, frustrated and angry. He said he did not think it was fair that for the past six months he had received no benefits (since release from prison) and that nothing happens despite his efforts. Mr E said that he was getting into debt with rent arrears and that friends had lent him £200 for food. It was noted that Mr E received food vouchers from the team and that he had attended Spires day centre, however Mr E felt ashamed of his current situation. It was recorded that Mr E was clear that there was a part of him that wanted to get through this period of difficulty with support - he had attended appointments and had responded to calls and letters. However it was also recorded that part of Mr E felt angry and thought "why should he be taking his medication" that "makes him angry and I don't need so much anyway". Mr E acknowledged his mental health condition and that if he was non compliant for a period he could relapse. The team explained the longer term effects of having several episodes and his condition becoming more difficult to treat. Mr E said that he had considered breaching his probation by not attending a few appointments so that he could be back in prison and have food and vocational activities. The team recorded that their emphasis was on keeping hope that things would resolve. Mr E presented with reasonable self care, was of average build and dressed in casual clothes. He was difficult to engage in that it was uncertain at what point he was listening to the information offered, and he had poor eye contact. Mr E seemed agitated and restless and his demeanour was dismissive as if the efforts from the team were insufficient. Speech delayed in responses and some questions had to be repeated, but no clear formal thought disorder. Mood seemed low, apathetic and hopeless, however could think through options with support, but default was to give up. No clear dysphoria, no suicidality expressed, no history of suicidal acts, no elation. Distractable at times and appeared more triggered by frustration. Did not present as irritable or aggressive. Alert and oriented in time, place and person. Fair understanding of mental health condition however due to current stress he was ambivalent about need and willingness to remain on treatment.

Date	Source	Event	Information
			Alternatives to medication discussed - Mr E claimed olanzapine made him feel angry. Would not agree to injection as he had a fear of needles and would only agree to the same oral medication on a lower dose. Due to history of severe illness, risk to others when unwell, uncertainty of his compliance with medication, major life event (not receiging any benefits) referral to home treatment team considered. Mr E was reluctant about this approach and said he would attend the team base on average twice per week. Agreed that any further deterioration in his mental health, or if he stopped collecting his medication, or stopped attending the team base that Mr E would be referred to the home treatment team to monitor compliance with medication and provide additional support from services to prevent admission under section.
Wed 07/11/12	SLAM records	Nursing note	Mr A, Benefits Advisor advised that Mr E went into the team base the previous Wednesday seeking reassurance about his benefit. Mr A encouraged Mr E to proceed with his application for JSA whilst waiting for the decision of his appeal for ESA. Mr A reported that he did not observe any psychotic symptoms at that time and that Mr E engaged well. The outcome of the meeting resulted in the need for Mr E's doctor to write a letter to support his ESA claim.
Fri 09/11/12	SLAM records	Nursing note	Ms C recorded that Ms H had received an email from Ms K requesting that a CPN be present at her next meeting with Mr E at his home address on 22/11. The purpose of this to monitor Mr E's mental health, review his living environment and assess his current needs. Attempts by Ms C to contact Mr E on his mobile were unsuccessful. Mr E had previously told Ms C and Ms H that he wanted to sell his phone as he doesn't have enough money to support himself. Mr E was discouraged from doing so as it would limit the ability for him to receive calls regarding his benefit queries and limit his ability to engage with the CMHT. PLAN: attend home visit with probation officer on 22/1/12 and follow up on consultant letter to support Mr E's application for benefits.

Date	Source	Event	Information
Mon 12/11/12	SLAM records	Nursing note	Mr E met with Ms L and Ms C to inform them of the new development in his claim for Job Seekers' Allowance (JSA) and Employment Support Allowance (ESA). Mr E appeared bright, pleasant and engaged well. He was appropriately dressed for the weather, reported that he had been compliant with his medication and denied any sleeping problems. Mr E handed in a letter he had received from the job centre in response to his appeal against the decision to disallow income related ESA - this stated that Mr E was not a qualifying person as he did not satisfy any of the categories prescribed in regulation 6 of the immigration policy. It further stated that Mr E was not treated as habitually resident in the UK because he did not have a right to reside in the UK, unless he can provide evidence that he is seeking employment in the UK and has a genuine chance of being engaged. Ms C advised that Mr E's consultant would write a supporting letter to accompany Mr E's appeal. PLAN: continue to support Mr E with his benefit claim, contact Mr E and offer weekly reassurance. NEXT MEETING: home visit with probation officer 22/11/12.
Sat 17/11/12	SLAM records	Nursing note	LATE ENTRY - ENTERED 19/11/12 Mr C attempted to conduct a MH screening assessment at West End Central Police station on 17/11/12. Mr E had been arrested for breach of a court order issued on 4/7/12 in relation to harassment of a female. The arrest following an argument Mr E was having with the same female. Mr E attended for interview but did not engage meaningfully with the assessment, often presenting in a surly manner, however no obvious florid/acute MH symptoms that would indicate diversion to hospital. Mr E denied many symptoms, although admitted to some stress linked to financial problems - benefit issues with knock on effect on housing benefit. Mr C reported that Mr E appeared to be engaging with the CMHT and that he had reporting being compliant with his medication.

Date	Source	Event	Information
Mon 19/11/12	SLAM records	Nursing note	Ms H recorded that she had received information from the Forensic Mental Health Practitioner that Mr E had been out drinking with his ex-partner. Mr E had clearly been intoxicated and he was reported to have pushed his ex-partner resulting in police involvement and Mr E being taken into custody. Ms B gathered from Mr E that he had some psychological problems that he needed help dealing with but that he was not accepting the help available to him.
Tue 20/11/12	SLAM records	Nursing note	Email received from Mr E's Probation Officer, Ms K advising that she had managed to get confirmation from the court system that Mr E's SSO was activated the previous day and that he was sentenced to 24 weeks in custody, this took into account the 60 days he had served on remand for the previous offence. She advised that Mr E's SSO had been revoked and that he would be released in 12 weeks' time with no order and no supervision. She noted that Mr E was currently in HMP Belmarsh. Ms K advised Ms L that the home visit planned for Thursday would no longer go ahead and that she would leave it to the discretion of Ms L regarding informing housing . Ms K further advised that the offence had been committed against the same victim and that she was planning to contact the police to get new contact details for the victim.
Tue 27/11/12	SLAM records	Letter sent	Letter sent. Supporting Mr E's appeal against the decision to disallow his income related ESA from and including 4/7/12.
Fri 07/12/12	SLAM records	Nursing note	Email received by Ms L from Mr O at Belmarsh Prison confirming a telephone conversation. Advising that Mr E had reported to the In-reach Mental Health Team at Belmarsh Prison that he had mental health problems and was under the care of Ms L. Mr O requested that Ms L forward information about Mr E's psychiatric history, reports, medications and any other relevant information so that Mr E could be appropriately managed whilst in prison.

Date	Source	Event	Information
Wed 12/12/12	SLAM records	Nursing note	Email received by Ms L from Belmarsh Prison stating that Mr E was being released that day. Email described Mr E's mental state as settled at time of release, that he had been given a week's TTA medication and that Mr E's GP would be notified. Ms L contacted Mr E on his way back to arrange an assessment for the next day and reported that Mr E sounded cheerful and coherent in his speech. Mr E advised that he would be attending the job centre the following morning to sort out his benefits and that he would attend the clinic afterwards. PLAN: Meet with Mr E the following day, encourage him to stay for the Christmas dinner, arrange a medical review asap, arrange a joint home visit. Email from Mr O In-reach Prison Team stating that he had left several messages with Ms L to call him regarding Mr E but that he had not heard from her. Mr O advised that Mr E would be released on 12/12/12 and that he would see him just prior to release and advise him to report to Ms L.
Thu 13/12/12	SLAM records	Nursing note	Mr E seen briefly when he came for the Christmas party. He left before Ms L could engage with him. It was reported that he sounded incoherent in his speech and confused about being there. He was leaving the building as Ms L approached him but promised to come back on Friday. PLAN: Mr E to attend for monitoring on Friday; Mr E to pick up medication; arrange a medical review with his consultant.
Mon 17/12/12	SLAM records	Nursing note	Mr E discussed at review meeting. Suggested that if Mr E did not attend for monitoring, he should be refererd to the HTT. Mr E DNA. Referral to HTT made at the end of the day. Ms L suggested that it would be practical for the CMHT to meet with Mr E and assess him properly before making a referral if necessary.
Mon 17/12/12	SLAM records	CR/HTT practitioner	Telephone referral from Ms L, CMHT who reported that Mr E had been released from prison a few days earlier, seen briefly by Ms L on 13/12. Mr E appeared a bit confused and did not stay for his appointment. Ms L has concerns he may not be taking his medication as prescribed, risk of self neglect. Ms L said that further appointment had been offered but Mr E DNAd. Referral to HTT for support, monitor mental state and daily supervision of medication. Referral not accepted.

Date	Source	Event	Information
Thu 20/12/12	SLAM records	Nursing note	Reported to Ms L by a colleague that Mr E was seen coming into the TB. Mr E was gone by the time Ms L got down to see him. Ms L reported that Mr E's mobile number was no longer working when she tried to call him. PLAN: carry out a home visit asap, deliver medication before the weekend.
Mon 24/12/12	SLAM records	Nursing note	Mr E DNA'd for medication and monitoring of mental state. Case discussed at team review and plan agreed to carry out a joint visit to deliver his medication. Ms L went to Mr E's flat with a colleague but there was no sign of Mr E so the medication couldn't be delivered. Crisis information leaflet posted through letterbox and information that Spires is open on Christmas Day for him to spend the day with others and where he can get a cooked meal. PLAN: to make contact with Mr E by the end of the week.
Fri 28/12/12	SLAM records	Nursing note	Ms L received call from Ms D Single Homeless Unit to advise that Mr E had been referred to them as he was about to be evicted for non-payment of rent. Ms D stated that she had already met with Mr E whose behaviour had been inappropriate during the meeting and therefore Ms D wanted more information about Mr E's mental health. Ms L advised that Mr E was not engaging and that staff were unsure how he was at that time.
Wed 09/01/13	GP records	Letter sent	Letter from Dr P sent to the CMHT advising that no recent Care Programme Approach information had been received. Requested an update on his mental health state, current medication and care co-ordinator details.
Thu 14/02/13	GP records	Letter sent	Letter from Dr P sent to SLAM to inform internal investigation. Dr P advised that he had not seen Mr E since 23 April 2012 and that the last correspondence he had received from Streatham CMHT had been 28 November 2011. Dr P had requested an update on Mr E's care plan on 9 January 2013 and as at 14 February he was still waiting for it to arrive.