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

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

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1 Executive summary

1.1 NHS England, London commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of a mental health service user [Mr H]. Niche is a consultancy company specialising in patient safety investigations and reviews.

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 and the investigation of serious incidents in mental health services.[2] The terms of reference for this investigation are given in full in Appendix A.

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 We would like to express our condolences to the family of Nicholas. 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 H.

Mental health history

1.6 This investigation relates to the care and treatment provided to Mr H by South West London & St George's Mental Health NHS Trust (to be referred to as the Trust hereafter). Mr H first presented with symptoms of mental illness while in prison in early 2012.

1.7 Mr H was assessed by clinical staff from Shaftesbury Clinic, the Trust's Forensic service, and was transferred from prison in April 2012 under Section 47/49 of the Mental Health Act.[3]

1.8 He was discharged from hospital by a Tribunal in April 2013, and was released on licence which meant he was supervised by probation, as well as receiving mental health services supervision in the community.

Relationship with the victim

[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-incidents*

[3] *Section 47/49 Mental Health Act 1983, Part III Transfer to hospital of prisoners. https://www.legislation.gov.uk/ukpga/1983/20/section/47*

1.9 Mr H and Nicholas grew up in the same neighbourhood, and were described as childhood friends. We have not been able to ascertain whether anything occurred between them that had any bearing on the homicide.

Offence

1.10 On the evening of 13 August 2014 the victim, Nicholas was playing football on the enclosed playing area at the rear of an estate in Tooting. Three men approached the victim on the playing area, and one of these was Mr H. Mr H stabbed Nicholas in the chest and leg and he was pronounced dead that evening.

1.11 Mr H was transferred to a secure mental health hospital in October 2014 and he was found guilty of murder in October 2015 and sentenced to life imprisonment, to serve at least 28 years.

Internal investigation

1.12 The Trust conducted an internal investigation that has been reviewed by the investigation team.

1.13 The internal investigation for the Trust was carried out by the Trust safeguarding and serious incident lead, and a consultant Forensic psychiatrist.

1.14 The internal investigation made four individual recommendations and the Trust has developed an action plan.

Independent investigation

1.15 This independent investigation was commissioned by NHS England and has drawn upon the internal process and has studied clinical information, police information, internal reports, and organisational policies. We met with clinical staff who had been in contact with Mr H, and senior staff from the Trust and the supported housing support provider.

1.16 Mr H's mother met with us and gave us her views that Mr H should have been monitored more closely, particularly to make sure he took his medication.

1.17 We met with Nicholas' mother who asked to be kept informed of the outcome of the investigation.

Conclusions

1.18 From reviewing the notes we consider that Mr H appears to have been prone to mistrustfulness and suspiciousness, and when mentally unwell this became paranoia. His signs of relapse appear to be an exacerbated sense of being at risk, which he is reluctant to share with others largely because of his socialisation and core beliefs.

1.19 We consider that the use of the probation licence introduces a lack of clarity about roles, as happened here, by avoiding formal 'health' conditions. Trust staff were not formally required to report non-attendances, and in this case it appears that probation did not report them.

1.20 We consider that it was certainly predictable that Mr H may be involved in violence or a violent acquisitive offence. Predictability is "the quality of being regarded as likely to happen, as behaviour or an event".[4] 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 with a threat to life, at that time, was high enough to warrant action by professionals to try to avert it.[5]

1.21 In coming to our view as to whether the homicide of Nicholas was predictable, and in considering all the information before us, we have considered whether Mr H's mental health history, his words, actions and behaviour should have alerted professionals that Mr H might, at that time, engage in such violence with a threat to life. We have considered whether, based on what mental health services knew, or should have known, there was a real risk of Mr H committing homicide at that time as a result of his mental illness; and whether that risk was high enough to warrant action by professionals to try to avert it.

1.22 We consider that it was certainly predictable that Mr H may be involved in violence or a violent acquisitive offence in the future.

1.23 However, although he has a previous history of violence, this has been of aggravated assault with weapons in the context of theft and robbery, and in prison, assaults associated with paranoia due to his psychotic illness. There is nothing in his history or his presentation at the time that would suggest he was very likely to commit an act of such extreme violence, therefore we consider that the homicide of Nicholas was not predictable.

1.24 Prevention[6] 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.

1.25 We conclude that there is no evidence that this homicide could have been prevented by mental health services. Previous episodes of violence which may be said to relate to his mental state were when he was in prison, and there has been no violence to others during his care and treatment by mental health services.

1.26 However, the systems of support and supervision across agencies should have been better coordinated, with a clear lead agency managing information about risk. It became clear after the homicide that Mr H had not been taking the prescribed medication, which historically has contributed to feelings of paranoia and suspiciousness. There was no indication of any potential risk of Mr H committing a homicide, although there is learning for the systems providing supervision of people on licence in the community.

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

[5] *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*

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

Recommendations

1.27 This independent investigation has made 10 recommendations for the Trust to address in order to further improve learning from this event.

Recommendation 1

The Trust should ensure that where there is a probation licence condition of contact with mental health services, a joint agency care plan with clear communication lines and escalation protocols should be in place and agreed by all parties.

Measures to ensure that agreed interagency care plans are adhered to should be implemented, with routes of escalation if there are concerns.

Recommendation 2

The Trust must provide assurance that the 'guidance on supporting community clients on oral medication' in the community is implemented and is being effective.

Recommendation 3

The Trust must provide assurance that the 'guidance on supporting community clients on oral medication' in the community is shared with partner agencies and services, and that relevant collaborative care plans are in place.

Recommendation 4

The Trust should build awareness of risks and gang culture in the catchment area, and develop appropriate links with Police to ensure that they are connected to local established networks for raising awareness, information sharing and action about those at risk from or engaged in gang activity.

Recommendation 5

The Trust must develop appropriate communications and working relationships with local supportive faith organisations through the Department of Spiritual and Pastoral Care.

Recommendation 6

The Trust should ensure that serious incident action plans are outcome focussed and have measurable aims.

Recommendation 7

The Trust zoning protocol should include the levels of intervention expected at each zone.

Recommendation 8

The Trust must ensure that carer's assessments are offered and appropriate action taken, and that families are offered the opportunity to take part in care planning.

Recommendation 9

NHS Merton/Wandsworth CCG should work with GP practices to ensure robust structures, processes and systems are in place to identify and manage (incidents) where patients on long term antipsychotic prescriptions default with prescriptions.

Good practice

1.28 The practice of Mr H's first community care coordinator in 2014 was assiduous and they made great efforts to tie together health, care home and probation.

1.29 The Forensic Outreach Service holds twice weekly meetings where every patient is mentioned care plans are updated and decisions are recorded.

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 on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

2.2 The main purpose of an independent investigation is to 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.

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

2.4 The investigation was carried out by Carol Rooney, Head of Investigations for Niche, with expert advice provided by Dr John McKenna, consultant forensic psychiatrist.

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

2.6 The report was peer reviewed by Nick Moor, Partner, Niche.

2.7 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[7]

2.8 Mr H gave written consent for his records to be accessed as part of this investigation. We wrote to Mr H at the start of the investigation, explained the purpose of the investigation and asked to meet him.

2.9 We used information from:

- South West London & St George's Mental Health NHS Trust;
- National Probation Service;
- Figges Marsh GP practice;
- NHS Merton Clinical Commissioning Group; and
- Metropolitan Police Service.

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

2.10 As part of our investigation we met with:

Trust staff:

- Lead Investigator/Named Nurse for Safeguarding Children
- Consultant forensic psychiatrist, report co-author
- Consultant forensic psychiatrist Shaftesbury Clinic
- Consultant forensic psychiatrist for Mr H (community responsible clinician or RC)
- Head of Nursing & Quality; Forensic, National, Specialist and CAMHS
- Team Leader and community nurse - Forensic outreach service
- Quality Governance Business Manager
- FOS care coordinator who had left the Trust (telephone)

Other organisations:

- Registered Manager, Beecholme Adult Care [8]
- Financial Director Beecholme Adult Care

We conducted telephone interviews with:

- Active Change[9] Mentor
- Head of Croydon, Merton, Sutton & The Foreign National Unit, National Probation Service
- GP at Figges Marsh surgery

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

2.12 The draft report was shared with NHS England, the Trust, NHS Merton Clinical Commissioning Group, National Probation Service, Merton, and Beecholme Adult Care and Figges Marsh Surgery. 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.

[8] *Beecholme Adult Care is is a provider of adult mental health care in the community in Mitcham, Surrey*

[9] *Active Change Foundation Ltd is a charity aiming to protect young people & communities from extremism and violence in all its forms by raising public awareness, challenging conflict through dialogue and developing resilience through training and our direct support services https://www.activechangefoundation.org/*

Contact with the victim's family

2.13 Nicholas's mother Mrs B, a family friend and a representative from the Hundred Families Charity[10] met with the lead investigator, and NHS England representative.

2.14 Mrs B said that the Trust did not talk to family and friends as part of the investigation, and she would have wanted to be approached to find out how they were doing, to be offered support, and to be kept up to date with the progress of the investigation.

2.15 She acknowledged that the Trust did attend a community event, but has had no recent contact. Areas that she wished the independent investigation to focus on were:

- whether a community treatment order was considered when he was discharged from hospital in April 2013;
- how Mr H's medication was monitored;
- how his exclusion zone was being enforced;
- when was he diagnosed with a mental illness (i.e. before or after his trial in 2015);
- what support and supervision was there for him when he moved to the step down unit;
- why was there no probation involvement in the Trust report; and
- has the Trust put an action plan in place, for instance about monitoring medication.

2.16 We have provided an index at Appendix E that indicates the relevant sections of the report which addresses these questions.

2.17 We met with Mrs B and her advocate prior to publication of the report. We were provided with comments through Mrs B's advocate which we have responded to.

Contact with the perpetrator's family

2.18 We met Mr H's mother to hear her perspective on Mr H's care and treatment. She told us that she was concerned that he had lost a lot of weight in the summer of 2014, and appeared 'hyper' and agitated. She said she had wondered whether he was taking his medication, but he told her he was taking it and had lost weight because he was keeping fit. It was important to

[10] *Practical information for families affected by mental health homicides in Britain. http://www.hundredfamilies.org*

her to know that plans would be put in place in the future to make sure that medication was taken by people with mental health issues in the community.

2.19 Mr H's mother said she had been invited to meetings and felt involved when he was in Springfield University Hospital, but was not invited to be involved in his care after he moved to Beecholme Adult Care. She confirmed that Mr H and Nicholas knew each other, and Nicholas had visited her home many times when they were younger. She wanted to convey her condolences to his family.

2.20 She had not contributed to the Trust internal report, but had been sent a copy some time later. She found the report upsetting, particularly as it contained information about Mr H's childhood experiences when she had been abroad, that had not been disclosed to her by family.

2.21 We offered the opportunity to meet with us prior to publication of the report. The draft report was sent to her, although she did not respond to invitations to meet.

Contact with the perpetrator

2.22 We wrote to Mr H at the start of the investigation, and met him to explain the purpose of the investigation.

2.23 We met him again in August 2017 to offer him the opportunity to share his thoughts about his care.

2.24 He said he was happy to be discharged, but didn't think he needed a mental health hostel like Beecholme. He said he took the medication because he thought he would be brought back if he didn't take it. He was unhappy with the licence conditions, and felt excluded from where he grew up, but could talk to the probation officer Ms G.

2.25 Mr H said he has always felt very wary of people, and doesn't trust people easily. After he moved to the step down unit he told the FOS community nurse, Mr E that he did not need to see him anymore. It was in April or May 2014 that he stopped taking his medication, because he thought he no longer needed it. His mother and sister noticed that he seemed unwell, and was paranoid.

2.26 Mr H said he began to feel more wary of other people and thought others were planning to harm him. He told us that he had started carrying a kitchen knife whenever he was out of the house, to protect himself.

2.27 He found talking about the actual homicide very upsetting, and we were unable to discuss this with him. He did say however that it was not about revenge.

2.28 We met with Mr H again to share the findings prior to publication of the report. He said he understood more about what happened, but was still unable to discuss it with us. There were no comments he wished to make on the report.

Structure of the report

2.29 Section 3 provides background information about Mr H's personal life.

2.30 Section 4 sets out the details of the care and treatment provided to Mr H. We have included a chronology of his conviction history at Appendix C.

2.31 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.

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

2.33 Section 7 sets out our overall analysis and recommendations.

The homicide

2.34 On the evening of 13 August 2014 the victim Nicholas, a young man known to Mr H, was playing football on the enclosed playing area at the rear of a block in Tooting. There were approximately 20 to 30 people in the area at the time, some playing football, spectating or playing in the park as the area is popular with local residents and youths. Witnesses state that a minicab approached and stopped close to the playing area and four males got out. One of these men, [Mr H], approached the victim Nicholas on the playing area with two others. For reasons that remain unclear at the time of writing, [Mr H] produced a large knife and proceeded to stab the victim in the chest. The victim collapsed and [Mr H] and the others made off from the scene on foot. The London Ambulance Service were called to attend and efforts were made at resuscitation. Despite these, the victim was pronounced life extinct shortly afterwards.

2.35 Police were called to the scene and cordons established with the body of the victim remaining in situ. Initial enquiries revealed a number of visible stab wounds to the upper and lower chest. The police Homicide Assessment Team were called to attend the scene and a murder investigation was launched.

2.36 Local enquiries quickly revealed that an individual known as [Mr H] was believed to be responsible for the stabbing. According to the police report, [Mr H] was well known and feared in the local community and has a reputation for violent and unpredictable behaviour. Enquiries with his family confirmed that prior to the incident, he and two others had been at a family member's home address for dinner. Her premises is approximately 15 minutes' drive from the scene of the incident and CCTV enquiries have confirmed that the three men all attended a local minicab firm shortly after leaving his family's address and took a vehicle to the scene. The progress of this vehicle can similarly be tracked along the route driven by CCTV.

2.37 Ms S, a local resident, describes local children attending her home address immediately after the incident stating that "[Nicholas] has been stabbed by [Mr

H]", and also describes the immediate aftermath of the incident, although she provides no direct eyewitness evidence.

2.38 Cause of death was determined as a stab wound to the chest and left leg. Both injuries sustained have been described by the pathologist as lethal injuries which either could have caused the death of the victim.

2.39 Intelligence traced [Mr H] to his brother's address late in the evening of the following day. Mr H was subsequently was charged with murder, contrary to Common Law and threatening with a blade/sharply pointed article in a public place, contrary to s139AA(1) Criminal Justice Act 1988.[11] He was cautioned and made no reply. He was remanded in police custody to appear before a local magistrate's court. August 2014.

[11] *Criminal Justice Act 1988. Articles with blades or points and offensive weapons. Section 13. https://www.legislation.gov.uk/ukpga/1988/33/section/139*

3 Background of Mr H

Childhood and family background up to age 14

3.1 Mr H was born in 1990 of Jamaican background, described as 'mixed heritage'. He was 24 at the time of the homicide in August 2014. He was the only son of his parents, and his father went on to have fifteen (or sixteen) children in all, although in 2012 Mr H reported that he had at least 26 paternal half-siblings (as well as three maternal half-sisters). His mother also had other children.

3.2 The other family members noted in records are a stepfather (reportedly died in a shooting in Jamaica circa. 2002) an older maternal half-sister (born circa. 1981, an older maternal half-sister (born circa. 1984) an older full sister (born around 1987 who converted to Islam circa. 2009; described as Mr A's second wife), and a younger maternal half-sister (born circa. 1997).

3.3 Mr H has reported that he was born in St Georges Hospital, Tooting, and then lived in Battersea. There are no recorded difficulties with his birth or early development, no history of head injury of seizure disorder, and no significant past medical history. His speech may have been slightly delayed, and there were no educational difficulties at primary school.

3.4 When he was aged five, the family moved to Tooting. His parents separated when he was aged six, with his father apparently then going (reportedly, he was deported) to Jamaica, where he stayed. Mr H has stated that he had no bond with his father, or with his step-father. He said that as a child he looked after himself rather than turning to anyone for comfort. He has reported that after his parents separated, he lived with his mother, step-father, and his aunts and sisters. It is reported that Mr H's mother spent extended periods in Jamaica during his childhood. In November 2012, a nurse noted that Mr H 'looks forward to talking to his sister because he feels very close to her even more than his mother'. In 2000 (aged around 10), the family moved to an estate in Wandsworth.

3.5 It has been suggested in social services records that he apparently lived a relatively deprived and chaotic life as a young person. In June 2012, at a CPA meeting, it was noted that social services records state that there was 'evidence of neglect as a child'. There is no known history of abuse. Mr H has reported conduct disordered behaviour in childhood, attending three primary schools due to being excluded for behavioural difficulties including fighting, and attending two secondary schools after being expelled for fighting. He has stated that he used cannabis occasionally from around the age of 8, and regularly from the age of 10 or 11. He has reported first robbing a person when aged 10.

3.6 Mr H was in care for several months when aged 12 (circa 2002), apparently the police attended his home address on several occasions because of incidents between him and his sister.

3.7 On 2 September 2003, Mr H (aged 13) was convicted of theft. He has reported that he began involvement in supply of drugs aged 13, initially as a 'runner'. A chronology of Mr H's conviction history is at Appendix C.

3.8 In around March 2004, Mr H's mother went to Jamaica for six months, reportedly to visit her husband, accompanied by his sister. Mr H was left in the care of his maternal grandmother, who had recently been diagnosed with breast cancer. On 20 April 2004 two siblings and their cousin alleged that Mr H asked them to 'touch him around his genital area'. The mother of the siblings (described as a close friend of Mr H's family) reported this to the police, and Mr H was reportedly moved from the estate in the interests of his own safety. The police made a referral to social services. Mr H had by then been excluded from Battersea Technology College. On 18 May, he was interviewed and charged. Later in May, Mr H was placed with a foster carer, apparently while his mother was in Jamaica and his grandmother was having surgery.

3.9 It is reported that on 4 May 2004, Mr H was convicted of two offences of robbery and sentenced to nine months detention in a Young Offender Institution (YOI). He and another male followed two victims, aged 12 and 13, from a shop and stole money and goods from them (the offence date is not recorded).

Chronology: aged 15 - 19

3.10 On 26 July 2005, Mr H (aged 15) was convicted of going equipped for theft (bolt-cutters, allegedly to steal mopeds), and on 13 December he was convicted of theft. It appears that he was released from custody in December 2005 (seemingly HMP YOI Feltham).

3.11 Also while aged 15, Mr H was excluded from another school, and arrested for smoking cannabis (or, other reports state, for dealing it on the premises).

3.12 Mr H was convicted of a third offence of robbery on 30 March 2006. It is reported that he and another male intended to kidnap a 16 year old boy and 17 year old girl who were described by Mr H as "snitches" who had strayed onto their estate, and that Mr H told them to get into the boot of a car before robbing them at knifepoint.

3.13 Mr H subsequently did not work, but continued to use illicit substances and to offend. It is reported that he was involved in the supply of cannabis "throughout the Borough of Wandsworth".

3.14 Mr H's mother travelled to Jamaica for three months from March 2006. On 2 May, the home was found to be unkempt, with no food. Mr H did not have a bed, and was always wearing the same clothes. He was living with his sisters (aged around 19 and 9). On the same day, Mr H was convicted of criminal damage and of failure to surrender. On 8 May, he would not allow a social worker into his address, and said that his 19 year old sister looked after him. On 9 May his maternal aunt reported that his sister was cared for solely by her, and that Mr H spent a lot of time with her older son, aged 20.

3.15 On 15 August 2006, Mr H (aged 16) was convicted of breach of a supervision order; and on 25 October he was convicted of failure to surrender.

3.16 Mr H has disclosed that from 2007, he had benefitted financially from other people selling drugs on his behalf. On 2 January 2007, he was convicted of theft from a vehicle, and was made subject to a four month Detention and Training Order (DTO).

3.17 On 8 March, he was convicted of robbery (his fourth such conviction) and of attempted robbery, and received two four month DTOs. It appears that Mr H and another male dragged a brother and sister from a bus stop to a block on the Henry Prince estate, threatened them with violence, and stole property from them. It is reported that he converted to Islam while at HMP YOI Feltham in 2007.

3.18 On 14 September 2007 Mr H (aged 17) committed an offence of robbery (the fifth). He and two others entered a shop and immediately punched the victim in the head and face repeatedly, and stole cash, alcohol and cigarettes. Mr H admitted punching the victim while holding him in a headlock.

3.19 On 23 October 2007 he was convicted of harassment. This related to harassment of a family who lived nearby, and against the child of which Mr H had previously committed a robbery (leading to his conviction). He had made regular threats to the children about an earlier robbery while walking past their house in the period June to September 2007.

3.20 According to a pre-sentence report for court, during 2007 Mr H was made subject to an ASBO,[12] alongside three other young men. Local media indicates that this order was in fact made in February or March 2008 (and was intended to last for five years).

3.21 On 15 February 2008, Mr H was convicted of robbery, and was sentenced to three years YOI detention (at which point the ASBO was revoked). During 2008, he attended hospital after banging his head against a cell wall.

3.22 Mr H (aged 18) was released on licence in February 2009, but could not stay with his mother as she was subject to a suspended eviction on the grounds he did not spend time at her address in Earlsfield. He went to a hostel. It appears that Mr H was recalled in June 2009, for failing to attend appointments or residing at an approved address.

Last community period: November 2010 - February 2011 (aged 20)

3.23 It appears that Mr H remained at HMP YOI Portland from June 2009 (aged 18) until his release on 26 November 2010 (aged 20). It is reported that he then failed to engage with St Giles Trust (which offered temporary accommodation) - citing gang rivalries in the Croydon area and 'a lack of perceived assistance'. Mr H stated he had enemies in several London areas. He may have stayed with several relatives, but was described (by a probation

[12] *Antisocial Behaviour Order.* https://www.gov.uk/asbo

officer in 2011) as being 'reluctant to provide full details' and as 'rather secretive' about previous accommodation arrangements. His mother had by this point been rehoused in Tooting.

3.24 As of February 2011, Mr H was effectively homeless and reportedly sofa surfing at the Hammersmith address of the mother of his younger paternal half-brother (also described as a step-brother), Mr C. He was also subject to licence conditions. In March 2013, it was stated in a probation report that before his last imprisonment, Mr H:

> 'led a chaotic lifestyle, failed to keep appointments, disengaged from his supervision by probation and lived an itinerant lifestyle dependent on the proceeds of his criminal activities … has never before had to deal with the admin of claiming benefits, opening a bank account and budgeting … his literacy skills are poor he has only recently started to write his signature…'

3.25 It has been reported that his main social contacts were members of a street gang based around his old neighbourhood of the Henry Prince Estate.

3.26 Mr H committed two offences of robbery (his sixth and seventh) on 12 and 13 February 2011, while still subject to a 'notice of supervision licence'. It appears he has reported that he grabbed jewellery from a woman leaving a jeweller's shop, but this does not match the police account. The police record states that Mr H and Mr C approached two males (also brothers) on a Wandsworth street in the early hours of the morning, and told one of the men to "give me everything". It is unclear whether a knife was involved, but one of the perpetrators claimed to have a knife. Both victims were pushed to the floor. Belongings were removed from their pockets, and they were told not to move as the perpetrators made off. Each brother denied the involvement of the other.

Custody: February 2011 - April 2012 (aged 21)

3.27 As of 16 February 2011, Mr H was at HMP Feltham. He reported a history of daily cannabis use.

3.28 When seen for the police interview, Mr H continued to deny that his brother had been involved, and stated "I've gone past the point of caring for other people" and "I don't do stuff for the money, I do stuff because it feels good". He said he had been staying at a female friend's address temporarily and intermittently. Mr H was described as lacking interest in employment opportunities, and has having little formal structure and no formal income (he had rarely been in receipt of state benefits).

The police interview states: 'He stated he would continue to commit criminal acts to accrue money until his legitimate income was substantial enough to render it unnecessary … It is clear that [he] has created a reputation for himself in his local borough that marks him as violent and reckless….although he wouldn't have considered himself part of a gang per se, he did associate with a group of young people who were consistently involved in criminal activity … [he] reports that due to his gang affiliations he cannot go into

certain areas such as certain parts of Wandsworth, Croydon, Norwood and Streatham. [He] describes himself as belonging to a 'Muslim community' … has aspirations to involve himself in humanitarian work …'
'He spoke about enjoying the feeling of power when involved in violent situations … lack of empathy for the victims … lack of consequential thinking … His offending … would indicate he holds attitudes that support a view of himself as someone who believes himself above the normal social rules and who can 'take' whenever he chooses and from whoever he chooses.
… When challenged as to how his religious aspirations sit alongside these acts he suggests that they are 'an act of war … we live in a land of war'
…Youth offending records indicate that previously [Mr H] had commented that he was 'born to be a criminal' … [he] has adapted his religious attitudes to support rather than condemn his behaviour … '

3.29 He saw himself as a 'punisher' of those who 'need to be punished'. The police record (26 May 2011) noted that it was believed that some of his associates were linked to particular gangs.

3.30 On 13 Jun 2011, at Kingston-upon-Thames Crown Court, Mr H was sentenced to six years imprisonment (following convictions of two offences of robbery). This was an extended sentence for public protection, with a Parole Eligibility Date of 15 November 2012 and a Sentence Expiry Date of 14 February 2017.

3.31 Mr H was located at HMP/YOI Isis from 4 July 2011. On 28 October and on 3 November (aged 21), he was admitted to the segregation unit. It has been reported that at Isis he had been:

'espousing radical extremist views emanating from his religious beliefs and concerns were also expressed around him preaching'.

3.32 While in HMP/YOI Isis, he also stated that it was 'his duty' to kill another prisoner known to have killed a Muslim and Mr H was involved in several assaults upon this prisoner.

3.33 He was referred to Probation's Central Extremism Unit and [they] … sponsored Active Change Foundation[13] (ACF) agreed to work with him on 'issues around his cultural and religious identity'.

3.34 In January 2012, after prison officers had noted 'bizarre' behaviour, Mr H was referred for a mental health assessment. He believed his food was drugged and that officers were trying to sedate him in order to control and harm him because he had 'figured them out'. There was no history of any prior mental health service contact. It appears that an assessment was attempted by a mental health nurse on 16 January 2012, but that Mr H refused, saying "I'm not mentally sick" and denying any bizarre behaviour. As of 23 January, he was in the segregation unit (seemingly after urinating on the landing).

[13] *ACF is a charity whose mission is to protect young people & communities from extremism and violence in all its forms by raising public awareness, challenging conflict through dialogue and developing resilience through training and our direct support service https://www.activechangefoundation.org/*

3.35 On 6 February 2012, he did not attend for psychiatric review. When the visiting consultant psychiatrist assessed Mr H on 14 February, he found no evidence of mental illness and discharged him back to prison primary care services. Mr H reported that he had no contact with his parents or siblings, saying he no longer needed them (although he was in touch with a cousin). He reported past cannabis use, and was described as a single man with no long-term relationships (although there is also a contemporaneous report that he had a child but denied paternity).

3.36 On 23 March 2012, Mr H seriously assaulted a prison officer (one report states it was 'two or three' officers), who sustained a fractured arm when he forcefully struck a desk with his extendable baton. Mr H had said that he felt unsafe, and when invited to talk to an officer he became aggressive and lashed out. When moved to the segregation unit (having failed to comply with instructions), he did not engage with staff, and was seen to be shadow boxing while naked. He repeatedly told staff he felt unsafe, without further elaboration. Subsequently, Mr H was observed to be keeping his head under a blanket, rocking, mostly mute, and talking to himself. He was also seen to urinate in communal corridors.

3.37 On 27 March, the consultant psychiatrist who saw him in February heard Mr H talking to someone who he claimed was outside his window. Although he presented as elated, incongruous in affect, overfamiliar and mildly irritable, Mr H said he was unconcerned by his situation and did not wish to be interviewed further. The consultant psychiatrist prescribed risperidone (1 mg daily), and requested a transfer to a prison with in-patient (mental health) facilities. On 29 March, he asked the Shaftesbury Clinic,[14] Springfield University Hospital, Tooting, to 'urgently review' Mr H to consider a medium secure hospital admission for assessment, on the basis that he was 'becoming mentally unwell' and that he had 'an antisocial personality disorder'.

3.38 On 10 April, a urine drug test was positive for subutex.[15] At some point, officers removed a package from Mr H's cell suspected to be cannabis. Another report mentions that he was thought to be involved in the supply of cannabis within prison.

3.39 Dr C, specialist registrar, Shaftesbury Clinic,[16] assessed Mr H on 11 April, and on 20 April completed a Section 47[17] MHA report:

> 'Nursing staff reported he is guarded, expressed paranoid thoughts … he has said that 'people are out to poison my food' and has been seen

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[14] Shaftesbury clinic is the secure forensic service of SWLStG. http://www.swlstg-tr.nhs.uk/our-services/specialist-services/forensic-service.

[15] Subutex sublingual tablets contain the active ingredient buprenorphine, which is a type of medicine called an opioid. Short term effects of Subutex abuse include: euphoria, decreased pain, and even sedation. http://www.netdoctor.co.uk/medicines/brain-and-nervous-system/a7763/subutex-buprenorphine/

[16] The Shaftesbury Clinic is the medium secure service for SWLStG Trust. http://www.swlstg-tr.nhs.uk/our-services/specialist-services/forensic-services

[17] Section 47 of the Mental Health Act 1983. Removal to hospital of persons serving sentences of imprisonment. https://www.legislation.gov.uk/ukpga/1983/20/section/47

whispering to himself … increasingly uncommunicative and suspicious … he had persecutory thoughts that prison staff were putting 'something' into his food … because his food tastes 'bitter' and 'metallic' … expressed persecutory thoughts about 'people playing games' with him and then said that 'their' ultimate goal was to 'control me' but that they could also 'kill me' if they chose … gave a description of prison officers talking outside his cell … he did not believe he was suffering from mental health problems … He said that he had recently been spitting out risperidone'.

3.40 A prison nursing discharge summary also refers to Mr H claiming officers were spying on him, whispering outside his cell, and trying to control his mind. He said his legal letters had been tampered with, as well as his food, that he was in danger of being killed, and that TV programmes had subliminal messages within them. It also states he had been refusing risperidone. Dr C ascribed a diagnosis of schizophrenia, and recommended admission to the Shaftesbury Unit.

3.41 On 13 April Mr H set a potentially serious fire in his cell. It was considered that this may have related to persecutory delusions; he wanted to be moved, as he believed there was a camera filming him in his cell. In hospital, he provided a different motivation: '[Mr H] states he set fire to his cell as he wanted to get himself moved to a CCTV room, where he could be watched all the time, as this would mean that he would be safer from the attacks by prison officers'.

3.42 On 20 April, Mr H was transferred to the Addison Unit, HMP Wandsworth (where he remained in segregation), and diazepam 10 mg daily was also prescribed. He remained suspicious and paranoid, and refused medication.

4 Care and treatment of Mr H

4.1 The services involved in Mr H's care from April 2012 are listed below:

Shaftesbury Clinic is the secure unit of the Forensic service run by South West London and St George's Mental Health NHS Trust.

Forensic Outreach Service (FOS) was called the Community Forensic Team in the internal report, and later changed its name. The FOS provides community care and treatment for patients who are living in the community but require the supervision of the Forensic service.

National Probation Service is the statutory criminal justice service that supervises high-risk offenders released into the community. The Central Extremism Unit supports a multi-agency approach to identify and provide support to individuals who are at risk of being drawn into terrorism, through the 'Channel' and 'Prevent' programmes.

Beecholme House is a rehabilitation service that can accommodate and provide support for up to fifteen younger males with a past or present experience of mental ill health. The service specialises in helping people to develop the necessary skills to move onto more independent living. The service is divided into a main hostel located at 2-4 Beecholme Avenue where up to 12 people can live and a nearby three bedded 'step down' unit at Downe Road.

The step down house is not permanently staffed and people who stay there live more independently than the people living at the main house.
Staff at Downe Road visit daily, and each resident is allocated a key worker to maintain oversight of the wellbeing plan and communicate with Trust staff and other agencies.

Active Change Foundation is a charity with the aim of the prevention of crime within urban communities, in particular terrorism and violent crime perpetuated by gangs and the protection of property or people living or working within urban communities, so as to provide safer urban communities.

The charity is also involved in the promotion of religious and racial harmony for the public benefit by promoting knowledge and mutual understanding between different racial groups and persons of different faiths and raising awareness so as to promote good relations between those groups and persons.

Shaftesbury Clinic: April 2012 - April 2013

4.2 Mr H was admitted from HMP Wandsworth to Halswell ward, Shaftesbury Clinic on 24 April 2012, under the provisions of Sections 47 and 49 Mental

Health Act 1983 (MHA), and under the Responsible Clinician care of Dr G, consultant forensic psychiatrist.

4.3 There was evidence of paranoia and hallucinations, and Mr H was prescribed olanzapine[18] which he initially refused. He asked to be called a name that he associated with Islam. Mr H presented as irritable, anxious, agitated, and suspicious. He maintained that he was not unwell, and believed staff were talking about him and plotting against him. It was noted that he 'displays a number of features of antisocial PD (sic)'. His mother told staff that 'she has not heard from him in months'.

4.4 On 25 April, Mr H stated that from late 2011 he had known that he was being spied on by staff, there was a camera in his room, and people were talking about him outside. He admitted he was using cannabis at this time. He said he used it a lot in prison, described it as "my treatment ... when I needed a spliff (sic) I had one". He denied using other drugs, and could not explain the positive UDS[19] for subutex in April … he was asked about the covering of a mirror yesterday. He admitted it was in relation to concerns re spying.… happy to continue taking [olanzapine] as prescribed …'

4.5 A UDS was negative, and he was prescribed olanzapine 20 mg daily.

4.6 On 27 April, Mr H reported that he has always found it difficult to trust people and was suspicious of people's motives. On 29 April and 30 April, he said that at the age of 14 he started to feel that people were plotting against him, that people were pretending with him and saying things about him. He said he only had two friends throughout school and that generally he didn't trust people and thought that others talked and plotted about him behind his back. He first noticed this at about aged 10, he thought people would try and get him into trouble so he would become angry as they found this entertaining. He made the comment "I'm the one that everyone wants to scheme against" and this appears to have been his view for some time.

4.7 On 8 May, while there continued to be strong evidence of paranoia and hearing voices, Mr H was described as not believing he was ill. He preferred not to have medication, and believed there was a plot involving harming him. When a change to his medication was discussed with him, he stated: "what if the [paranoid] thoughts are correct and the medication slows me down and something happens to me?"

4.8 Clonazepam[20] was added on 9 May. Regarding the original offence, Mr H denied using any threats, pushing the victims to the ground or having a weapon. When asked about his future, [he] seemed to struggle to contemplate a different lifestyle. He described his life as "a dangerous circle

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[18] Olanzapine is an antipsychotic medicine used for treating schizophrenia. http://www.netdoctor.co.uk/medicines/brain-and-nervous-system/a27924/olanzapine-uses-and-action/

[19] Urine drug screen

[20] Clonazepam is a sedative used to treat anxiety. https://bnf.nice.org.uk/drug/clonazepam.html

where you go round and around". He said he did not want to keep committing crimes but did not have any sense of how else life could be.

4.9 On 14 May, Mr H stated that while he had been in prison:

> "a chip was inserted in to his hand to control him and this was done by ISIS[21] … he would like to open his hand and prove to everyone there is a microchip in there" …. some paranoid thoughts about [three] nurses … they are "playing games with me, laughing at me and ignoring me" …. Thinks the voices are achieving what they want by making him "look mental" …. asked "I'm not getting better so how do I know you're not all in on it?".

4.10 On 15 May, because of lack of improvement, olanzapine was switched to aripiprazole[22]10 mg increased to 30 mg by 21 May.

4.11 In a letter requesting escorted leave to a general hospital dated 15 May, Dr G noted that Mr H reported auditory hallucinations and persecutory and self-referent paranoid ideas, and that since admission he had been:

> 'settled with no evidence of hostility or aggression … some person-specific paranoid ideas about a male healthcare assistant but has not acted on these … compliant with all medication and engaging well with the care team … ongoing paranoid ideation …'

4.12 On 21 May, it was recorded that Mr H had been in the company of fellow patient Mr A until evening, and he appears to be under Mr A's influence. 'Unsettled mental state. Paranoia about food and water being contaminated … Guarded … Told nursing staff … there was a "big plot to kill him" …'

4.13 Over the following weeks and months there are repeated references to Mr H spending much, or most of his time with Mr A. Shortly afterwards (see below), staff discovered that Mr A's second wife (a relationship generally recorded using inverted commas in the notes) was Mr H's sister.

4.14 On 22 May, a nurse recorded that Mr H asked if he could have olanzapine undissolved, and there were some concerns that he disappeared quickly after taking the tablet.

4.15 On 23 May, after Mr H reported a two month history of unusual smells, an electroencephalogram (EEG)[23] was requested. Also, he was observed listening intently to a fellow patient advising him not to listen to staff and also not to provide a lot of information to members of staff. Mr H reported that he did not accept the diagnosis of schizophrenia. He said that he knew that someone or some people are plotting to attack him … the plotters could be staff or fellow patients … he is prepared for any attack and that he would

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[21] ISIS stands for so-called Islamic State in Iraq and Syria and is an extremist militant group that rules by Wahhabi/Salafi law. In Arabic, the group is also known as Daesh. http://www.yourdictionary.com/isis.

[22] Aripiprazole is an antipsychotic medication used to treat schizophrenia. https://patient.info/medicine/aripiprazole-abilify

[23] EEG: An electroencephalogram is a recording of brain activity.

defend himself. He was convinced there was a plot against him and the food was being tampered with.

4.16 From about this point onwards, an improvement in Mr H's mental state is reported. At a ward round on 28 May, he was described as guarded and paranoid. He was eating breakfast but no other meals on the ward, relying on food deliveries. He had been encouraged by another patient and by Mr A not to disclose symptoms. The team have found out that [Mr H]'s sister is Mr A's second wife. [Mr H] was described as believing that the clinical team are involved in a conspiracy with ISIS.

4.17 On 1 June, it was noted that staff believed that Mr A had met Mr H's sister in the last few weeks and then a marriage was arranged. Mr H was noted to be continually in the company of Mr A, who appeared to be influencing his behaviour and decisions.

4.18 During June, Mr H reported that voices had reduced in volume and frequency, and that a male voice told him not to trust people and to assault others. He stated that in custody he felt that staff were trying to control and kill him, that he was being spied on, that his food was being poisoned, that people were whispering about him, that a chip had been implanted in his hand (which caused voices) and that he received messages about plots from the TV and radio, and he reported a general suspicion of healthcare professionals. He said that TV and radio gave out subliminal messages to all people, encouraging behaviour that went against Muslim beliefs.

4.19 Mr H was assessed as having very high self-esteem, and on the WAIS-III[24] he obtained IQ scores of full scale = 90 (average), verbal = 83, performance = 100, verbal comprehension = 82, perceptual organisation = 107, working memory = 94, and processing speed = 86. There were no major areas of concern on neuropsychological testing.

4.20 At a home visit on 14 June, it was noted that Mr H's mother lived in: 'a chaotic overcrowded council house' in Tooting with her daughters I (24), R (14) & I's children N (5) & K (2)'.

4.21 At a care plan review meeting on 18 June, it was noted that Mr H was settled in mental state. Probation were visiting regularly to try and build a positive relationship with Mr H as he has never built a strong professional relationship with anyone. He seemed to accept the possibility that his symptoms may be attributable to mental illness but finds it hard to think of being on medication long term. He said he doesn't want to return to a criminal lifestyle and acknowledged that he feels better on the medication.

4.22 On 20 June, a psychologist spoke to Mr H about the alleged prison assault. He maintained that he could not remember doing this and does not believe it happened. At the time he believed prison officers were putting thoughts in his head and that his life was in danger. He still believes his life was in danger in

[24] *Wechsler Intelligence Scale for adults (WAIS or IQ test). https://wechslertest.com/*

prison and that if he committed the assault, then he was justified in doing so as he thought he needed to protect his life.

4.23 On 27 June, a psychologist noted that Mr H continued to deny many behaviours that have been mentioned in other reports and did not want to talk to about much of his offending. He was noted to have a tendency to externalise responsibility of antisocial behaviours. He said that currently he finds his religion keeps him away from drugs and violence and said he did not think he needed to do any work on his substance misuse as he said he is coping fine without using cannabis and does not see this changing. He did not agree with the psychologist's interpretation that his experiences in prison were a result of paranoia, and maintained that his experiences were real.

4.24 The following was noted at a ward round on 2 July: 'Spends majority of his time with [Mr A] ….. concordant with medication …. Has started smoking but this seems linked to when [Mr A] smokes. Denies having a mental illness …. Is now wearing full Muslim outfit ….Not accepting responsibility for forensic history. Spoke about initial conversion to Islam - found it supportive to keep him away from drugs and violence. However under times of stress reverted back to his old ways. Currently feels he would not revert and that his strong Muslim beliefs will protect him from future incidents … [he] requested that he return to Wandsworth prison'.

4.25 On 3 July, Mr H told a nurse that he did not want to attend his CPA as he already told the team what he wants. He maintains that he thinks ISIS were trying to kill him and he was convinced that they wanted him to die in the fire he set in his cell.

4.26 On 7 July, Mr H told a nurse that he had heard his younger brother had been stabbed in HMP/YOI Isis, and felt the prison wardens had deliberately set up the situation so that his brother could be stabbed. He went on to say the prison wardens have done this as revenge because of remembering when he was in the same prison and was violent to the prison wardens.

4.27 As of 9 July, it was reported that Mr H had generally, and significantly, improved in the previous two weeks, and the nursing report for the CPA meeting on that day noted he had been a 'model patient'. However, he continued to hold paranoid ideas about prison staff, and disputed a diagnosis of schizophrenia, saying he had been unwell due to stress. He saw no reason to remain on the ward, asked to return to prison, and said he would take medication voluntarily.

4.28 He declined to attend his CPA meeting, and stated that his sole request was to return to prison. He had recently reported that the apparent stabbing of his younger brother was part of the plot against him. He had said he intended to continue medication should he go back to prison, and that he did not want to return to his previous lifestyle of drugs and criminality.

4.29 At the July 2012 CPA meeting, it was noted that Mr H had reported that even aged 10 he thought people were whispering about him and expressed some paranoid beliefs. He described a general mistrust of other people so has only

had a few close friendships. His probation officer visited regularly, accompanied by a mentor from ACF. In early June his close friendship with Mr A was recognised. It soon emerged that Mr H had known him prior to admission and that in fact his sister was married to Mr A under Islamic law. He had never previously disclosed where he lived and appears to have moved regularly between the houses of friends and family. The probation officer has been working with Mr H since April 2011. This was described as initially a very difficult relationship but he became more open and cooperative. The probation officer echoed that he was vulnerable to other peoples' beliefs and behaviours, and had strong normalised views around violence and aggression.

4.30 The probation officer reported that when he was in HMP/YOI Isis, when Mr H did start to engage he was pulled from groups because he was considered at risk of 'radicalising' other inmates. When first in Isis he seriously assaulted another inmate (between February and April 2011), he said he felt it was his duty to take the life of this prisoner as he had killed a Muslim man in the community.

4.31 On 11 July, nursing staff were told that there was no record of his brother having been stabbed. On 14 July, Mr H told a nurse that his brother had been "stabbed in the ear by another inmate but that it did not seem to be a very serious incident".

4.32 On 13 July, it was reported that Mr H was no longer hallucinating, was less paranoid, had been compliant with the treatment programme, and had not been violent. He was aware he would likely remain in hospital beyond his Earliest Date of Release.[25] On 15 July, Mr H said he was aware that another patient had told staff that he was being bullied by Mr H, and maintained that these claims were lies.

4.33 An EEG on 18 July was within normal limits (as was an MRI[26] brain scan on 6 September 2012). On 30 July, Mr H's mother spoke to staff after visiting him. She said she had recently been dealing with a lot at home …. one of her daughters had her drink spiked, and the police were involved. She said that she did not want to tell [Mr H] as he would 'explode' - this was due to [him] being so protective over his sisters.

4.34 At a Multi-Agency Public Protection Arrangements[27] (MAPPA) meeting held on 23 August 2012, Mr H was described as 'a known violent robber in the borough of Wandsworth'. He had indicated being linked to a known gang.

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[25] A prisoner serving a determinate sentence is normally released automatically halfway through their sentence. If their sentence is 12 months or more, they will be released on probation. This s their earliest date of release (EDR).

[26] Magnetic resonance imaging (MRI) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. https://www.nhs.uk/conditions/mri-scan/

[27] Multi-Agency Public Protection Arrangements. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders. November 2017. https://mappa.justice.gov.uk/connect.ti/MAPPA/view?objectId=7134100

'while in prison …. his ideology caused concerns - noted that his offending is linked to his belief that he is a 'punisher' who has a duty to punish people for their 'sins' and has suggested that the victims of his offending have not been 'innocent.' While in prison he had made threats against another prisoner, stating that it was his duty to kill this prisoner as he had harmed one of Mr H's 'Muslim brothers' while in the community … has been referred to the Probation Central Extremism Unit who have been engaging with Mr H with one-to-one work alongside Mr A of Active Change Foundation. While in hospital, visits were being made by probation and Mr A every two weeks. Probation are conducting visits every two weeks for one-to-one work and Mr A as appropriate … there is concern over another patient at Springfield Hospital who has influence over Mr H, to the degree that he has married Mr H's sister'.

4.35 The Trust internal investigation report states that from about August 2012, no psychotic symptoms were identified and that Mr H made a good and complete response to treatment as an in-patient.

4.36 At a ward round on 3 September, Mr H was described by nursing staff as: settled, and doing better since Mr A's movements have been restricted and he spent less time with him. A social worker reported that his probation officer (Ms G) had recently visited him, and she had asked him about his relationship with Mr A. Mr H had said that Mr A was 'controlling'. She also gave some information about the ACF mentor's contact and that he reported concerns about Mr A's influence over Mr H.

4.37 On 28 September, Mr H started attending a substance misuse group, where he reported that he was aware that cannabis could adversely affect his mental state and that he wished to abstain from it.

4.38 On 29 September 2012, Mr H was referred to Dr S, forensic psychiatrist, South West London Community Forensic Outreach Service (FOS).

4.39 On 2 October, Dr G recorded that she had told Mr H that she had now applied to the MoJ for escorted leave in his case, because he has made such good progress and is so close to his Earliest Date of Release (EDR),[28] so they may agree that it is appropriate to test him out before he is discharged. Mr H was noted to be keen not to get rehoused in Wandsworth. Dr G explained again that she would probably place him on a notional Section 37 MHA[29] after his EDR, in order to be able to identify a hostel that suits him and plan care and support in the community. It was noted that Mr H said he understood and accepted this.

4.40 On 4 October, Mr H's solicitor made a Tribunal[30]application on his behalf.

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[29] *Notional Section 37 of the Mental Health Act is used when an offender is in hospital at the end of his sentence and remains detainable under the Mental Health Act 1983.* https://www.legislation.gov.uk/ukpga/1983/20/section/37

[30] *First Tier Tribunals (Mental Health) are responsible for handling applications for the discharge of patients detained in psychiatric hospitals and on community treatment orders.*

4.41 Mr H attended a 'managing mental health group' between August and October. He denied any negative effects from cannabis and said he would not use it in future because of his religious beliefs. He was described as having a rigid thinking style. He appeared to see his own opinion as absolutely correct and struggled to incorporate other views and he sees the world as a dangerous place. He said that prior to prison he was involved with fights and violence and feared retaliation, so was sleeping with a machete next to his bed. He said that he would get into fights to feel better and talked about how fighting has been a big part of his life and how he used it to improve his mood.

4.42 A CPA meeting on 15 October was attended by Ms R1. Mr H was described as asymptomatic, compliant with medication and engaging well with the OT and psychologist. He was adamant he wanted to move to a different area to avoid contact with previous affiliates and victims, and has asked that he is referred to drug and alcohol services. He was happy to be tested and realises drugs could get him back into offending, and is looking for external restrictions before he can develop internal control. He asked for engaging with mental health work to be on his license. The Team considered a CTO,[31] but thought that license conditions may be enough.

4.43 When he was assessed by a psychiatrist and nurse from the FOS on 14 November, his care team reported that he had improved significantly, his mental state was stable, and he was involved in many ward OT activities. He was due to commence escorted ground leave imminently, and there had been no incidents of aggression since admission or concerns about substance misuse.

4.44 At interview for the assessment it was noted that most of the time he gave short answers and had to be repeatedly asked to elaborate in order to give further information, which was at times hard to extract. This was particularly difficult when assessing his views on past experiences and crime, especially revolving around family members, whom he refused to discuss.

He told the assessing team that that he now realised he was unwell in prison but was unsure as to whether he actually needed medication any further, since he has been stable for a while and therefore would logically think that he does not need it any further. He talked about the wish to go on a drug-free trial.

Mr H refused to discuss his index offence or previous offending in detail and did not wish to discuss any involvement or associations within his family in terms of his previous lifestyle, although he did not have any specific plans or interests for the future, although his life had revolved completely around crime. He stated it would be easy and simple to say 'no' if and when he came across previous or wrong crowds. He believed that prison was enough a deterrent to keep him from getting involved in crime in the future and did not

[31] *Section 17 A of the Mental Health Act The responsible clinician may by order in writing discharge a detained patient from hospital subject to his being liable to recall in accordance with section 17E,; known as a community treatment order or CTO.. https://www.legislation.gov.uk/ukpga/1983/20/section/17A.*

have insight into the need for [treatment] any further at present or in the future.

He refused to discuss any problems with specific members of his family who have in the past been co-defendants and have a history of criminal activity. He stated that he would stay out of the exclusion zone and that this would be enough to keep him out of involvement with his previous gangs. He did not show any interest or motivation into things that he could do in the community to ensure he has a robust structure which would reduce the risks of him going back to his previous peer groups and lifestyle. It was thought that he would be likely to disengage in the community and discontinue medication without the provision of intense support. It was felt that there was a high risk of non-compliance, as he failed to understand that he will continue to need monitoring and supervision within a hostel accommodation.

4.45 It was concluded that Mr H was not at that time suitable for discharge and follow-up by the FOS.

4.46 His EDR was reached on 15 November 2012. On that date (and under the provisions of Chapter 6, Criminal Justice Act 2003) he was eligible for conditional release on licence (with supervision ending on 14 February 2017), and he remained detained in hospital under a notional Section 37 MHA.

4.47 The licence conditions included him not directly or indirectly contacting or associating with the victims of the original robbery, or with his co-defendants. He was to permanently reside at an approved address, was to attend medical appointments, and was excluded from entering certain parts of South West London without prior approval.

4.48 A drug use questionnaire completed by Mr H on 18 November (DAST-10)[32] scored just 2 out of 10, indicating low risk. He said he was always able to stop using drugs when he wanted to, and denied using drugs other than those required for medical reasons.

4.49 Mr H first had escorted ground leave in November 2012. On 19 November, he was granted one hour escorted ground leave daily.

4.50 At a CPA meeting on 3 December, Mr H was noted to be very keen to progress with leave, raising some concerns that he intended to meet up with a brother-in-law who was an in-patient on the Springfield site (low secure forensic ward). However this was not agreed, because he had shown minimal engagement with the mentalization (MBT)[33] group and had refused to start an offending group as he did not want to discuss his past offending. A later report states that his brother-in-law was Mr A, and that staff had concerns that '[Mr A has a malign influence over him and their relationship is to be discouraged'.

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[32] DAST-10 is a drug abuse screening tool. Skinner, H. A. (1982). The Drug Abuse Screening Test. Addictive Behavior, 7(4),363–371https://www.drugabuse.gov/sites/default/files/dast-10.pdf

[33] Mentalization-based therapy (MBT) is a type of long-term psychotherapy. Mentalization is the ability to think about thinking. https://tavistockandportman.nhs.uk/care-and-treatment/treatments/mentalisation-based-therapy/

4.51 Concerns were expressed about increased interaction with Mr A. It was thought that this was possibly having an influence on his reduced engagement with psychology/OT work, and that he may be requesting unescorted ground leave to meet Mr A. It was agreed it was important to liaise with ward staff to avoid Mr H being on escorted or unescorted leave in the future, at the same time as Mr A being in the grounds.

4.52 On 4 Dec, Dr G recorded that Mr H was currently feeling very well, and that he understands that he has a mental illness and accepts that the medication is helping him.

He was also asked about his relationship with fellow patient [Mr A] who recently moved to Hume, as there was concern by the team that they have been meeting in the grounds and that Mr A may have been casting a malign influence over Mr H - in particular encouraging him to sabotage treatment and not to attend psychology and OT. Mr H denied this was the case - he said that he valued Mr A's support and friendship and said that, on the contrary, Mr A had been encouraging to go to all his groups and to work with the team, as that would be the best way for him to get out of hospital. Mr H started the offending group on 5 December. Beecholme was suggested as a potential next step in his care pathway. Mr H reported that Mr A influences him in a positive way, and described that he asks him to engage with team and attend all groups. Mr H became irritable that the team should have any concerns about his interaction with Mr A as he is part of his family.

4.53 On 4 January 2013 Mr H mentioned that he would prefer not to go to Beecholme because of its close proximity to his exclusion zone but he would 'do anything to get out of the ward because he does not want to be here, and that if he does not take Beecholme he felt that he will be here much longer'.

4.54 Mr H was granted daily unescorted ground leave (one hour) on 7 January. He also had ground escorted community leave for three hours, three times weekly.

4.55 On 9 January, Mr H said he no longer wished to attend individual psychology sessions or the offending group, and said "he did not want to 'jump through hoops' anymore". He later re-started the individual sessions. He is also quoted as saying he was "sick of this hell hole". On 10 January, he reported that he did not like having to talk about his past, was very frustrated about still being in hospital, and that he had never wanted to attend the offending group and had only done so to "tick the boxes". On 14 Jan, it was reported that he was refusing to attend the offending group and did not want to talk about his offence. He re-engaged with psychology sessions on 17 January, and with the offending group on 23 January. He was noted to have stated that he enjoys and derives pleasure from committing acts of robbery, and expressed little or no remorse for his actions. He was described as remaining blasé about previous offending.

4.56 On 17 January Mr H spoke to the psychologist about to 'live a righteous life' … praying, giving to charity, doing good deeds and believing. He described how he was already doing each of these things … said that he had

committed crimes since being a Muslim, and explained this by saying that before he believed, but did not fear God … he started to read a lot of Islamic books in prison, which talk about prayer being a 'preventer', and this helped him to want to take a different path … talked about the idea of paradise and hell that he read about, and said that this 'freaked him out' and he remembered this when crime presented itself to him. He talked about how the Quran talks about the least of punishment being your feet burning and your brain boiling, Mr H said that thinking of this helped him to stop engaging in crime. He also said that at those times when crime presented itself to him he would think "this is not going to help me get into paradise".

4.57 On 21 January, Mr H was reported to have said he was not keen on Beecholme House and would prefer to be placed in Richmond. He was not attending the offending group and had stopped his shop-work scheme and disengaged from groups completely. A nursing CPA report prepared on 24 January (for a meeting on 28 January) noted that Mr H's general presentation had continued to improve over the previous few months, and that he had "started to engage with all his peers". He had refused to attend groups which were making him feel uncomfortable as he does not like to go over and over his past crimes. He felt he has paid for this and he should not have to talk about what happened again.

4.58 Mr H had been offered a place by two placements, and favoured the one in Mitcham (Beecholme House) because of its distance from Wandsworth. He was unsure what he wanted to do after discharge, and said that he would be working with his brother-in-law. He reportedly had criticisms about the hostels being 'too much' like hospitals as they had many staff and rules.

4.59 At a forensic community multidisciplinary meeting on 22 January 2013 it was noted that, regarding placements that he has viewed, Mr H feels they are 'too near the exclusion zone … he says he wants to be totally away from the areas around the exclusion zone, as he does not want to be near gang related areas in case he bumps into gang associates'.

4.60 A clinical psychology report dated 25 January noted that Mr H had attended a substance misuse group (September - November), a managing mental health group (August - October), offending behaviour group (December - to date), and mentalization-based therapy group. He had also had nine individual sessions. Mr H had been adamant that he stopped using cannabis before coming into hospital. He was noted to have a very rigid thinking style, and his main motivation to abstain from cannabis was his Islamic faith. He would often see his opinion as 100% correct and was unable to incorporate other views or evidence. He denied being mentally ill at the time of his index offence and he identified key factors as growing up with peers who commit many crimes, and seeing offending behaviour as 'normal'. He holds a number of core beliefs that life is unpredictable and that he is unable to play a role in making changes that will keep him out of trouble, and seems easily influenced by those around him. It was thought that his suggestibility may leave him potentially vulnerable to other people's interpretations of his Muslim faith.

4.61 It was noted that [Mr H] has reported an intention to avoid antisocial behaviour and drug use in the future, which he links to his Muslim faith … engagement and motivation have fluctuated and this seems influenced by both the influence of others and his own core beliefs that life is unpredictable and therefore there is no point trying to make changes to influence the future…[his] probation officer has reported concerns about his reported attitudes and beliefs (e.g. beliefs about the necessity of revenge and not talking to the police) … they are likely to be very ingrained.

4.62 At a CPA meeting on 28 January 2013 (attended by his probation officer Ms R1), Mr H was described as stable and free of psychotic symptoms, with very inconsistent engagement with psychology. He did not see the point in attending OT sessions as he would soon be leaving hospital. At this meeting all parties agreed that Mr H would require close supervision in the community in order to keep him mentally well and to avoid him reforming with old criminal associates and falling back into criminal activity. The plan was to aim towards discharge in the coming months on a Community Treatment Order (CTO)[34] and to be followed up by the community forensic team (now known as Forensic Outreach service or FOS).

4.63 He was granted unescorted community leave at this point. The community multidisciplinary meeting (MDT) minutes for 29 January noted that he would be discharged on a CTO, and have engagement with probation and mental health professionals.

4.64 On 30 January 2013, a social worker noted that Mr H considered that being discharged on a CTO was "an added burden" given that he will also be reporting to Probation until 2017. On 1 February 2013, he visited Beecholme for the second time, and it was noted that it became clear that Mr H is deterred when hearing terms such as 'structured programme' which he equates with hospital care.

4.65 By 11 February, Beecholme was confirmed as the discharge destination. By that time he was using several hours' unescorted leave in the community, and had appealed against his section because he "does not want a CTO on discharge". On 12 February, Ms R, a forensic social worker in the FOS was identified as the community care co-ordinator.

4.66 A Tribunal[35] report dated 19 February 2013, prepared by Dr C, senior trainee in forensic psychiatry, confirmed a diagnosis of paranoid schizophrenia. Mr H continued to see a mentor from ACF, and a North London placement was being considered (close to the ACF Centre). When examined by Dr C (on 13 Feb), she noted that he presented as:

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[34] Section 17A Community treatment orders (1)The responsible clinician may by order in writing discharge a detained patient from hospital subject to his being liable to recall in accordance with section 17E.. Mental Health Act 1983 (rev 2007). https://www.legislation.gov.uk/ukpga/2007/12/section/32

[35] The First Tier Tribunal reviews appeals and renewals from patients detained under the Mental Health Act. https://www.gov.uk/courts-tribunals/first-tier-tribunal-mental-health

'scruffily dressed … appeared unhappy at having to speak to me and had a fixed stare and blank expression … difficult to achieve any rapport … gave minimal responses … irritable and was blunted in his affect … appeared more hostile when I asked him about his reluctance to engage with the FOS … limited insight regarding his mental health … he wanted to 'get off section' so he wouldn't require follow up by the FOS … didn't want any input from mental health services in the future and furthermore he did not feel that he needed it. He said that he would continue to take his medication … His plans regarding the future appeared vague … stated that he would get a job … had no concrete plans about how he would do this … expressed a firm desire not to re-engage with [drugs and past criminal influences] … could offer me no concrete plan about how he would be able to achieve this … he wasn't entirely sure that his cannabis use had been a negative experience and he said it had helped him relax … struggled to explain anything that he had learnt in the [psychology groups] other than to say that they had been used for 'discharge planning' … we felt that it was important for him to have continued follow up in the community … He would not accept this point of view … Concerns have been raised … that Mr H is at risk from organisations looking to recruit young Muslim males … is very suggestible and easily led and he is very devout to his faith … had a fixed and unusual stare making interaction difficult …

The management plan (discharge under a Community Treatment Order) will ensure that he is properly supervised within the community and his mental health is closely monitored by the FOS'.

4.67 On 20 February, Mr H said that he considered the proposed plan to discharge him on a [CTO] an added burden to the fact that he will also be on licence and reporting to probation. He did not want any follow-up by FOS or community mental health services generally and does not believe that he needs that supportive framework to stay well, abstain from illicit substances and avoid his former criminal lifestyle.

4.68 He told a psychologist at his last individual session that he knows that crime is wrong now, and will think of the consequences of his actions, including the feelings of the victims and his own unpleasant feelings of guilt and remorse for having acted like this in the past. Mr H said that he will drop any friends who are involved in crime or who encourage him to commit crime, and reported that he has already begun to make new friends through the Active Change Foundation and his mentor Mr A.

4.69 Mr H was reported by ACF to have engaged well and that his attitudes had shifted. However, they observed that he was very vulnerable to the influence of others and will be vulnerable to adopting and changing his beliefs depending on those he is associating with. On 22 February, Mr H declined to attend the ACF project.

4.70 The probation officer Ms R1, was from the Hammersmith office, and as of early 2013 she intended to transfer his case to Ms G, Mitcham office.

4.71 At a CPA meeting on 11 March, neither his probation officer nor Mr A from ACF were in attendance. It was reported that he has not attended ACF as previously planned on three occasions. Concern was expressed about over how Mr H would structure his days on discharge. The FOS team had some concerns regarding disengagement, and a CTO was again discussed. The planned conditions of the CTO would be: taking medication, follow up from FOS, attending ACF, urine drug screens. His unescorted leave was increased to allow attendance at ACF and Beecholme hostel.

4.72 On 11 March, the Tribunal was postponed until 8 April. Mr H had sought an immediate discharge, but the panel noted that several factual issues required resolution, including: victim issues, the availability and funding of hostel accommodation for the patient on discharge, the operation of the exclusion zone currently imposed by the terms of the patient's prison licence, and the details of monitoring when discharged, by MAPPA, the Probation service and the community mental health teams.

4.73 On 14 March, Ms R1 introduced him to Ms G. An OT assessment dated 15 March noted no difficulties with personal care, food and drink preparation, medication management, laundry, household cleaning, finances, shopping, mobility and transport or functional communication.

4.74 On 21 March, Beecholme House staff reported on Mr H's first trial leave on 20 and 21 March. He had decided to enrol at South Thames College, Merton (to start a bricklaying course on 8 September) and to start an adult literacy and numeracy course at the Learn Direct Centre. He enrolled at the local library and took out 'History of Islam', and was described as 'cooperative, very receptive and demonstrated a willingness to be engaged in activities'.

4.75 On 23 March, Mr H attended ACF and his mentor reported good participation.

4.76 On 26 March, medical staff recorded that Mr H did not fully accept his diagnosis, because he was still of the opinion that he wanted to be discharged from his Section so he would not require follow-up from the FOS. At a FOS MDT meeting on 26 March, the conditions of the CTO were discussed.

4.77 Mr H went on day leave to Beecholme again (unescorted) on 27 and 28 March, and was due to attend to ACF on 30 March. On 27 March, Ms R visited Merton probation office to meet Ms G and also a Senior Probation Officer, Mr S, from the Central Extremism Unit, and manager of Mr A, ACF.

4.78 On 29 March, Mr H completed a care plan document with his key nurse stating that his 'recovery goals' were discharge, attending ACF, doing a bricklaying course, abstaining from cannabis, keeping his cool and gaining paid employment. He did not attend ACF that day, later stating he had lacked confidence in case he met any of his old enemies and he still clearly had concerns about meeting his old associates. He asked for a staff escort to attend ACF, stating he did not feel comfortable travelling alone and referring to bumping into 'enemies'.

He said he will not travel on his own when he is discharged and was hoping that Beecholme will transfer him soon, and he is hoping that ACF will be able to help him to find somewhere across London outside of this area… he just wanted to leave hospital. He appeared distressed in regards to travelling on his own in and around Tooting area.

4.79 On 5 April, invitations were sent out for a discharge planning meeting on 15 April, at which time it was known that the precise funding arrangements for Beecholme would not be known before 10 April. It was hoped to discharge Mr H to Beecholme on 16 April, subject to a CTO and with FOS supervision. Funding was subject to a panel application being heard by the local authority planned for 10 April, later pushed back to 17 April, seemingly due to staff sickness. The draft CTO conditions related to residence, structured daytime activities, taking medication, attending appointments, providing urine samples and complying with his care plan. He was still homeless, so there remained a risk of sofa surfing around the criminal fraternity and extended family (and hence disengagement).

4.80 At a ward round on 8 April, discharge was still planned for 16 April. Later that day, a Tribunal decided that Mr H would be discharged from liability to be detained on 23 April. It concluded that it was not satisfied that Mr H was suffering from a disorder that made it appropriate for him to be detained, or that it was necessary for his health or safety or for the protection of others that he should be detained for treatment. Mr H had sought a deferred discharge, to allow the funding application to be heard. The Tribunal accepted his submissions that:

> 'He was willing to comply with the care and treatment plans on a voluntary basis and that … the conditions of the CTO were covered by his probation licence so that … the CTO was not necessary.

The Tribunal decision was that:

> 'A robust plan including a number of agencies, all of whom have worked together, has been put in place. Mr H is to be discharged to a hostel that he has been visiting regularly in recent weeks and where he will have a keyworker and an activities officer, he will be seen weekly by his probation officer, he will be subject to MAPPA, he will see his care co-ordinator regularly and have regular medical reviews by his Community Responsible Clinician, both of whom will be members of the Community Forensic Team, and he will continue to be mentored by someone from the Active Change Foundation…
> All of these plans are covered by his licence conditions and if Mr H does not comply with them he will be in breach of his licence and liable to recall to custody. His licence does not expire until February 2017 and is far longer than any CTO would be likely to last. Furthermore, as Mr H has not had any experience of receiving mental health treatment in the community there is no history to suggest that a CTO is needed and he does not meet the usual conditions for a CTO'.

4.81 Mr H visited Beecholme on 10 April and 11 April. He stated he did not want to attend ACF until after discharge (he was due to go on 12 April), because being asked questions about why he was on a ward made him feel uncomfortable. The Section 117 MHA[36] meeting on 15 April was attended by Ms R and Ms G, but not Mr A. Dr G said that at the Tribunal the team had recommended a CTO, as there were concerns about Mr H :

> 'keeping up activities and motivation to stay focussed on staying well and safe … he has a history of non-compliance with licences …the licence states he needs to attend all mental health appointments … FOS and probation will need to stay in close contact … if he misses 3 appointments [any] he will return to prison … going to ACF is NOT a condition at present'.

Dr G put forward concerns about his vulnerability should he be recalled to prison. Ms R said she favoured treatment over prison, but this is much more difficult without a CTO. There was to be weekly follow-up by probation and FOS.

4.82 Mr H visited Beecholme on 17 April. On 18 April, funding was approved. On 19 April, Mr H said he would not go to Beecholme again prior to discharge. At a ward round on 22 April, it was noted that Mr H had requested a passport (stating he wished to visit Jamaica at some point), and that Beecholme and probation would be sent a relapse plan. He was discharged on the afternoon of 23 April 2013.

Beecholme: April 2013 - April 2014

4.83 Ms R reportedly saw Mr H on 24 April. On 25 April, Ms R (FOS) telephoned Mr A (ACF) to introduce herself. She also telephoned Mr H, who reported that he was settled.

4.84 Mr H did not attend ACF on Fri 26 April. He was seen by his probation officer on 29 April, and by Ms R on 30 Apr, who noted that 'he said that he has been visiting his family … We exchanged phone numbers … I suggested that he considered doing another daytime activity until his course starts - he said he was happy just visiting his family … I asked him if anyone had told him that he stares intensely, he smiled, apologised and said no … He said he reads the Quran daily … I got the sense that he keeps himself to himself within the placement … he engages when specific questions asked but is not spontaneous with information'.

4.85 Dr S, consultant forensic psychiatrist, FOS, reviewed Mr H on 2 May:

"Polite but taciturn … has completed online computing course (six modules) and obtained certificate … has completed the Six Book Challenge - all the books he read were about Islam, but were not extremist in nature … literacy level 1 course with Learn Direct due to start at Norwood Centre 13th May, first appointment with Active Change Foundation in Waltham Forest on 17th May,

[36] *Section 117 is the duty to provide aftercare after certain sections of the MHA have been applied* https://www.legislation.gov.uk/ukpga/1983/20/section/117

has applied for bricklaying course to start in September at South Thames College (Merton Campus) … weekly cooking sessions at hostel to start on Monday 6 … says he sees his family most days, for most of the day … but hostel records show he has only done this on Friday/Saturday; on other days he visits for briefer periods if at all, and only goes out of the hostel for short shopping trips … Overall, settling in well. Staff are happy with him and have no significant concerns at this stage'.

4.86 At a FOS MDT meeting on 7 May it was noted that Mr H was 'being escorted when out of the placement by staff'. Mr H was seen by Ms G on 7 May. He was reviewed by Ms R on 8 May: it was reported that he again talked about when he was previously released from prison that he was housed in an 'ordinary' hostel. Ms R advised him that he needs a more supported placement, he has also been advised that he should not be around the placement in his pyjamas smoking cigarettes. He also said he does not have to take medication, but he will at the moment.

4.87 On 9 May, Ms R left a message for Ms G, and also rang the Beecholme manager. She reported that she had a long conversation with Mr H regarding his wish to leave the placement and to reassure him of the support available to him. She stressed the importance of two way feedback particularly as Mr H appears to be in conflict about 'toeing the line' at present.

4.88 On 10 May, Ms R attended a FOS MDT meeting where it was recorded that Mr H had said he is placed in a 'mental hostel' and this has impacted on how he feels. At the MDT meeting on 13 May (which probation attended) it was noted that he planned to discuss his issues regarding his wanting to move on with the probation officer.

4.89 Ms R reviewed Mr H on 15 May, finding that he was a lot more positive and engaging. Although he still wanted to leave Beecholme, he accepted he cannot and seemed prepared to make a go of it. He had enrolled in a 'Learn Direct' literacy/numeracy course and had a UDS screening which was negative. He said he was considering whether or not to go to ACF. He made a point of saying, he does not like to be told what to do, he continues to visit his mother, sister and brother also friends and is keeping out of trouble. He has avoided going through Streatham and remains mentally well, compliant with medications and hostel boundaries.

4.90 The Beecholme manager, Mrs C provided a report for a MAPPA meeting on 17 May, noting that Mr H had been visited weekly by Ms R. He was described as adamant that he does not wish to stay at Beecholme. He believed that Beecholme has too many rules, boundaries and structure. His views continued to fluctuate, although he had a fully structured weekly programme. He was reported to takes his Islamic faith very seriously, prays regularly, and was fully compliant with rules and policies.

4.91 Ms R and Mrs C attended this MAPPA meeting on 17 May (where he remained subject to Level 2), and it was reported that he is engaging more with the hostel structure, but staff are still trying to seek a 'safe' mosque for him to attend. When he is at the hostel he was reported to be regularly talking

with someone on the telephone, but would not disclose who. One significant point raised by the probation officer was the fact that the relationship between Mr H and his younger brother needs to be monitored due to the negative effects he has/they have together.

4.92 Ms R reviewed Mr H on 22 May, and this was discussed the following day at the FOS MDT meeting. Beecholme staff feedback was positive, he was compliant with medication and the hostel regime. He was attending Learn Direct for six hours per week. He said he was not happy at being at Beecholme and does not like the curfew time, but he would comply. He had been seeing his family. Regarding [ACF], he said he is not ready to go, and he may think about this in the future. Otherwise, he was mentally well. The probation officer was not visiting him at the placement, nor were they feeding back to the placement following his appointment with them. An action was agreed for Ms R to contact the Probation officer to discuss this.

4.93 Ms R reviewed Mr H on 29 May, and this was discussed the following day at the FOS MDT meeting:

He looked well, staff had no concerns, he was compliant with hostel regime but he was not happy with the curfew at the placement, but accepts this. He was still attending college, and seeing his family members. He reads his Quran every day and if he does not understand anything he speaks to his sister's partner (Mr A), but said he would not necessarily do what he is advised in this regard, and he would challenge anything he was told that he did not agree with and also check with the Iman. He was again encouraged to attend ACF, he said he has not ruled this out and is taking on board what he is advised. He said he is seeing his probation officer and said they talk about similar things that Ms R discussed, i.e. his family and if he has been stopped by the police, which he has not.

4.94 Her own record included the following:

Please be aware that [Mr A] (sister's husband) and Mr H's brother are believed to have a negative impact on him … Liaise with Probation - 3 way discussions to be encouraged. Probation are not feeding back to FOS or Beecholme'.
It was agreed that this would be raised and copied to the senior probation officer.

4.95 On 4 June, Mr H's curfew was extended. On 7 June, Mr M (the new care co-ordinator) reviewed Mr H and reported that he did not appear to want to talk much and his mood was flat. He said he is yet to attend sessions at ACF: "I don't have the views I used to hold" and that "I can go when I want to". He said he does get to visit with his family who "live down the road".

4.96 Mr M reviewed Mr H again on 10 June, and he stated that he feels that things have been going alright … 'gets on well with other residents and he is satisfied and confident with the routines there plus the various activities that he is engaged in … weekly contact with probation officer; also attends Learn Direct … UDS done on 15 May 2013 gave negative results'.

4.97 At a FOS MDT meeting attended by Mr M (and not by Ms R) the same day, Mr M had checked the licence conditions regarding him engaging with ACF and there are no conditions regarding him engaging with ACF. Mr M has contacted ACF and it was reported they agreed to contact Mr H to ask if he will engage. [He] does say he does not have any radical ideas currently in regard to Islam. Mr M reported he can become angry in discussions.

4.98 At a FOS MDT meeting attended by Mr M (and not by Ms R) on 11 June. It was noted that the hostel progress feedback was good, Mr H seemed well and cheerful in his mood. It was noted that the curfew had been changed to 11pm, although it is not clear who authorised this change.

4.99 Mr M reviewed Mr H on 18 June and noted that Beecholme staff reported that he needs lots of prompting and motivation to attend Learn Direct sessions. He has also requested for an overnight leave. He is reported to have a calm quiet personality and doesn't mingle a lot with his peers. However that they do not have any current concerns. He informed Mr M that 'things are going good' and also that he is sleeping and eating okay and compliant with antipsychotic medication. He confirmed that he wants an overnight leave for 18 July 2013, saying quite abruptly that he intends to spend the time with his mother and or with sister. Mr M explained and confirmed the process for requesting leave although he insisted that he is informal and for that matter would not require any formal permission. However he apparently understood that there are conditions imposed by his Licence under probation. It was explained to him that it need to be discussed with his RC. He reported that he feels angry and unfairly treated in the sense that residents who had been in Beecholme for less time than he has have been granted overnight leave. He still had not made contact with [ACF], and was advised and encouraged to do so.

4.100 On 26 June Mr M saw Mr H and had no concerns, and he appeared appropriate in mood and behaviour. Mr M called Merton probation about his request for home leave and noted that Ms G was not available. Mr M agreed to send an email to explore Mr H's request, to clarify whether his sister's address is within or out of the exclusion zones as per his licence.

4.101 He emailed Ms G that afternoon, asking whether Mr H's sister's address was within the exclusion zone. On 27 June, she replied that she could not answer this question because she did not know his sister's address. This was discussed at the FOS MDT meeting that day.

4.102 It appears that on 1 July, Ms G emailed Ms R, Dr G, Beecholme, ACF and the senior probation officer Mr S to express 'concerns'. A Beecholme report states that Ms G had indicated some concern from her about a 'downturn' [sic] in his emotional well-being. He also expressed to her that he did not want to be at Beecholme and felt that he was being treated like a prisoner.

4.103 Her email stated: 'I met with Mr H today and I am concerned about the down-turn in his emotional wellbeing in addition to the lack of engagement with the mentor. He states he wants to leave Beecholme but recognises this is unlikely to happen in the near future. Grateful for input on case management.

States no further contact with Police … attended this morning looking down in the dumps. He tells me that he is feeling really depressed and this is in keeping with his affect and presentation … says that his feelings of depression relate to being at Beecholme, that it is worse than prison … telling me that sometimes the staff talk to him like he is stupid. He states if he is not allowed to leave he anticipates a 'downward spiral' in his emotional wellbeing … tells me that he does not know why he is there as he is better now … has been thinking other possibilities for being released … aware given recent conversation with Mr M … that CMHT will not support him being released from Beecholme at this time … Mr H aware that I do not control proceedings and that my main response to this meeting will be advising CHMT, Beecholme etc of current concerns and Mr H states he is happy for me to do as such'.

4.104 On 2 July, Mr S, Counter Terrorism lead for London, Manager Extremism and Hate Crime Unit, emailed Mrs C, Ms R, Ms G and others, stating that he was to meet Mr A on 3 July to discuss 'how we can try and engage Mr H again with ACF and get him moving forward again'.

4.105 On 3 July, Mr H reported that he had been told that his older sister had been attacked by four men and admitted to hospital. On that day, he left Beecholme before a planned appointment with Mr M. [The Trust investigation states this was on 4 July.]

4.106 On 5 July, at the FOS MDT meeting, Mr M reported that when Mr H returned to the hostel, he did not give to staff any details of the alleged assault of his sister. It was also noted that Mr M was leaving the team.

4.107 Just after noon on Mon 8 July, Ms G emailed Mr M and Dr S:

"I am worried about Mr H … He presents as very unhappy with Beecholme, and states considering breaching the terms of his Licence to get out. He tells me that he has had no contact with any agent from CMHT for a month. I would be keen to attend the next session with Mr M, if possible."

4.108 About an hour later, Dr S asked the team administrator to contact Ms G to explain that he was on leave and that Ms R had resumed working with Mr H, and ask either the team manager or Ms R to get in touch with her about her concerns (which the team share).

4.109 On the morning of 9 July the FOS, social worker tried to telephone a senior probation officer, and requested a call from Ms G to discuss concerns and clarify matters as there appeared to be some misunderstanding of the issues in this case.

4.110 In the MDT meeting it was noted that Ms R is of the view that these concerns that Ms G has raised are already known to the team, and are not new concerns, and felt Ms G would have a better understanding of issues if she liaised with the team on a regular basis, hence the request for a joint meeting with Ms G and the FOS team. The team manager suggested that these are regular meetings to keep continuity regarding his care in the community. It was noted that an official letter should be sent to Ms G of Probation Services

as there has been no response from emails sent to Ms G, and with a possible invite to CPA.

4.111 The minutes of the FOS MDT meeting for 11 July noted that a letter has been sent to [Ms G] in regard to Ms R not receiving a reply to request for a meeting between Ms R and Ms G, Ms R will see him next week on 16 July.

4.112 The FOS MDT meeting minutes of 17 July noted that Ms R had planned to see Mr H on 16 July, but when Ms R arrived at placement he was not present; Ms R telephoned him, he said is seeing his probation officer today at 12 pm and reported he has attended the Active Change Foundation, but Ms R had not received any feedback regarding this, Ms R will liaise with his Keyworker and Ms G … for feedback. Ms G has requested Ms R to see her today but Ms R will not be able to attend … and will contact Ms G to inform and arrange another meeting."

4.113 Also on 17 July, Mr H was seen by Ms G, Probation Officer, Merton, who then emailed Mrs C: 'I saw Mr H today in the absence of Ms G. Mr H stated that he is awaiting authorisation for overnight leave tomorrow (18 July) to spend his birthday with his sister in Roehampton, and he was frustrated that a decision had not yet been made. I said to him that I was unaware of this but would check with Beecholme and he gave me your mobile number. You should be aware that Mr H indicated that he would take the overnight leave without permission as he said he could see no reason why he should not be able to go to spend a night with his sister. I advised him that he should not take any overnight leave without the necessary authority and that he would be in breach of his licence conditions. I would be grateful if you could update Mr H with what decision has been reached regarding his overnight leave. As you suggested, I have copied this email to his social worker and consultant for information.

4.114 On 17 July, Ms G received a telephone call from Mrs C at Beecholme: Mr H was seen by Ms R, he was requesting overnight leave to stay with his sister and is anxious for this to be approved… apparently said that he will go regardless … He was assured that a discussion will take place re confirmation.

4.115 Ms R rang Mr H on the morning of 18 July and explained that everyone involved in his care have to obtain permission before his leave can be confirmed. He was asked to be patient. He said he made the request some time ago, and was told him that it will be discussed with Dr S and the team would get back to him. He agreed to this.

4.116 At the FOS MDT meeting that morning: Ms R again discussed the importance of probation liaising with the FOS team, which is important for sharing information. The Trust investigation noted that during the first half of 2013, there were concerns that liaison between the probation services and the hostel on one hand and with FOS on the other had been:

'sufficiently weak as to engender some concern. As a result of this, a number of email exchanges and a formal letter were written to attempt to improve the interface arrangements … this interface had improved by January 2014'.

4.117 CPA Meeting was held on 18 July 2013, attended by Ms R, Mr H, Dr S, and Mrs C (but no probation officer). [Mr H] said that he had been feeling depressed, and that this had begun a couple of weeks ago. He said that this predated his sister's assault on 3 July, but that that was a factor. He said it was just about being 'stuck' at Beecholme and in the mental health system … he said that [sister] was now OK.

4.118 Ms R reiterated his licence conditions and the fact that for the time being he had no alternative to residing at the hostel and she emphasised that the goal was for him to move on to more independent accommodation. Mrs C noted that he had expressed disquiet at having to live in a mental health hostel from when he first moved in. Mr H explained that when he felt depressed it was simply a feeling of 'not being as happy as I could be' and that his appetite, sleep, energy levels and activities were unaffected. Ms R explained that he could not simply be moved to another hostel outside the mental health system.

4.119 He continued to take his medication, which is administered by hostel staff, without problems. He has not experienced any unusual or distressing thoughts.

4.120 Mrs C said that she thought [Mr H] has been doing well [he] was good at keeping up his sessions with Learn Direct which at first he was escorted to. He disliked the escorts because he felt 'like he was in prison'; Mrs C therefore persuaded Learn Direct staff that they were no longer necessary. However, later he 'lapsed' and his Learn Direct co-ordinator contacted the hostel to check he was OK. After discussion with him, he started going more often again.

4.121 On Tuesdays, he has his appointment with his probation officer. On Wednesdays, he attends the Service Users' Meeting at the hostel, where he takes little part; he described himself as 'just a quiet person' … He spends his remaining free time visiting his family (mother, brother, sister, cousin, grandmother) and friends. He usually only stays with them for a couple of hours.

4.122 Ms R checked that he has not had any trouble with the police or the public when he has been out with friends; he said he had not. He has not had any contact with gang members and nobody has tried to influence him to do anything he should not … [He] said that he felt safe at the hostel and that he "got on alright" with the others.

4.123 Ms R confirmed that he is still monitored by Merton MAPPA but said that no specific concerns had been raised by MAPPA agencies …[Mr H] said that he sees his probation officer each week, but not on a consistent day. He said that his sessions with her were "going good" and that he kept all their

appointments … Ms R asked whether he would be happy for her and Mrs C to meet the probation officer, Miss G, with him, to improve liaison and consistency of approach; Mr H said that he would not object to this.

4.124 The Responsible Clinician[37] (RC) noted that strictly speaking a decision on what Mr H called 'overnight leave' had to be made by probation because he is on a licence and not any mental health order. However, the assistant probation officer had effectively asked the FOS to make the decision on their behalf. Ms R said that Mr H has been compliant and reasonable and that she and Dr S had no reason to reject this request. She and Mrs C said that as long as he continued his activities they would be happy to agree to individual nights spent elsewhere as long as he gave them advance notice and allowed them to check the details of where he would stay, with whom etc … in the light of his good progress [Ms R] will reduce her visits to fortnightly. The next CPA review was provisionally scheduled for 13 January.

4.125 On the same day, Mr H completed a document 'my personal recovery goals', stating that the goals he wanted to work towards were 'overnight leave' and 'come out of here. A Beecholme report prepared by Mrs C the same date noted: 'medication is currently administered under staff supervision … has been compliant'. …

4.126 At a FOS MDT meeting on 19 July, reference was made to the previous day's CPA meeting: 'no concerns, Ms R to arrange a meeting with Probation Officer regarding him being on licence'.

4.127 Ms R reviewed Mr H on 24 July. At the FOS MDT meeting on 25 July it was reported that overnight stay at his sister's went well. He said all was fine, though he remains unhappy about having to reside at a mental health hostel. He said he will continue to engage with the hostel regime and attend [ACF], he said he has attended there about three times. Mr H has requested further overnight leave to his sister's home, he has been advised that this will be discussed among the FOS team. It was planned that Ms R to call his sister for her feedback.

4.128 At the FOS MDT meeting on 26 July, it was noted that Ms R had emailed Ms G and had arranged to meet on 30 July at probation office, along with Mrs C. Also on that day, Ms R rang Mr H's sister J, who was requesting a medical support to support a benefits claim, since Mr H's Employment and Support Allowance[38] (ESA) had stopped on 8 July. She confirmed that the overnight visit went very well. Mr H visits regularly and enjoys being with his nieces, nephews and the rest of the family and she is happy to have him stay over anytime. Ms R said that Mr H has asked for more overnight visits and that the team were pleased with his current behaviour, attitude and progress therefore

[37] *The 'responsible clinician' means the responsible clinician within the meaning of Part 3 of the Mental Health Act 1983, who has clinical responsibility for the patient. https://www.legislation.gov.uk/ukpga/2007/12*

[38] *Employment and Support Allowance. https://www.gov.uk/employment-support-allowance*

were in agreement. It was also stated that his Probation Officer will need to be in agreement.

4.129 Ms R reviewed Mr H on 29 July, and found him mentally well and engaging in structure. At the FOS MDT meeting on 31 July, it was noted that when Ms R and Mrs C had travelled to the Probation Office the previous day, they were advised that Ms G was off sick, after which Ms G sent her an email, emphasising that it was important that Mr H sees the teams jointly making important decisions concerning his health and social care needs, and requesting a meeting to discuss this.

4.130 Ms R reviewed Mr H (as did another probation officer Ms S, of probation, in the absence of Ms G). He was noted to be mentally well and had discussed his request for leave with Ms S. He has been informed he needs to wait until Ms G returns to work before a decision is made and informed that he will have a new care coordinator as Ms R will be leaving the team. Zoning was reviewed and it was agreed currently this could be lowered to green [from amber]. Ms R has informed staff of another resident Mr A soon to be discharged to the community in Wandsworth, and the impact this may have on Mr H, and this will need to be monitored.

4.131 This (1 August) appears to be the last time Ms R formally reviewed Mr H in her role as care co-ordinator. Mr E took over as care co-ordinator, reportedly from 18 September.

4.132 On 2 August, Ms G emailed Mr S to advise him that Mr H had reported attending ACF several times recently, and that a meeting between Beecholme, ACF, probation and health would be useful when Ms G returned to work. On 5 August, Mr S emailed Mrs C and others to ask about meeting on week commencing 19 August.

4.133 On 9 August, Mr H attended the office to pick up a duplicate medical certificate, from Ms R as the original had been mislaid in the post, therefore he had been without any benefits for a number of weeks. This appears to be the last contact between Mr H and Ms R. On the same day, he was discussed at a MAPPA meeting, and it was recorded:

‘Noted as up and down emotionally by Mrs C, wants greater freedom than able to have. Not happy at Beecholme but he is not ready to leave. He wants his own flat but needs to do further work. Consideration has been given to another placement. He coped with a recent incident where his sister was attacked by four men. Continuing to liaise with [ACF] re place to worship and mentorship”.

4.134 Later that day, Ms G emailed Mrs C, asking her to confirm the Roehampton address of Mr H’s sister, and also emailed Ms R asking for information (name and address) about the man who reportedly had married that sister. We found it surprising that probation did not already have this information.

4.135 On 19 August the FOS team leader attended a meeting at Merton Probation office, and it was agreed that:

- Ms G to liaise with a named community care coordinator who is caretaking the case of [Mr A], so as to minimise the likelihood of both being granted overnight leave to the sister's address at the same time.

- Ms G to speak with Mr H in supervision on 22 August 2013. Let him know that regular overnight visits are being considered and hope to be able to provide confirmation such is acceptable every three weeks in the near future. The team leader will be liaising closely with Mrs C and obtaining feedback on conduct prior to each overnight visit with his sister, which will rely on good reports. This period of increased freedom will be used to test Mr H's capacity for more independent living. I will also seek Mr H's views on which area he wants to live in when moved, put forward Mitcham step-down property (Downe Road) as likely to be suitable.

- Mrs C to take Mr H to visit proposed step-down accommodation in Mitcham.

4.136 At the FOS MDT meeting on 21 August, it was noted that a Haswell ward social worker had emailed two FOS team members. There was an incident last Sunday [18 August] when a Haswell ward patient was out on unescorted leave. He met with Mr H and returned to the ward with a bottle of Lucozade which proved to contain alcohol, and it was suspected that Mr H had supplied it. This was further explored at Beecholme and Springfield and conflicting accounts were given by Mr H and other inpatients.

4.137 On 22 August, Ms G emailed Beecholme, Ms R, Mr S, the team leader and ACF following her meeting with Mr H that day:

- 'Weekend visits to Sister's house. I explained that I have run checks on the given property but that I am required to assess the property further prior to granting permission for him to stay there every few weeks. I did not disclose that the part of the assessment that remains incomplete is liaison with the care coordinator of Mr A so as to minimise the likelihood of them staying overnight together. Mr H tells me that he and Mr A are friends and that he is not a good or bad influence. He advises to have maintained contact with Mr A since release, stating that they speak on the phone sometimes and that they see each other in person but not often. He described Mr A as a perfect Muslim.

- Move-on plans. Mr H tells me that he wants to stay close to his family when he moves out of Beecholme. I explained that Mrs C has identified a step down property in Mitcham … Mr H said it sounds good'.

4.138 On 27 August, Mr H again failed to attend an appointment with a FOS CPN Ms T, apparently because he was attending Learn Direct. When contacted by telephone, he stated he was 'too busy' to see her. Mrs C told Ms T that Mr H had been suspicious about Ms T wanting to see him and feeling as though there may be plan to take him back to hospital. Mrs C said she had explained

to him that FOS work as a team and in Ms R's absence other members would cover for her.

4.139 This was discussed that the FOS MDT meeting on 28 August, and Ms T went to see Mr H later that morning. He did not think he needed a visit but was happy to engage. He has been in the hostel for a few months and has consistently stated that he does not like living there, because it is associated with the mental health system and he wishes he could be placed elsewhere. Mrs C had spoken with him about the possibility of a move to the step down it was noted that Mr H appeared to want to move away from the mental health system. Staff also confirmed that Mr H is reluctant to have structure to his day and week, and is pushing against the boundaries.

4.140 Ms T asked Mr H if he knew what had happened on his last visit to Springfield, he admitted that he had met two current inpatients from Halswell ward in the grounds. He described these as his friends and he was informed that both had been found to have used alcohol and have a juice bottle filled with alcohol as well as one of them having some cannabis.

4.141 Mr H denied that he had supplied the alcohol and/or drank any alcohol. Ms T asked why his friends had named him as the supplier he stated "maybe they were drunk and did not know what they were saying. Or maybe they were under pressure" … [He] stated he would continue to come and see them and visit the grounds … Mr H did not like the idea of perhaps meeting them elsewhere off site and stated he would continue to visit as "there is no evidence I did anything wrong. Anyway me not drinking alcohol is not one of my licence conditions so even if I did it, it would not matter".

4.142 Mr H continues to attend the Active Change Foundation and stated he enjoys going there and that he can use the mosque there for prayers, as part of his licence he cannot visit other mosques as none are deemed to be safe. When asked why this was he stated that his interpretation of Islam was not the generally accepted view, he could not give Ms T an example.

4.143 At the FOS MDT meeting on 30 August, attended by Dr S, the team leader, Ms T and others, it was suggested that Ms T ask the Forensic Security Officer to write to Mr H stating that he should not come on site unless he has an appointment.

4.144 On 4 September, Ms R uploaded an email from Mr A from ACF, in which he apologised to Mr S (probation) and Ms G (probation) for being unable to attend a meeting with them, and forwarded them a report about Mr H. On the same day, Mrs C emailed Ms G to state that she would emphasise to Mr H the need for 'compliance and engagement' and explain to him what is expected of him in order to progress to step-down.

4.145 On 12 September, Dr S emailed Mrs C saying he was not convinced that moving Mr H out of a supervised environment was the right thing to do currently, while also not objecting in principle to a visit to the step-down unit. Ms R confirmed that she had completed a handover with Mr E, noting that Mr H appeared to be pushing the boundaries and maybe consideration to viewing

the stepdown accommodation should be put on hold as a consequence. A UDS on this date was negative.

4.146 At the FOS MDT meeting on 13 September (attended by Ms R), it was noted that Mrs C had reported that Mr H was pushing boundaries and not returning at the correct time of hostel agreement. He was not carrying out all activities, and says he is not being influenced by anyone, and does not like to be told what to do. It was noted that this would be handed over to Mr E.

4.147 It seems that the visit to step-down was put on hold. Ms R emailed Mrs C to say that one of the issues to be discussed at a later CPA meeting was effective joint working between the FOS, Beecholme and probation. This appears to be the last FOS MDT meeting attended by Ms R.

4.148 Mr E visited Mr H on 18 September and noted he appeared calm and pleasant in his interactions and made good eye contact. He was thought to be doing well at present and is generally adhering to the Hostel rules on a daily basis. He was attending the service user meeting on a weekly basis with some encouragement from staff. He continued to attend Active Change once/twice weekly with positive reports, completed a maths course through Learn Direct on Monday and passed the course. Mr H would like to pursue a course in Bricklaying but is reluctant to commit to the demands of the course.

4.149 Two areas of concern were noted: he broke curfew on two occasions over a six week period by returning to the hostel late, and suspicion of bringing alcohol to a client on the ward.

4.150 This was noted at a FOS MDT meeting on 19 September. On 1 October, Mr H was not present when Mr E attended a planned appointment. He said he was in Roehampton and unable to attend the follow up appointment, and was dismissive of the importance of attending appointments.

4.151 This was noted at the FOS MDT meeting on 3 October. Mr E reviewed Mr H on 8 October there were no concerns, Mr H was meeting all house conditions and there had been no incidences of volatile or aggressive behaviour. He reports to be doing well at present and enjoyed spending weekend leave with his sister. The leave was agreed from Friday to Sunday and he returned within time limits. Mr H said he was spending his time with his sister and her two children and the remaining time with his friends. He denied using any illicit drugs recently and appears motivated with continuing his progress and living independently in the future. Mr H was said to be ‘fully concordant with prescribed medication’.

4.152 Mrs C confirmed the weekend leave was agreed with probation at the last MAPPA meeting. The leave can be used every three weeks with a view of increasing if all goes well.

4.153 This was noted at the FOS MDT meeting on 9 October. On 11 October, Mrs C emailed Mr E to say that Mr H had stated he was going to a mosque in Tooting, and it was not clear whether this had been approved via ACF (and Mr A told her he would investigate this).

4.154 Mr E visited Mr H on 24 October and reported that Mrs C highlighted an improvement in his mental state and general presentation. Mr H is socialising well with fellow clients and fully appropriate in his interactions. With Mr E he presented as calm and pleasant, was now attending a Mosque in Tooting three times weekly. He is preparing to attend his new course in construction on 4 November. He had not broken any house rules/curfews and returns … within time limits. He is hoping to be moved to the step-down house in the coming months but is aware that this may take some time. He is using his overnight leave to his sister's address appropriately and without any incidents reported. He is granted weekend leave every three weeks which may be increased by his probation officer soon.

4.155 Mr E visited Mr H on 5 November and he presented as calm and pleasant … continues to spend the majority of his time between visiting his family and staying at Beecholme. He attended an interview/assessment yesterday to attend a construction course in South Wimbledon. He was attending the Mosque three times weekly and reports to meet friends there regularly. He has not been to Active Change for two weeks but plans to attend this week or next week.

4.156 When discussed that the FOS MDT meeting on 6 November, Mr E reported that Mr H became guarded in his response when asked about friends at the mosque, and noted that it would be difficult to prevent him meeting Mr A when he visited his sister (and Mr H himself felt there was no reason for them not to meet). On 7 November, Mr H was reviewed by a Specialist Registrar R, Dr B. He noted 'good reports from the hostel and from Mr H regarding how things are progressing; happy with his engagement with the FOS; compliant with his medication and continues to meet with Mr E. He denied any voices/paranoia on questioning, and recognised the benefits of his medication in preventing this. He continues to engage with the spiritual charity and other activities in the hostel. Planning to start a construction course soon'.

4.157 Mr E reviewed Mr H on 19 November, and reported he feels he is 'doing alright at the moment' and was delighted to highlight that he passed the building construction assessment and is awaiting a place in college in the New Year. Mr H used his leave to his sister's address and spent his time socialising with his family. He has not attended [ACF] in several weeks and has no plans to attend this week. He was unable to give a strong reason for this change only to saying it was a long way to travel regularly. He reported reducing his visits to the Mosque to once daily. There was no evidence of psychotic feature present and his mood appeared euthymic.

4.158 On 20 November, at the MDT meeting, Mr E fed back that Mr H was bored and that he felt that hostel staff were not pushing and prompting Mr H.

4.159 On 2 December, Mrs C telephoned Mr E after speaking to Mr H, and reported that when Mr H was seen and asked about the activities that he should be doing, he was very polite but said that he was due to start at college on the 4 November and that it is their fault why he had not started because they wanted ID which he did not have at the time and was not told that he needed to present it. He agreed that he would be starting in the New Year 2014.

4.160 However shortly afterwards Mr H came to the office door and before being allowed in, he requested in a calm but direct manner, 'can I see the Doctor, I am feeling depressed?' He was asked why he is feeling the way he is and he replied that he did not know and quickly added, "I will not kill myself". He admitted to feeling this way for some time and that he had mentioned this to Mr E in the past.

4.161 On 3 December, Mr E told the FOS MDT meeting that Mr H and Mr A had met at his sister's house, but it was not known how often this had happened. He reviewed Mr H on 4 December, and he presented as flat in affect and at times difficult to engage, mostly with monosyllabic responses. He spent periods of time just sitting on the chair not engaging. He mentioned feeling despondent with his current situation at Beecholme and being under the care of mental health services. He would ideally like to move to independent living and have little or no contact with mental health services. He did accept the idea of moving to a step-down house in the future but is reluctant to accept some of the requirements associated with the move such as cooking for himself. He feels that cooking 'should not be a requirement' and therefore has no intention of learning these skills.

4.162 He appeared de-motivated … finding it difficult to identify any positivity in his life … He mentioned having some personal issues in his 'blood family' but was very guarded and stated that he did not want to discuss this particular issue. Some of the issues discussed were: reduced contact with his father, and Mr H fears for his safety. His grandmother in Jamaica is physically unwell at present and he is worried about her wellbeing. His grandmother in London is also recovering from a hip operation which is causing him some worry.

4.163 Mr H denied having any particular issues with Mr A. He is aware that Mr E was currently the care coordinator to both individuals and he agreed to inform him if any issues develop between him and Mr A in the future. There was no clear evidence of depressive symptoms, and it was felt to be more likely that he was experiencing elements of being despondent with his current situation.

4.164 On 5 December, Mr E confirmed at the FOS MDT meeting that Mr H appeared low, blunted and lacking motivation, and was seeing his sister fortnightly. He said he has some social issues, but would not discuss this with Mr E. He is aware of Mr A's recent difficulties but denies any conflict issues. He wants to move away from MH services so that he can get on with his life. Mr H's zoning was raised (from green) to amber.

4.165 On 12 December, Mr H was not present when Mr E visited, and said he was at his mother's. He was seen on 17 December, when he reported he had been granted two extended leaves at his mother's address over Christmas and New Year. He said he telephoned his father regularly and said he believed his father is likely to be involved in criminal activity in Jamaica which may put his welfare at risk. On 18 December, Mr E told the FOS MDT meeting that Mr H appeared better, and his zoning was lowered back to green. During December, a random UDS was negative.

4.166 When Mr E reviewed him on 7 January 2014, Mr H reported that he had established a relationship with an ex-girlfriend whom he spends time with during the week, but denied this to be a formal relationship. He remains concordant with prescribed medication would like to move to Step Down accommodation in the near future, and is awaiting contact with another organisation regarding the next available college place. He was not attending [ACF] regularly and last attended in November, but maintains phone contact with Mr A.

4.167 On 8 January, Mr E fed back more detail to the MDT meeting. Mr E asked Mr H how he would cope if he was confronted by gang members; he said he would defend himself by any means necessary. He said he does not carry weapons, but physically would need to defend himself as gang members who may confront him would probably have weapons … said he does not enter the exclusion zone, but stated that gang members may come to the area where he is; and he feels they would not approach him in regard to his 'street' reputation … feels content that others do not know about his mental illness and historical background.

4.168 A CPA review on 13 January 2014 was attended by Mr H, the RC, Mrs C and Ms G. Mr E summarised his feedback; 'Mr H presents as being stable in mental state, except for a brief period a few weeks ago when he described a short episode of low mood' … [Mr H] was noted to have said that it was not that he had experienced an improvement in mood, merely that he had presented himself differently (i.e. stopped expressing lowered mood).

4.169 Mr E said that in his view Mr H's main concern was to move out of the hostel into his own flat at the earliest opportunity. Mr H agreed with this. Mr E said that he had discussed medication with Mr H and that he believed Mr H would continue to take aripiprazole[39] 30 mg. Mrs C noted that [Mr H] said consistently that he did not want to be at Beecholme. Nevertheless, he engages well at the hostel and there have been no concerns about his behaviour … takes part in the community meeting and gets on well with other residents [and] does his chores when it is his turn to do them. He has complied with the terms of his 11 p.m. curfew and the other hostel rules.

4.170 Mrs C said that she had been considering recommending that he move to the more independent shared house linked to Beecholme, which is situated a few streets away [Downe Rd]. The outstanding issues … are his episodes of low mood and the fact that he is not yet self-medicating ...

4.171 Ms G was now seeing him only once every fortnight, as his risk assessment has declined from high to medium risk of further offending. He always turns up in time … She regards her sessions with him as productive. She thinks that he takes the licence and its conditions seriously and she would support him moving to step-down accommodation.

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[39] *Aripiprazole is an antipsychotic medication prescribed it to relieve the symptoms of schizophrenia. https://patient.info/medicine/aripiprazole-abilify*

4.172 Dr S regarded him as having remained mentally well since his discharge … was also pleased with his compliance with his licence and with hostel rules… Dr S asked about ACF and [Mr H] explained that he did not like admitting that he was 'in the mental health system', which he experiences as stigmatising and shameful …

4.173 Mr H said that he found it difficult to be in touch with many of his former friends, because he does not want to explain (or in his view, admit) that he has been in a mental hospital or that he is subject to mental health supervision … [He] said that despite what he might have said that could have implied otherwise, he very much wanted to move to the shared house, which he saw as a step towards leaving the mental health system …

4.174 Mrs C said that this would need to take into account him taking on responsibility for managing his own medication successfully, as well as cooking on a regular basis, and adopting some kind of regular activities … once these were in place, she would deem him ready to move to the step-down house. She suggested that it would be feasible for him to do this and move in March or April.

4.175 The Responsible Clinician (RC)[40] Dr S confirmed that Mr H had been reduced to MAPPA Level 1 and would therefore no longer be discussed at the multi-agency meetings. The next CPA review was provisionally scheduled for 14 July.

4.176 Mr H was not self-medicating and not cooking regularly, and was not involved in regular external activity such as ACF or voluntary work. Mrs C stated that changes in these three domains would in her view mean that he could move to the step-down house, perhaps in March or April. Self-medication was approved (i.e. via the hostel's protocol of graded introduction). The next CPA meeting was scheduled for 14 July (but seemingly later changed to 6 August).

4.177 On 22 January, the FOS MDT meeting discussed an email from Mrs C to Mr E:

> 'Mr H came up to my office at about 5:10 pm and asked to speak with you … he is having some bad thoughts … he met an old friend in Tooting some time ago (probably a week or so) and ever since, he has been having 'bad thoughts to do something with him' but he will not tell me what it is … these thoughts are continuous and he cannot seem to get it out of his mind … [I told him I suspected that] it is something involving robbery; to which he looked at me with his wry smile and immediately replied 'yes' … He said that when he met the friend (whom he had not seen in a while) … the friend went on to say … you could be doing much better and reminded him of the past stating that they could do something together and get a rush … Mr H realised what he meant at that point and told him that this is no longer part of his life. The friend then said to him 'you could be living the life and have the

[40] *The Responsible Clinician means in relation to a patient liable to be detained by virtue of an application for admission for assessment or an application for admission for treatment, or a community patient, the approved clinician with overall responsibility for the patient's case. https://www.legislation.gov.uk/ukpga/1983/20/section/34*

things you once had ....' … ever since this conversation, this thought has been on his mind to act upon it …in the past if he had this thought, he would act on it rather than speak to anyone'.

4.178 Mr E reviewed Mr H that afternoon and found him to be well dressed and made good eye contact … spoke at length about the recent proposition made to him by an old gang member and how this has played on his mind … spoke openly about the temptation to make a large amount of money quickly which he could then use to support his family. He did not disclose exactly the type of criminal actively planned and reported being afraid of jeopardising his future and 'going in reverse' and the likelihood of getting caught and ending up in prison. He is hopeful of progressing to a step down accommodation in April …. He agreed that Ms G (probation) be informed of the recent events.

4.179 When seen by Mr E on 5 February, Mr H reported enjoying his college course, and looking forward to overnight leaves with his mother. At the FOS MDT meeting on 6 February, it was noted that he had identified his mother as a carer. On 28 February, Mr H cancelled a meeting planned for that day as he was on 'home leave'. It seems he was next seen by Mr E on 27 March (i.e. a gap of nearly six weeks. The Trust investigation states this was 21 March, but progress notes clearly state 27 March.

4.180 Mr H was reported to be excited about moving to the step down house in Downe Rd in two weeks' time. He reported to have seen some of his old friends from the criminal world over the past few weeks … at times he can become tempted to revisit his old ways … has now finished his course (level 1) and is signed up for level 2 in September. He enjoyed the course and is looking forward to further enhancing his skills in construction … remains consistently well and without any overt psychotic symptoms'.

4.181 On 28 March, Mr E told the FOS MDT meeting that Mr H had told him that he would not feel safe in any part of West London, East London and also some parts of South London, but feels he would probably feel safer in South London. He said ideally he would like to move out of London for a fresh start and then seek paid work, maybe in the Kent area. Mr H said he now realises the extent of his anxieties in regard to his past involvement with street gangs. He said when he comes close to any exclusion zones he does panic a bit. He said he felt his street reputation has helped him at times when he has felt vulnerable.

Downe Rd: April - 15 August 2014

4.182 On 7 (or 9 or 11) April, Mr H moved to the Beecholme Step Down unit at Downe Rd in Mitcham, described as 'an independent living facility with minimal supervision and monitoring'. It appears there were two other male residents. After the move (hostel staff visited daily only) Mr H collected his prescriptions from a GP and his medication from a chemist. There were no mechanisms to corroborate self-reported medication adherence.

4.183 Mr H was visited on 17 April: by the time Mr E had seen the two other patients, Mr H had left the premises and had also apparently switched off his

mobile telephone. By this point, Mr H had been seen once between 5 February and 17 April (around ten weeks). By the time he did see him, it was once in twelve weeks. On 22 April, Mr E advised the MDT meeting that Mr H had also missed a planned meeting with Mrs C. When Mr E reviewed Mr H on 30 April, it was reported that he was settling in well into the step down accommodation and reports having a good relationship with the fellow house mate. He was not participating in structured activities and spent his time visiting friends and family. He denied getting involved in criminal activities and continues to avoid his old criminal gangs and planned to enrol in a construction course in September. He continued to visit the Mosque weekly but had not yet revisited ACF since last November.

4.184 On 1 May, the FOS MDT meeting noted that Mr H had confirmed that he had telephoned an in-patient. 'He claims that he was speaking to someone else on the ward. He then was encouraged to speak to the patient as a hoax for 'April Fool's Day' and say that he had taken some money from the patient. Mr E has spoken to Mr H about the inappropriateness of his behaviour and the risks he is posing to himself and the negative impact upon the other patient's mental and psychological wellbeing. Mr H was reluctant to accept Mr E's explanation regarding his behaviour and tried to argue and question Mr E's reasons. Mr E has stressed the importance of [safeguarding] issues and planned to liaise with probation with regard to Mr H's attitude to this.

4.185 It appears that also on 1 May, Mr H tried to contact Mr E because he had not received his DLA as expected, and he told staff he was stressed about this. When Mr E reviewed Mr H on 14 May, no problems were noted and he was felt to be progressing well. He was spending long periods at the family home, and was encouraged to seek employment. This was discussed at the FOS MDT meeting on 15 May. Dr S saw Mr H at Springfield on 16 May, to complete a benefits form, noting that the delayed payments meant he was acutely short of money.

4.186 On 27 May, Mr H cancelled an appointment with Mr E that day, and he then failed an appointment with him on 2 June, apparently due to a misunderstanding around dates. Mr H spoke to Mr E by telephone (about the benefits situation) on 6 June, and later saw him when he attended the Newton 2 building to collect a loan. On 11 June, Mr E saw Mr H at Downe Rd, who reported he was due to receive a sum of £1,900 in benefits. He was regularly attending the mosque in preparation for Ramadan (27 June - 28 July). He agreed to provide a UDS the following day (as he had emptied his bladder just before the visit). It is not clear from the records that this took place. The CPA date was changed to 21 July.

4.187 On 30 June, Mr H was visited (unannounced) by Mr E. He was 'dressed in religious clothing' and expressed feelings of wanting to be able to return to his exclusion zone, Wandsworth. He said he feels that he is safer in this area due to it being where he is from and having family in the area. He believes he was in greater danger where he currently is, due to opposing people in the area but confirmed that nobody has approached him to ask him to return to previous gang activity. He discussed Kent and Surrey being possible places to move to in the future.

4.188 Mr H expressed no worries or concerns and appeared mentally well. Eating well at night for Ramadan and sleeping well. Agreed to UDS next visit with Mr E.

4.189 On 1 July, at the FOS MDT meeting, mention was made of 'information' (also described as 'confidential summaries') found in a Tooting (or Mitcham) food takeaway shop in around mid-June. Mr H said he was carrying the documentation to present to [Ms G] who had requested previous reports. He had not disclosed to Mr E that the papers had gone missing … said he has not been approached by any gang members but had passed a message to gang members some months ago that he will not be involved in gangs again. He said he feels safer in the actual exclusion zone, as where he is currently residing is where some of his victims reside, and was advised to discuss this with [probation]. He appeared mentally well.

4.190 When Mr E reviewed him at Downe Rd on Wednesday 9 July, Mr H reported that a good friend was 'killed last week'. Although Mr H was vague when giving details about the incident, it would appear that the killing was gang related which may induce a revenge attack. Mr H denied having any plans to get involved in a revenge attack but he did highlight that he "would not stop things from happening", "what will be will be". Mr H was encouraged to inform his probation officer at his review next week.

4.191 Mr H did disclose that he drank alcohol with friends when the news broke about the death of his friend, and this was during Ramadan. He reported this to be an isolated case and has no plans to drink alcohol in the near future although he could not guarantee that he will not drink alcohol again.

4.192 Mr H engaged very well and appeared fairly open in his responses. He did appear to be vague about giving certain information relating to his friends and family. No evidence of any overt psychotic features or mood changes was noted. A UDS given when requested, with a negative result obtained.

4.193 On 10 July, Mr E told the FOS MDT meeting that he considered the incident had had 'an effect' on Mr H, and that after he got drunk (during Ramadan) he had felt 'vulnerable'. Mr E said he would contact the probation officer: 'view of team is that some information sharing is appropriate. The Trust investigation states he emailed the probation service.

4.194 On 18 July (Mr H's birthday), Mr H met with his step down supervisor Mr D, and reported that Mr H had hinted that he was very upset because a friend had just died. He said he suspected he was murdered in a gang related attack. He said he was thankful that he moved away from such a lifestyle. He also indicated that he will not attend the CPA for next week because he was upset and he needed time to settle down. During this conversation he became agitated.

4.195 An undated CPA report (post 18 July, and pre 6 August) prepared by Mr D states that he had 'continued to maintain his independence and has made a lot of progress since moving to step down. 'There have not been any incidents or complaints'. A daily programme stated that on Monday he did his

laundry at his mum's house and collected his medication from a chemist, and that on Wednesdays he saw his probation officer or care co-ordinator (each fortnightly - there is no indication he had missed any appointments). He attended a mosque on Friday afternoon. The report noted that he was self-medicating and that he looks healthy although detests cooking, and gets on well with everyone. He was fasting in Ramadan.

4.196 Neither Mr H nor his probation officer attended the CPA review planned for 21 July. Mr H had told staff that he could not bear to attend because of the way he still felt about the death of a former gang acquaintance a couple of weeks ago. He left the accommodation before the time of the CPA and could not be contacted.

4.197 Mr E was to arrange a new CPA date. Accompanied by Ms M, Social Care and Assessment Team, he reviewed Mr H on 29 July. Mr H was pleasant in his interactions, he feels he has settled in well and does not have any major concerns about staying at his current address. He explained that he did not need to cook because he had people around him such as his mother and female friends that wanted to cook for him. Mr H spends most of his time out with friends, with family or helping to look after some of the children in his family. Mr E asked Mr H about the construction course which he was due to re-start in September, which he now feels he may not continue. Mr H feels that he does not necessarily need to enjoy the job he is doing, as long as he is getting paid for it, therefore he does not feel motivated to continue.

4.198 Both Kent and Surrey are areas Mr H has considered, although was unsure when mentioning Croydon being part of Surrey as he feels the further he is, the safer he is. It was decided that this would be discussed in 6-12 months. Other than this, Mr H reported no worries or concerns and continues to remain mentally well.

4.199 This contact was noted at the FOS MDT meeting on 31 July. On Tuesday 12 August, it was noted that no new CPA date had yet been agreed. Mr H was last seen by Mr E that afternoon. It was reported that Mr H was not expecting to be seen but agreed to wait until he had finished seeing other clients. Mr H presented as appropriately dressed with intermittent eye contact throughout. He was subdued at times and not really showing any real interest in the review, and mentioned feeling that he did not want to engage with mental health services in the future as he cannot see the need for the constant monitoring. He described feeling mentally well for some time and spends little time worrying about his 'mental health'. He clearly stated that he will stop engaging with mental health services when he sees fit and will not have his life directed by mental health services. He is aware of his previous mental health breakdown and is also aware of the potential risks to himself and others when unwell but he believes that he is a stronger person now and does not need FOS to be monitoring his mental state regularly.

4.200 He said he did not attend his last CPA for the above reasons and is not wanting to reschedule a further CPA. After some discussion, Mr H did agree to work with Mr E on a fortnightly basis but has decided to have no further CPA meetings.

4.201 He engaged well in the review and there are no immediate concerns surrounding his mental state. Mr H spoke about how he would like to move forward and where he sees himself in the near future, at which point he became somewhat vague and mentioned wanting to own a big house and have lots of money in his bank account. When asked how he intends to obtains such large material things, he smiled and did not answer. There was no clear evidence of grandiose or delusional thinking but he may decide to reduce his level of engagement in mental health services.

4.202 Mr H also mentioned having had a difficult conversation with Mr D (Beecholme) regarding his behaviour in the house. Mr H would not give any details only stating that he (Mr D) was very disrespectful towards him which upset Mr H. He denied getting volatile or aggressive towards David and did not use any swear words but “I did put my point across".

4.203 Mr E recorded that he planned to discuss these issues with FOS and Mr H’s probation officer, aiming for a professionals meeting to formulate a plan, and to follow him up in three weeks.

4.204 The homicide occurred at 9 pm on Wednesday 13 August 2014, and involved a young man being fatally stabbed on a basketball court in Earlsfield, reportedly witnessed by several people.

4.205 The FOS MDT meeting minutes for the morning of Fri 15 August noted:

4.206 Mr H was seen on 12 August by Mr E. Mr H said he is annoyed that he is being monitored and staff and team are questioning his movements. He does not feel he is mentally unwell and said he does not need to be under mental health services. He said he attends probation as it is in place because it has to be. Mr E has discussed this and a professionals' meeting was to be arranged between Mr E, Mr H and Ms G (probation officer). He said he does not want a CPA and it is his decision. Mr E explained the process of CPA and he has been advised a Professionals' meeting will be organised.

4.207 It was felt the CPA structure should be recorded still and it should be noted that he does not want to attend. He had made it clear that his refusal to engage applied to all mental health teams not just Forensic. Mentally there were no changes in his presentation. The only concern of Mr E and keyworker Mr D of the step down accommodation is that he is starting to resist with engagement and how his behaviour can be volatile at times. Mr D has said to Mr E that he finds Mr H's behaviour difficult at times. The Professionals' meeting was planned to take place on 8 September 2014. Legal status - informal, mentally well and has capacity but it is a condition of his Licence that he engages with the FOS for follow up, and adhere to conditions of the Licence. The approach of probation was seen as paramount to the follow up and this was to be discussed at the Professionals meeting. A meeting venue was to be agreed.

Custody: 15 August 2014

4.208 Mr H had been arrested on suspicion of murder at 2.30 a.m. that day, and taken to Lewisham Police Station. A custody nurse found no evidence of symptoms of psychosis, mood disorder or other mental illness. An entry dated the afternoon of Friday 15 August states: “still being interviewed - this has lasted for several hours so far. He is showing no signs of mental ill-health during interview.”

4.209 The Trust review concluded that “from the evidence … Mr H was free of psychotic symptoms and stable in the period immediately before and after his arrest … The panel did not consider that the patient’s arrest was likely to have arisen from relapse of his psychotic illness…”

4.210 On the morning of 15 August, a police officer advised that Mr H had reported that he had not been taking his medication for two months. He was seen by Dr S who noted that Mr H had always stated that he was taking the aripiprazole on every occasion that Mr E asked him; and his mental state and behaviour gave no reason to believe there had been any change in his compliance.

4.211 Later that afternoon, Mr E confirmed with the GP surgery that Mr H had not collected his medication since May.

4.212 Mr H was received into HMP Wandsworth on 18 August. The FOS MDT meeting for that date states: ‘FOS informed on [15 Aug] that he has been arrested on a charge of murder (the suspected attack on Nicholas) He told a custody nurse that he had stopped his antipsychotic two months earlier; hostel staff and FOS believed that he had been taking it based on interviews and hostel reports, but on checking with the GP on Friday he had not collected prescriptions after May. Mr H was later charged with murder and remanded to prison.

4.213 During October 2014 Mr H was admitted to a secure hospital under the provisions of Sections 48 and 49 MHA.

4.214 Mr H was found guilty of murder in October 2015 and sentenced to life imprisonment, to serve at least 28 years.

5 Internal investigation and action plan

5.1 The Trust commissioned a Grade 2 Level 2 Comprehensive RCA report as expected under the NHS England Serious Incident Framework (2013) which was in place at the time. This was commenced in August 2014, after the Trust received the information about an alleged homicide committed by a patient under the care of the Forensic community service.

5.2 The internal investigation team comprised:

- External Consultant Forensic psychiatrist (chair and lead author);
- Serious Incident Lead and Named Nurse Safeguarding Children;
- Trust Patient Experience Lead (Wandsworth);
- Safeguarding Adults Lead; and
- Quality Governance Administrator (administration support).

5.3 The terms of reference require us to:

- 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.

5.4 The internal report is a well-constructed and detailed report, which evidences the use of root cause analysis techniques. It contains an identification of care and service delivery problems, and made six recommendations to address these, which was accepted by the Trust. We have reviewed this report first, and we will provide our own further analysis of issues which we feel the internal report has not identified in Section 6 of this report, using the structure of the terms of reference for the independent investigation.

5.5 The report was approved by the Medical Director on 8 December 2014, just without the expected 60 day time frame, and was subsequently accepted by the Trust Board. The Trust Board papers in March 2015 note that the Trust was in the top percentile nationally, achieving 100% for timely completion of serious incident reports submitted to the CCG on time.

5.6 Feedback from NHS Merton/Wandsworth CCG was that the CCG and NHS England and NHSE received the Trust's internal report in January 2015. The action plan was noted to be progressing well by June 2015. No detail was provided on how the CCG was maintaining oversight of the action plan.

5.7 The Trust commissioned the investigation immediately, and it was completed on 9 February 2015, which was within the expected time frame of 60 days. It was given executive approval by the Trust Medical Director on 3 March 2015. The internal investigating team reviewed the care and treatment of the patient

in detail from April 2013, when he became a community patient, to the incident date on 15 August 2014. The investigation also reviewed the Trust care and treatment for the previous year when Mr H was an in-patient.

5.8 A case note and electronic record review was described, and the use of a tabular time line, NPSA contributory factors framework and 'fishbone' diagram. These were not included in the final report, however care and service delivery problems are described, although it is stated that there were no contributory factors.

5.9 Patient factors are described as 'the limited information available to the panel means that it is not possible to know what factors in the patient; patient gave rise to his alleged actions. The panel did not find that there was evidence of deterioration in the patient's mental state at the material time. His background history, including his behavioural and offending profile and associations and links with others were noted as possible contributory factors'.

5.10 The terms of reference for the internal investigation were detailed as below:

Purpose

- The panel was established to conduct a Root Cause Analysis (RCA) investigation into a homicide incident that occurred in August 2014 allegedly involving [Mr H]. By conducting a critical analysis of the patient's care and treatment in the three months prior to the incident the panel aims to establish the facts and to identify the root causes and key learning from this incident.

- To establish any care and service delivery problems, contributory factors and possible root cause of the incident.

- To make recommendations based on the findings to either eliminate or to reduce the opportunity for recurrence of further harm to patients or others and to identify learning.

Objectives

- To establish the facts: what happened, to whom, when, where, how and why

- To establish a clear chronology of the contact the patient had with South West London and St George's Mental Health NHS Trust

To examine:

- The care provided by the staff of the Forensic Community Team/Forensic Outreach Service with detailed analysis of the care and treatment received in the three months prior to the incident. The patient's early history and background and in-patient stay will also be reviewed to provide context.

- The contributory factors for any serious care lapse or service weakness, and where possible the root causes to each significant concern identified.

And:

- To establish a clear chronology of events leading up to the incident through the review of patient records and statements from relevant staff.
- To establish whether failings occurred in care or treatment.
- To look for improvements rather than to apportion blame.
- To provide a report and record of the investigation process & outcome.
- To formulate recommendations to support the team in developing an action plan.
- To provide a means of sharing learning from the incident.

Key questions/issues to be addressed:

- Care and Treatment – management plan of the patient from when inpatient up to the time of his arrest.
- Information sharing and liaison with other agencies including the probation service.
- Background information; history of patient, physical health, care planning.
- Risk Management.
- Policies and Procedures.

Key Deliverables

- Investigation Report.
- Recommendations and Action Plan.
- Report to Trust Board.
- Shared learning with the family.

5.11 A detailed chronology was prepared and is included in the report.

5.12 Staff interviews were conducted with the FOS Team Manager, FOS Consultant Forensic Psychiatrist, FOS former Team Manager, FOS ST6 doctor (now Consultant Forensic Psychiatrist), FOS care coordinator September 2013 until August 2014), Shaftesbury Clinic Consultant Forensic Psychiatrist, Shaftesbury Clinic social worker (Halswell Ward), Consultant Clinical Psychologist, Step Down coordinator, Beecholme Former Manager.

5.13 Four care and service delivery problems were identified, although which of these are care delivery and which are service delivery problems is not identified. Three ‘lessons learned’ were identified and six recommendations were made.

5.14 The four care and service delivery problems identified were:

- Following Mr H's move to the step-down accommodation, there were no mechanisms in place to corroborate his own account of medication adherence. The team were unaware that the patient was misrepresenting his compliance.

- Liaison between the FOS and Beecholme, and the probation service was not operating well during the months immediately after [Mr H] was discharged from hospital, and there remained some difficulties, at times, in maintaining consistent liaison thereafter.

- The lack of clarity in relation to 'lead agency' status hampered decision making regarding Mr H's arrangements at certain times, for example when requesting to stay with his family.

- The absence of a team psychologist and a team OT on the FOS meant that it was not possible to attempt to provide more specialised support to the patient in respect of his lack of structured activity, nor to build on the psychological work undertaken as an in-patient, nor was it possible to have the benefit of these specialist views at team discussions.

5.15 Three 'lessons learned' were identified, from which six recommendations were made.

- Individuals under the care of out-patient services who are prescribed oral medication may give misleading accounts of their adherence to treatment. Options to allow for some corroboration of adherence would be of benefit in monitoring such patients.

- Multi-agency liaison needs to be supported through agreed protocols and firm arrangements for regular and ad-hoc contact that should match the requirements of any patient's/client's care and management plans.

- Staff involved in the care and management of service users would benefit from training to ensure they have the skills and support to recognise vulnerabilities and susceptibilities that may lead to exploitation of service users by people who are able to influence and manipulate them to commit crimes through the promotion of extreme ideologies. If concerned that a vulnerable individual is being exploited in this way, they can raise these concerns in accordance with the Trust's policies and procedures.

Evidence of progress on internal action plan

5.16 There were six internal recommendations in the body of the report, but only four in the executive summary and action plan.

5.17 Of the original six recommendations, three individual recommendations were made about vulnerability to influence, these were:

- access to raising the awareness and understanding of PREVENT,

- to consider what measures may be available to them to assist the clinical services when dealing with patients who may be at risk of gang related influence or direct risk from gang members, and

- to consider strengthening its links with supportive Faith organisations.

5.18 These three recommendations were all absorbed into Recommendation 4, which is to 'improve the knowledge and awareness of Trust staff with regard to gang related risk and incidents, PREVENT and the risk of radicalisation'.

5.19 The Trust action plan addresses four recommendations, which have not been given any priority order. An update on the progress of actions was provided by the Trust in June 2017.

5.20 Recommendation 1

The Trust to review with partner agencies the follow up arrangements for patients subject to probation.

Action 1
The Forensic Service to organise a joint multi agency meeting to review and discuss by March 2015.

Trust Action 1 update - partially completed

- Attempts to meet with probation date back to June 2015. Meeting booked with probation on the 9 July 2016 to be chaired by a Springfield unit consultant forensic psychiatrist, this meeting wasn't attended. Attempts made to contact since July 2016 to no avail. The Head of Croydon, Merton, Sutton & The Foreign National probation service attended a meeting with consultant forensic psychiatrist on 22 March 2017 the following actions were agreed:

- Probation to obtain the independently conducted serious case review report commissioned by the probation service and share this with Springfield. Probation has confirmed that this doesn't address partnership working.

- Probation to check the MAPPA minutes to clarify decision making in the case of [Mr H] about the lead agency role, the role of health and whether a representative from health (FOS) attended the meetings.

- Probation to look into issues internally with regard to the hand over between probation staff in Merton.

- In due course, probation to advise on the outcome of a probation review of discharges from hospital across London of patients known to the probation service.

- Probation to share the Merton Local Authority review into MAPPA arrangements when this work is completed. The Trust has been advised that probation have requested authority to share.

5.21 It is clear that the Trust has attempted to engage with the probation service to draw out learning from Mr H's experience of the pathways of health and probation.

5.22 It is not possible to conclude that this action is completed, despite the efforts of the Trust. We also requested access to the probation 'serious further offence' report that we were informed has been completed, and have not received it. This is a significant absence, and our findings are consequently limited to what was known by mental health services.

5.23 MAPPA guidelines[41] have been updated and now include a definition of 'lead agency' as:

> 'Lead agency is the agency with the statutory authority and responsibility to manage a MAPPA offender. This management will involve appropriate information-sharing in order to properly identify risk. The lead agency will have primary responsibility for referring the offender to level 2 or level 3 MAPPA management or for continuing management at level 1'.

5.24 It is clear in this updated guidance that if an offender is released on licence the lead agency must be identified pre-release and a plan shared at MAPPA review meeting. 'When an offender is released on licence or discharged from hospital, the Responsible Authority will be identified by the agency managing the case'. Discussions with the Head of Croydon, Merton, Sutton & The Foreign National Unit (Probation) as part of this investigation confirmed the Probation were the lead agency in this case, and should have been visiting weekly.

5.25 NHS Trusts are listed as agencies with a 'duty to co-operate' with MAPPA arrangements. Section 325(5) of the Criminal Justice Act 2003[42] requires the Responsible Authority and each 'duty to co-operate' agency to draw up a memorandum setting out how they are to co-operate. All agencies involved with managing an offender must contribute to the risk assessment process by sharing information. This includes both responsible authorities and duty to co-operate agencies.

[41] *MAPPA Guidance 2012 updated November 2017. https://mappa.justice.gov.uk/connect.ti/MAPPA/view?objectId=5682416*

[42] *Criminal Justice 2003,Act 325 Arrangements for assessing etc risks posed by certain offenders. https://www.legislation.gov.uk/ukpga/2003/44/section/325*

Recommendation 1

The Trust should ensure that where there is a probation licence condition of contact with mental health services, a joint agency care plan with clear communication lines and escalation protocols should be in place and agreed by all parties.

Measures to ensure that agreed interagency care plans are adhered to should be implemented, with routes of escalation if there are concerns.

5.26 Recommendation 2

The Forensic Service to develop the multi-disciplinary makeup of the Forensic Outreach Service.

Trust Action 2

The Forensic Service to benchmark and review against similar Forensic Community Services.

Trust Action 2 update - completed

Consideration has been given to developing the multi-disciplinary makeup of the service but given current constraints with staffing the team are of the view this would impact on caseload sizes and risk so have requested care co-ordinators remains either social work or nursing. With recent changes to the team this is under consideration at this time. Currently OT advice can be sought from the in-patient OT team.

5.27 We consider that this action has been completed.

5.28 Recommendation 3

The Forensic Outreach Service to introduce clear protocols for monitoring collection of and compliance with prescribed medication.

Trust Action 3
The Forensic Service to review current processes and develop exemplar practices.

Trust Action 3 update - completed

A revised medication protocol was agreed in June 2015 with the team and ratified with the community modern matron. This was incorporated into Medicines Code policy dated September 2016, as Appendix 30, 'Guidance on supporting community clients who are prescribed oral medicines'.

5.29 The new guidance applies to all Forensic and other 'high risk' clients whose medication is prescribed by their GP and collected from community pharmacies. It is expected that care plans must incorporate this element. The

guideline requires staff to see the patients' medicine supply, check the dispensing date, count the number of tablets and calculate if the patient has been taking the medication since last dispensed. If any of the following issues arise: the supply was not dispensed recently, the patient refuses to show medications, or the patient shows medication that is out of date or no longer required; then the care coordinator is expected to discuss this with the MDT, modify the patients' zoning, and modify crisis and care plans accordingly.

5.30 A meeting to plan an oral medication audit for FOS patients was held in December 2016. A spreadsheet was compiled of all FOS patients taking oral medication, which was to be reviewed every month at the FOS business meeting. An agreed format for the care plan was developed by the FOS team and it was agreed that an 'oral medication audit would be carried out in three months' time. This would have been in March 2017. We have not seen any audit results, and suggest that the Trust should report audit results back to the Monthly Learning Group to provide assurance that this new guidance has been implemented and is effective.

5.31 In our view this action misses an opportunity to share learning with partner agencies and services. There is also the expectation that medication may be administered by other services, such as Beecholme in this case. We learned from Beecholme management that the structures for supervision of medication have been changed both at Beecholme and Downe Road, and staff would now ensure that spot checks and discussions about medication compliance are routine.

Recommendation 2

The Trust must provide assurance that the 'guidance on supporting community clients on oral medication' in the community is implemented and is being effective.

Recommendation 3

The Trust must provide assurance that the 'guidance on supporting community clients on oral medication' in the community is shared with partner agencies and services, and that relevant collaborative care plans are in place.

5.32 Recommendation 4

Improve the knowledge and awareness of Trust staff with regard to gang related risk and incidents, PREVENT and the risk of radicalisation.

Action 4
To be included in Trust risk and safeguarding training.

A Trust wide learning event focused on gang related risk, radicalisation and PREVENT.

Trust Action 4 update

Available PREVENT workshops were delivered across the forensic service in May, June, July and August 2015. Workshops to Raise Awareness of Prevent (WRAP) have taken place over the last two years and the Trust has four trainers identified, this training has since been delivered to the Senior Leadership Group. Training needs analysis currently under review across the Trust.

Basic Prevent Training is included in Trust Induction for all staff. There is a Trust Prevent Information Leaflet on Weekly Bulletin to all staff and available on 'InSite' Channel Awareness training is on e-learning on Compass accessible to all staff. Compliance is monitored through Executive Safeguarding Meeting and through quarterly returns to CCG and NHSE. Currently the CFOT (FOS) have all completed the face to face or COMPASS PREVENT training.

5.33 We have been provided with training compliancy figures for November 2017 on the 'Workshop to Raise Awareness of Prevent (WRAP)' at 19.2% and 'Basic Prevent Awareness Training (BPAT)' at 50.4%.

5.34 We have also seen the PREVENT Workforce Development Plan for 2107/2018 which notes that SWLStG NHS Trust has duties outlined in Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) to have "due regard to the need to prevent people from being drawn into terrorism".

5.35 This workforce development plan has strategies in place to increase the training compliance figures through 2017 and 2018 to 95% for Basic Prevent Awareness Training, and 85% for the 'Workshop to Raise Awareness of Prevent'.

5.36 There has been a campaign to raise awareness of the issues involved and of this training across the Trust, which has been endorsed by the Chief Executive Officer.

5.37 In our view this action is complete, albeit with action ongoing. We consider that the Trust has incorporated the requirement for Prevent awareness into its 'business as usual' and made the training mandatory.

5.38 However we consider that the Trust has not addressed the issues around how the service may need to respond if a patient is under the influence of gangs or at risk from gang members, or to the action to 'consider strengthening its links with supportive Faith organisations'.

Recommendation 4

The Trust should build awareness of risks and gang culture in the catchment area, and develop appropriate links with Police to ensure that they are connected to local established networks for raising awareness, information sharing and action about those at risk from or engaged in gang activity.

Recommendation 5

The Trust must develop appropriate communications and working relationships with local supportive faith organisations through the Department of Spiritual and Pastoral Care.

Internal action plan analysis and discussion

5.39 The Trust has clearly completed some of the actions identified in the action plan, and has provided some evidence of completion of others. We concur with the recommendations highlighted above, but in our view some of the actions identified focus on transaction rather than transformation. The action plan that has been implemented appears in some areas to be focussed on actions rather than implementation of systems to embed change.

5.40 We consider that the internal investigation largely met the terms of reference, but this is somewhat difficult to determine given the inclusive and descriptive nature of the expectations, describing 'purpose, scope, outcomes, key questions to be addressed, and deliverables'.

5.41 One exception to this is the expectation that 'to examine the contributory factors for any serious care lapse or service weakness, and where possible the root causes to each significant concern identified'.

5.42 There is a lack of detailed examination and breakdown of each care and/or service delivery factors and no attempt to consider which contributory factors may be relevant. The 'contributory factors' analysis in the internal investigation report concludes that none of the care and service delivery problems 'contributed to or would have predicted or prevented the incident, which from the limited information available to the panel, appears to have arisen through factors that were not amenable to intervention on the part of the FOS'.

5.43 There is a statement that the 'root causes of the incident that led to the patient's arrest are not known to the panel, beyond the fact that he was arrested and charged with a fatal attack'.

5.44 This was discussed with the internal panel as part of this independent investigation, and it was clarified that a causal link between his mental state and the alleged (at the time) offence could not be established, therefore this

was thought to be a logical hypothesis. However, the NPSA guidance[43] identifies the root cause as the:

- 'earliest point at which action could have been taken to:
- strengthen the support system for appropriate care to be delivered,
- avert the cause of the incident or prevent its occurrence, and
- significantly reduce its impact or recurrence'.

5.45 We question the lack of exploration of root cause, which in our opinion should have been considered with reference to the care and service delivery problems identified. In comment on the draft report, the Trust clarified that in the internal investigation the identified care and service delivery problems were not considered to be contributory factors, and therefore could not be identified as root causes.

5.46 Patient factors are described in the report as:

> 'The limited information available to the panel means that it is not possible to know what factors in the patient; patient gave rise to his alleged actions. The panel did not find that there was evidence of deterioration in the patient's mental state at the material time. His background history, including his behavioural and offending profile and associations and links with others were noted as possible contributory factors'.

5.47 Again the patient factors that are relevant here should have been explored, such as his attitude to mental health services and offending, and his reluctance to engage and accept medication and other treatment.

5.48 Three of the four recommendations are presented in language which requires the Trust to 'consider', 'review' or 'improve' without an action oriented or outcome focussed objective. The actions all had a target date and allocated responsible individual, and identified individual for senior 'sign off' when completed. Three of the associated actions require the Trust to 'review', and the evidence of progress and completion are given as meeting minutes, rather than any definite outcome. We recommend that the Trust should focus its SI recommendations on measurable outcomes.

Recommendation 6

The Trust should ensure that serious incident action plans are outcome focussed and have measurable aims.

5.49 The Trust developed a Monthly Learning Group in 2015, which replaced the Serious Incident Governance Group. This group reviews and acts on a range of risk issues including complaints, serious incidents. Data, themed reports

[43] *NPSA 'Root Cause Analysis (RCA) toolkit'*

and related audits are all reviewed and discussed. Part of the function of this group is to monitor and maintain a 'Trust wide Learning Themes and Action Plan arising from Serious Incidents, SCR's, IMR's & Complaints'. The action plan resulting from the homicide by Mr H was reviewed and monitored in this forum.

5.50 An 'Integrated Learning Group' was developed, chaired by the Director of Nursing, which focusses on ensuring that learning from serious incidents is embedded in Trust practices. A monthly 'Learning Bulletin' is distributed by the Clinical Governance Department. There is also a weekly 'Quality Review Group' which is authorised by the Integrated Governance Group to investigate any activity within this Terms of Reference and to seek all information required and request the attendance of individuals and authorities with relevant experience and expertise if it considers this necessary.

5.51 Within the Forensic service there is a Directorate Governance group and local 'cluster' governance groups where issues and lessons learned are cascaded.

5.52 The Trust has also introduced a model of 'Oxford Learning Events' which is a Trust wide learning event, usually on a theme, and an example was given of a recent event focussing on learning from absent without leave incidents.

5.53 There is a Trust wide 'virtual risk service' that is led by the Trust lead for serious incidents. A virtual risk meeting can be requested by a clinical a team that has concerns about risk with a particular patient or patient group, and was used frequently in 2015, with up to 110 requests in the year. A proposal to extend the service and audit its success was proposed in October 2016. We have not been provided with any audits related to this service.

Family contact

5.54 The NHS England Serious Incident Framework in place in 2013[44] required that when a serious incident occurred and was to be investigated:

> 'The designated director, as defined by local policy, plus other relevant members of the senior management team, should be advised as soon as a serious incident has occurred or is discovered. In line with the principles set out in 'Being Open', the patient and their family or carers must be informed that a serious incident has occurred and appraised of any actions being taken to address the situation. This should include details of the process being undertaken to investigate the incident and ensure learning is captured to prevent recurrence. A named contact from the provider should be identified and details provided to the family'.

5.55 This predates the expectations of the Duty of Candour requirements in place since November 2014, where every Trust has a statutory responsibility in relation to 'Duty of Candour', that makes explicit the requirement to inform

[44] *Serious Incident Framework March 2013. NHS Commissioning Board.*

service users and carers where as a result of a patient safety incident the patient has sustained moderate level harm or above.

5.56 The decision made at the time was not to contact Mr H or his family directly, because the police and court processes were ongoing. The investigation was completed some considerable time before the case came to trial, and it was thought that there should not be an approach which could be seen to prejudge the outcome at court. There was no contact made with Mr H or his family throughout the investigation process. Mr H's mother was sent a copy of the internal report, but has had no discussions with the Trust about it.

5.57 Contact with the Trust was instigated by Nicholas' mother, with the support of the Hundred Families Charity. A meeting was arranged with the family and the report authors to go through the report and provide an opportunity to ask questions. The Trust also attended a community event arranged in memory of Nicholas that focussed on trying to promote a crime free local community.

5.58 It was accepted by the Trust that the NHS England guidance about family contact contained in the March 2105 Framework[45] is much more comprehensive, and they have changed their processes since then to make earlier contact, and identify a Trust liaison person to work alongside the police family liaison structures.

[45] *Serious Incident Framework March 2015. NHS England*

6 Arising issues, comment and analysis

6.1 This section is structured using the headings of the Terms of Reference.

Review and assess compliance with local policies, national guidance and relevant statutory obligations

Care planning

6.2 Mr H was treated under the Care Programme Approach (CPA). We have referenced the Trust CPA Policy from April 2016. This policy was reviewed in 2014 to include work on the Trust Recovery strategy and comprehensive care planning guide, plus updated CPA status. The policy states that 'CPA applies to all service users' who are accepted for Trust secondary mental health services if they have complex needs. Characteristics to consider when deciding if support of CPA is needed are: need input from several agencies and are considered to have a high level of risk. Mr H clearly met these inclusion criteria and had a CPA care plan in place.

6.3 Mr H had a care plan in place which was written in March 2014. His overarching aim was to stay out of hospital, and it is noted that he was happy to be out of hospital, was accepting of the diagnosis of paranoid schizophrenia, but did not like being in a 'mental health hostel'. The care plan is structured under the headings of 'Challenges and Needs' with categories of safety & risk management, physical health, and occupational / social / environmental. In the area for his views, it is noted that 'I am visited fortnightly by [Mr E] CPN/care-coordinator, FOS team visit. I also visit my Probation Officer, [Ms G] fortnightly. I intend to restart attending Active Change in the coming weeks'.

6.4 His goals for safety and risk management were: to maintain healthy mental state, and his plans were to take prescribed medication, seek help when feeling unwell and stay away from cannabis. His own views were: 'since my discharged to Beecholme hostel, I have been able to see my family and friends and this is important to me. I am keeping out of trouble. I see my Probation Officer every 2 weeks. I stick to the conditions but would prefer to live elsewhere'.

6.5 His goals for 'occupational / social / environmental' were to get a job in the future and have my own place. The interventions were to attend a construction skills course two days per week and feedback any issues to his mental health team; to attend ACF every Friday and use the time there appropriately, use his relapse prevention plan to help him to stay away from using drugs. After completing the construction course he hoped to apply for paid employment in bricklaying, carpentry or painting/decorating.

6.6 Mr H's views on 'physical health' were: 'I am compliant with medication which I'm given by staff daily. I'm on aripiprazole 30 mg daily. I will be starting to self-administer medication in coming weeks in preparation for a step down accommodation'.

6.7 These plans were reviewed through visits by the care coordinator, and regularly at formal CPA meetings, which meets the expected underpinning philosophy of the policy 'care planning is the daily work of mental health services and supporting partner agencies and not just the planned occasions where people meet for reviews'.

6.8 Between April 2012 and August 2014 there were CPA meetings held on: 9 July 2012, 28 August 2012, 15 October 2012, 28 January 2013, 11 March 2013, 18 Jul 2013, 13 Jan 2014 and 21 July 2014. These intervals meet the requirements expected by the policy.

6.9 Mr H did not attend the CPA meeting on 21 July, and was not contactable when staff tried to phone him. He had voiced his intention to disengage with mental health services before the meeting, and made it clear that his refusal to engage applied to all mental health teams not just Forensic. Mentally there were noted to be no changes in his presentation. The only concern of Mr E and the keyworker of the step down accommodation is that he was starting to resist with engagement and how his behaviour can be volatile at times. Because of these concerns, a professionals meeting was planned for 8 September to discuss his care. It was intended the care coordinator Mr E, Dr S and the probation officer Ms G would attend.

6.10 The CPA policy states that:

> 'refusal to engage with services should be discussed urgently in the relevant clinical meeting. It may be appropriate to contact the Consultant Psychiatrist and Team Manager before the next scheduled clinical meeting. The care co-ordinator, in-conjunction with the team, must make an assessment in relation to risk posed by the service user not engaging with services and make plans accordingly. Once assessment of risk has been completed, it may be deemed appropriate to assess the service user under the Mental Health Act 1983 with a view to compulsory admission to hospital'.

6.11 Mr E saw Mr H on 29 July with a FOS social worker to review the situation with him. At this meeting Mr H sad he was spending most of his time with family and friends. He said he may not continue with the college course, he didn't see the need to learn to cook because his family provided meals for him. He also discussed possible areas he may live in the future, including Kent or Surrey. This contact was discussed at the FOS MDT meeting on 31 July, but his zoning status was not discussed and remained at 'green'.

6.12 The FOS operational policy (February 2012) stated that 'every patient will be allocated to one of four 'zones' indicating their current level of need and risk, as follows:

- Red zone – for patients who are at risk or in crisis and whose care requires daily review. This includes those who are verging on or experiencing relapse; those who have stopped medication or contact with the service; and those who have extensive unmet need.

- Amber zone – for patients who are mentally unwell but who do not present major risk factors. Typically these clients will exhibit more positive global functioning than those in the red zone, and attend appointments independently, but remain in need of a comprehensive plan of care requiring significantly more staff input than patients in the green zone.

- Green zone – for patients who are stable and receiving maintenance care. Patients who have been in the green zone consistently for a long period of time might be in the process of being transferred to another team.

- Black zone – for patients whose day to day care is provided entirely by another team (such as at a hospital hostel in the community with its own RC and social workers), where the community forensic team's responsibility is limited to attending CPA meetings and co-ordinating funding and readmission if necessary.

6.13 It was further stated that 'the team will have a half-hour zoning meeting at 9.30 am every week day'. This requirement is also in the updated FOS operational policy (2016). We have seen the FOS brief for the zoning meetings which is a structured approach to discussing patients in each zone. At interview we were informed that there was not always time to discuss all the 'green' patients. Mr H was not seen as someone with a complex presentation, however in our view the description for green below does not adequately describe Mr H's presentation:

> 'Patients who are stable and receiving maintenance care. Patients who have been in the green zone consistently for a long period of time might be in the process of being transferred to another team'.

6.14 The zoning protocol provides a description of a level of need, but does not provide any structure to guide team interventions when need has been assessed.

6.15 We suggest that the zoning protocol is expanded to include a description of the level of team response and interventions expected at each zone.

Recommendation 7

The Trust zoning protocol should include the levels of intervention expected at each zone.

6.16 Mr E made an unannounced visit to Mr H on 12 August, and it was noted that he said he was annoyed at being monitored by mental health services, he does not feel he is mentally unwell and said he does not need to be under mental health services. He said he attends probation because he has to. It was noted that mentally there are no changes in his presentation. The only concern of Mr E and the Downe Road keyworker was that he was starting to resist with engagement and how his behaviour can be volatile at times, but there was no concern about violence. A professionals' meeting was planned

for September. The meeting notes record that '[Mr H] is informal, mentally well and has capacity but it is a condition of his Licence that he engages with the FOS for follow up, and adhere to conditions of Licence. The approach of probation is paramount to the follow up and this will be discussed at the professionals meeting'.

6.17 We note that there is no documented discussion with probation about any concerns regarding disengagement, and the last contact with probation which is documented in the clinical record is an email to the probation officer from Mr E, after concerns about Mr H's reaction to his friend's death were discussed on 9 July. See recommendation 1.

6.18 There was 67 weeks between his discharge in April 2013 and and the homicide in August 2014. In first 33 weeks, there were 21 face to face contacts with his Trust care coordinator, and five missed appointments. In the second 34 weeks, there were 14 face to face contacts and six missed appointments. There is no explanation for the reduction in frequency of contacts. Appointments were not planned in tandem with probation, and this is discussed further at section 6.29.

Family involvement

6.19 We were told by Mr H's mother that she was involved in his care whilst he was in the Shaftesbury Clinic, and was invited to meetings. There is evidence of her being invited to CPA meetings, and of being consulted by telephone prior to the Tribunal report in April 2013 to ascertain her views on the proposed CTO. She said she was not invited to meetings while he was at Beecholme or Downe Road. The internal report notes that staff at interview stated that Mr H expressed the wish that members of his family should not be involved in his care planning, but there is no evidence of this being documented. However Mr H is noted to have identified his mother as a carer in February 2014, when it was known he was staying overnight at her house.

6.20 There was a note for Mr E to follow this up with Mr H's mother, but there are no records of this being followed through. This appears to have been a missed opportunity both to offer a carers' assessment and to gather the perspective of Mr H's mother. Under the Care Act 2014[46] the Local Authority has a responsibility to offer an assessment of the ability of carers to provide care' but the Trust CPA policy notes that 'If an assessment is requested the Local Authority shall carry out such an assessment and shall take into account the results of that assessment in making any decision regarding the relevant person. The Trust may fulfil this duty on behalf of the Local Authority'.[47]

6.21 Mr H's mother told us that she was concerned about how much weight he had lost over the summer of 2014, and he appeared to be always 'hyper' and agitated. She was aware that he had a tendency to put on weight because of the medication he was on, and when she had asked him about it he said he

[46] *Assessment of a carer's needs for support. Care Act 2014.* http://www.legislation.gov.uk/ukpga/2014/23/section/10/enacte

[47] *Trust CPA policy, p9.*

was exercising and keeping fit. The question of weight loss has not been mentioned in his clinical records, and this information could have contributed to his care plans and risk assessments.

Recommendation 8

The Trust must ensure that carer's assessments are offered and appropriate action taken, and that families are offered the opportunity to take part in care planning.

Risk Assessment

6.22 The Trust Clinical Risk Assessment and Risk Management policy issued August 2016. Minor changes only made since issued in September 2007 and 2013. Policy states that

> 'a full, formal risk assessment should be undertaken with every patient new to the service, at the first contact, as well as at every CPA at least every six months while the patient is under the care of a clinical team'. 'The main risk assessment screen on RiO must be completed or updated whenever an assessment of risk is undertaken. The completion of this section of RiO does not, of itself, constitute a risk assessment'. 'HCR-20[48] Risk tools are used in the Forensic Service. The HCR-20 has been widely used in clinical populations and provides for a standardised assessment of dangerousness to others. It consists of 10 Historical, 5 Clinical and 5 Risk Management items relating to a patient. Each can be scored as definitely present, probably or partially present, or absent. This is also available on RiO'.

6.23 Mr H had undergone an HCR-20 assessment in July 2012, and this identified risks related to his illness, and those that were not, in particular his well-established offending history, peer group and substance misuse. In addition it was understood by his care teams, partly as a result of his pre-sentencing report by his former probation officer, that Mr H could be at risk from adverse influence by others, including gang and crime connected individuals, and those who could impose a negative influence on the patient's Islamic Faith. It was also recognised that his Faith afforded an opportunity to support his expressed aim to distance himself from offending and maladaptive behaviours.

6.24 The Trust Risk Assessment documentation was completed in April 2012, and updated in May 2013, July 2013 and January 2014.

6.25 At the time of his CPA meeting in January 2014, his risk rating from a probation perspective, had been reduced, from 'high' to 'medium' and he was

[48] *HCR-20 is a set of professional guidelines for violence risk assessment and management. Douglas, K. S., Shaffer, C., Blanchard, A. J. E., Guy, L. S., Reeves, K., & Weir, J. (2014). HCR-20 violence risk assessment scheme: Overview and annotated bibliography. HCR-20 Violence Risk Assessment White Paper Series, #1. Burnaby, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University.*

re-graded within MAPPA from level 2 to level 1, which meant that he would not routinely be discussed at MAPPA meetings.

6.26 The plan for Mr H's discharge from the Shaftesbury Clinic was originally that he be discharged from the notional Section 37 order under the auspices of a Supervised Community Treatment Order (CTO). This had been recommended in the report prepared for the FOS following referral from the in-patient forensic service, and was in the reports prepared for the First-tier Tribunal. The discharge by the Tribunal meant that it was not possible to impose a CTO at the time of his discharge. The rationale for this was clearly set out in the decision from the Tribunal:

> 'A robust plan including a number of agencies, all of whom have worked together, has been put in place. Mr H is to be discharged to a hostel that he has been visiting regularly in recent weeks and where he will have a keyworker and an activities officer, he will be seen weekly by his probation officer, he will be subject to MAPPA, he will see his care co-ordinator regularly and have regular medical reviews by his Community Responsible Clinician, both of whom will be members of the Community Forensic Team, and he will continue to be mentored by someone from the Active Change Foundation…
> All of these plans are covered by his licence conditions and if Mr H does not comply with them he will be in breach of his licence and liable to recall to custody. His licence does not expire until February 2017 and is far longer than any CTO would be likely to last. Furthermore, as Mr H has not had any experience of receiving mental health treatment in the community there is no history to suggest that a CTO is needed and he does not meet the usual conditions for a CTO'.

6.27 We discussed this with Mr H's community RC, Dr S. There had been an initial referral to the FOS team in November 2012, and Mr H was not accepted as he was not seen as able to engage with his own relapse prevention. He was later re-referred and accepted, and a Section 117 meeting was held prior to his possible discharge, after his solicitor applied for the Tribunal.

6.28 The focus on discharge was concern over reoffending, raised by probation, and mental health services were seen as supporting the resettlement in the community by probation, rather than requiring mental health services supervision. An open debate about this and Mr H's attitude to mental health services was described, which included Wandsworth probation. It was planned that he would be discharged to Beecholme, while under the supervision of the known Wandsworth probation officer, and later hand over to a Merton probation officer, because he would then be in the Merton probation catchment area. A new probation officer was introduced (Ms G) in March 2013 just prior to his discharge to Beecholme.

Expectations and effectiveness of communications, care planning and risk management between the hostel, FOS, probation and GP

6.29 The MAPPA[49] panel is the structure which provides a multi-agency public protection function. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders.

6.30 Mr H was registered as MAPPA 'Category 2: Violent Offenders and Other Sexual Offenders' and was to be managed at 'Level 2'. MAPPA cases should be managed at Level 2 where the offender:

- is assessed as posing a high or very high risk of serious harm, or
- the risk level is lower but the case requires the active involvement and co-ordination of interventions from other agencies to manage the presenting risks of serious harm, or
- the case has been previously managed at level 3 but no longer meets the criteria for level 3, or
- multi-agency management adds value to the lead agency's management of the risk of serious harm posed.

6.31 The initial MAPPA meeting was held in August 2012 at Hammersmith & Fulham. It was noted that this was a Wandsworth case being held by Hammersmith and Fulham, and would need to be handed over to Wandsworth in due course. Mr H's then probation officer Ms R attended, and apologies were received by the then FOS team leader, and from Mr A from ACF. His previous offending was discussed, and the MAPPA review expressed concern regarding his previous violent offending and likelihood to disengage with services. Mr H had been referred to the probation 'Central Extremism Unit' as there was a concern that he may use his religious ideologies as motivation for violence, and his previous affiliation with a gang in Wandsworth. A possible licence condition of engaging with mental health services was discussed, along with consideration of mosques and religious groups he could access. This was to be reviewed at an October 2012 MAPPA meeting, with Wandsworth probation to be notified that Hammersmith & Fulham were 'holding' the case. At this stage Ms R was visiting Mr H in hospital every two weeks for ongoing probation supervision.

6.32 The clinical notes record that a MAPPA meeting in May 2013 was attended by Ms G and Mrs C of Beecholme. It was reported by Ms G that he was engaging more with the hostel structure, but staff are still trying to seek a 'safe' mosque for him to attend. When he was at the hostel he is always

[49] *The Criminal Justice Act 2003 provides for the establishment of Multi-Agency Public Protection Arrangements ("MAPPA") in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders.*

talking with someone on the telephone, but does not disclose who … one significant point raised by the ex-probation officer is the fact that the relationship between Mr H and his brother needs to be monitored due to the negative effects he has/they have together.

6.33 Later in May the Beecholme team reported to Ms R of the FOS that the probation officer was not visiting Mr H at the hostel, and was not reporting back to the hostel. It was agreed that Ms R would contact the probation officer Ms G, and emails were sent to Ms G and to the senior officer at the Central Extremism Unit. This appears to be the beginning of concerns about three way communication between the Trust (FOS), Beecholme and probation.

6.34 A MAPPA meeting was also held on 9 August 2013 and it was noted by Mrs C that he was more settled emotionally, but still wanted to leave Beecholme, wanting greater freedom than he is able to have. Consideration has been given to another placement, and he said he wants his own flat but needs to do further work. Continuing to liaison continued with ACF regarding a place to worship and mentorship.

6.35 The aims of a probation licence period are to protect the public, to prevent re-offending and to secure the successful re-integration of the offender into the community. Licence conditions should be preventative as opposed to punitive and must be proportionate, reasonable and necessary.

6.36 The conditions of probation licence in place in 2013 were the conditions published in 2011.[50] The wording of any 'additional contact' beyond the expectations of probation officer contact are as below:

> '(a) Attend all appointments arranged for you with [… INSERT NAME …], a psychiatrist/psychologist/medical practitioner and co-operate fully with any care or treatment they recommend.
> (b) Receive home visits from [… INSERT NAME …] Mental Health Worker. This condition should only be used if the offender consents to the treatment. Declining to co-operate with this condition means the offender is not addressing his/her offending behaviour and the possible consequence of this needs to be explained to the offender'.

6.37 The licence conditions which were revised in 2015[51] provide more detail on the expectation of complying with visits from a mental health worker in relation to contact with gangs or extremist groups:

'This group and organisation condition may be appropriate for certain offenders, but only if there is a clear link between the offending behaviour and/or current risk factors and one or more identifiable groups or organisations such as extremist groups or gangs. As with other conditions that

[50] *National Offender Management Service, LICENCE CONDITIONS, 26 April 2011.* https://www.justice.gov.uk/downloads/.../pi_07-2011_licence_conditions_final.doc

[51] *National Offender Management Service: LICENCE CONDITIONS, LICENCES AND LICENCE AND SUPERVISION NOTICES, March 2015.* https://www.justice.gov.uk/downloads/offenders/psipso/psi-2015/psi-12-2015-licences-conditions-supervision.pdf

engage the offender's rights, this condition can only be used where it is necessary and proportionate to manage the risk posed by the offender. You will need to take into account the nature of the offending to check that the condition is justified. Prohibited activity should always be subject to the clause '…..without the prior approval of your supervising officer'. The supervising officer must determine if it is appropriate to grant such approval in all the circumstances of the case.

6.38 A 'Risk Management Plan' and 'Sentence Plan' should be put in place by the probation service, and made clear to the individual. In Mr H's case, there was a transfer to Wandsworth/Merton probation in March 2013, just as his discharge was being arranged.

6.39 A further complication was that we were informed that at this time, probation services were undergoing a transformation from one service to two. Community Rehabilitation Company[52] (CRC) is the term given to a private-sector supplier of Probation and Prison-based rehabilitative services for offenders in England and Wales. A number of CRCs were established in 2014 and 2015 as part of the Ministry of Justice's Transforming Rehabilitation[53] strategy for the reform of offender rehabilitation. A separate public-sector National Probation Service (NPS)[54] was established to manage the supervision and rehabilitation of medium and high risk of serious harm offenders. The Trust has clarified that the FOS team was not made aware of these changes; only that Mr H's probation care had been transferred. It is not clear from the probation input to this investigation how exactly this impacted on the service provided to Mr H.

6.40 Staff in the Wandsworth/Merton area were undergoing the transfer from one organisation to another, and the allocated probation officer (Ms G) was originally managed by the CRC, later changing to the NPS. From our interviews, reflections of the FOS team were that the handover from one probation service to another could have been better managed by the FOS team, with a more detailed handover of Mr H's care plans and with joint expectations agreed. The Section 117 meeting on 15 April 2013 was attended by the FOS team leader, Ms G from probation, but not Mr A from ACF. It was noted by the Shaftesbury RC that Mr H had a history of non-compliance with licences. His licence stated that he needs to attend all mental health appointments, and that the FOS and probation will need to stay in close contact. It was noted that if he missed 'any 3 appointments' he would be recalled to prison, but that attending ACF was NOT a written condition.

6.41 The detail of Mr H's Risk Management Plan' and 'Sentence Plan' were not shared with the FOS team, and expectations of communicating and reporting in both directions appeared to be unclear. The internal report suggest that a

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[52] *Transforming Rehabilitation: a Strategy for Reform. Ministry of Justice, May 2013.* https://consult.justice.gov.uk/digital-communications/transforming-rehabilitation/results/transforming-rehabilitation-response.pdf

[53] *2010 to 2015 government policy: reoffending and rehabilitation.* https://www.gov.uk/government/publications/2010-to-2015-government-policy-reoffending-and-rehabilitation/2010-to-2015-government-policy-reoffending-and-rehabilitation

[54] *The National Probation Service is a statutory criminal justice service that supervises high-risk offenders released into the community.* https://www.gov.uk/government/organisations/national-probation-service

'lack of clarity in relation to 'lead agency' status hampered decision making regarding [Mr H]'s arrangements at certain times, for example when [Mr H] was requesting to stay with his family'.

6.42 It is clear from the standard probation licence conditions that probation are the 'lead agency' in all circumstances when an offender is released on licence. This does not appear to have been clear when applied to practice between the FOS and Ms G. In Mr H's case, decisions such as agreeing for Mr H to stay with his family were deferred to the mental health service to make a decision. This caused confusion and frustration for Mr H.

6.43 There were attempts by the FOS to make regular contact with probation, with some effect, but email and telephone communications were not always successful. Visits to Mr H were not planned in tandem, which may be as a result of this lack of coordination. We would expect that weekly or fortnightly meetings would be planned in sequence wherever possible, so that he was visited frequently. The clinical notes show that he was often seen by probation and FOS within one or two days of each other, meaning that the length of time between professional visits was unnecessarily lengthened. It also became clear that he was not regularly attending ACF, and there was no shared information about whether an appropriate mosque had been identified.

6.44 This communication was noted in the internal investigation to have improved when Mr E took over as care coordinator in September 2013, but was never well established. We have discussed this with the current Head of Probation, who indicated that any concerns regarding coordination should have been escalated. There is evidence in the notes that efforts were made to make contact with senior probation personnel, but there was confusion about whether the appropriate manager worked for the CRC or NPS.

6.45 We found that this confusion was replicated in our contact with probation officers regarding information gathering for this independent investigation. We were informed that there has been a probation review,[55] because the homicide is categorised as a serious further offence that was committed by Mr H while he was on a probation licence.

6.46 'Serious Further Offence' (SFO) reviews will be required in any of the following cases:

> 'any eligible offender who has been charged with murder, manslaughter, other specified offences causing death, rape or assault by penetration, or a sexual offence against a child under 13 years of age (including attempted offences) committed during the current period of management in the community of the offender by the NPS or a CRC; or whilst subject to Release on Temporary Licence'.

[55] *NOTIFICATION AND REVIEW PROCEDURES FOR SERIOUS FURTHER OFFENCES, (PI 15 / 2014, AI 15/ 2014) NOMS. 1 June 2014.*

6.47 We have not been able to discuss this with the probation officer involved as they no longer work in the service. We have requested access to the probation SFO report, but it has not been made available to us.

6.48 We have had sight of a probation review of Mr H's management by probation. The summary states that '*in terms of compliance [Mr H] reported on time with few exceptions. He was supported at the care home by the manager, psychiatric social workers, and consultant forensic psychiatrist, but displayed intermittent reluctance to engage in ongoing work. Overall, however, he complied with the regime. He also fluctuated in his engagement with his ACF mentors, although they were pro-active in attempting to keep him engaged. An appropriate Mosque was identified which [Mr H] attended. The Serious Further Offence of murder was committed on 13 August 2014. This was within his exclusion area'*.

6.49 Mr H was obliged to report to probation weekly, but this was reduced to fortnightly by the probation officer without discussion, and his probation officer informed all parties that his risk was reduced to medium, without any interagency discussion. No reason has been recorded for this and there appears to have been no management oversight of the decision. The report notes that this should have been discussed in a multiagency forum and consideration should have been given to how Mr H's mental health needs and medication would be monitored.

6.50 The probation management review noted that there appeared to have been no clear framework of roles and responsibilities in place and no agreement as to how mental health and probation would jointly manage this case, with consideration of frequency and coordination of appointments. In particular it was noted that his request to stay at his sister's house should have been risk assessed by probation, and his reaction to his friends' stabbing in July 2014 was recorded as information indicating heightened risk and should have prompted a formal review of risk and a referral to MAPPA Level 2.

6.51 While we cannot comment on the actions of probation any further, we recommend that for future probation licence conditions that require contact or engagement with mental health services, the Trust ensures that a joint agency care plan with clear communication lines and escalation protocols is in place and agreed by all parties. See recommendation 1 above.

6.52 Mr H was moved to MAPPA to supervision at Level 1 in January 2014.

Level 1 cases are:

> 'Where the risks posed by the offender can be managed by the agency responsible for the supervision or case management of the offender. This does not mean that other agencies will not be involved, only that it is not considered necessary to refer the case to a level 2 or MAPPA meeting. It is essential that information-sharing takes place, disclosure is considered, and there are discussions between agencies as necessary. The Responsible Authority agencies must have arrangements in place to review cases managed at Level 1 in line with their own policies and procedures'.

6.53 Beecholme House is a CQC registered provider of accommodation for persons who require nursing or personal care for 15 adult men who are in need of supported accommodation and care. There is a 'step down' unit at Downe Road nearby that provides three beds for men who are able to live more independently. There is a contract in place with the Trust to provide aftercare for patients requiring rehabilitation, and many of these are moving on after discharge from the Forensic service.

6.54 Beecholme staff regularly attend Trust CPA and ward meetings to discuss transfer and planning arrangements, and did so in the care of Mr H. There is evidence of regular communication and information sharing both formally and informally with Trust and FOS staff.

6.55 At Beecholme each resident has a 'wellness' care plan which is regularly reviewed. Following the CPA meeting in January 2014, the process of transfer to the 'step-down' accommodation linked to Beecholme was begun. Mrs C had said that this would need to take into account him taking on responsibility for managing his own medication successfully, as well as cooking on a regular basis, and adopting some kind of regular activities, and once these were in place, he would be considered him ready to move to the step-down house. She suggested that it would be feasible for him to do this and move in March or April 2014. There was concern expressed to Mr E by Mrs C, after Mr H approached her in January 2014 to discuss his concerns about a recent proposition made to him by an old gang member and how this has played on his mind.

6.56 Mr E met with him to discuss this in early February 2014 and he spoke openly about the temptation to make a large amount of money quickly which he could then use to support his family. He did not disclose exactly the type of criminal actively planned, but reported being afraid of jeopardising his future and 'going in reverse' and the likelihood of getting caught and ending up in prison. He said he was hopeful of progressing to a Step Down accommodation in April and agreed that Ms G (probation) be informed of the recent event. It is not known what action was taken by probation.

6.57 Mr H cancelled his next meeting with Mr E because he was visiting family, and the next meeting was recorded as 27 March 2014, a gap of nearly six weeks. The feedback to the FOS MDT on 28 March by Mr E was that Mr H had said he would not feel safe in any part of West London, East London and also some parts of South London, but feels he would probably feel safer in South London. He said ideally he would like to move out of London for a fresh start and then seek paid work, maybe in the Kent area. Mr E conveyed the extent of Mr H's anxieties in regard to his past involvement with street gangs. He said when he comes close to any exclusion zones he does panic a bit. He said he felt his street reputation has helped him at times when he has felt vulnerable.

6.58 Mr H was transferred to Downe Road in April 2014, remaining there until his arrest in August. By this point, Mr H had been seen once between 5 Feb and 17 Apr (around ten weeks). By the time Mr E did see him, it was once in twelve weeks. See recommendation number 1 above.

6.59 Communication with the GP practice is discussed in the management of medication below at section 6.86.

FOS team configuration

6.60 This includes the planning of structured activities and support provision in management of the Mr H's violent aggressive thoughts and vulnerability to gangs/peers, and any impact on [Mr H]'s care and treatment by operating without a psychologist or OT.

6.61 As discussed in the action plan update, the Trust has given consideration to developing the multi-disciplinary makeup of the service. Current constraints with staffing give rise to concerns that changing the multidisciplinary makeup of the team would impact on caseload sizes and risk, so have requested that care co-ordinators remain either social workers or nursing. With recent changes to the team this is under consideration at this time.

6.62 OT advice and psychological input can be sought from the in-patient Forensic team.

6.63 Standards for Community Forensic Mental Health Services[56] were developed by the Royal College of Psychiatrists in 2013.

6.64 The relevant standard (B3.10) is:

> 'The multi-disciplinary team consists of or have ready access to staff from a number of different professional backgrounds (e.g. forensic psychiatrists, community psychiatric nurses, forensic and clinical psychologists, social workers, occupational therapists, clinical pharmacy) in order to enable a holistic understanding of the service user group'.

6.65 There is no definitive expectation that other professions be included in the team, rather that there is access when required.

6.66 Mr H was provided with psychological therapy whilst an inpatient regarding his attitudes to offending and anger management, with varying levels of engagement. He had 24 hour professional support in Beecholme, with a focus on structuring his day, practising activities of daily living and self–management.

6.67 He had responded to this to some degree, but his attitude to cooking and washing was that his mother and family would provide for him. He was supported to access college courses and at times was enthusiastic about his attendance and achievements. The expectation of his taking medication, residing at Beecholme and cooperating with professional visits were accepted reluctantly.

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[56] *Standards for Community Forensic Mental Health Services. Royal College of Psychiatrists, 2013. https://www.rcpsych.ac.uk/PDF/QNFMHS%20Standards%20for%20Community%20Forensic%20Mental%20Health%20Services%20-%20Final.pdf*

6.68 The probation work should have been focussed on his attitudes to offending and prosocial behaviours. The ACF input was intended to provide mentoring to move away from criminal attitudes and lifestyles. Mr A found Mr H very sedated in the later months of his contact with him in Beecholme and Downe Road, and felt this interfered with his ability to interact. Mr A would have recommended a change of environment to support him in moving away from his old lifestyle.

6.69 We have developed a tentative formulation of his presentation gathered from the clinical records, interviews and meetings with Mr H below:

6.70 Mr H clearly has a diagnosis of paranoid schizophrenia, which became manifest whilst serving a prison sentence in 2012, and his symptoms included paranoid ideas about others, being convinced the officers were plotting against him, and food was poisoned. Violence in prison appears to have been directly influenced by symptoms of mental illness, but it is difficult to attribute his previous serious violent and acquisitive offending to mental illness.

Predisposing factors

6.71 His father had a history of substance misuse, and of allegedly dealing drugs, it is recognised that such problems in in a parent may increase the risk of their children developing similar problems.

6.72 He has stated that he used cannabis from around the age of 8, and regularly from the age of 10 or 11. He has reported first robbing a person when aged 10.

6.73 Local authority records refer to a chaotic impoverished living environment, in which his mother was absent for long periods when he was a child. His history and account suggests a background that included neglect, lack of concern by others, and a belief that others were unreliable.

6.74 There is no known history of abuse. Conduct disordered behaviour in childhood has been reported, attending three primary schools due to being excluded for behavioural difficulties, including fighting, and attending two secondary schools after being expelled for fighting.

6.75 The first recorded episode of clear psychotic illness occurred in 2012, although he has spoken of feelings of suspicion and hearing voices as a child.

Precipitating factors

6.76 His use of drugs and alcohol may have precipitated episodes of psychosis.

6.77 His coping mechanisms appear to be based on some fundamental beliefs about the world as a hostile place, that other people are untrustworthy and he has no sense of a different kind of life.

6.78 He has described gaining a feeling of power and pleasure when offending, which has lifted his mood.

Perpetuating factors

6.79 He continued in his denial of the need for medication and for mental health services supervision.

6.80 His life was unstructured, without education or employment and he persisted in beliefs that others such as family would provide practically for him.

6.81 He has consistently tried to avoid the supervision of mental health services, which he saw as unnecessarily intrusive, stigmatising and shameful. He cooperated to a greater degree with probation because it was a mandatory part of his licence. His poor engagement with supervising community services, except where this was mandated as part of licence conditions, contributed to his continuing mental illness.

6.82 He continued to be secretive about his associations with criminals and/or gangs, and would not discuss this openly with either mental health services staff or the ACF mentor.

6.83 Mr H was regarded as vulnerable to the influence of others, evidenced by his associations prior to conviction in 2011, and his vulnerability to extremist influences in prison and hospital.

6.84 He was thought to have a rigid, inflexible thinking style, tending to believe his version of events is correct. He has expressed his belief in revenge as appropriate and justified and described himself as remorseless.

Protective factors

6.85 Mr H has maintained contact with his sisters and his mother, and seems to have enjoyed some family life with them in 2013 and 2014.

6.86 When he was released on licence to Beecholme he was initially enthusiastic in trying to access education and structuring his life more positively.

6.87 The role of religion in his life may be seen as providing a sense of belonging, boosting his self-esteem, and giving order and propose to his life. However conversely he was thought to be vulnerable to the more extreme views, such as jihad, the world as a dangerous place, and prayer as a ‘preventer’ of violence.

6.88 With the formulation above, a role for OT and psychology can clearly be seen. It was recognised during his previous admission that he had a rigid and inflexible thinking style involving high self-esteem, that violence was pleasurable and psychologically rewarding, and that he had a generally paranoid, suspicious and secretive interpersonal style. These issues could predictably influence engagement, collaboration and compliance in the community, and indicate the need to take a broad, multi-disciplinary approach to supervision and management. However we consider that Mr H did have multiagency input into these areas and consider that a lack of this input in the FOS team cannot be said to have a direct bearing on subsequent events.

The management of medication compliance

6.89 Mr H was prescribed aripiprazole 30 mg, which was prescribed by the GP. The prescription was requested by the sending of CPA review letters to the GP, who were also routinely invited to CPA meetings, but did not attend.

6.90 Medication was initially administered by Beecholme staff, until self-administration was agreed by April 2014. The self-medication policy in place at the time did not include the expectation of checking compliance. Beecholme have revised their medication management policy[57] to include that:

> 'A full audit of the medications used in self-medication will need to support the tracking of the medication from the point of ordering, receipt into the home, the date given to the self-medicating Service User, the usage of the medication by the Service User and the destruction or disposal of any superfluous medications'.

6.91 During visits by Mr E, there is evidence that the question of medication adherence was discussed regularly. Mr E observed no changes in his mental state or presentation and Mr H assured him that was taking his medication. There were no systems in place to provide any objective checking of this.

6.92 After his arrest in August 2014, Mr H stated that he had not been taking his medication since May 2014. On checking with the GP, it was confirmed that electronic prescriptions were issued between June 2013 and April 2014. The GP confirmed that no further prescriptions were issued after 14 April 2014.

6.93 The GP practice confirmed that this would not have been flagged as a concern through any routine alert process. The GP does not appear to have had a summary of the issues in Mr H's care, and had no contact with either the FOS or probation. There are quarterly meetings in place with local community mental health teams, which appear to support communication. It was evidenced in the GP notes that Dr S had requested a full health screen from the GP practice, which had not been carried out or communicated.

6.94 The FOS have implemented a mechanism for checking medication compliance as discussed above, however we consider the the GP practice should be involved in the monitoring of medication, in combination with their obligation to report on annual health checks with long term conditions.

Recommendation 9

NHS Merton/Wandsworth CCG should work with GP practices to ensure robust structures, processes and systems are in place to identify and manage (incidents) where patients on long term antipsychotic prescriptions default with prescriptions.

[57] *CM02 - Medications Policy and Procedure, Beecholme, August 2015.*

The management of the potential risks of engaging with gangs and disengagement from treatment/therapy

6.95 As discussed above, our view is that there was a lack of clarity in the multi-agency approach to Mr H's care. However, concerns about undue influences were explored and discussed him by the FOS team, Mr E, the RC Dr S, Beecholme staff, Mr A from ACF and (presumably) probation.

6.96 Mr H consistently denied any engagement with gangs, and this was explored in relation to the reported death of his friend in July 2014, and in discussing potential group retaliation. Mr H was reported to have said he would not take part but would not stand in the way of others. After the homicide in August 2014, the other residents of Down Road reported unknown men being around Mr H, but they felt too intimidated to report this to staff. Mr E was also care coordinator to these other residents, but they reported feeling too frightened to disclose this to him.

6.97 The exclusion zone imposed was intended to support the separation from his victims and from gang affiliation. It is alleged by witnesses to the homicide in August 2014 that Mr H was regularly seen on the estate in Wandsworth that he was specifically excluded from. This information was not known to Trust staff, and we are unaware of any probation intelligence.

6.98 Recommendations have been made above (at recommendation 4) regarding actions the Trust should take to support staff in the risk assessment and interventions in issues regarding gang affiliation. A review of available literature suggests that issues related to trauma emanating from being victimised and being a perpetrator should be explored.

6.99 A strong influence of group affiliation, i.e. loyalty to the gang/group is likely to be relevant to successful interventions. The problem of risk to and from others is an important consideration, particularly in terms of how the offender views those others and perceives that they view him. [58] [59] [60]

6.100 There have been media reports of 'gang involvement' in the homicide of Nicholas, and we attempted to explore this issue with Mr H, but he has not been forthcoming about any details, and it is beyond the scope of this investigation to explore what are essentially police matters.

6.101 Mr H did tell us that he had been becoming increasingly paranoid and suspicious over the preceding few months. He had begun to carry a kitchen knife with which to protect himself, taking it whenever he went out of Downe Road.

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[58] *Gang involvement: Psychological and behavioural characteristics of gang members, peripheral youth and non-gang youth. Alleyne E, Wood JL, Aggressive Behavior (2010), 36, 423-436.*
[59] *Gang Membership, Violence, and Psychiatric Morbidity. Coid et l,American Journal of Psychiatry (2013)*
[60] *Gang Membership, Drugs and Crime in the UK. Bennett T & Holloway K, BRIT. J. CRIMINOL. (2004) 44, 305–323*

6.102 He did not disclose any paranoia levelled at any individual, but an overriding sense of being in danger. He was clear the he did not disclose this to any professionals working with him.

Engagement of family in his care

6.103 Mr H's mother did not feel involved in his care when he was discharged to Beecholme, as discussed above (see section 2.17). She was identified as a carer, and there is no evidence that this was followed up.

6.104 Mr H was visiting his sister's home as part of his overnight leave whilst at Beecholme, as discussed above. There is no evidence of attempts to assess the family situation from the Trust perspective. It may be that this was assessed by probation, but if so there is no evidence that this was shared with Trust. See recommendation 9 above.

7 Overall analysis and recommendations

7.1 From reviewing the notes we consider that Mr H appears to have been prone to mistrust and suspiciousness, and when mentally unwell this became paranoia. His signs of relapse appear to be an exacerbated sense of being at risk, which he is reluctant to share with others largely because of his socialisation and core beliefs.

7.2 He did not accept that he was mentally ill and in need of treatment, and the argument for discharging him on the CTO was for treatment and reducing the chances of relapse and re-admission.

7.3 In our view the logic of assuming (by the criminal justice services) that a probation licence can be substituted for a CTO was faulty, as the probation licence is purely for public protection and reducing offending. The probation licence allows recall to prison only, not hospital. We acknowledge however that the FOS team made no such assumption, and the internal investigation focused on his care from the FOS team in the community, rather than on the decision making at his discharge.

7.4 Furthermore, he already had an established history of non-compliance with Court orders and requirements.

7.5 We consider the use of the licence introduces a lack of clarity about roles, as happened here, by avoiding the need to establish clear 'health' conditions. Trust staff were not formally required to report non-attendances, and in this case it appears that probation did not report them.

Predictability and Preventability

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

> 'Risk management is a core function of all medical practitioners and some negative outcomes, including violence, can be avoided or reduced in frequency by sensible contingency planning. Risk, however, cannot be eliminated. Accurate prediction is never possible for individual patients. While it may be possible to reduce risk in some settings, the risks posed by those with mental disorders are much less susceptible to prediction because of the multiplicity of, and complex interrelation of, factors underlying a person's behaviour'.[61]

7.7 Predictability is "the quality of being regarded as likely to happen, as behaviour or an event".[62] An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been

[61] *Royal College of Psychiatrists (2016) Rethinking risk to others in mental health services. Final report of a scoping group. p23. http://www.rcpsych.ac.uk/pdf/CR150%20rethinking%20risk.pdf*

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

predictable, it means that the probability of violence with a threat to life, at that time, was high enough to warrant action by professionals to try to avert it.[63]

7.8 In coming to our view as to whether the homicide of Nicholas was predictable, and in considering all the information before us, we have considered whether Mr H's mental health history, his words, actions and behaviour should have alerted professionals that Mr H might, at that time, engage in such violence with a threat to life. We have considered whether, based on what mental health services knew, or should have known, there was a real risk of Mr H committing homicide at that time as a result of his mental illness; and whether that risk was high enough to warrant action by professionals to try to avert it.

7.9 We consider that it was certainly predictable that Mr H maybe involved in violence or a violent acquisitive offence.

7.10 However, although he has a previous history of violence, this has been of aggravated assault with weapons in the context of theft and robbery, and in prison, assaults associated with paranoia due to his psychotic illness. There is nothing in his history or his presentation at the time that would suggest he was very likely to commit an act of such extreme violence, therefore we consider that the homicide of Nicholas was not predictable.

7.11 Prevention[64] means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

7.12 We conclude that there is no evidence that this homicide could have been prevented by mental health services. Previous episodes of violence which may be said to relate to his mental state when he was in prison, and there has been no violence to others during his care and treatment by mental health services.

7.13 However, the systems of support and supervision across agencies should have been better coordinated, with a clear lead agency managing information about risk. It became clear after the homicide that Mr H had not been taking the prescribed medication, which historically has contributed to feelings of paranoia and suspiciousness. There was no indication of any potential risk of Mr H committing a homicide, although there is learning for the systems providing supervision of people on licence in the community.

Recommendations

7.14 This independent investigation has made 9 recommendations for NHS services to address in order to further improve learning from this event. The recommendations are grouped in priority order as follows:

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[63] *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*

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

7.15 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.

7.16 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.

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

Priority One

Recommendation 1

The Trust should ensure that where there is a probation licence condition of contact with mental health services, a joint agency care plan with clear communication lines and escalation protocols should be in place and agreed by all parties.

Measures to ensure that agreed interagency care plans are adhered to should be implemented, with routes of escalation if there are concerns.

Recommendation 2

The Trust must provide assurance that the 'guidance on supporting community clients on oral medication' in the community is implemented and is being effective.

Recommendation 3

The Trust must provide assurance that the 'guidance on supporting community clients on oral medication' in the community is shared with partner agencies and services, and that relevant collaborative care plans are in place.

Recommendation 8

The Trust must ensure that carer's assessments are offered and appropriate action taken, and that families are offered the opportunity to take part in care planning.

Recommendation 9

NHS Merton/Wandsworth CCG should work with GP practices to ensure robust structures, processes and systems are in place to identify and manage (incidents) where patients on long term antipsychotic prescriptions default with prescriptions.

Priority Two

Recommendation 4

The Trust should build awareness of risks and gang culture in the catchment area, and develop appropriate links with Police to ensure that they are connected to local established networks for raising awareness, information sharing and action about those at risk from or engaged in gang activity.

Recommendation 5

The Trust must develop appropriate communications and working relationships with local supportive faith organisations through the Department of Spiritual and Pastoral Care.

Recommendation 7

The Trust zoning protocol should include the levels of intervention expected at each zone.

Priority Three

Recommendation 6

The Trust should ensure that serious incident action plans are outcome focussed and have measurable aims.

Appendix A – Terms of reference

Core terms of reference

To identify whether there were any gaps or deficiencies in the care and treatment that the service user received which could have been predicted or prevented the incident from happening. The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required which could help prevent similar incidents from occurring. Specifically,

- 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 the service user's first contact with services to the time of their offence.
- Compile a comprehensive chronology of events leading up to the homicide.
- Review the appropriateness of the treatment of the service users 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 the service users harming themselves or others.
- Examine the effectiveness of the service user'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 post investigation evaluation.

Outputs

- A succinct, clear and relevant chronology of the events leading up to the incident which should help to identify any problems in the delivery of care.

- A clear and up to date description of the incident and any Court decision (e.g. sentence given or Mental Health Act disposals) so that the family and members of the public are aware of the outcome.

- A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed).

- Meetings with the victim and perpetrator families and the perpetrator to seek their involvement in influencing the terms of reference.

- Independent panel to involve police (including Family Liaison Officers) within the review process.

- At the end of the investigation, to share the report with the Trust and meet the victim and perpetrator families and the perpetrator to explain the findings of the investigation.

- A concise and easy to follow presentation for families.

- A final presentation of the investigation to NHS England, Clinical Commissioning Groups, provider Board and to staff involved in the incident as required.

- We will require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented. The investigator should produce a short report for NHS England, families and the commissioners and this may be made public.

Timescale

The investigation process starts when the investigator receives all the clinical records and the investigation should be completed within six months thereafter.

Specific terms of reference

- To provide a clear description of the incident

- To understand the reasons for lack of communication between the hostel, Forensic Outreach Service (FOS), probation and GP.

- To understand the reasons for FOS operating without a psychologist or OT input.

- To understand the processes for managing lack of engagement, planning of structured activities and support provision in management of the patient's violent aggressive thoughts and vulnerability to gangs/peers,

- To explore the management of medication compliance and the effectiveness of communication between FOS, GP, probation and hostel.

- To explore the quality of a joint risk assessment and care planning and their management.

- To explore in detail the management of the potential risks of engaging with gangs and disengagement from treatment/therapy, and to understand the actions taken by FOS, hostel, probation and GP.

- To engage in the investigation process all relevant agencies such as hostel, GP and probation to support joint learning in understating the issues around communication, joint risk assessment & care planning and the disengagement around his medication.

Appendix B – Documents reviewed

South West London & St George's Mental Health NHS Trust documents

- Medicines Code policy September 2016, Appendix 30, Guidance on supporting community clients who are prescribed oral medicines
- Clinical Risk assessment Policy, August 2016
- Care Planning and Care Programme Approach (CPA) Policy (final draft) November 2016
- Clinical Strategy 2015 - 2020
- Data Protection Policy, October 2016
- South-West London Community Forensic Team Operational Policy, February 2012
- South-West London Forensic Outreach Team Operational Policy, June 2016
- Information Governance Policy, October 2016
- Incident Reporting and Management Policy & Procedure, June 2017
- Zoning Meeting Check List undated
- Blue Book, Guidelines for the Management of Common/Selected Psychiatric Emergencies and Certain Trust Policies and Procedures, August 2015

Other documents

- London MAPPA Share Safe information sharing agreement July 2014
- MAPPA Guidance 2012, Version 4.2 [Updated November 2017]
- Figges Marsh GP Surgery clinical records
- Standards for Community Forensic Mental Health Services. Royal College of Psychiatrists 2013
- Beecholme Adult Care Medication policy and procedure August 2015
- Beecholme Adult Care Risk Assessment Policy and Procedure August 2015
- Probation Instruction licence conditions, PI 07/2011, April 2011
- Probation Instruction Managing Terrorist and Extremist Offenders in the Community, PI 10/2014, June 2014

- Probation Instruction, Notification and review procedures for serious further offences and PI 15 / 2014, June 2014

Appendix C – Conviction history

Date	Offence	Sentence
May 2003 Youth Court	Interfering with a vehicle on 30 November 2002 Failing to Surrender to bail on 12 December 2002 Failing to Surrender to bail 18 February 2003	Absolute discharge Absolute discharge Absolute discharge
September 2003 Youth Court	Theft- shoplifting	Referral order 6 months
May 2004 Youth Court	Robbery	Supervision Order, Young Offenders 9 months
July 2005 Youth Court	Going equipped for theft (other than a motor vehicle) on 5 June 2005	Supervision Order, Young Offenders 12 months, curfew order with electronic tagging
December 2005 Youth Court	Theft, shoplifting on 23 November 2005	Conditional discharge, 9 months
March 2006 Crown Court	Robbery on 2 December 2005	Supervision Order, Young Offenders 12 months, with offence related programmes
May 2006 Youth Court	Destroy or damage to property, on 18 September 2005 Failing to surrender to custody at appointed time at 10 October 2005	Supervision Order, Young Offenders 12 months Supervision Order, Young Offenders 12 months,
August 2006 Youth Court	Breach of supervision order 6 May 2006 to 15 June 2006	Resulting from original conviction, curfew to continue order 30 days between 21.00- 07.00
15 October 2006 Juvenile Court	Failing to surrender to custody at appointed time at 27 September 2006	Fine £10
January 2007 Youth Court	Theft from motor vehicle 3 November 2006, offence committed on bail	Detention and training order 4 months
March 2007 Youth Court	Robbery and 1 attempted robbery 4 December 2006	Detention and training order 4 months

October 2007 Juvenile Court	Harassment	Attendance centre 18 hours, curfew for 3 months, electronic tagging with restraining order
February 2008 Crown Court	Robbery	3 years, Young Offenders, ASBO- varied on appeal
June 2011 Crown Court	Robbery (two counts) on 13 February 2011	Young Offenders 42 months on both counts, concurrent. Extension period of licence 30 months
October 2015 Central Criminal Court	Murder 13 August 2014 (offence committed on bail)	Life imprisonment

Appendix D – Professionals involved

Pseudonym	Role and organisation
Dr C	Specialist Registrar, Shaftesbury Clinic
Dr G	Consultant Forensic psychiatrist, Shaftesbury Clinic
Mr A	Mentor from Active Change Foundation
Mrs C	Beecholme Manager
Mr D	Key worker, Downe Road
Dr S	Consultant Forensic psychiatrist, South West London Community Forensic Outreach Service
Ms R	Forensic social worker, FOS
Ms T	Team Leader, FOS
Mr M	Community nurse, care coordinator
Mr E	Community nurse, care coordinator
Ms R1	Probation officer, NPS Hammersmith & Fulham
Ms G	Probation officer, NPS Merton
Mr S	Senior Probation Officer, Counter Terrorism lead for London, Manager Extremism and Hate Crime Unit

Appendix E – Questions raised by the family of Nicholas

Questions	Index
Whether a community treatment order was considered when he was discharged from hospital in April 2013;	4.66,4.80-4.83 & 6.26-6.28
How Mr H's medication was monitored;	5.28-5.31 & 6.86-6.91
How his exclusion zone was being enforced;	4.73, 4.102, 4.182, 6.94
When was he diagnosed with a mental illness (i.e. before or after his trial in 2015);	Diagnosed in 2012
What support and supervision was there for him when he moved to the step down unit;	4.183-4.209
why was there no probation involvement in the Trust report;	Unknown
Has the Trust put an action plan in place, for instance about monitoring medication.	5.39-5.53

Appendix F - Glossary

1	NPSA	National Patient Safety Agency
2	CCG	Clinical Commissioning Group
3	CAMHS	Child & adolescent mental health service
4	FOS	Forensic Outreach Service
5	CPA	Care Programme Approach
6	DTO	Detention and Training Order
7	ASBO	Antisocial Behaviour Order
8	HMP	Her Majesty's Prison
9	YOI	Young Offenders Institution
10	ACF	Active Change Foundation
11	MHA	Mental Health Act
12	RC	Responsible Clinician
13	EEG	Electroencephalogram
14	WAIS	Wechsler Intelligence Scale for adults (IQ test)
15	MRI	Magnetic resonance imaging
16	MAPPA	Multi-Agency Public Protection Arrangements
17	EDR	Earliest Date of Release
18	DAST	Drug abuse screening tool.
19	OT	Occupational therapist
20	MDT	Multidisciplinary team
21	CTO	Community Treatment order
22	UDS	Urine drug screen
23	CMHT	Community mental health team
24	RCA	Root cause analysis
25	PREVENT	Government counter terrorism strategy
26	WRAP	Workshops to Raise Awareness of Prevent
27	MBT	Mentalization-based treatment
28	SCR	Serious case review
29	IMR	Individual management review
30	HCR-20	Historical Clinical Risk assessment tool
31	CRC	Community Rehabilitation Company
32	NPS	National Probation Service
33	SFO	Serious Further Offence
34		