Independent Investigation of the Case of BC

July 2012

A report for NHS London

Undertaken by Caring Solutions (UK Ltd)

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Incident Investigation Title:	Independent Investigation into the Homicide of AD by BC
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Acknowledgements

The independent investigation panel would like to thank all those who helped us to gain a better understanding of the issues in this case. Given the nature of the case we had to interview members of the two Trusts and a voluntary organisation which provided care and treatment for BC and we are to be able to say that all who were asked to do so, agreed to be interviewed. Those who were interviewed were open and frank in their discussions with us even though several were still deeply upset by the events of May 2009.

We wish to thank our liaison contacts in Sheffield Health & Social Care NHS Foundation Trust and Oxleas NHS Foundation Trust for all their work in gathering together the records and papers relating to the case as well as making all the interview arrangements. We wish to thank all the members of staff in both Trusts who worked with BC who gave their time to talk to the independent investigation about his care and treatment. Staff at Wathwood Hospital Regional Secure Unit very kindly made arrangements for us to meet BC and his current responsible clinician.

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EXECUTIVE SUMMARY

Introduction

1. On 4th May 2009 BC attacked AD, his cousin, with an axe in the flat they shared in south east London. AD died at the scene as a result of the injuries he received. BC had been an inpatient of Sheffield Health & Social Care NHS Foundation Trust until 31st March 2009 and had moved to London within about thirty-six hours of leaving hospital. It was decided that BC should be discharged from the Care Programme Approach (CPA) on 28th April because he had left the Sheffield area. On 29th April 2009 he was brought initially to the Accident and Emergency Department of Queen Elizabeth Hospital, Woolwich (part of South London Healthcare NHS Trust) before being taken to Oxleas House (part of Oxleas NHS Foundation Trust), which is on the same site, where he stayed for about twenty-four hours in the assessment area before being allowed to leave in the care of his cousin with a view to him returning to Sheffield. BC appeared in court on 16th September 2010 and received a hospital order under *ss* 37/41 of the Mental Health Act (MHA) 1983.
2. Following the incident Oxleas NHS Foundation Trust set up an internal serious untoward incident investigation team which produced a report of its findings in August 2009. The report generated five recommendations:

    1. *The assessment team to put in place a system for having an identified staff member taking on management responsibilities on each shift; these responsibilities include:*
        a. *Allocating tasks such as assessment to team members*
        b. *Ensuring these tasks are completed adequately*
        c. *Ensuring documentation about patients that is not entered on RiO* [electronic records system] *(e.g. drug chart) is secured and appropriately disposed of when the patient moves out of the assessment suite*
        d. *Giving overall approval for decisions about the move-on of each patient*
    2. *There is a visible 'at a glance' system in the assessment team office to track every patient under the assessment team's care at any point in time.*
    3. *The assessment protocols within the assessment service operational policy be reviewed and update training provided to duty senior nurses, the bed manager and the assessment team with regard to effective assessment (including risk assessment).*
    4. *The transfer protocols within the assessment service be reviewed and update training provided to duty senior nurses, the bed manager and the assessment team with regard to the safe transfer of patients to other trusts.*
    5. *The role of the bed manager in relation to the assessment service be reviewed.*

3. Sheffield Health & Social Care NHS Foundation Trust also set up an internal serious untoward incident investigation team which produced a report of its findings in September 2009. In addition to a number of lessons learned the report generated one recommendation - clinical teams should ensure that systems are in place to deal with initial enquiries.

4. This report sets out the findings of the independent investigation panel. The team reviewed both of the Trusts' internal serious untoward incident reports into the care and treatment of BC. In addition the independent investigation report was informed by interviews with key personnel and stakeholders, a review of BC's health record (for which consent was provided), and a review of both Trusts' documentation including policies and procedures.

Purpose

5. The independent investigation was jointly commissioned by Yorkshire and the Humber Strategic Health Authority and London Strategic Health Authority. An independent investigation is required when a homicide has been committed by a person who is, or has been, under the care of specialist mental health services in the six months prior to the incident. The purpose is to examine all the circumstances surrounding the care and treatment provided and in each case to identify any errors or shortfalls in the quality of the service and to make recommendations for improvement as necessary.
6. The independent investigation panel was required to address Terms of Reference agreed by Yorkshire and the Humber Strategic Health Authority and London Strategic Health Authority in consultation with the NHS organisations involved in the commissioning and delivery of the care and treatment of BC. More specifically, the Terms of Reference were:

   To examine:

   - The care and treatment the service user received from the NHS organisations and the suitability of the care and treatment in view of the service user's history, vulnerability and assessed health and social care needs
   - The suitability of the discharge and ongoing support planned for the service user
   - The extent to which the care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies.

   To investigate:

   - The interface, communication and joint working between the two mental health trusts and any other agencies involved in providing care to meet the service users mental, physical health and social needs
   - The adequacy of the risk assessments of the service user including the risk posed to others
   - The involvement of carers, relatives and other organisations when preparing discharge plans
   - How the care plan was tailored to meet the mental health service user's needs including the geographical split of his family responsibilities
   - The perceptions of the service user's family of the level and quality of care and treatment provided.

   To comment upon:

   - The quality of the internal investigations, their ability to identify root causes, the clarity in which those were presented in the reports and the strength of the recommendations to address these.

- The quality of the internal action plans, the strength of the proposed activities to resolve the recommendations and the evidence of the effective audit and review of those actions.
- The collaboration between Sheffield Health & Social Care NHS Foundation Trust and Oxleas NHS Foundation Trust in the internal investigation activity.
- The progress made towards the implementation of the internal action plans.

To identify:

- Aspects of the service user's treatment and management which were of good quality or commendable practice.
- Learning points for improving systems and services.

To produce:

- Realistic, measurable and specific recommendations for action in conjunction with the NHS organisations involved to address the learning points to improve systems and services
- To produce a final report that complies with all relevant legislation for presentation to the Board of Yorkshire and the Humber Strategic Health Authority via the Independent Investigations Committee and the Board of London Strategic Health Authority via the Mental Health Incident Strategic Review Group.

Methodology

7. The independent investigation was informed by:
    - An interview with BC (subject of the report and perpetrator of the homicide).
    - Interviews with staff members from both Trusts who were involved in BC's care and treatment, or who were responsible for policy making in the two Trusts.
    - A review and analysis of BC's health record including records from primary care and the two specialist mental health trusts which cared for him as either an inpatient or an outpatient.
    - A review and analysis of both Trusts' key policies and procedures in place at the time of the homicide (May 2009) and currently.
    - An audit and analysis of the Trusts' internal serious untoward incident reports completed in August and September 2009.
    - A review of (relevant) national policy guidance.
8. The independent investigation panel had hoped to interview one or both of BC's brothers who had been in touch with him during his inpatient stay in Nether Edge Hospital, Sheffield Health & Social Care NHS Foundation Trust, and had provided accommodation and support for him when on home leave but they did not respond to our requests for a meeting.

Summary of main conclusions

9. It has proved difficult to identify the immediate direct cause(s) that led to BC killing his cousin AD on the 4th May 2009, largely because of a lack of independent evidence and because BC's recollections are confused and somewhat contradictory. It has not been

possible to establish a precise date and time of death. This lack of certainty is due to inconsistencies between dates given in police and witness statements. The body was discovered by the police on 4th May 2009 and life was officially pronounced extinct on the morning of 5th May and BC was subject to a MHA assessment that morning. An additional complication being that this was a Bank Holiday weekend. Identifying the less direct or immediate causes has been simpler as sets of contemporaneous written notes exist and these have been supplemented by statements to the internal inquiries, and interviews with key participants by the independent investigation panel.

10. BC had access to good quality nursing care during his time in Nether Edge. Staff tried to engage him in daily activities. All of the mental health services with which he was in contact demonstrated a high level of sensitivity towards his ethnicity and his cultural needs. Ward staff also recognised that they were not able to provide for all his cultural needs.

11. The independent investigation panel concluded that most of the care and service delivery issues and contributory factors were patient factors in that although BC was involved in decisions about where to live on discharge he changed his mind on a number of occasions and was not actively engaged in the final decision. BC had a poor medication compliance history when on home leave and he was known to use khat on a regular basis. Although khat use is not illegal in the UK, BC was assessed as being at low-medium risk of illicit drug use; he was also known to use cannabis, but less frequently. At the same time, this was known to those planning his after-care and a contingency plan could have been organised on that basis.

12. BC had experienced a variety of medication regimes over the years. In the 1990s he was on a depot antipsychotic which allowed him to live in the community, although his functioning varied over time. He suffered such severe side effects that he was sent for a neurological assessment. When he was better he was able to attend college and no longer needed a carer. He was off antipsychotics for about twelve months in 2000 but then his condition relapsed. BC's mental state deteriorated when under stress, for example, when his Disability Living Allowance (DLA) was cut, and when he was evicted from his accommodation. He then went back to regular khat use. This would in turn lead to him becoming anxious and confused to the extent that he failed to attend outpatient appointments. At some point in 2005 BC was prescribed a tricyclic antidepressant, possibly by his GP. It is not clear what his mental state was when he moved to Sheffield in 2005 and got married. He held down a job at that time as a hotel kitchen porter. In 2007 he took an overdose and was prescribed Olanzapine due to increasing paranoia in respect of his family.

13. When BC was hospitalised voluntarily in 2008 he was prescribed a number of medications including Olanzapine, Haloperidol and Lorazepam. It was thought at the time that he might benefit from a long-term antidepressant. His dosage of Olanzapine was increased to 20 mgs. He was prescribed Zopiclone about three months into his inpatient stay though this was stopped after a week or so and Temazapam was substituted. Shortly after that Paroxetine was prescribed. In August 2008, his medication was changed to Risperidone and amounts of Olanzapine were reduced. BC said he felt more confident when taking the Risperidone. At the end of September 2008 it was decided that BC should be prescribed Clozapine subject to weekly blood tests; BC agreed

to the change. This change seems to have been induced to some extent after BC's brothers complained of his behaviour on home leave - they expressed the view that he needed "*a stronger medicine*". BC's objective state improved although he complained about side effects. The dosage of Clozapine was very slowly increased throughout October, November and December 2008 until the daily dosage reached 400 mg in early January 2009, however there were times when on home leave that this treatment was interrupted. At the end of January, when he failed to return from home leave, it was decided that Clozapine would be suspended and another antipsychotic substituted to be administered as a depot. However, Quietiapine was begun instead at the end of January and the dosage was increased to 600 mg daily by mid February. At the end of February the decision was taken to reduce Quietiapine and to re-start Clozapine. The wisdom of re-prescribing Clozapine in the light of BC's known non-compliance does not seem to have been discussed. BC was being prepared for discharge and while a rehabilitation ward was considered this does not seem to have been pursued and applications were made to supported accommodation in which BC would be responsible for taking his medication.

14. Mental health service staffs' knowledge of BC and his family structure was limited; he maintained a flat in south east London throughout his time in Sheffield and was probably registered with a GP there as well as in Sheffield. There is no clear evidence that anything more than cursory attempts were made to contact his wife and children in Sheffield. BC treated his brothers as his nearest relations and they were clearly significant to him as he spent his home leaves with them but they are never referred to by name in any of the case notes. The complexity of family relationships and the lifestyles of his brothers were not known to anyone who had responsibility for planning BC's care. The existence of AD, the victim and BC's cousin, was completely unknown to services and they were all ignorant of AD's behaviour when dealing with people in positions of authority.

15. BC had been a regular khat user for many years and this use continued throughout his time as an inpatient in Nether Edge. This drug use was associated with previous periods of decline in his motivation and of self-neglect. On occasions BC recognised the effects khat use had on his mental state but he regarded its use as a low risk activity. BC would also use cannabis as well if it was offered. Various opportunities were offered to BC to help him desist from drug use but none of the offers were accepted. These offers seemed to have been very tentative and refusal was not effectively challenged.

16. The decision was taken in January 2009 that BC should be discharged into the community to avoid institutionalisation even though he still gave evidence of paranoia and delusional thoughts; thoughts of self-harm were no longer present. The rationale for making discharge plans based on staying in Sheffield is difficult to accept fully as his home leaves had been spent in London, he had a flat there, and was registered with a London GP. By this stage BC's links with Sheffield were limited as he had given up contact with his wife and children. Clearly BC was not easy to provide care for as he changed his mind about his eventual location several times in the months leading up to his discharge. BC was accepted by Sheffield African Caribbean Mental Health Association (SACMHA) and he was to live in one their flats supported by a support worker. The flat

was located across the road from a new GP practice which was prepared to take blood samples as part of the process of monitoring his taking of Clozapine.

17. There is no written record of any discussions of expectations of the frequency of contacts between BC and his SACMHA support worker apart from a contact so that BC could be accompanied to his weekly blood tests. The support worker with whom BC had contact when he was an inpatient left the organisation at the time BC was leaving hospital and a new support worker took over. It is not clear whether this change in personnel had any impact on what happened subsequently.. BC had the same care co-ordinator from Sheffield Health & Social Care NHS Foundation Trust who provided continuity of care and support.

18. The discharge summary dated 31st March 2009 stated that BC was much more settled on discharge. He was seen as more motivated, had increased energy levels and was engaging well with ward staff. His fixed delusions appeared more settled and he appeared less distressed by them. His mental state had remained stable for a considerable period of time on the ward before this discharge. BC expressed no thoughts of self-harm.

19. BC moved to the flat on 31st March 2009 but within about thirty-six hours he left the flat without telling any one of his plans. His support worker visited the flat repeatedly over the next few days to check on him but BC did not return. His care co-ordinator and his support worker both tried to contact him on his mobile phone without success; his care co-ordinator also tried to contact his brothers in London but could get no reply. On 15th April 2009, the Metropolitan Police found BC at his flat in London and reported back to Sheffield Health & Social Care NHS Foundation Trust that he was 'safe and well' and in the company of a carer.

20. The time interval between BC going missing and the request for a 'safe and well' check is not an indication of inactivity. BC was discussed by his care co-ordinator and her colleagues in the Sheffield Health & Social Care NHS Foundation Trust, following local policies in place at the time. BC was an informal patient who was seen as presenting a low risk of harm to others, though with a higher level of risk of self-harm or self-neglect, he had been compliant with medication whilst in hospital. He was also thought of as being capable of deciding that he did not want further involvement with mental health services and as a result services did not actively pursue him.

21. When BC arrived at the Accident and Emergency Department of the Queen Elizabeth Hospital (South London Healthcare NHS Trust, Woolwich) in the evening of 29th April 2009 he was thought be in a distressed state, unable to account for his presence there, and was uncommunicative. He was taken to the assessment area in Oxleas House (which is on the same site as the Queen Elizabeth Hospital although it is part of a different NHS Trust) and went in a calm and accepting way. The independent investigation panel was told not to think of the assessment area as a physical entity but either as a team or a function. All of the communications about BC between members of the assessment area were verbal rather than written, and some staff initially believed he had been brought there by the police. The informality of the area's procedures meant that some information about BC - such as the belief that as he came from Sheffield he was to be transferred back there - was communicated diligently between shifts while other information - that he should be assessed by a doctor in the morning - was not.

22. The local patient information system showed that BC had been living in Sheffield and that he had a care co-ordinator and a GP there. The use of the NHS register would have shown that BC was registered with a second GP in south east London.
23. Communication was established between the acting bed manager in Oxleas House and the care co-ordinator in the Sheffield Health & Social Care NHS Foundation Trust although this communication concentrated on cost codes when it should have been about BC's Mental Health Act (MHA) and Care Programme Approach (CPA) status, his medication, information about BC's living arrangements, and risk issues such as his khat use and history of non-compliance with medication. It was claimed that none of this information was either requested or volunteered though this has been contested by the care co-ordinator in Sheffield Health & Social Care NHS Foundation Trust. It is not clear how much the imminence of a Bank Holiday and the need to clear beds weighed in the thinking of the acting bed manager. He took the decision to entrust BC to his cousin's (AD) care as that seemed the safest thing to do. The acting bed manager was told that BC had access to his medication and support while he made his way back to Sheffield. The acting bed manager did not know about AD's circumstances and, at one level, there was no reason for him to question either what AD said or how he presented himself. BC left Oxleas House in the care of his cousin with the stated intention of returning to Sheffield in the next couple of days.
24. The independent investigation panel found that BC's daily nursing care in Nether Edge Hospital was Notable Practice. Daily nursing care was of high quality and everyone involved in his care recognised the need to be sensitive to his ethnicity and his cultural needs.
25. The relationships between Sheffield Health & Social Care NHS Foundation Trust and the pharmacy service seem to have been effective throughout BC's time in Sheffield. There is strong evidence in the notes relating to the close liaison with clinical staff over decisions about the type and levels of medication BC should be given. The pharmacy service were able to refine the sensitivity of drugs screening tests used with BC to identify his khat use as the standard test would have shown this type of drug to be an amphetamine.
26. The relationships between Sheffield Health & Social Care NHS Foundation Trust and primary care services seem to have been good throughout BC's time in Sheffield. These relationships were tested as the main contact Sheffield Health & Social Care NHS Foundation Trust had with them was when BC was overdue from leave. The GP surgery in London SE7 responded to phone calls so that their information system would flag up BC if he came to the surgery. The practice administrator gave Sheffield Health & Social Care NHS Foundation Trust staff information which helped them confront BC over the truthfulness of his claims that he was getting his medication from the GP practice. Most of these contacts occurred in times of crisis when BC was missing and Sheffield Health & Social Care NHS Foundation Trust staff were trying to find him. Clearly arrangements were in place even though no action followed, as BC did not make contact with primary care services. The GP practice across the road from BC's SACMHA supported flat was prepared to take blood samples to monitor his Clozapine.
27. The independent investigation panel's conclusions about the adequacy of risk assessments of BC including the risk posed to others are that risk assessments were

carried out at regular intervals during BC's treatment and the risk assessments were based on discussion with BC by both his named nurse and his care co-ordinator. There was a risk assessment at Oxleas NHS Foundation Trust on the day before he was discharged in the care of his cousin. However, while the rationales behind the risk assessments were not transparent; the assessments were consistent over time. There was a risk management plan drawn up for BC's discharge at the end of March 2009 but it is debateable as to whether there was a realistic contingency plan, apart from general instructions to go to the GP or Accident and Emergency if BC's condition deteriorated even though it was known that BC had little insight into his own situation and this was made worse by his use of khat. Given this knowledge it is not clear why BC was not referred as a matter of urgency to Oxleas NHS Foundation Trust's services. Risk assessments were not readily accessible in the Sheffield Health & Social Care NHS Foundation Trust information system when accessed from different locations. Both the realism and robustness of the risk management plan are open to considerable doubt as many of the assumptions on which it was based were known to be questionable from previous experience of BC.

28. Attempts were made to involve BC's relatives in his discharge planning. BC had regular visits from an uncle when he was an inpatient in Nether Edge Hospital as the uncle seemed to be a Sheffield resident. BC's brothers were less easy to involve as their jobs and life-styles frequently took them out of the UK. They would arrive late at night or in the early hours to collect BC for home leaves and rarely met BC's nursing or medical staff. There were a variety of expectations of the brothers as carers built into BC's discharge plans but it is not clear that these expectation were communicated to the brothers or that they were in a position to comply. Staff knew little or nothing about the wider family - their names were never recorded and the family structure was not fully mapped out.

29. Two voluntary organisations were approached to provide supported accommodation for BC on discharge and he was accepted by SACMHA which was able to supply an ethnically supportive setting. The flat he was offered was across the road from a GP practice which was prepared to take weekly blood tests as a part of his Clozapine regime. The independent investigation panel have concluded that relationships with other organisations in the preparation of discharge plans for BC were good.

30. The independent investigation panel concluded that attempts were made to tailor the care plan to meet BC's needs. But there was clearly a series of changes of mind and plans over a period of a year covering BC's contact with mental health services following his suicide attempt in April 2008. BC's two children represented a strong family connection to Sheffield for some of this period but there seemed to have a distinct cooling towards the children after it was thought he had discovered that his wife was seeing someone else. There has never been any formal attempt by either party to separate legally or to secure a divorce; at least that it is recorded in the case notes. BC often seemed indifferent to plans for his discharge and then he could suddenly change his mind. On the day of his discharge he had forgotten that he was due to leave the hospital. All those involved in BC's treatment and care seemed torn between a wish to prevent him becoming institutionalised while not knowing how he could be discharged

safely. The suggestion that he should go to a rehabilitation ward does not seem to have been followed up.

31. Perhaps BC should have been given a trial leave period with SACMHA, if that was possible, to see how he reacted to the new surroundings. BC had invariably gone to London on previous home leaves, so this might have been one way of testing his willingness to stay in Sheffield. The lure of the flat in London was always there in spite of attempts to get him to give it up. He could not be forced to do so, but his continuation of the lease should perhaps have been a warning that a move to London was still a strong possibility. It would appear that the local authority which owned the London flat did not know that BC lived in his in-laws' home in Sheffield.

32. Unfortunately, the independent investigation panel has not been able to meet BC's family to discuss their perceptions of the level and quality of care and treatment provided for BC.

33. Since the homicide both Trusts have carried out internal inquiries into BC's care and treatment and have put forward action plans. Both reports miss part of the connection between the root causes they identified when they came to setting out the lessons learnt. Oxleas NHS Foundation Trust identified three root causes: the failure to transfer information between the Trusts on 30th April 2009; the lack of a nominated member of assessment area staff on each shift to ensure that assessment and patient management processes were carried out adequately; and, the lack of thorough documentation being prepared on BC before he was discharged. The internal investigation panel concluded that the lessons learnt were to do with the clarity of responsibility for assessments and the need for clear and visible documentation of each service user's pathway through the assessment process. Considerable work has been done subsequently by the Trust in the related area of risk assessment and management, in the form of a new *Guide to the assessment and management of risk.* Neither the report nor the *Guide* refer specifically to service users with a connection to more than one geographical area, whom the independent investigation panel were told were not infrequent. Searches of electronic record systems do not readily throw up the fact that a service user can be registered with more than one GP in different areas of the country and staff would not expect such situations to exist. This seems to be an instance of learning a wider lesson while not recognising a more specific one.

34. Sheffield Health & Social Care NHS Foundation Trust saw the root causes as BC's behaviour in the three weeks leading up to the homicide. BC had a patchy history of compliance with medication and soon after discharge at the beginning of April he went missing and did not attend his weekly blood test so could not be dispensed repeat prescriptions. His care co-ordinator kept in touch with his support worker by phone until 14th April when she arranged for BC to have his blood tests taken and then to be escorted to the pharmacy by his support worker. This plan was based on the assumption that BC was in Sheffield, but when his support worker arrived at BC's flat he was not there. BC was reported to the police in Sheffield as a missing person and he was found 'safe and well' the next day in London. On 28th April 2009, a CPA review took place and it was decided that BC should be discharged from CPA and information was then forwarded to Oxleas NHS Foundation Trust, BC's London GP, and his brother. The lessons learned were that teams should ensure that there is a system in place to support

staff when requests for information are made and staff are away from their home base. The internal investigation panel also asked questions about whether Oxleas NHS Foundation Trust should have been invited to BC's discharge meeting, or whether Sheffield Health & Social Care NHS Foundation Trust should not have discharged BC until Oxleas NHS Foundation Trust had accepted him onto their caseload. They also say that the need for co-ordinated discharge / admission planning / handing over is vital when dealing with service users who have connections to more than one geographical area. The panel's recommendations were that clinical teams should ensure that systems are in place to deal with initial enquiries.

35. The independent investigation panel considered carefully the progress made against implementation of the action plans arriving from the Trusts' internal investigations of the incident; and, in particular the embedding of lessons learned from their investigations. In order to facilitate this analysis the independent review team adapted a measurement framework similar to the approach adopted by the National Health Service Litigation Authority (NHSLA) which uses a set of risk management standards within Healthcare Organisations. The Trusts 'populated' the framework with evidence of the action taken to implement the action plans and to embed the lessons learned.

36. Sheffield Health & Social Care NHS Foundation Trust prepared *An Action Plan* early in 2010 [the exact date not stated on document] which was then updated on 20th April 2010. The panel's single recommendation was that "*clinical teams [are] to ensure systems are in place to deal with initial enquiries*". It is not clear how the internal investigation panel was going to accomplish this. An audit was to be undertaken at points of contact and this was to be included in the 2010/11 audit plan. This was to be tested in the form of a scenario based audit, both in and out of office hours to test the organisation's capacity to be able to direct enquiries to the appropriate area. This is initially scheduled for early March 2011.

37. Under the heading of "*Lessons learned action*", the action plan stated "*the need for co-ordinated discharge / admission planning / handing over is vital in cases of people who are of a transient nature*".

38. Sheffield Health & Social Care NHS Foundation Trust has undertaken a telephone audit in a sample of locations with the aim of ascertaining whether a timely response was made to an external investigation and the Trust believes that a re-audit would be beneficial. The independent investigation panel notes this positive outcome but takes the view that this was only part of the problem demonstrated in this case. There is the matter of communicating accurately and effectively information about the current MHA and CPA status of the individual in question and pertinent information about risks posed and medication history. Sheffield Health & Social Care NHS Foundation Trust have re-issued guidance to staff on communication with the intention of improving the effectiveness of communication it is recognised that it is not possible to write guidance to cover all individuals and circumstances in which staff will be contacted.

39. Since the completion of Oxleas NHS foundation Trust's internal investigation report a system has been put in place to identify a lead person for each shift in the assessment area and to ensure that all staff are aware of who the shift lead is. The Trust provided evidence for this by stating that a white board is in place and is used to identify the shift lead and it lists the actions to be taken by that shift. The shift lead carries a bleep

through which all referrals are made, and all referrals have to be entered into a handover book. All paperwork is then passed to administrators for filing. This system is being monitored by the assessment team. The whiteboard also allows the progress of patients through the assessment process to be tracked. The assessment team's operational policy has been amended to ensure that all assessments are carried out by competent professional staff. All assessors have been reviewed and have participated in a structured induction programme together with supervised practice over a nine-week induction period. Samples of clinical assessments are reviewed during supervision every four weeks. The work of the limited number of bank staff is reviewed by the team manager and no other bank staff are allowed to carry out reviews.

40. The Trust's transfer protocols have been reviewed to ensure the safety of patients being transferred to other Trusts has been accomplished though changes in the assessment team's operational policy. The role of the bed manager has been reviewed and changed so that the bed manager is no longer associated with the assessment role, nor is the duty senior nurse.

41. Oxleas NHS Foundation Trust has produced *A Guide to the Assessment and Management of Risk* (Oxleas NHS Foundation Trust 2010) which includes a section on the 'Assessment of people presenting with self-harm or suicidal ideation' which may have covered the presentation of someone like BC at the Accident and Emergency Department of Queen Elizabeth Hospital. The Guide begins by setting out a series of questions to be asked. The first three questions are:

- *Is the patient alert and with no reduction in conscious level?*
- *If the patient has been using drugs/alcohol are they fit for interview?*
- *If not where do they need to be? Accident and Emergency / psychiatric ward overnight for safety?*

In the discussion of dynamic risk factors the Guide mentions 'treatment adherence' which includes any failure to attend appointments and level of engagement as well as considerations about medication.

42. In the main, the independent investigation panel are satisfied that both Trusts have implemented their action plans based on their internal investigation reports although there are questions about them drawing the appropriate conclusions, a question which is addressed in the Recommendations section below.

43. The independent investigation panel concluded that BC had been suffering from schizophrenia for many years and had persistent delusions of a persecutory nature and auditory hallucinations which caused him distress. He showed signs of gradual deterioration in his level of social functioning.

44. He had been treated over a prolonged period of time with at least two typical neuroleptic (antipsychotic) drugs one of which was administered as a long acting depot injection. He had shown some signs of stabilisation in the earlier days of treatment but had deteriorated further over time.

45. The decision to start BC on Clozapine was entirely consistent with NICE and other guidelines. Clozapine is the Gold Standard drug for people suffering from treatment resistant schizophrenia. BC was pleased with this change in his medication and reported

improvement quite early on and was also willing to re-start it after a time when it had been stopped because of a fear of side effects.

46. The main drawback for BC being on Clozapine was that it can only be administered orally and that the supply of it is very closely monitored, at first, via weekly blood tests. BC was not compliant when not being closely supervised so that whenever he was away from hospital, and particularly when he overstayed his leave, he was likely to have stopped taking it meaning that on resumption of administration he had to start back on a lower dose.
47. BC believed that Clozapine was helping him, as did his medical team, and this meant that it would have been advantageous to his further recovery for him to have been on a therapeutic dose for at least six months (or until he was demonstrating good insight into the importance of taking it regularly) before he was moved into a living situation in which the administration was not supervised at each dose.
48. Relapse or deterioration on cessation was very likely and there is some evidence that the efficacy of Clozapine reduces each time it is stopped.
49. Transfer to a rehabilitation ward, where his continued treatment could have been closely supervised was considered but rejected; instead he was discharged to sheltered accommodation which did not include twice daily supervision of his medication. In view of his clear lack of compliance when away from hospital it is most unfortunate that this decision was made at what was a relatively early stage of his recovery and before he had demonstrated sufficient insight and motivation to be a reliable pill taker.
50. There has been a continuous move nationally to reduce the number of inpatient beds but this has not taken into account the fact that seriously ill people need time to recover in a safe environment with the sort of supervision that ensures medication compliance.
51. The independent investigation panel cannot be certain that this homicide would have happened during the Bank Holiday weekend if any one individual had behaved differently or had made different decisions. The independent investigation panel concluded that a combination of five or six decisions led to BC being in his flat that weekend with fatal consequences. To the best of the panel's knowledge staff followed local policies that existed in their Trusts at that time; several of these policies were defective. The panel takes the view that five or six decisions would have had to have been different in order for this homicide to have been prevented. These decision makers acted in good faith on the basis of what they knew or believed at the time.
52. The independent investigation panel identified a number of care and service delivery problems, the principal one of which was BC himself. BC had a long-standing treatment-resistant condition which was exacerbated by changes in his medication regime as a well as by occasional non-compliance with medication and his use of khat. BC changed his mind about where to live on discharge and his commitment to the Sheffield area was tenuous while he seemed to see south east London as home. The NHS rules about location depending on GP registration meant little to him; especially as he seems to have been registered with one GP in Sheffield and another in London.
53. There was a service delivery problem in that there was a failure to understand the extent of BC's illness when he was seen in the Oxleas House assessment area. The acting bed manager, who took the decision to allow BC to leave the area in the care of his cousin AD, was dealing with a former voluntary patient who was asking to leave. The

acting bed manager might have had doubts about the wisdom of releasing BC so he could return to Sheffield but these seem to be have been dispelled when AD arrived and offered not only to provide care and support but also to take BC back to his medication.

54. The independent investigation panel identified a policy failure in Sheffield Health & Social Care NHS Foundation Trust's 'Difficult to Engage Service Users'. This policy allowed informal patients like BC to disengage from services, if they were thought capable, to exercise their right to decline treatment if they had moved out of the area. The decision taken to remove BC from CPA in late April 2009 meant that any re-engagement depended on BC or his family recognising deterioration in his mental state and then taking himself to his GP or to an Accident and Emergency Department. This policy was superseded in 2009 and CPA cannot be terminated simply by the service user moving out of area.

Recommendations

55. The independent investigation panel was surprised by the fact that BC was able to register with more than one GP at the same time and was able to remain registered even though he was an inpatient for nearly a year in total. This situation needs to be investigated and resolved, if only, to prevent some of the problems that occurred in this case. These recommendations are derived from the independent investigation. Some of the recommendations are Trust specific but the first five have general application to Trusts working with mental health service users.

Recommendation 1 - Service users with more than one known address should be flagged so that other Trusts can be informed if they suddenly move to another area. Trusts should ensure that staff check the national GP registration system to see if patients have strong ties or (potentially) second homes in other towns and cities and use this knowledge when planning discharge or follow up treatment.

Recommendation 2 - There should be closer cooperation with the police so that they have access to a qualified mental health worker when safe and well checks are made.

Recommendation 3 - Full social histories should be completed with particular care taken with service users who come from cultural backgrounds where extended family networks are common; other agencies and individuals should be used to confirm the facts.

Recommendation 4 - When Trusts are communicating with each other about a client they should ensure that key clinical information is prioritised before financial and administrative issues.

Recommendation 5 - Trusts should ensure that proper policies, procedures and training are in place to allow the rapid transfer of key clinical data to other Trusts 24 hours a day in an easily accessible format to a known recipient using Safehaven principles. All relevant staff should be competent to use these systems and processes.

The following recommendations apply specifically to Sheffield Health & Social Care NHS Foundation Trust and / or their Commissioners:

Recommendation 6 - Service users with histories of long-term treatment-resistant illnesses and when there is little knowledge of their previous behaviour in the community should be discharged to appropriate supportive accommodation or via a rehabilitation ward.

Recommendation 7 - When service users are discharged to third sector or other organisations their support and care package should be formally agreed and there should be suitable robust contingency plans in place if service users go missing.

Recommendation 8 - Service users with long-term illnesses who relocate outside the Trust's area should only be discharged from CPA when a full and proper hand over has been completed with the receiving Trust.

Recommendation 9 - The Trust should audit the information systems and take appropriate steps to ensure that care co-ordinators have access to clinical information about their clients irrespective of location within the Trust.

Recommendation 10 - The Trust should revise its 'missing persons' policy and it should be tested regularly.

Recommendation 11 - Sheffield PCT should review the services commissioned from Sheffield Health and Social Care NHS Foundation Trust with specific emphasis on access to talking therapies and in-reach drug and alcohol misuse therapies.

The final recommendation is specific to Oxleas NHS Foundation Trust:

Recommendation 12 - Oxleas NHS Foundation Trust should audit the use of clinical assessments as part of monthly supervision sessions and benchmark their use against practices in other Trusts.

INTRODUCTION

Summary of the incident

56. On 4th May 2009 BC attacked AD, his cousin, with an axe in the flat they shared on south east London. AD died at the scene as the result of the injuries he received. At the time BC was a recently discharged outpatient of Sheffield Health & Social Care NHS Foundation Trust who had moved to London within about thirty-six hours of discharge. It was decided that BC should be discharged from the Care Programme Approach (CPA) on 28th April because he had left the Sheffield area. On 29th April 2009 he was brought initially to the Accident and Emergency Department of Queen Elizabeth Hospital, Woolwich (part of South London Healthcare NHS Trust) before being taken to Oxleas House (part of Oxleas NHS Foundation Trust) which is on the same site where he stayed for about twenty-four hours in the assessment area before being allowed to leave in the care of his cousin with a view to him returning to Sheffield.
57. Precise information about the events leading up to the killing of AD by BC is limited as the main source is BC and his recollections are confused and partial. Some additional information is available from court papers. AD was a fellow Somali whose application for asylum in the UK had been refused. AD was well known in the local south east London community and he was a member of the local informal social club scene. He was known to sell khat to the local Somali community. He was last seen by friends who were watching Match of the Day at one of the local clubs.
58. At some time over the Bank Holiday weekend AD and BC had an argument during the course of which BC said that AD questioned his sexuality and then ordered BC out of the flat. BC said that it was his house and AD should go. In the fight that followed BC struck AD with an axe. AD suffered multiple fatal axe wounds to the head and neck as well as several defensive blows to both arms.
59. During the evening of Monday 4th May 2009 (Bank Holiday Monday) three of AD's friends became concerned about his welfare as they had not seen him since the previous day and they decided to visit his home address (in London SE3, a local authority owned flat which BC rented) to check on him. On their arrival, they found the property in darkness and called out repeatedly for AD to come to the door. When he failed to do so, the friends became worried and forced the door. When they checked the premises they found AD apparently dead in the living room area. A bloodstained axe and a handwritten note were found close to the body. The three men left the premises and called the London Ambulance Service and the police to attend. The Ambulance Service attended first and provisionally confirmed life extinct as the body was cold and rigour had set in (life was confirmed extinct officially by the forensic medical examiner at 10:34 on the Tuesday morning). Whilst police officers were in the process of setting up crime scene preservation measures, BC returned to the area outside the flat where he was identified by the three men who had found the body as the other resident of the flat.
60. BC was then arrested and taken to Plumstead police station and the police recorded that it was clear from the outset that BC was suffering significant mental health issues, presenting paranoid and schizophrenic symptoms in the custody suite. A full set of forensic samples were obtained and the clothing BC wore on arrest were seized. Owing

to concerns about his mental health, BC was eventually sectioned under *s* 3 of the MHA (1983) and conveyed to secure mental health accommodation pending further assessment. On analysis BC's blood did not show any signs of Clozapine or of the active components of khat, though the forensic scientist pointed out in evidence that the samples were taken at least eighteen hours after the killing. There were no traces of any other commonly abused drugs found. It was not clear whether BC had consumed any alcohol prior to the offence.

61. On 16th September 2010 an order was made under *ss* 37/41 of the MHA following a trial by a jury of the facts at the Central Criminal Court as BC was not fit to plead.

Background and context

62. BC was born in Somalia on 28th June 1974 and arrived in the UK in 1994 as a political refugee. He was subsequently awarded UK citizenship on an unknown date. In July 2008 it was recorded (apparently for the first time) that BC had four older step brothers and five younger full brothers. In August 2008, the names and ages of his four older and his five younger brothers were recorded in the notes for the first time. The two younger brothers nearest to him in age were identified as having mental health problems and being in the care of Oxleas NHS Foundation Trust. BC also had four uncles, one of whom (PO) lives in the UK and visited him on a number of occasions when he was in hospital. The case notes also include the statement that BC witnessed his mother and sisters being killed during the war in Somalia. His experiences of the war led one clinician to ask whether he was suffering from Post Traumatic Stress Disorder.
63. The first recorded medical report available to the independent investigation was written on 25th May 1995 by a consultant physician in the Department of Respiratory/General Medicine at Greenwich District Hospital informing his then GP that BC had completed six months of anti TB chemotherapy. Residual shadowing showed signs of further clearing and although he had not gained weight he was otherwise well.
64. On 13th December 1995 the GP records BC's uncle as stating that BC had attacked one of his brothers three days before with a knife. BC was released from custody without charges but the uncle was concerned that he had been getting 'paranoid' for some time and was looking at the possibility of arranging psychiatric intervention. BC was admitted as an inpatient to a hospital in south east London, though it is not clear from the records precisely which hospital it was, on 21st December 1995 where he remained until 27th February 1996. His discharge summary stated that he was suffering from a depressive illness with an associated paranoid state.
65. He was seen by a consultant psychiatrist initially on a fortnightly basis and later this was changed to quarterly. His record of attending seems to have been patchy though attending more frequently than not. Outpatient clinic sessions seem to have been of variable quality as he sometimes attended with a brother or cousin who acted as interpreter but sometimes not.
66. Although BC attended the Accident and Emergency Department of St George's Hospital in March 1996 having taken an overdose of nine tablets of Clomipramine he claimed to

have taken them by mistake. He described his mood as low when he took the tablets but was now relieved to be alive and was not now suicidal.

67. He was detained under the Mental Health Act (1983) and admitted in March 1997 for 9 days. The diagnosis at the time was severe depression with psychosis. He was seen as being not very compliant on the ward and was caught giving another patient khat. He was admitted again later in the same month but the precise dates are not available.

68. BC had the same consultant psychiatrist until October 1997. The consultant thought he was suffering from psychotic depression. BC had a fixed belief that one part of his brain was not working well and had been turned to liquid following a blow struck by a brother. BC expressed very negative feelings towards his brothers but the consultant could not decide whether these beliefs were delusional. BC believed that his uncle was trying to break up the family and it was his brothers who had hit him and that they had threatened him with knives. The consultant arranged for BC to be seen by a Somali psychiatrist. The symptoms seemed to worsen when he was around his family so arrangements were made for him to be found his own accommodation.

69. In 1998, his new Responsible Medical Officer (RMO) under the Mental Health Act 1983 saw him as an outpatient and recorded BC as feeling better. It was recommended that he should attend a MIND project with a Somali worker but did not do so. During 1999 BC attended appointments every two months as required and the consultant thought that his psychotic symptoms were controlled but he was suffering from severe side effects, for example, gross tremors and choreoathetoid movements [the occurrence of involuntary movements in a combination of chorea or irregular migrating contraction and athetosis or twisting and writhing], so was referred to a consultant neurologist.

70. In 2000, a new RMO suggested that BC had markedly abnormal movements and this led him to question the diagnosis of a psychotic disorder. These symptoms gradually improved when BC came off medication. BC was living independently and attending college. He was showing a good deal of insight and so it was decided that he should be discharged from the CPA system. He had a relapse at the end of December and expressed paranoid delusions that someone was putting things in his food, that his uncle was spreading rumours about him and was, somehow, controlling his life. Late in the month he was reported as being much brighter and feeling much better since he re-started taking his medication.

71. In 2001, BC was reported as chewing khat all day which made him feel tired, lacking in motivation, and having a poor appetite and sleep pattern. It was thought that little could be done for him while he continued to use khat. BC had housing problems during the year as his understanding of English was too poor for him to cope with the local Housing Department. Assistance was arranged for him to work on his housing problems. He had similar problems with the benefits system. These problems continued throughout 2002 and 2003.

72. In the CPA review notes for 2003 BC is described as being worried by his khat consumption which he was unable to control. Its use was affecting him physically and mentally. He was in a vicious circle of use which left him feeling anxious so he would chew more khat and become more anxious. He had become completely dependent on his brothers and friends for food and shelter. His medication (Sertraline) made him feel

nauseous and gave him tachycardia [an abnormal increase in heart rate]. He complained also of confusion and lack of motivation.

73. In 2004, BC attended only two CPA reviews as he said he was getting confused and forgetful. He was also forgetting to take his medication though he continued to use khat regularly. In 2005 he attended only one CPA review appointment. It is not clear why his care co-ordinator did not try picking him up and bringing him to interview.

74. Sometime during 2005, BC moved to Sheffield and at the same time disengaged from services. He married during the year and worked as a kitchen porter in a local hotel. The Sheffield Health & Social Care NHS Foundation Trust internal investigation report states that he was living with his wife, his wife's mother, his wife's sister and her husband. The one record for 2007 was made by his GP stating that he took an overdose of an antidepressant in August of that year. In February 2008 he was started on Olanzapine due to increased paranoia towards his family. His wife could not cope with his behaviour and sometime in March his brothers came up from London and took him to live with them. There was a child (aged fifteen months) at this time and his wife was then three months pregnant.

75. In the case records there is a certain amount of confusion about the identity of BC's wife who is given three different first names and is known to use all three. She is also described on one occasion as being of Jamaican origins. Despite numerous attempts no one from the various health services appears to have made contact with her. When phoned she either denied knowledge of BC, or said that she was not married to him, or simply hung up. Both the police and social services were involved because of a child protection component but there does not seem to have been any formal communication between social services and health although a few details appear in the case notes.

Purpose

76. The independent investigation was jointly commissioned by Yorkshire and the Humber Strategic Health Authority and London Strategic Health Authority. An independent investigation is required when a homicide has been committed by a person who is, or has been, under the care of specialist mental health services in the six months prior to the incident. The purpose is to examine all the circumstances surrounding the care and treatment provided and in each case to identify any errors or shortfalls in the quality of the service and to make recommendations for improvement as necessary.

77. The independent investigation panel was required to address Terms of Reference agreed by Yorkshire and the Humber Strategic Health Authority and London Strategic Health Authority in consultation with the NHS organisations involved in the commissioning and delivery of the care and treatment of BC as set out in full below.

Terms of reference

78. The Terms of Reference were set jointly by Yorkshire and the Humber Strategic Health Authority and London Strategic Health Authority in consultation with the NHS organisations involved in the commissioning and delivery of the care and treatment of

the service user identified in the Serious Untoward Incident (SUI) and the appointed independent investigator.

79. The NHS organisations involved in commissioning and delivering the care and treatment to this service user were:
    - NHS Sheffield
    - Sheffield Health & Social Care NHS Foundation Trust
    - NHS Greenwich
    - Oxleas NHS Foundation Trust.

80. To examine:
    - The care and treatment the service user received from the NHS organisations and the suitability of the care and treatment in view of the service user's history, vulnerability and assessed health and social care needs
    - The suitability of the discharge and ongoing support planned for the service user
    - The extent to which the care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies.

81. To investigate:
    - The interface, communication and joint working between the two mental health trusts and any other agencies involved in providing care to meet the service users mental, physical health and social needs
    - The adequacy of the risk assessments of the service user including the risk posed to others
    - The involvement of carers, relatives and other organisations when preparing discharge plans
    - How the care plan was tailored to meet the service user's needs including the geographical split of his family responsibilities
    - The perceptions of the service user's family of the level and quality of care and treatment provided.

82. To comment upon:
    - The quality of the internal investigations, their ability to identify root causes, the clarity in which those were presented in the reports and the strength of the recommendations to address these.
    - The quality of the internal action plans, the strength of the proposed activities to resolve the recommendations and the evidence of the effective audit and review of those actions.
    - The collaboration between Sheffield Health & Social Care NHS Foundation Trust and Oxleas NHS Foundation Trust in the internal investigation activity.
    - The progress made towards the implementation of the internal action plans.

83. To identify:
    - Aspects of the service user's treatment and management which were of good-quality or commendable practice.
    - Learning points for improving systems and services.

84. To produce:

- Realistic, measurable and specific recommendations for action in conjunction with the NHS organisations involved to address the learning points to improve systems and services
- To produce a final report that complies with all relevant legislation for presentation to the Board of Yorkshire and the Humber Strategic Health Authority via the Independent Investigations Committee and the Board of London Strategic Health Authority via the Mental Health Incident Strategic Review Group.

Methodology

85. Consent was sought and given by BC to access relevant health and other records prior to these being seen by any members of the independent investigation panel. The independent investigation process was informed by:
    - Interview with BC (subject of inquiry)
    - Interviews with key staff (interviews were audio-recorded and transcripts sent to interviewees for confirmation of accuracy / amendment):
    - liaison psychiatrist, assessment area, Oxleas House, Oxleas NHS Foundation Trust
    - manager of the assessment area, Oxleas House, Oxleas NHS Foundation Trust
    - acting bed manager of the assessment area, Oxleas House, Oxleas NHS Foundation Trust (as he was in 2009)
    - medical director (previously clinical director), Oxleas NHS Foundation Trust
    - manager SACMHA
    - service director for Recovery, Rehabilitation and Specialist Services, Sheffield Health & Social Care NHS Foundation Trust (as the job title was in 2009, now service director for the Community Directorate)
    - care co-ordinator, Sheffield Health & Social Care NHS Foundation Trust
    - continuing needs manager, Sheffield Health & Social Care NHS Foundation Trust
    - clinical director for Recovery, Rehabilitation and Specialist Services, Sheffield Health & Social Care NHS Foundation Trust (as the job title was in 2009, now clinical director for the Community Directorate)
    - senior house officer (SHO) in the assessment area, Oxleas House, Oxleas NHS Foundation Trust
    - BC's current responsible clinician at Wathwood Regional Secure Unit
    - A review and analysis of BC's health record including primary care records and records from the two specialist mental health trusts which were responsible for his care and treatment as both an inpatient and an outpatient;
    - A review and analysis of both Trusts' key policies and procedures in place at the time of the homicide (4th May 2009) and subsequently (as listed in Appendix Three);
    - An audit and analysis of both Trusts' internal reports and appendices dated August 2009 (Oxleas NHS Foundation Trust) and (Sheffield Health & Social Care NHS Foundation Trust) dated September 2009.

86. The independent investigation panel had hoped to interview one or both of BC's brothers but they have not responded to our attempts to contact them, nor did they respond to the initial NHS London notification that the investigation was taking place.
87. The panel completed a detailed time line for BC's involvement with services up to the incident date (4th May 2009).
88. The panel undertook:
    - A review of BC's treatment and care provided by Oxleas NHS Foundation Trust and Sheffield Health & Social Care NHS Foundation Trust.
    - A review of the Contributory Factors leading up to the homicide and a Root Cause Analysis.
89. From their analysis of the findings of the investigation, the team made recommendations for consideration by Oxleas NHS Foundation Trust, Sheffield Health & Social Care NHS Foundation Trust, London Strategic Health Authority and Yorkshire and the Humber Strategic Health Authority to support further organisational learning from the homicide.
90. The independent investigation panel is required to present their report to London Strategic Health Authority and Yorkshire and the Humber Strategic Health Authority for consideration and implementation.
91. The independent investigation panel was composed of Dr Tony Fowles, Dr Michael Rosenberg and Mr Tony Thompson.
92. This Level 3 (independent) investigation was commissioned by NHS London and NHS Yorkshire and the Humber from Caring Solutions (UK) Ltd. The investigation commenced in January 2011.

FINDINGS

93. The next section of the report covers the detailed Chronology of events in respect of BC, any Notable Practice reported in respect of BC's care and treatment and an analysis of any Care and Service Delivery Issues and Contributory Factors disclosed during the investigation.

Synoptic chronology of events

94. The chronology of event that follows is necessarily synoptic as BC had 32 outpatient appointments over the period 1997 to 2005. His stays as an inpatient have produced many hundreds of pages of daily notes which add little to the event in May 2009. They have been summarised in the Background and Context section. More details are provided here about his contacts with various mental health services between April 2008 and April 2009. A more detailed chronology is given in Appendix One.

Date	Event or activity
28/06/1974	Born in Somalia
1994	Arrived in the UK
25/05/1995	Letter to GP on completion of 6 months of anti TB chemotherapy
13/12/1995	GP records knife attack on brother 3 days previously
21/12/1995	Admitted as an inpatient to the David Lieberman Centre, Greenwich
27/02/1996	Discharged from hospital
03/03/1997	Sectioned and admitted [it has not been possible to identify the hospital]
12/13/1997	Discharged from hospital
1997	Attended 3 outpatient appointments
1998	Attended 3 outpatient appointments
1999	Attended 5 outpatient appointments
2000	Attended 5 outpatient appointments
2001	Attended 4 outpatient appointments
2002	Attended 2 outpatient appointments
2003	Attended 5 outpatient appointments
2004	Attended 4 outpatient appointments
2005	Attended 1 outpatient appointment
03/09/2005	Married and moved to Sheffield
09/08/2007	Outpatient case notes - overdose of tricyclic antidepressant drug
April 2008	BC was admitted on 12th to the Northern General Hospital, Sheffield Teaching Hospitals NHS Foundation Trust, after a serious suicide attempt where he was seen by Liaison Psychiatry. The bleach BC had ingested had caused internal damage. He showed no signs of depression and there was no evidence of disordered thinking. He was able to concentrate fully and there had been no evidence of audio or visual hallucinations while on the ward. BC no longer had any intention of killing himself or harming others.

	BC was discharged from the Northern General Hospital on 24th and a discharge summary was sent to his GP at a health centre in south east Sheffield
May 2008	Sometime after discharge BC went to stay with his brothers in London and on 27th he was brought to Accident and Emergency Department Queen Elizabeth Hospital Woolwich, South London Healthcare NHS Trust. BC's brother had great concerns about his mental health as he had been expressing thoughts that people were making him paranoid, doing black magic on him and controlling him. He was non-compliant with his medication [Olanzapine]; and was not sleeping and eating, nor was he attending to his self care. BC was then seen in the assessment area of Oxleas House, Oxleas NHS Foundation Trust. BC denied being paranoid towards his wife and his brother. He was offered informal admission but declined as he wished to return home. MHA assessment was carried out and he was detained under *s* 4 of the MHA 1983. The care plan was that BC should have a physical examination and urine drug screen be carried out. There was to be contact with his wife to gather further information. BC was given an initial diagnosis of psychosis together with the possibility of mental and behavioural disorders due to khat use. He was then started on: Olanzapine 5 mg twice daily, Clonazepam 1 mg twice daily, and Lorazepam 1-2 mg as prescribed. It was thought that the precipitating factors for this episode were non-compliance with prescribed medication; disengagement with psychiatric services; chewing khat on a daily basis; paranoia against his wife resulting in breakdown in relationship; and, not sleeping and eating well. At first BC was uncommunicative and it took staff some time to discover that he came from Sheffield.
June 2008	BC began to respond to increased dosages of Olanzapine (10 mgs twice daily), participating in some ward activities, seeing the Imam, and asking for permission to go shopping. Nursing notes record that he said on several occasions that he wished to return to Sheffield on discharge. Contacts were then made with Sheffield Health & Social Care NHS Foundation Trust so that BC could be transferred back to their care and arrangements were made to affect the transfer on 10th. But when the day arrived, BC said that he did not wish to go and refused to comply with his medication as a protest against the move. On 10th BC was transferred from Oxleas NHS Foundation Trust Woolwich to Nether Edge Hospital, Sheffield Health & Social Care NHS Foundation Trust and was admitted for assessment. He was described as being tired and hungry after the ambulance trip; he tried to sleep but could not because of his mental distress. Nursing notes show that later in the month, BC refused to be on Modecate. He was having suicidal thoughts again. Oxleas House was asked for notes on his previous medication.

	At the end of the month, an MDT meeting took place and it was recorded that he thought his medication was helping him. His MHA status was that of an informal patient but it was agreed that he would detained compulsorily under *s* 4 of the MHA if he tried to leave. Contacts were then made with the North Recovery Team Oxleas NHS Foundation Trust about a transfer back to London as he had GP there and planned living with his brother. BC was then told that he would have to stay in Sheffield as he was registered with a GP in the city.
July 2008	At the beginning of the month, PQ became BC's care co-ordinator. The Oxleas House discharge summary arrived in the middle of the month. Arrangements were made for a khat specific drug test as a more general test would mean that khat would show up as amphetamine. BC was described as still having persecutory thoughts. He was reported as saying occasionally that he still wanted to return to London. Staff reported that BC's wife had expressed concern about him being around their 18 month old child. Staff found BC using khat on the ward and he was very apologetic about it.
August 2008	MDT notes record BC as still wishing to visit his child and that staff had been unable to contact his wife. PQ was to try to make contact to find out if his wife still wished to continue the relationship otherwise the plan was for BC to live with his brother in London. In the middle of the month, one of the urine samples was found to have been diluted and this was discussed with BC. For the first time a comprehensive and detailed family structure was taken by a specialist registrar and BC described his childhood in pre civil-war Somalia and the war's traumatic effects on his family. At this point BC was offered a place on a drugs scheme for Black men but did not see his khat use as a problem. Inquiries were made about BC going back to London to live with his brother and staff were then told about his London flat. It was agreed that staff would liaise with London services so that BC would be supported on discharge. Later in the month, the brothers said that they were happy for BC to move back to London although BC was told that he was not yet well enough to be discharged. Towards the end of the month, BC's medication was changed with Risperidone 1 mg initially being given twice daily and then increased to 2 mg twice daily; his Olanzapine was reduced to 10 mgs daily. At the end of the month, BC visited his wife to see his child but his wife shouted at him and threatened to call the police; eventually he was allowed to see the child.
September 2008	At the beginning of the month, BC was described as not having made any improvement yet, he was not engaging well, and his presence on the ward was not evident. He was still having psychotic delusions about his wife and family and their use of black magic to kill him.

	Although BC had initially said that he felt his medication was having a positive effect on his mental state this was no longer true and he now felt the same as he was when he first came into hospital. His dosage of Risperidone was reduced to 2 mg twice daily instead of 2.5 mgs twice daily. Towards the end of the month BC was to go on home leave with his brother but initially the arrangements did not work out and staff expressed their concerns about the vagueness of contacts with BC's family. BC failed to return on time from his home leave and one of his brothers phoned to ask for an extension to be told that BC must return within 24 hours or he would be out of medication. On his return, the brother said that the home leave had been without problems although he thought that BC could benefit from a stronger medicine. At the end of the month, the decision was taken to start BC on Clozapine which was explained to BC and he agreed to the change. BC informed staff that he had registered with a GP whilst on leave. BC had 4 days home leave.
October 2008	BC approached staff requesting advice when he began taking Clozapine, they reported that he demonstrated some insight and understood his current symptoms as part of his mental illness. BC was given support and reassurance and encouraged to talk to staff if he had any more questions. After two weeks on Clozapine, BC complained of its side effects (drowsiness, unsteadiness on his feet, feelings of restlessness, nervousness and feelings of increased aggression, as well as heightened blood pressure in the morning). BC agreed to continue with Clozapine on being told that his body would take some time to adjust to the medication. A few days later it was noted that despite an objective improvement since taking Clozapine, BC was saying that he did not like the medication and wished to stop taking it. Four days later (21st) he attempted to secrete his medication in his hand. The nurse who was administering the Clozapine noticed and when BC was challenged he swallowed the medication. On the last day of the month the case notes record that BC was feeling happier, had more energy, was sleeping better, had improved appetite and was less focused on his psychotic delusions although he still believed in them. The plan was for the Clozapine dosage to be increased in November to 100 mgs.
November 2008	During the first week of the month, BC was seen to be visibly upset and when nurses inquired they were told that he was crying because his brother had been shot. Nursing staff were able to check the next day and were then able to reassure BC that his brother had been sacked, not shot. BC said that he wished to move to Scotland on discharge as there were fewer Somalis living there. There was a discussion of how long BC would have to take Clozapine and he was told it was a long-term treatment, so would have to take it for a few years. By the 11th the care plan suggested increasing the Clozapine dosage to 200

	mg daily. There was a note that suggested that he had been using khat over the previous weekend. In the middle of the month BC went on home leave to his brothers and over-stayed. Attempts were made to contact BC and his brothers but without success. The staff were unsure whether or not BC had sufficient medication with him. A missing person procedure was set in place and the brothers' address was obtained from BC's uncle. BC was returned to the ward at 02:30 on the morning of 20th saying that the leave had not gone well as the Somali community wanted nothing to do with him. BC was vague about his plans for a place to live on discharge but he told staff that his wife had given birth to his second child two days previously. He phoned his wife and left a message. On 26th staff reported that BC had tried to visit his wife but had not been allowed into the house. Efforts were then made to contact an advocacy scheme to help BC gain access to his children. On 27th BC spent some time with an SHO who recorded that she felt he might be autistic as he had difficulty expressing himself. The SHO recorded that his delusional beliefs were unchanged and that BC had admitted chewing khat while on home leave. BC was very upset as he had tried to visit his new-born child with a present but again had not been allowed into the house. BC also said that his wife was involved in an affair and that neither of the children were his. It was agreed that one of the doctors would try to contact his wife but this was not successful. BC had home leave for 4 days and overstayed by 3 days
December 2008	The case notes report that BC was still obsessed with his thoughts; he wished to move to London although he believes that all his brothers are involved in harming him. It was agreed to increase his Clozapine dosage and to invite his brothers and his uncle to an MDT meeting. The MDT meeting was held on 9th where BC complained of being over-sedated so the Zopiclone he had been taking since returning from home leave was stopped. His wife agreed that he could see his new child and it was decided not to cancel the arrangements to see an advocate. On 19th, it was decided to increase the dosage of Clozapine again as his mental state was again not good and as result it was decided that he could not have home leave at present. At the end of the month it was suggested that BC should be referred to a community team in London and a letter was written to his London GP requesting a booking with the appropriate team. BC told staff he no longer wished to have contact with his children and implied that his ex wife was having an affair and that had a bearing on his decision.
January 2009	On 2nd there was an MDT meeting during which BC's consultant psychiatrist and the ward staff discussed their concerns over where BC should go on discharge. He said that he felt safe on the ward but had been told that he could not stay in hospital for ever. BC has resolved to return to London but he remained completely convinced that his illness was due

to black magic. The ward team were keen to think about discharge plans but BC's brothers seemed to be avoiding contact with them. Concerns were also expressed that Clozapine did not seem to have made any difference and it was more difficult/risky to discharge someone on that particular medication as they would need weekly blood tests and be well supported by a community team. There was a discussion as to whether or not a more standard antipsychotic should be recommenced to make his eventual discharge more appropriate. Work was also planned to see if BC's beliefs about the Somali community could be improved.

At the end of the first week of the month BC wanted to know when he would be discharged. He was told that he would have to identify where he would be living in London and told staff that he would initially be living with his brother and that he had a GP in London SE7. He had chewed khat in the preceding week and was upset because he had tried to visit his children again and his wife had not accepted the gifts he had brought.

On 13th a CPA meeting was convened and it was recorded that BC had made some progress as his GP in London had now been identified, BC was beginning to realise the negative impact of khat on his mental health, he sees his brother as a good role model, and was beginning to accept that his beliefs about community hostility were not based on any evidence. It was agreed that the dosage of Clozapine would be increased to 400 mgs daily over the next few days. The staff tried to check that BC would be able to stay with his brother on discharge but had not been able to contact him as he worked shifts. The next day it was established that BC's flat was located close to his brother's house, so there could be support. On 16th a formal request was made to transfer BC to an Oxleas NHS Foundation Trust community team.

On 19th BC was initially refused permission to go on home leave as his Clozapine dosage had recently been increased but this decision was reviewed and after consultation with the specialist registrar he was allowed to go on two days leave.

On 23rd BC's home address and GP details were confirmed but it was also noted that BC had not yet returned to the ward.

On 26th BC's care co-ordinator PQ noted that his wife's family did not want him to have contact with his children. Ward staff confirmed that although BC had been registered with a London GP since November 2008 he had not yet had any contact with them. BC had been telling ward staff that he was seeing this GP to get his Clozapine while on home leave. BC had not yet returned from home leave, so it was agreed that he would be reported as a missing person if he had not returned the next day. A letter from the North Recovery Team manager, Oxleas NHS foundation Trust was received about arranging the transfer of his care. PQ believed that BC was quite vulnerable and would need the support of a community team as well as a GP.

On 27th BC's brother phoned to say that BC was refusing to accept a lift

	back to Sheffield. BC had been reported as a missing person with the police but this was cancelled after it became clear he was with his brother and was an informal patient. On 29th BC arrived back in Sheffield having travelled back by coach by himself. On 30th BC was discussed in the Oxleas House referral team meeting (Oxleas NHS Foundation Trust) and it was agreed that a great deal more detail on BC would be needed as well as a letter from the referring psychiatrist to the Oxleas House psychiatrist. On the same day there was a CPA meeting in Nether Edge Hospital when BC was discussed and his brother attended. BC acknowledged that he was suffering increased anxiety and was preoccupied with his thoughts both of which were related to him missing his medication for 3 or 4 days. PQ reported that it was very unclear how best to support BC and he was not able to say what he wanted. She explained to the staff that she was unable to find any risk assessment of BC anywhere on the patient information system. She thought that BC might benefit from discharge to supported accommodation or a rehabilitation ward but BC was insistent on returning to London. The nursing notes recorded that BC had now been commenced on Quietiapine with the aim of eventually giving a twice daily dose of 150 mgs. The MDT meeting notes reported that the consultant psychiatrist wanted a clear plan to be decided that day and there was a discussion over sheltered versus supported accommodation. BC had originally told staff that he had done nothing while on leave but told the meeting that he had sorted out the gas and electricity supplies to his flat. He was challenged about this as he had been lying when he told staff that his GP was giving him Clozapine. BC was told that his behaviour could not be tolerated any longer and that he could not stay on the ward forever. BC then said that he wanted to return to London and to be given Clozapine; he refused a depot as this made him unsteady on his feet. In a meeting with BC's brother it was noted that a friend was currently living in BC's flat. The brother said that when BC was in London all he did was go off and chew khat and then he lacked motivation to do anything. The brother did not think that BC was capable of living independently because of his khat chewing. The brother was told of the plan to transfer BC's care to London. BC had 7 days home leave and overstayed by 1 day
February 2009	On 2nd an MDT meeting was informed by BC's consultant psychiatrist that supported accommodation should be found in the light of the information provided by BC's brother, because BC was still psychotic and threatening to kill people, the lack of support from BC's brother, and the fact that BC's London flat lacked resources. BC had a community team in place in Sheffield, so PQ should look for accommodation in the city.

	BC's Clozapine was stopped after he returned from home leave and it was re-started during the second week of the month. BC apologised for having brought khat onto the ward. He complained that his brothers did not look after him properly - there was no bedding or heating when he stayed with them in London. BC stated his belief that he was being medicated for depression. On 9th BC's brother attended the ward and expressed concerns about BC being discharged to London and it was agreed again that supported accommodation in Sheffield should be sought. On 12th PQ met BC to discuss his discharge and it was agreed that BC should give up his London flat and find accommodation in Sheffield where he would be safe. The choice was between Halfway housing which provides practical and emotional support to people with mental health problems and SACMHA where BC was unlikely to come into contact with Somalis. These plans were based on BC giving up his London flat. On 13th BC woke early and had an altercation with another patient for no apparent reason. BC was given 1 mg of Lorazepam to reduce his agitation and aggression. BC was talking about the Somali community coming for him, and there was a man on another ward with connections to the Somali community. He was later given another 1 mg of Lorazepam. The night shift staff said that there was a suspicion that BC had been smoking cannabis with another patient the previous night. The North Recovery Team manager (Oxleas NHS Foundation Trust) phoned PQ regarding more information being given about the transfer of BC to London. On 16th the MDT notes recorded that BC was more unwell during the previous week with his delusional ideas more evident. It was decided that his Quietiapine dosage should increased to 600 mgs daily. On 26th the nursing notes recorded that BC had been out to the shops that evening with another patient and there were suspicions that he and other patients had been smoking cannabis.
March 2009	On 1st BC was helped to complete the SACMHA application forms. The nursing notes recorded that he was clearly experiencing paranoia and later admitted to staff that he had been given cannabis by his peers during the last few weeks. By the 3rd the MDT notes stated that he was more settled and less aggressive though he still had some paranoid thoughts. The accommodation application to SACMHA was thought to provide access to workers with more cultural sensitivity and able to support his need to integrate with the local Somali community. On 5th the nursing notes recorded that BC had been speaking about seeking his discharge to London, he appeared to accept that this was what he was going to do next and had visited his uncle to say his goodbyes. That evening he was discovered chewing khat and had given some to one, or possibly, two others. On 6th PQ attended BC's interview at Halfway housing where he spoke

	openly and well about his problems. He talked about finding out about his wife's affair and having bought a gun. PQ recorded that she was unaware of this and would request that the information was added to BC's risk assessment. BC later explained that he had borrowed the gun from a friend but had no intention of using it or to hurt anyone and so had returned it to his friend. On 8th a risk management care plan was drawn up - BC was not considered a risk of harm to others at that time. On 12th it was recorded that Halfway housing had not accepted him but that SACMHA had agreed to take him. Applications for a community care grant for furniture were completed. On 15th BC was reported as stating that he was bored and that he has been attempting to cope without the use of his prescribed medications. On 17th the North Recovery Team manager (Oxleas NHS Foundation Trust) was in contact asking about the transfer and was told that BC was now planning to stay in Sheffield. BC asked for two days home leave as he was paying rent on his flat in London as well as one in Sheffield. BC said that he wanted to give up his London flat and to stay in Sheffield. Staff were not able to close the London flat as they did not have any information about it. On 20th the MDT notes recorded that BC was paranoid at times, he had had cannabis on the ward, and had told his brother he wanted to kill himself. BC denied the threat to kill himself and indeed denied having spoken to his brother. He said that someone pretending to be his brother was phoning the ward. On 23rd PQ visited BC on the ward and said he was happy that the discharge plans were progressing. PQ was told that BC had been aggressive towards the staff member who helped complete his grant forms. Staff reported their belief that he had been chewing khat and this made him unpredictable. On 27th it was recorded that he was now registered with a GP in Sheffield near his flat and that basic furnishings were being provided by SACMHA until his community care grant came through. Arrangements were made for his first weekly blood tests. The CPA meeting notes recorded that the staff felt he should be discharged though he was not yet registered with a new GP; his care co-ordinator would visit him weekly. He might still be psychotic but he was much improved, there had been no untoward incidents whilst on home leave and he was functioning better. He was to be discharged with medication for 7 days. A support worker from SACMHA would ensure that he attended regularly for blood tests and would also help him with his finances. On 31st all of the discharge arrangements were in place. SACMHA had organised bedding etc. PQ, the care co-ordinator passed details of the case to the CMHT consultant psychiatrist and agreed on the first joint home visit. The support worker was ready to help BC. BC's new GP was prepared to carry out the weekly blood tests at the surgery and a short-term

	prescription of aspirin and Clozapine was made out. A discharge plan at enhanced level CPA was drawn up together.
01/04/ 2009	A discharge summary briefing was prepared and the risk assessment stated: Risk to self: low; risk of sexual vulnerability: low; risk to others / aggressive behaviour: low; risk of non-compliance: low; risk of self neglect: medium; risk of taking illicit substances: medium [though khat use is not illegal in the UK].
02/04/2009	OP, the SACMHA support worker, visited the flat and found that BC was not there
14/04/2009	The police were informed that BC was a missing person.
15/04/2009	Metropolitan Police report that BC had been found 'safe and well' at his flat in London. They had no concerns about his mental state. PQ believed that BC would be returning to Sheffield during the day.
28/04/2009	CPA review meeting held in Sheffield Health & Social Care Trust. It was decided that BC should be discharged from CPA as he appeared to be staying in London and had had no contacts with Sheffield services. A care plan was sent to BC with copies to his brother and his GPs. A formal risk assessment for BC was prepared by PQ Risk to self: medium; risk to others: low; risk of abuse by others: low; risk of self neglect: low. Risk assessment by PQ Safety strategies: very difficult to ascertain what BC's coping/safety strategies are. Seems that he can become agitated and fearful and responds well to reassurance and being in a safe environment. Understood that his wife has no contact with BC but his brothers are supportive. Safety issue 2: BC's mental health deteriorates. Circumstances 2: If BC becomes distressed, if he stops taking medication. Warning signs: irritability, aggression, paranoia. Plan 2: BC should report to his GP and Accident and Emergency if his health deteriorates. Person responsible 2: BC, his family.

95. By the time BC was discharged from Nether Edge Hospital, Sheffield Health & Social Care NHS Foundation Trust, on 31st March 2009 he had effectively been an inpatient for almost a year as he was originally admitted to Northern General Hospital on 12th April 2008. He spent just under five weeks (24th April to 27th May 2008) in the community.

96. There was very little information available to the independent investigation panel about BC's time in London during April 2009. He seems to have spent a large part of his time travelling around south London by bus. He was seen by one person to be behaving oddly - wearing a heavy overcoat during a period of very warm weather. The next reliable information about BC relates to his stay in the care of Oxleas NHS Foundation Trust

between 29th and 30th April 2009 which had an important impact on events, so it has been set out in considerable detail - on an hour-by-hour basis on occasion.

Date and time	Events or activities
29/04/2009	BC referred by Accident and Emergency Department at Queen Elizabeth Hospital, Woolwich (South London Healthcare NHS Trust) unable to give the reason he presented. Presenting problem - difficult to assess as he kept saying "I don't know" to all questions and does not know what is going on. Said he was hijacked from Sheffield 20 days ago - living now in London SE3. Those who did it wanted to kill his brothers and abuse him. Said he had not slept for some days and needs rest. Plan - needs further assessment. AB (assessment nurse) was called to assess BC in the Accident and Emergency Department at Queen Elizabeth Hospital (South London Healthcare NHS Trust). Due to his level of agitation and not being able to go through the assessment process AB suggested to BC to accompany him to Oxleas House which he did. AB escorted him and he was quite cooperative and did not pose any risk or danger. AB handed BC's case to the duty doctor and duty senior nurse at Oxleas House for further assessment/review when settled. BC arrived with assessment nurse AB in the assessment area of Oxleas House. HI (health care assistant) introduced himself to BC. BC was put on level 2, 15 minute observations as per Trust protocol. Spent most of his time pacing up and down the corridor. Later said he was tired and wanted to sleep and was shown to a bed. HI handed BC over to night Accident and Emergency nurse EI at the end of his shift at 21:00.
20:45	NO (senior house officer) arrived at 20:45 in the Oxleas House assessment office. As part of the verbal handover in the presence of the Oxleas House duty senior nurse and others were informed by AB, that there were no patients waiting for assessment during the night shift. The evening duty junior doctor informed NO about other patients and a pending task involving assessing a new admission to an older adult ward, but did not hand-over any plans regarding BC. AB said that BC had been picked up by police wandering. He reported that BC had been taken to Accident and Emergency because they were concerned by his wandering behaviour. He reported BC could not provide a coherent narrative of his problems or background history. Was unsure if he was acutely psychotic. Reported that he had been admitted to psychiatric hospitals both here and in Sheffield. Also described that he had used khat and had been treated for psychosis. AB said that BC required further assessment the next day and that he was

	warranting immediate admission to an inpatient ward. Clarified why immediate admission if further assessment was not necessary and AB described how BC had provided very limited information at interview. AB reported that his presentation was clearly not due to acute mental illness and that he was previously known to misuse khat. On NO's suggestion AB agreed that this could mean that his presentation was due to intoxication and that it could improve by morning. AB also said that BC was under follow up by Sheffield services and had been admitted to local services with mental illness in the past. AB agreed with NO that this could mean that his presentation could be better understood with collateral information from others who knew him during the next working day. NO clarified with AB that based on his assessment there was no past behaviour or anything about his current presentation that would make it unsafe for him to be cared for in the assessment area overnight, such as aggression, violence to others or convictions. He reported that this was the case and that he had walked from Accident and Emergency alone. On the basis of this information NO agreed with his plan. LN, the Oxleas House evening duty staff nurse (DSN), expressed agreement with this plan. NO had observed BC's persistent fast paced walking up and down the assessment area corridor. He saw this behaviour as suggestive of some agitation and distress, so he asked the evening assessment team nurse if he felt that BC would benefit from Lorazepam being prescribed. Both he and the Oxleas House DSN agreed that this would be useful. Therefore oral Lorazepam was prescribed by NO. When he returned to the assessment area at midnight, NO did observe BC was not walking in the assessment area. ML, the day DSN, handed over BC to LN stating that he was referred from Queen Elizabeth Hospital Accident and Emergency after he presented with strange behaviour and restlessness. Also that the assessment nurse was unable to carry out a full assessment due to BC being vague and mute during the interview. BC was later transferred to Oxleas House and the agreed plan was for him to stay in the assessment area overnight and to be seen in the morning by the Duty Doctor. Also, that his care is in the process of being transferred to the Recovery Team from Sheffield. In addition, she tried to make contact with his family but they kept placing the phone down. LN observed BC calmly pacing up and down, opening and closing the doors to the bedrooms. Later approached him and introduced herself as DSN but got no response. BC was approached several times by staff but declined to communicate. LN later discussed BC with duty SHO and it was agreed to give BC 1 mg Lorazepam for his agitation. Approached him and offered the tablet which he took and was observed falling asleep in the assessment area.

Approx 23:30	LN showed BC to his room and told to have some sleep and he was able to sleep from approximately 23:30 until 06:00 to 06:30 when he woke up.
30/04/2009 06:00 – 06:30	BC approached LN and asked for some sugar. Asked him if he would like a cup of tea or coffee but got no answer. LN gave him the sugar and he made himself a cup of tea which he sat and drank in the assessment area.
Electronic record 06:32	Care management in process of being transferred from Sheffield Health & Social Care NHS Foundation Trust. Assessment impossible as BC is aroused and non-communicative. Given 1 mg Lorazepam with good effect. Slept for 7½ hours. To be assessed by duty SHO next morning.
Approx 07:15	LN handed BC's care over to the day shift duty senior nurse, ML, and stated that staff were unable to do a full mental state assessment on BC or offer him any nursing intervention due to him being mute and not engaging with staff. Also BC should be assessed by the Duty SHO the same morning and that he belongs to Sheffield Health & Social Care NHS Foundation Trust.
Approx 08:00	NO did not observe BC walking up and down again until around 08:00 when he saw BC making tea. Around this time the night shift DSN enquired about his care plan. He was visible in the assessment area and she reported that he had been observed by the Oxleas House staff to have slept during the night. NO reiterated that it had been planned that he would be reassessed by the assessment team in the morning
09:00	NO verbally handed over to the assessment team including the nurse EG and health care assistant regarding any pending assessment. NO highlighted that BC had slept overnight in the assessment area and that further assessment was planned. They asked why this was the case. NO said that BC may have been intoxicated with khat and that it was felt further collateral information was needed, possibly from his family or Sheffield services. EF, the Assessment Team Psychiatrist, was not present in the room during this hand-over, but when NO went to her office to hand her the bleep she asked if there was anyone waiting to be seen. NO reported that the man she had observed to be walking up and down in assessment area was waiting to be reassessed and that he had handed over more details to the team in the assessment team office. EF, attended the morning handover when no new referrals were handed over by NO. However TU, the acting bed manager, mentioned the case of BC awaiting transfer to Sheffield. He was dealing with Sheffield Hospital to arrange the transfer. A few hours later EF enquired about the progress of the transfer and TU confirmed that it would still go ahead. EF terminated her duty and left Oxleas House at 13:00 hrs.

	TU checked BC's personal details on RiO and started contacting PQ whose number he found on RiO with view to transferring BC if he required admission. Did not reach her in the morning but left messages.
14:45	BC came to the office to ask for permission to attend mosque but was refused by TU.
Approx 16:00	TU phoned PQ - informed her that BC was in the assessment area for assessment and that TU will transfer him if he is to be admitted. PQ said that he should stay in London as he has relatives in London. TU then requested a cost code in the event it was needed for a private bed. CE, a community mental health nurse/senior practitioner at Nether Edge, phoned TU - discussed the need for a cost code.
Approx 17:00	MB, a mental health nurse, was asked by TU to assess BC as this had not been done. Not able to do so as she was going to the Accident and Emergency Department but agreed to do the assessment when she returned.
Approx 17:45	TU assessed BC. TU spoke to him in the interview room lengthily and throughout the interview he was alert, talking clearly and expressing himself coherently and logically. After assessment TU explained that he was not for admission as all risks were low and that he was to remain in the assessment area so that TU could clarify the address recorded at the Accident and Emergency Department at Queen Elizabeth Hospital (South London Healthcare NHS Trust) before he could be discharged home or assist him to return to Sheffield on Saturday 02/05/2009. He remained in the assessment area when TU went to get some food for him.
Approx 19:00	Around this time TU returned to the assessment area and BC approached staff including TU and requested a phone call. The call was facilitated and BC was speaking to someone who BC identified as his cousin; telling him that he was going to be returned to Sheffield as he lives there. It was during their conversation that his cousin requested to speak to staff. TU spoke with his cousin who confirmed his name as AD and stated that BC was staying with him for the past weeks and that he could return home if discharged. AD confirmed the address which was the same address given on BC's registration and referral from the Accident and Emergency Department at Queen Elizabeth Hospital (South London Healthcare NHS Trust). TU asked AD about BC's wellbeing and he responded that BC was usually at home or resting. TU further asked about the issue around BC stating that he was hijacked from Sheffield but this was not substantiated as AD responded that BC came from Sheffield on his own accord. TU asked about BC's plan to

	return to Sheffield and he confirmed this. TU enquired if BC had being taking any medications and AD confirmed that there was medication at home and that BC has being taking his medication. TU discharged BC to his cousin's address following this conversation with AD. TU asked BC about how he was going to get home and he provided an oyster card to use on the bus. The plan agreed with BC was: he was discharged to his cousin's address, for him to return to Sheffield on Saturday 02/05/2009 and to report to the nearest Accident and Emergency Department when he was in crisis. Risk assessment overview Harm to self: no risk identified on assessment. History of self-harm by overdose. Harm from others: expressed he was hijacked yesterday but no evidence to substantiate this statement after speaking to his cousin who confirmed he has been staying with him. Harm to others: no risk identified. History of overdose. Other risk behaviours: no risk identified. Factors affecting risk: BC is addicted to khat and chews it on a daily basis. Expressed that his tribe people are dying in Somalia and will be reporting it to his mosque to advise them to stop fighting. Slightly anxious but calmed after prescribed medicine. Summary: no suicide or expressed intent of suicide, or self-harm, or harm to others. Low to moderate risk of substance abuse (khat).
04/05/2009	(Bank Holiday Monday) Three of AD's friends became concerned about his welfare as they had not seen him since the early hours of the previous day and they decided to visit him at his home address to check on him. AD was well known in the local south east London area and frequently attended informal social clubs common in the area. He was also known to sell khat. On their arrival, they found the property in darkness and called out repeatedly for AD to come to the door. When he failed to do so, the friends became worried and forced the door. When they checked the premises they found AD apparently dead in the living room having suffered massive injures to the back of his head. A bloodstained axe and a handwritten note were found close to the victim. The three men left the premises and called the London Ambulance Service (LAS) and the Police to attend. The LAS attended first and provisionally confirmed life extinct (life was confirmed extinct officially at 10:34 on 5th May 2009). The police attended and instigated crime scene preservation measures. Whilst the officers were in the process of doing so, BC arrived on the scene. He proceeded, apparently unconcerned by the police presence, to the front door where he was stopped by the police. The three men then pointed out BC as the other resident of the flat.

	BC was then arrested and taken to Plumstead police station. The police record states that it was clear from the outset that BC was suffering significant mental health issues, presenting paranoia and schizophrenic symptoms in the custody suite. A full set of forensic samples were obtained and the clothing BC wore on arrest were seized. Owing to concerns about his mental health, BC was eventually sectioned under *s* 3 of the MHA and conveyed to secure mental health accommodation pending further assessment.
06/05/2009	The North Recovery Team manager - Oxleas NHS Foundation Trust received Sheffield Health & Social Care NHS Foundation Trust CPA review, care plan and risk assessment dated 28th April 2009 by post from Sheffield Health & Social Care NHS Foundation Trust. Post marked 30/04/2009.

97. At several points the issue of GP registration became important and for that reason an overview of BC's history of registration is presented. From the correspondence on file it appears that BC was registered with a practice in London SE3 from 1995 to March 1997; he was then registered with a practice in London SE10 for part of 1997 and he was registered with a practice in London SE18 between 1997 and 2005. In 2005, he registered with a medical centre in south east Sheffield and changed to another practice in Sheffield on discharge from hospital at the end of March 2009 as his flat was in a different part of the city. There is also information about another GP practice in London SE7 which was copied into correspondence while BC was an inpatient at Nether Edge [19th December 2008] and BC claimed that he used this GP practice to prescribe Clozapine when on home leave [30th January 2009]. There is a note of BC being registered with this practice in November 2008 but there is no information about how long he was registered with that practice.

Notable practice

98. BC's daily nursing care in Nether Edge, Sheffield was of a high standard with nursing staff trying to engage him in one-to-one activities every day. When they were not able to do so they recorded the fact and explained why it had not been possible.
99. Generally throughout BC's contact with mental health services as either an inpatient or an outpatient in Sheffield there was a high level of sensitivity towards his ethnicity and his cultural needs. Attempts were made to have interpreters available on a routine basis for CPA meetings. On occasions this task was carried out by one of his brothers but more usually it was a professional interpreter. BC was put in touch with Somali speakers such as Imams and MIND scheme workers. On more than one occasion the services of a Somali psychiatrist were sought to help distinguish between any cultural basis for BC's beliefs and his mental illness. It is unfortunate that BC was often hostile to the individuals involved as their knowledge of him fed into his views of persecution by the Somali community. His discharge plans in 2009 were based on his accommodation needs being met by SACMHA.

100. Though it should also be noted that Sheffield Health & Social Care NHS Foundation Trust record the statement that the ward staff did not feel able to cope with BC's cultural needs - at least they recognised this.
101. The Sheffield Health & Social Care NHS Foundation Trust internal investigation report states "*Discharge arrangements were thoroughly set up for care in Sheffield*". The independent investigation panel take the view that this is true but there was no contingency if BC did not stay in Sheffield.

Care and Service Delivery Issues and Contributory Factors

102. The Oxleas NHS Foundation Trust's internal investigation report concluded that the decision to discharge BC from the Oxleas House assessment area was made without an adequate assessment being completed represented a Care Delivery Problem. There are also some aspects of BC's care and treatment that represent a Service Delivery Problem. The Sheffield Health & Social Care NHS Foundation Trust's internal investigation report did not differentiate between the two types of issues. The following analysis is drawn from a fundamental review of all the written material relating to BC as well as new interview material.

Patient factors

103. BC had received care from two mental health trusts: Sheffield Health & Social Care NHS Foundation Trust and Oxleas NHS Foundation Trust. He had been discharged from Sheffield Health & Social Care NHS Foundation Trust to supported housing in Sheffield on 31st March 2009, following a nine-and-a-half -month admission. It appears that he left relatively quickly for London, probably within thirty-six hours of discharge, certainly before the seven-day follow-up visit by his care co-ordinator. He was reported missing to the Sheffield police on 14th April 2009. It is noted in a Sheffield Health & Social Care NHS Foundation Trust CPA discharge document (dated 28th April 2009) that BC was last seen by the Metropolitan Police on 15th April 2009 when they carried out a 'safe and well' check.
104. BC was prescribed Clozapine by Sheffield Health & Social Care NHS Foundation Trust. It was suspected that he stopped taking his medication at some time after this discharge. Case notes from Sheffield Health & Social Care NHS Foundation Trust showed that BC relapsed fairly quickly when not taking medication and that relapse could lead to significant risks - both in relation to self-harm (in April 2008 he had made a suicide attempt) and risk to others (his case notes contain references to his having held a knife to his brother's throat, carried a knife around the house, and he told staff that he had obtained a gun at the time when he believed his wife was being unfaithful to him). All of these factors were exacerbated by his use of khat.
105. When a lengthier assessment of BC took place post incident in the police station on 5th May 2009, there was some evidence that his illness was demonstrated by delusional thinking which required investigation through conversation; thus he may have looked calm and his behaviour appropriate while, in fact, his thinking was very disordered.

106. A key patient factor was the role of the cousin (AD) with whom BC was sharing an address. AD spoke to the acting bed manager in the evening of 30th April and following this conversation, the acting bed manager was assured that BC had an adequate supply and was taking his medication, and that he was returning imminently to Sheffield although he did not enquire as to what the medication was. What was not known by the acting bed manager (but was later confirmed to Oxleas NHS Foundation Trust by BC's brothers) was that the cousin's status in this country was uncertain and that he always sought to minimise contact with statutory services. This may have led to him (AD) presenting an inaccurate picture of BC and his situation to the acting bed manager.
107. BC had long-term contacts with mental health services in both London and Sheffield culminating in a nine-and-a-half month stay in Nether Edge. But it is clear that in terms of his life history, London was his main place of residence. Throughout the period under review BC retained a flat in London and was registered with a GP there most of the time, or so it would seem.
108. It is clear from the Chronology that BC's views about where he would go on discharge were extremely capricious. He looked to London most of the time as his final destination and took his home leaves there. The NHS 'rules' about access to services being determined by GP registration meant little to him, and he seemed to have been registered with GPs in both locations apparently for most of the time, so either destination could have been equally valid.
109. BC was seen as lacking insight into his mental illness and he had a significant history of illicit drug use - both khat and also cannabis but mainly the former. This assessment was recorded despite the fact that khat use is not illegal in the UK. BC's records show that there were periods when he chewed khat every day. BC's khat use affected his mental state. There were also a number of references to problems of non-compliance with his medication which in turn was another risk indicator of relapse.
110. From a review of BC 's medication records it is clear that the longest consistent period during which BC may have been on a therapeutic dose of Clozapine was forty-nine days - from 7th December 2008 to 25th January 2009. A blood sample taken on 15th December 2008 indicated that his Clozapine plasma level was within the therapeutic range when he was on a daily dosage of 300 mgs of Clozapine. It is generally accepted that Clozapine, at therapeutic levels, should be tried for a minimum of three months before deciding whether or not it has been effective. BC reported that he felt better on the medication, which was taken to be a good sign. In addition, further improvement can be seen over time.
111. Each time Clozapine is stopped, its effect the next time it is used is reduced. If Clozapine has been shown to have been partially beneficial then it can be supplemented with another drug, so for instance when BC was switched to Quietiapine, it would have been reasonable practice to use Quietiapine as an addition to Clozapine rather than as a substitute for it.
112. It is equally hard to understand why when the decision had been made to stop the Clozapine, BC was then put on another oral antipsychotic rather than a depot. He had been on Risperidone earlier in this admission though there is no indication that switching him to the depot form - Risperidone Consta – was ever considered.

113. The independent investigation panel is of the opinion that BC should have stayed as an inpatient for a longer period so he could have benefited from a more established medication regime before being discharged into the community. Whenever BC was given home leave he stayed away longer than intended and there seemed to have been breaks in his pattern of medication. There is no evidence that a Treatment Order under *s* 3 of the MHA was ever considered as a means of increasing the chance of him remaining in hospital without leave to increase the consistency with which he took the Clozapine. It should be remembered that BC had been an inpatient for nine-and-a-half months when he was discharged while the average stay is about three months. There was obviously a psychological and professional pressure to return him to the community, as well as a financial one.

Individual staff factors

114. TU was the assessment area acting bed manager as well as being qualified to carry out assessments which he had done on many occasions. The roles of assessment nurse and bed manager represent a potential conflict of responsibilities to the organisation and its functions. On this occasion the requirements of the bed manager, perhaps motivated by the need to clear some beds before a Bank Holiday weekend, seem to have predominated over other concerns and this led to a reduction in his concern with the safety of BC. This point was confirmed when the independent investigation panel interviewed TU.

Task factors

115. The assessment area in Oxleas House is subject to a lengthy protocol setting out the responsibilities for the daily coordination and management of the unit. The protocol covers:
    - handovers
    - arrival of patients to Oxleas House for assessment
    - risk assessment within the assessment area
    - observation within the assessment area
    - patients wishing to leave
    - documentation
    - assessment log
    - patients assessed as requiring admission
    - patients arriving at Oxleas House under *s* 136 MHA
    - patients currently under Oxleas House Mental Health Services
    - AWOL & missing patients
    - use of interpreters
    - links to other policies.
116. Observations were carried out but it appears from the electronic records that BC was not interviewed at any length by any member of the assessment team during his twenty-four hour stay in the assessment area.

117. The duty senior nurse's handover of clinical issues (as in the electronic records) during the evening of 29th April 2009 and the morning of 30th April 2009 noted BC's need for "*assessment by the duty doctor in the morning*".

118. No formal assessment was attempted during the evening of 29th April 2009 as BC was described as being unable to provide a coherent account of his situation or background. The day shift assessment nurse (AB) was unsure whether he was acutely psychotic. BC told staff that he used khat in the past. There was a discussion between the assessment nurse and the night-shift duty SHO (NO) during which it was suggested that BC's presentation might be due to intoxication and that it could improve by the morning. BC was later observed walking up and down the assessment area corridor in a persistent and fast-paced manner. The duty SHO (NO) discussed this behaviour with the duty senior nurse (LN) before prescribing Lorazepam to BC. However, the medication chart could not be found when requested by the Oxleas NHS Foundation Trust Internal Inquiry Panel. BC slept from about 23:30, so there was no opportunity to assess BC's thinking and perception that night.

119. The assessment team doctor on duty during the morning of 30th April 2009 (EF) does not recall being asked to carry out the assessment of BC as requested in the handover records and the covering junior doctor was not asked to see the patient in the afternoon.

120. The assessment team nurse practitioner (EG) agreed that the acting bed manager (TU) was to carry out BC's assessment in the afternoon of 30th April 2009 in order to facilitate discharge. TU was a qualified nurse (Band 6) and had conducted assessments in the past.

121. During the day of 30th April 2009, there were at least three phone conversations between the Oxleas NHS Foundation Trust's acting bed manager (TU) and the Sheffield Health & Social Care NHS Foundation Trust: the first was to BC's Sheffield Health & Social Care NHS Foundation Trust care co-ordinator (PQ) but she was on a home visit so TU spoke to the Sheffield Health & Social Care NHS Foundation Trust bed manager. There was a further call with BC's care co-ordinator when she returned to the office in the afternoon; and the third with a senior manager in Sheffield (CE). TU stated that BC's care co-ordinator did not provide any information about BC's mental state, medication and current care plan, nor did he ask for this information. The only focus of the second and third conversations was to establish who had clinical and financial responsibility for BC's care. No one in Sheffield Health & Social Care NHS Foundation Trust seems to have volunteered information about BC's CPA and MHA status and his medication. TU did not ask about any of these. PQ's recollection of the conversations differs in that she says that she communicated the important information to TU but all he wanted to hear was about cost codes.

122. There was historical information available in Oxleas NHS Foundation Trust's records relating to BC's time as an inpatient in May and June 2008 that was not taken into account when the decision was made not to admit BC and for him to be transferred to Sheffield Health & Social Care NHS Foundation Trust.

123. The acting bed manager's record of 30th April 2009 at 17:18 consists of notes in relation to his actions around contact with Sheffield Health & Social Care NHS Foundation Trust, a telephone conversation with BC's cousin, and leaving arrangements including a risk assessment.

124. The acting bed manager took the decision to allow BC to leave without reference to other staff within the assessment team. He was entitled to do so.
125. There is no comprehensive assessment of BC documented on the electronic care planning system (RiO) for his contact with the assessment team on the night of 29th / 30th April 2009.
126. Whilst a Sheffield Health & Social Care NHS Foundation Trust discharge policy was in existence specific guidelines were not in place to support staff for emergency requests for information.
127. A clear knowledge and understanding of BC's family structure was lacking, for example, the brothers' life patterns and the existence of the cousin. The notes of a meeting held on 30th January 2009 with HC include reference to BC's London flat and the statement that one of his friends was living there at that time. There was no other reference to the cousin until the evening of 30th April 2009.
128. *Refocusing the Care Programme Approach* (Department of Health 2008) states that there should be a care plan related to substance abuse and that it should be considered in all assessments undertaken by mental health services.
129. The discharge plan for BC drawn up by Sheffield Health & Social Care NHS Foundation Trust was elaborate with significant amounts of cooperation between people and agencies. All had adequate information about BC but the extent to which BC 'bought into the plan' was never clear and there was no contingency plan. [There is considerable emphasis in *Refocusing the Care Programme Approach* on risk management, crisis and contingency planning.] Many of those involved in organising services for BC were aware of his previous history of spending his home leaves in London. It is an open question, as they asked in their internal investigation report, whether Sheffield Health & Social Care NHS Foundation Trust should have tried harder to engage Oxleas NHS Foundation Trust so they could quickly take over BC's care, albeit temporarily, if he returned to London while a more formal handover was put in place. More generally, it was not best practice to have decided to discharge BC from CPA without making more than one attempt to hand-over BC's care to Oxleas NHS Foundation Trust, or to have tried to re-establish contact through his brother(s).
130. There is the question of whether BC's brothers really understood what was expected of them in their role as carers, how well was this explained in Sheffield and were there any problems of language and cultural understandings? It is difficult to tell from the records how well decisions about BC were explained. HC complained at least once about the hospital letting BC out when he was obviously unwell and suggested that more powerful medicines should be prescribed for him.
131. Were policies and procedures followed the day BC was allowed to leave the assessment area? The assessment area seems to have worked with a degree of procedural informality that may have had positives, such as flexibility. There was no reliable source of information about patients independent of individual members of staff - no white board or patient admission book. There were verbal handovers reported by individual staff but the definition of a handover seems to have been open to interpretation - on the morning of 30th April NO thought he had been to a handover but other staff could not recall his presence. NO had been in the unit for some months so should have recognised a handover. Tasks seem to have been organised by individual recollections

about each patient - no assessment was needed for BC as he was being transferred to Sheffield Health & Social Care NHS Foundation Trust - an assumption that overrode other organisational procedures. Staff recollections could be faulty, for example, some staff believed that BC had been brought to the hospital by ambulance as he had been found wandering by the police; this later turned out not to be true. Those staff who believed the police had been involved in BC's arrival did not think of following the unit's *s* 136 procedures.

132. On 21st April 2009, PQ received a phone call from OP who had been to visit BC's flat in Sheffield but he was still not there and neither he nor his brothers were answering their phones. PQ explained that the current plan was that they should be in contact with each other as soon as BC turned up again and that everything that was possible had been done to support him.

133. They discussed what they should do: PQ suggested that OP should consult their policy on whether they can sustain a support service if someone is repeatedly not in. Beyond that question was the matter of what their policy would be on how long they kept the flat for BC. OP said he would talk to the SACMHA team and get back to PQ.

134. On 23rd April 2009, PQ consulted the 'loss of contact with services CPA policy' which was current at the time and then referred to paragraph 24.2 which stated that:

> *If it becomes clear that contact with the service user has been lost, a review meeting should be held to consider the next steps. Each member of the team should make every possible effort to re-establish contact. Consideration should be given to contacting the following: carer/family, service user's GP, housing, local Accident and Emergency departments and mental health teams in other areas. The Care Co-ordinator will take responsibility for coordinating this activity and the outcomes of attempts to contact the client should be fed back to them as soon as possible.*

135. On Insight PQ recorded that:

> *SACMHA, the police and me* [PQ] *have all attempted to make contact with the service user's family, and both his registered GP and his potential GP in London, his housing service SACMHA were aware, the police located him safe and well at his brother's last week* [i.e. 15th April 2009]*, but he has not returned to Sheffield. BC has not answered his phone today; his brother's phone plays a recorded message that he was not able to accept calls. SACMHA continued to try to contact him and his brother. We have contacted the police who are aware of the situation. I* [PQ] *have had an informal interview with SACMHA on the phone; and CMHT consultant psychiatrist and I* [PQ] *are due to meet on 28th April 2009.*
> *Care plan: email CMHT consultant psychiatrist to make aware, and to contact the CPA Manager in accordance with 24.3.*

136. Paragraph 24.3 stated: "*The CPA Manager should be consulted as to how contacts with teams in other areas can be made".* At 18:30 that day PQ recorded that SACMHA had been round to BC's flat and could not find him but there were no signs of distress, PQ

then reported BC to the police as a missing person and planned to make a joint visit with a SACMHA worker if BC had returned on 30th April.

137. On 24th April PQ had a discussion with CMHT consultant psychiatrist and they agreed to have a review, in line with Trust policy, which was booked for 28th April. PQ agreed to contact SACMHA and asked them to attend or to send a report as it was such short notice. PQ tried BC's phone again without success. PQ then received an e-mail from LM [the CPA Manager]

> *suggesting that they should continue to follow Trust policy and agreed with the need to balance past risk with a need to avoid institutionalising someone who may not want or need follow-up.*

138. Later PQ received a phone call from OP to say that the situation had been discussed at SACMHA and they would continue to review the case. OP said that he would go to see if BC had returned.

139. On 27th April 2009, PQ made a note stating that she had received a fax from the pharmacy confirming the discontinuation of Clozapine.

140. On 28th April 2009, PQ had a phone call from BC's new support worker (who had taken over from OP) and explained that Sheffield Health & Social Care NHS Foundation Trust had discharged BC from CPA as he appeared to be staying in London. The SACMHA team would shortly be receiving the minutes of the meeting where the decision to discharge BC was made.

141. The CPA Review and Care Plan Documentation include the following:

> *BC is now in London and has not had any contact with Sheffield services.*
> *This review is a discharge meeting.*
> *BC's last review was when he was in hospital. He was discharged on 31/03/2009 and was already in London before his 7 day follow-up visit.*
> *Was last seen by services on 15/04/2009 in a safe and well check. Was assessed as being well.*
> *Now out of medication.*
> *Copy of care plan sent by PQ to London address.*

142. In the formal risk assessment for BC completed on 28th April 2009 PQ concluded:

> *Risk to self: medium; risk to others: low; risk of abuse by others: low; self neglect: low.*

143. The accompanying risk assessment created by CE based on PQ's assessment stated:

> *Safety strategies:*
> *It has been very difficult to ascertain what BC's coping / safety strategies are. It seems that he can become agitated and fearful and responds well to reassurance and being in a safe environment. It is understood that his wife has no contact with BC but his brothers are supportive.*

Safety issue (1):
BC feels unsafe

Circumstances (1):
This is not clear at this stage

Plan (1)
BC has found contacting his brothers have helped in the past.
HC (mobile phone number) (brother)
PO (mobile phone number) (uncle)

Person responsible (1)
BC/staff

Safety issue (2):
BC's mental health deteriorates.

Circumstances (2):
If BC becomes distressed, if he stops taking medication.
Warning signs: irritability, aggression, paranoia.

Plan (2):
BC should report to his GP and Accident and Emergency if his health deteriorates.

Person responsible (2):
BC, his family.

144. The CPA Review and care plan documentation was sent to BC, his GPs in Sheffield and London, his support worker at SACMHA, BC's CMHT consultant psychiatrist in Sheffield Health & Social Care NHS Foundation Trust, the manager of the North Recovery Team - Oxleas NHS Foundation Trust and an AC who was described as BC's "*carer*" at BC's London flat. This last person seems to have been a misunderstanding of both BC's living arrangements and his family structure, the mobile phone number given for this person does not tally with either of the numbers given in the Risk Assessment. There was no contribution to the decision from WY who had most knowledge of BC's mental state based on her responsibility for his long-term inpatient care and treatment. The organisation of care in Sheffield Health & Social Care NHS Foundation Trust meant that a consultant's clinical responsibility for a service user ends as soon as they are discharged into the community. The care co-ordinator is the principal link between the ward and the community.
145. The two paragraphs 24.2 and 24.3 quoted above by PQ and colleagues as the basis for their decisions need to be seen in the wider context in the original Trust policy document. Section 24 was entitled "*Loss of Contact with Services*". Section 24.1 stated that this section applied to the care of clients who had lost contact perhaps because they had moved out of the area, or had changed accommodation, or had failed to keep

appointments without notifying services. It would normally have involved clients on Enhanced CPA but also may have applied to some clients on Standard CPA if the care co-ordinator was concerned. Section 24.4 stated that if contact had been lost with a service user who was judged to pose a serious risk to themselves or to others, for example through failure to attend an urgent appointment, then attempts should be made to contact the client through any appropriate means. If these failed, then consideration could have been given to informing the police.

146. The document continued stating that:

> *24.5 In the event of the service user not being located, they should not be discharged from the service but designated as 'out of contact'. The CPA Manager should be informed of anyone who has lost contact with the service, so that a central record can be kept. The GP should be informed in all cases.*
> *24.6 Service users may be discharged from Enhanced CPA in exceptional circumstances, when the service user has been out of contact for one year, or a shorter period if this is agreed by the team, in consideration of assessed risks. This decision should be fully discussed by the MDT and documented in the medical case notes.*

147. The following points may be made about this decision making process:

- There were numerous attempts made to trace BC after he left his accommodation in Sheffield initially by phoning BC and his brother, and then by setting up a safe and well check
- The care co-ordinator and colleagues followed the steps set out when there was "*Loss of Contact with Services*" in the relevant Trust policy document
- Even though BC was not thought to pose a serious risk to himself or others the police were contacted and the safe and well check was carried out.

But

- The safe and well check was carried out by the Metropolitan Police who are not qualified to make the sort assessment needed to assure mental health services as to the state of health of someone like BC. Sheffield Health & Social Care NHS Foundation Trust could have asked Oxleas NHS Foundation Trust to carry out a safe and well check once they had confirmed his presence at an address in London
- BC had been an inpatient for nine-and-a-half months and still exhibited the same symptoms as when he was admitted despite treatment with Clozapine
- BC was known to be non-compliant with medication and it was recognised that his mental state deteriorated quickly once he stopped taking his medication
- It was known from the pharmacy that by the end of April BC was out of medication - it later became clear that he had left all his medication in the flat in Sheffield
- The decision was taken to discharge BC and the documentation was posted to an area (south east London) where he was known to go once out of hospital whereas some more urgent attempt to set up a transfer might have been attempted
- There is no evidence that the decision to discharge BC was documented in the medical notes though this was discussed at the CPA review meeting
- The policy in existence at the time of BC's discharge did not default to safety in the sense that the invariable outcome ensured the safety of the service user who was known to be out of medication, and whose mental state was known to deteriorate quickly when off medication, and who was now out of contact with mental health services.

148. The current Sheffield Health & Social Care NHS Foundation Trust policy document - *Difficult to Engage Service Users (including Non Compliance with Treatment and Non Attendance)* originally dated November 2006 but actually issued on 13th May 2009. In this document 'Non-attendance' is defined as:

This is often referred to as DNA (Did Not Attend) and is used in this policy to describe clients who have been referred to a Trust service and who failed to attend an agreed appointment.

- *The client will be classed as DNA (non attendance) where they have failed to attend a service in the following circumstances*
- *The client does not attend for the initial assessment interview.*
- *The client does not attend for an outpatient or therapy session.*
- *The client is not at home when visited by a mental health professional when the date and time of the visit has been pre-arranged.*
- *The client has not attended Day or Community Services on one or more occasions. In some circumstances one failure to attend will give concern to take action*
- *The client has obviously moved from their usual place of residence and has given no indication of their new address.*

149. The Policy goes on to state that:

In the majority of cases where clients choose not to attend, or to disengage from all or some of the services offered, it is not problematic, but there will be occasions when this gives cause for concern.

150. The Policy notes seven reasons for non-engagement with services before adding that that loss of contact with services has been identified as a frequent feature of suicide and homicide enquiries by the National Confidential Enquiry.

151. There then follows a section *6 (2) Action To Be Followed In Cases Of Disengagement, Non Compliance With Treatment And Non Attendance* which lists eleven possible actions:

(i) Right to Refuse Care
(ii) Considering reasons and helpfulness of care offered
(iii) Informing the care co-ordinator
(iv) Preliminary Consideration of Risk to Inform Subsequent Action
(v) Subsequent Action
(vi) Advice / Involvement of Others
(vii) Other procedures
(viii) Primary Care and Re-referral
(ix) Medication
(x) Informing Others
(xi) Differences Between Professionals.

152. Would different decisions have been made under the new Policy? Because BC had never been subject to the MHA 1983 it could be argued that he had the right to refuse services. The assessments made of BC 's mental state were that he had a serious mental illness which necessitated a lengthy period as an inpatient and that his symptoms were treatment resistant both of which might negate his capacity to refuse. BC was assessed as being of low risk to himself and others and that would not have changed under the new policy. The actions required of the care co-ordinator would have been more or less the same under both policies. The use of other procedures such as involving the police as part of public protection would be unlikely as BC would still be seen as low risk. The section on medication states that where medication has been discontinued - "*the appropriate doctor should consider undertaking a medicine review in order to agree a medication plan that is acceptable to the service user*" but is silent on the situation where the service user is not present for such a meeting. The section on Informing Others states that "*the care co-ordinator and others involved in the person's care should give consideration as to any other Agencies to be informed of disengagement / non compliance with treatment*" which is similar to the previous advice.
153. The flow chart provided would only envisage discharge to primary care (with appropriate information) for a 'standard care' as opposed to CPA patient if there had been a "*preliminary assessment of risk to inform subsequent action"* followed by "*consultation with teams / others consider alternative method of contact e.g. phone, home visit, Crisis Assessment and Home Treatment Team*". Discharge is not now mentioned as an option for CPA patients.

Communication factors

154. Although both Trusts had electronic record keeping systems which were used regularly throughout the thirteen months covered in detail by this investigation it is clear that not all records are created quickly. The preparation of clinical records such as discharge summaries is a much slower process - a junior doctor writes up the notes and then a medical secretary types the notes onto the electronic system. This process may take a week or more.
155. Once clinical records have been completed there is the issue of the speed of communication of records to other services. In this case records were sent through the post as a matter of course though it was also clear that they could have been faxed or e-mailed. Much of the time the slower arrangements are acceptable but there are clearly exceptions. Mental health service users who have a connection to more than one geographical area can move around the country far more quickly than service providers are presently organised to respond.
156. There seemed to be limited access to risk assessments from different locations within the same organisations as evidenced by PQ's letter to GI (Executive Director of Operational Delivery) in July 2009 in which she complained that she had tried accessing risk assessments on several service users on the electronic record system from her office only to be informed by the system that this information did not exist. The information was apparently easily accessible to ward based staff. This would mean that any one from

another Trust contacting care co-ordinators would have had less information than if they had contacted the ward directly.

157. *Refocusing the CPA* (Department of Health 2008) has a section on "*capacity and effectiveness*" which mentions "*efficient communication processes and clinical information systems, aided by the use of technology*". This raises the question of whether the Sheffield Health & Social Care NHS Foundation Trust policy on communication was fit for purpose.
158. There was a lack of written documentation setting out the rationale for decisions taken and actions carried out, for example, no record of the Lorazepam prescription.

Team and social factors

159. There was no identified member of staff responsible on each shift in the Oxleas NHS Foundation Trust assessment area to ensure that processes for assessment and patient management were carried out adequately.
160. The failure to communicate the need to assess BC at the morning hand-over led to the acting bed manager carrying out the assessment after BC had been in the assessment area for about twenty hours.
161. The handover protocol states that the duty SHO should be present at handover; NO was not thought to have been present during the handover on the morning of 30th April 2009; this meant that there was not an opportunity for a medical contribution to the discussion about BC .
162. The night-shift duty senior nurse's (LN) hand-over to the early shift duty senior nurse (IM) said that an assessment of BC by the duty doctor was required.
163. The nurse practitioner (EG) for 30th April 2009 states in her evidence that an assessment by the doctor (EF) was required. On the other hand, the team doctor (EF) did not see it as her job to assess BC. She stated that she was 'not asked' to see BC and believed that the patient was going to Sheffield. Similarly, the night-shift duty SHO stated that as the patient was to be transferred to Sheffield Health & Social Care NHS Foundation Trust, he did not see the point of undertaking an assessment.
164. There was some ambiguity about the role of bed manager within the assessment area, particularly in relation to his responsibility for moving patients through the assessment team.
165. Staff in the assessment team expected BC to be transferred to Sheffield Health & Social Care NHS Foundation Trust and focused on moving him back rather than on assessing his mental state. This is in contradiction to expected good practice that all patients be assessed on presentation to services and their suitability for transfer is part of this assessment.

Education and training factors

166. An initial reading of the Sheffield Health & Social Care NHS Foundation Trust's records held on BC would appear at first sight to raise a question about the professional competence required of care co-ordinators. On several occasions PQ said or wrote that she did not know BC that well as she had met him on only four or five occasions. This

would seem to expose a significant flaw in the process of accumulation and communication of information about BC.

167. PQ had been allocated as BC's care co-ordinator in July 2008 and worked with him until the end of March 2009. But what became clear in discussion with PQ was BC was the only mental health service user whom she had been allocated directly from a ward. The usual means by which she came to work with service users was through contact with them in the community, though some might later become inpatients. PQ had attended BC's MDT and CPA meetings and she had met him on the ward but had never seen him in a community setting. PQ was involved in finding accommodation for BC on discharge but a discharge facilitator working on the ward was also doing so. The discharge facilitator was involved in trying to get accommodation for BC with Halfway housing while PQ was negotiating with SACMHA. This practice of involving several people in working towards BC's discharge can be seen as a positive in the sense of as shared responsibility or a weakness in the sense of it being a division of responsibility and a duplication of effort. But it would seem to have had implications for PQ's (or any other care co-ordinator's) ability to understand BC's level of functioning in the community.
168. This aspect of organisational structure resulting in a lack of knowledge of BC also had implications when it came to making the decisions to discharge him on 28th April 2009.

Equipment and resources factors

169. Historical information was available about BC on the Oxleas NHS Foundation Trust's patient information system RiO and in the clinical record archive. But other information systems would not indicate that a service user was registered with more than one GP.
170. Sheffield Health & Social Care NHS Foundation Trust had information that could have been faxed to the assessment team in Oxleas House, as happened in the early hours of 5th May 2009, at the request of the consultant on-call prior to her assessment of BC in the police station.

Working condition factors

171. The assessment area was usually under pressure and demand for beds was high; when BC arrived the unit was relatively quiet and there were no other patients in the assessment area overnight or for any substantial period during the following day (namely, 30th April 2009). On the other hand, EF's responsibilities were divided between the assessment area, Liaison Psychiatry and peri-natal work.

Organisational and strategic factors

172. Sheffield Health & Social Care NHS Foundation Trust had a discharge policy but guidelines were not in place to support staff for emergency requests for information.
173. Could BC have been admitted as an inpatient by Oxleas NHS Foundation Trust either voluntarily or by detention under the Mental Health Act? A decision to admit would have to have been based on the belief that BC was suffering from a mental disorder of either a nature or a degree; but also that he was judged to be a risk to himself and / or others.

174. On the first point there can be no doubt that BC met the criteria of nature of a mental disorder as he had a long history of a relapsing mental illness. On the question of degree, that is a judgement by the clinician at the time as to the presence of symptoms of mental disorder; it seems that several were present including delusional beliefs.

175. Even if both the nature and degree of mental disorder are present, then the assessing clinician must be satisfied that there is a risk to self or others to warrant compulsory detention. Although there was some history of these risks; Sheffield Health & Social Care NHS Foundation Trust had assessed BC as low risk except for risk to self which was assessed as medium; his relative was not raising concerns in this area, consequently, it would have been difficult to justify compulsory admission. However, part of the risk to self would be being judged to be unable to care for himself or being open to exploitation etc. Because it was believed that BC had support from his family at home, the possibility of lack of care would have been viewed as unlikely. The clinician would have needed to know much more about BC and his circumstances to come to conclusion of possible neglect or exploitation.

176. A decision leading to admission might have affected the outcome as BC would not have been at liberty that weekend but the decision-making process was complex. There were as many reasons against admission as there were in favour. On balance, the independent investigation panel determined that there was insufficient evidence to suggest that BC should have been admitted either voluntarily or otherwise.

SPECIFIC ISSUES ARISING FROM THE TERMS OF REFERENCE

The interface, communication and joint working between the two mental health trusts and any other agencies involved in providing care to meet BC's mental, physical health and social needs

177. Between May 2008 and the end of March 2009 (when BC was discharged from Nether Edge Hospital) there were three sets of interactions between Oxleas NHS Foundation Trust and Sheffield Health & Social Care NHS Foundation Trust. Sheffield Health & Social Care NHS Foundation Trust also had a number of contacts with primary care services in both Sheffield and London SE3. All of these episodes conformed to local protocols.

178. In April 2008, after a twelve-day stay following a suicide attempt, BC was discharged from Northern General Hospital to his marital home in Sheffield and a discharge summary from the Crisis Assessment & Home Treatment Service was sent to his GP located in the south east of Sheffield. The plan was that BC should be referred to Liaison Psychiatry when he was medically fit for discharge though this plan was overtaken by BC going to stay with his brother(s) in London.

179. Slightly over five weeks later BC was brought to the Accident and Emergency Department of the Queen Elizabeth Hospital, Woolwich by his brother who was greatly concerned about his state of mind. BC was uncommunicative and it took some time for staff to find out that he came from Sheffield and he eventually told staff that he had left Sheffield as his family were trying to kill him.

180. On 9th June 2008, Oxleas NHS Foundation Trust faxed a risk assessment and a core assessment on BC to Sheffield Health & Social Care NHS Foundation Trust and the following day he was transferred back to Sheffield. Later in the same month staff at Nether Edge phoned Oxleas NHS Foundation Trust to find out about the medications BC had been prescribed whilst a patient there.

181. On 26th June 2008, PQ phoned Oxleas NHS Foundation Trust as she wanted to know the right team to refer BC to as he was then due to be discharged to London. PQ said he was registered with a GP surgery in London SE3 and was intending to return to live with his brother. PQ was given details of the North Recovery Team to send a referral or request transfer to both the team manager and the consultant as per protocol. A few days later BC was told he would have to stay in Sheffield as he was registered with a GP there.

182. In January 2009, there was contact between Sheffield Health & Social Care NHS Foundation Trust and Oxleas NHS Foundation Trust about transferring BC to London but the two sets of records differ as to the precise mechanics of the process. The Oxleas NHS Foundation Trust's records state that PQ phoned them wanting to know the right team to contact to refer BC as he was due to be discharged to London. PQ said that BC was registered with a GP practice in London SE7 and was intending to return to live with his brother. PQ was given details of the North Recovery Team manager in Oxleas NHS Foundation Trust formally to request a transfer via both the team manager and the consultant as per protocol. The Sheffield Health & Social Care NHS Foundation Trust records show that PQ wrote to the North Recovery Team manager it could be that the letter followed an initial phone call which gave some details of BC which elicited the information needed to direct the letter to the right person. PQ wrote that BC wished to

transfer to this team for aftercare. She explained the circumstances of the case - delusion of belief that he was subject to a curse. She explained that in order to assess BC's situation, the ward had tried to contact his brothers but this had proved very problematic - his consultant described the brother turning up in the very early hours in the morning when staff were not able to speak with him, and the brother did not answer the phone when staff called. BC had a history of chewing khat which complicated assessments. He was now sure he wanted to return to London. BC planned to stay with his brother and the consultant wished to refer BC to their area in the near future.

183. PQ thought BC was potentially quite vulnerable and would benefit from follow up from a community team, as well as the support of his GP. She added that the Stanage ward staff had greater knowledge of him.

184. At the end of the month, the transfer request from Sheffield Health & Social Care NHS Foundation Trust was discussed at the Oxleas NHS Foundation Trust's referral meeting. The conclusion reached was that a lot more detail was needed from the referring team (core assessment, risk assessment, care plans and CPA reviews, social circumstances including discharge address, relevant contacts and brother's contact, medication). The referring psychiatrist would also need to write to the team's psychiatrist.

185. On 13th February 2009, the North Recovery Team manager phoned PQ to ask for more information about referral and left a message for her about this. On the 24th, PQ returned from leave to find a message from the North Recovery Team manager and she returned the call and, in turn, left a message on an answer machine. It was at this time that BC decided to stay in the SACMHA supported accommodation in Sheffield. On 17th March, the North Recovery Team manager phoned PQ wanting more information about the referral as they had received the referral but then had received no other details. PQ phoned back later in the day and explained that BC was now planning to stay in Sheffield. The North Recovery Team manager said to call and let them know if this changed in the future.

186. The next interactions between Sheffield Health & Social Care NHS Foundation Trust staff and Oxleas NHS Foundation Trust took place on 30th April. During the morning TU (Oxleas House, acting bed manager) found PQ's phone number on the electronic record system when he was checking BC's personal details. His intention was to transfer BC to Sheffield Health & Social Care NHS Foundation Trust if he was to be admitted after assessment. TU did not reach PQ as she was on a home visit at that time. The Oxleas House acting bed manager spoke to his counterpart in Sheffield instead. The Sheffield Health & Social Care NHS Foundation Trust bed manager then contacted PQ about TU's call. At about 16:00 TU spoke to PQ as she had returned to her office by then. TU informed PQ that BC was in the assessment area and that BC would be transferred if he needed admission. PQ said that BC should stay in London as he had relatives there. TU then requested a cost code in the event a private bed was needed.

187. PQ's recollections of the conversation were that information about BC was initially relayed to Oxleas NHS Foundation Trust via the Sheffield Health & Social Care NHS Foundation Trust bed manager. PQ explained that she had had limited contact with BC but was aware that he did not seem to want to be in Sheffield or to benefit from being there. The Sheffield Health & Social Care NHS Foundation Trust bed manager said that

he was under a lot of pressure from TU to transfer BC back to Sheffield and asked PQ to explain the situation to TU which PQ agreed to do on returning to her office. When PQ explained the situation to TU she said that he became quite angry and appeared to be under immense pressure to send BC back to Sheffield. TU explained there were no beds in London otherwise he would admit BC, he then said he was willing to find a private bed if PQ could supply a cost code. She then explained that she had no knowledge of cost codes and that it was not a decision she could either make or influence. At this point, PQ suggested talking to her senior practitioner which she said TU agreed to reluctantly. CE was consulted and she then phoned TU to obtain further clinical information. TU explained how BC was thought to have arrived at the hospital and that he was being assessed for admission. He stated that BC was assessed as being at risk of self-harm.

188. It is not possible for the independent investigation panel to determine whether or not PQ's assessment of the tone of the conversation with TU was correct or not but there do seem to be several points about these conversations:
    - At no point was it stated that Sheffield Health & Social Care NHS Foundation Trust had discharged BC from CPA on 28th April
    - TU recorded his belief that as to AD's address where AD was the occupier and BC was the visitor, rather than the other way around
    - It is impossible to tell how much of these conversations revolved around risk assessment and management but it is clear that PQ said she had limited knowledge of BC although she was his care co-ordinator and by then was back in her office with access to the record system which, at that time, gave limited access to risk assessment information when accessed off the wards
    - The exchange of information between the two Trusts worked reasonably well until there was an element of pressure or stress at which point potentially important information was not exchanged effectively, though whether this would have had any significant effect on events is open to doubt.
189. The relationships between Sheffield Health & Social Care NHS Foundation Trust and the pharmacy service seem to have been effective throughout BC's time in Sheffield. There is strong evidence in the notes relating to the close liaison with clinical staff over decisions about the type and levels of medication BC should be given. The pharmacy service were able to refine the sensitivity of drugs screening tests used with BC to identify his khat use as the standard test would have shown this type of drug to be an amphetamine.
190. The relationships between Sheffield Health & Social Care NHS Foundation Trust and primary care services seem to have been good throughout BC's time in Sheffield. These relationships were tested as the main contact Sheffield Health & Social Care NHS Foundation Trust had with them was when BC was overdue from leave. The GP surgery in London SE7 responded to phone calls so that their information system would flag up BC if he came to the surgery. The practice administrator gave Sheffield Health & Social Care NHS Foundation Trust staff information which helped them confront BC over the truthfulness of his claims that he was getting his medication from the GP practice. Most of these incidents occurred in times of crisis when BC was missing and Sheffield Health & Social Care NHS Foundation Trust staff were trying to find him but clearly arrangements could be put in place even though no action followed, as BC did not make contact with

primary care services. The GP practice across the road from BC's SACMHA supported flat were prepared to take blood samples to monitor his Clozapine.

The adequacy of the risk assessments of BC including the risk posed to others

191. BC was the subject of regular risk assessments during his time in the care of both the Sheffield Health & Social Care NHS Foundation Trust and the Oxleas NHS Foundation Trust. In addition to formal risk assessments, staff regularly discussed the level of risk he posed to himself and to others. Both Trusts used very similar formats for the assessment of risk.

192. On each occasion the assessments on each aspect of risk were almost identical as in the grid that follows:

Type of Risk Posed	Level of Assessed Risk
Risk of self-harm	Low-Medium
Risk to others / aggressive behaviour	Low
Risk of sexual vulnerability	Low
Risk of non-compliance	Low
Risk of self-neglect	Low-Medium
Risk of taking illicit substance	Medium

193. Assessments of 'risk of self-harm' varied over time. BC had been admitted on two occasions after attempts to take his life but for the greater part of his time under treatment there were few occasions when he expressed any suicidal ideation. A hospital ward was a reassuring environment where he felt safe though there were occasions when he became agitated and fearful though ward staff reported that he responded well to reassurance.

194. The 'risk to others' or 'aggressive behaviour' was invariably assessed as low. BC was rarely aggressive towards others on the ward but there had been one occasion when he was threatening to use a tin lid as a sharp edge and this alarmed some of his fellow patients. In 1995, BC had held a knife to the throat of one of his brothers and the police had been called though no charges followed. Later, in 1997, he was reported by members of his family to have been carrying a knife around their home. On 6th March 2009, PQ reported that BC had said at interview for the Halfway accommodation that he had borrowed a gun when he found out that his wife was having an affair. It was never possible to establish the truth of either of these claims though the belief in his wife's unfaithfulness was repeated on many occasions. The access to a gun was later reported back to the ward and BC's named nurse discussed this with PQ. BC later said that the gun was only borrowed from a friend and was returned unused to that friend. One long-standing aspect of BC's paranoia was his belief that people were trying to kill him. On some occasions BC claimed that his wife and brothers were attempting to kill him through the use of black magic; on others he claimed that the Somali community were trying to kill him because of their views of his sexuality. BC seems never to have acted on these beliefs unless the carrying of a knife around his family home and holding a knife to his brother's throat were part of his response to these beliefs. BC's paranoia does not seem to have changed in terms of the forms of his beliefs and his medication does not seem to have reduced these symptoms over the long term although there were several occasions when they were diminished.

195. The 'risk of sexual vulnerability' was assessed as low throughout BC's contact with the two Trusts. One aspect of BC's paranoia was that he had been the subject of sexual assault by an American visitor to his home and then in April 2009 when he arrived at Oxleas House he told staff that he had been kidnapped from Sheffield and had been raped while in London. He also believed that a video of the assault by the American visitor had been circulated among the Somali community and that they now believed him to be gay with the effect that he was now rejected by that community. These beliefs had impacts on his behaviour in that he refused most contacts with fellow Somalis and he wanted to live in parts of the country with few Somali residents. It was always assumed that none of this seems to have any basis in reality. Unlike his views about black magic there is no record of these views ever being taken seriously, nor was there any psychological exploration of these views or of his sexuality.
196. The 'risk of non-compliance' was assessed as low throughout the period. This rating is more difficult to understand as BC had a poor history of taking his medication when on home leave. On each occasion when BC was given home leave from Nether Edge he overstayed his leave and failed to take his medication. BC's attitude to his medication can be described as ambivalent though he was only once recorded as trying to avoid taking his medication on the ward. BC went through phases of believing that his medication was a help and others when he could not see any benefit from it.
197. At an MDT meeting on 2nd January 2009 PQ recorded that as WY felt that Clozapine seemed not to have made any difference and it was more difficult / risky to discharge someone on that (would need weekly blood tests and be well supported by the community team) perhaps he should be re-commenced on a more standard antipsychotic to make his eventual discharge more appropriate. Staff were concerned that BC was becoming institutionalised and that ways should be found to return him to the community. This concern may, however, have impeded effective treatment as it drove the discharge decision before effective treatment had been established.
198. The final risk assessment produced on 1st April 2009 stated that BC's risk of non-compliance was 'low' although he had a track record of non-compliance when on leave. He had been tackled very directly about this by WY after the hospital discovered that he had made no contact with his GP whom BC said was giving him his medication.
199. The 'risk of self neglect' was assessed as low-medium is also difficult to understand. A number of the outpatient assessments of BC in the 1990s included comments on his unkempt appearance but there was nothing comparable during his stay in Nether Edge. Perhaps staff observed his appearance although they did not actually document what they saw. BC told staff that his flat in London was of poor quality and had no heating. This does not seem to have been independently verified by a home visit. A community care grant was obtained for BC so he could equip his SACMHA flat properly.
200. The 'risk of taking illicit substances' was rated as medium which is somewhat unusual as khat use is not illegal in the UK. In reality, BC rarely used cannabis, which is illegal, though he did so when the opportunity presented. Staff behaved as if khat use was illicit in the light of its detrimental effects on BC's mental health and ability to function. There was no other way of recording and rating a service user's harmful history of substance abuse. This rating may have been an underestimate as staff knew that BC had a long record of chewing khat both in the community and while an inpatient in Nether Edge.

He was reported as chewing khat on a daily basis in the past, a habit which left him apathetic and paranoid. BC was suspected to have supplied khat to other patients and staff believed that his uncle had brought khat into the ward for him. BC was also known to have used cannabis while a patient in Nether Edge though not on a regular basis.

201. There are several comments in the case notes stating that BC had very limited insight into his mental health problems. Non-compliance with medication and the use of khat had been identified as precipitants leading to relapse. WY was concerned about BC's use of khat but BC viewed his use of the drug as casual and regarded it as a low risk drug. He missed the point of needing to remain drug free so staff could assess him, rather than it being a moral issue on abstinence. BC was offered access to a drugs scheme aimed at the Black community but he declined. BC was subject to routine drugs screening while in Sheffield but this did not serve as a deterrent to his khat use. The results of these tests were rarely recorded in the nursing notes. In January 2009, PQ noted that from reading the notes she concluded that BC was beginning to understand the effect khat was having on his mental health.

202. None of these observations should lead anyone to conclude that staff were indifferent to the risks posed by BC either to himself or to others. Staff in the Sheffield Health & Social Care NHS Foundation Trust knew that his delusions persisted and they wanted to know whether these affected his ability to function – "*How can we assess BC's level of functioning and risk when living in the community. Is there an alternative to discharge?*" (13th December 2008).

203. A risk management plan was drawn up for BC on 28th April 2009 but there is the question of how robust or realistic it was. The formal risk assessment was: risk to self - medium; risk to others - low; risk of abuse by others - low; and risk of self-neglect - low. In the discharge summary PQ wrote:

Safety strategies: very difficult to ascertain what BC's coping / safety strategies are. Seems that he can become agitated and fearful and responds well to reassurance and being in a safe environment. Understood that his wife has no contact with BC but his brothers are supportive.
Safety issue 2: BC's mental health deteriorates.
Circumstances 2: If BC becomes distressed, if he stops taking medication.
Warning signs: irritability, aggression, paranoia.
Plan 2: BC should report to his GP and Accident and Emergency if his health deteriorates.
Person responsible 2: BC, his family.

204. The realism of this plan is open to several questions:
    1. How realistic was it to expect BC to report to his GP and Accident and Emergency if his health deteriorated in the light of all the previous comments about his lack of insight?
    2. How likely was it that BC would stop taking his medication on discharge given his ambivalence towards it and his previous record of non-compliance when on home leave?
    3. How realistic was it that BC would keep off khat which was known to affect his mental health?

4. How well prepared were BC's family in London for his appearance in their midst and what was their knowledge of how to cope if he became seriously ill?

205. The independent investigation panel's conclusions are:
    - Risk assessments were carried out at regular intervals during BC's treatment
    - Risk assessments were based on discussion with BC by both his named nurse and his care co-ordinator
    - There was a risk assessment at Oxleas NHS Foundation Trust on the day before he was discharged in the care of his cousin
    - The rationale behind the risk assessments were not transparent; but the assessments were consistent over time
    - There was a risk management plan drawn up for BC's discharge at the end of March 2009 but it is debateable as to whether there was a realistic contingency plan, apart from general instructions to go to the GP or Accident and Emergency if BC's condition deteriorated even though it was known that BC had little insight into his own situation and this was made worse by his use of khat. Given this conclusion why was BC not referred as a matter of urgency to Oxleas NHS Foundation Trust's services?
    - Risk assessments were not readily accessible in the Sheffield Health & Social Care NHS Foundation Trust information system when accessed from different locations
    - Both the realism and robustness of the risk management plan are open to considerable doubt as many of the assumptions on which it was based were known to be questionable from previous experience of BC.

206. The authors of *Best Practice in Managing Risk* (Department of Health 2007) say that risk management works best when a service user's strengths are recognised alongside the possible problems that they might encounter and which they might present. They suggest that every time a problem is identified a strategy should be suggested and discussed, building on the positive skills of the service user. The emphasis should be on a recovery approach and the service user's ability to cope when they are feeling vulnerable or are having difficult demands placed upon them. This does not seem to have happened with BC as he had relatively few opportunities to experience demanding situations as he spent most of his time from May 2008 to April 2009 on Stanage ward. When he engaged in risky behaviour it revolved mainly about drug use and little seems to have been done apart from exhorting him to abstain. No on-ward services (for example, psychological support) were available. He seems to have gone on short term leave without problems but his longer term leaves ended in non-compliance with medication. Strategies do not seem to have been developed. BC did not use khat all the time he was in Nether Edge but the triggers that started BC's khat use were not systematically investigated with a view to long term abstinence.

207. It is not clear whether or not Sheffield Health & Social Care NHS Foundation Trust had a standardised approach to risk assessment based on systematic information collecting designed with evidence-based principles in mind which enabled staff to use clear and verifiable risk indicators and with opportunities for stating individual opinions. Forms of this type allow occurrences of harm to be recorded in as much detail as possible, setting out details of what happened, the circumstances of the incident, the consequences of

what happened and how what happened related to the service user's mental illness. Best practice suggests that the service user's own views of what happened should also be included.

208. The Department of Health document states that once a risk management plan has been developed or reviewed, it must become a live document and be communicated to the service user and all those involved in providing for their care. Risk management plans must be used as the basis for joint action. Although this was national policy from 2007, it did not guide action in the Sheffield Health & Social Care NHS Foundation Trust partly because BC showed so little commitment to his treatment plan.

209. The Oxleas NHS Foundation Trust's *Guide to the Assessment and Management of Risk* (2010) considers engagement to be one of the most important indicators of treatment outcomes. At the same time, focussing on engagement skills and strategies will enhance the likelihood of conducting accurate risk assessments and increase the chances of developing meaningful and workable risk management and contingency plans. If this policy had been in place in 2009 and had been followed, it is possible that there might have been a different decision made and perhaps BC would not have been allowed to leave in the care of his cousin.

The involvement of carers, relatives and other organisations when preparing discharge plans

210. BC's brother(s) and an uncle visited him on numerous occasions during his periods as an inpatient but their names were never recorded so it is impossible to infer how much continuity there was in family involvement. His brother(s) were also used on occasions as interpreter(s) in the preparation of CPA reviews, to the extent that some were regarded as less than satisfactory if a brother did not attend. The complex nature of the family structure was not fully recorded until August 2008

211. Although BC married in 2005 the name of his wife does not seem to have been firmly established for some time, her name is given as 'K' when first mentioned but later a completely different name was given 'F' but it was spelt differently when mentioned later. There were attempts by social services to make contact with her in relation to their safeguarding children inquiry. What, if anything happened as a result of this inquiry is not known as there is only a single reference to it in the medical records. It appears that the lady is known by all three names but will be referred to here as FC. FC was seen as a source of corroboration of information about the course of his mental illness but she seems never to have been visited although there were several (unsuccessful) attempts to contact her by phone. In the case notes compiled during his stay in Nether Edge there are reports of his wife stating that she had concerns about BC seeing his (then) eighteen month-old child and that she was unclear if she wished him to return. There is no indication as to how this information was obtained.

212. When Oxleas NHS Foundation Trust staff met two of BC's brothers after the incident it transpired that they were out of the country on a regular basis and so there does not seem to have been a high level of continuity in the care they might have been expected to provide as part of any care plan. This information was not known to anyone in the Sheffield Health & Social Care NHS Foundation Trust.

213. When the decision was made that BC would be remaining in Sheffield on discharge two organisations which provide supported accommodation were approached. The discharge facilitator helped BC apply to Halfway housing but he was not accepted there. PQ helped BC apply to SACMHA and BC was accepted there. It was thought that SACMHA was particularly appropriate as it could provide ethnically sensitive support. The flat selected for BC was located across the road from a GP practice which would take blood samples as part of his Clozapine regime. An application for a community care grant was successful and the flat was kitted out ready for BC's discharge.

214. In our discussions with a representative of SACMHA it was clear that they believed that they were able to cope with BC and his needs. The package of care, treatment and support was well planned. This experience has not affected SACMHA's willingness to work with Sheffield Health & Social Care NHS Foundation Trust subsequently.

How the care plan was tailored to meet BC's needs including the geographical split of his family responsibilities

215. Between 1994 when he entered the UK and 2005 when he moved to Sheffield, BC spent his life in south east London. Two of his brothers lived there and a further two brothers were in the care of Oxleas NHS Foundation Trust for a least part of that time. BC maintained a flat in London until 2009 although the starting date of his tenancy is not recorded. The flat was owned by the local authority; it is not clear how BC paid the rent as his finances were very limited when he was an inpatient in Sheffield.
216. As mentioned in the previous section BC moved to Sheffield when he married and went to live with his wife's parents, her sister and brother-in-law. The home was owned either by his wife or her family. There is also an entry in Oxleas NHS Foundation Trust's records in June 2008 stating that he was not resident in Sheffield but only visited every fortnight. Although no dates are included in any of the records, BC's first child was probably born in early 2007 (quoted as being eighteen months old in July 2008) and the second in December 2008 although this is inconsistent with the statement that BC's wife was eight months pregnant in August 2008.
217. BC was in Sheffield in April 2008 when he was admitted to Nether Edge after a suicide attempt and the discharge plan was for him to remain in Sheffield so the discharge summary was sent to a health centre in the south east of Sheffield. The address to which he was supposed to be going was not mentioned. BC seems to have gone to London very soon after discharge and towards the end of April when he was brought to the Accident and Emergency Department of Queen Elizabeth Hospital, Woolwich. Because he was thought to be from Sheffield BC was transferred back to Sheffield in June 2008 although he was not happy about the move and protested against it.
218. Almost as soon as he was back in Sheffield BC planned to be discharged back to London although he was told at the end of June that as he had a Sheffield GP he would have to stay in Sheffield. In the summer of 2008, BC seems to have been torn between wishing to see his child and wanting to return to London.
219. There are references in the various notes about staff plans to contact FC to see if she wished him to return to their home on discharge. It is not clear whether any of the Sheffield Health & Social Care NHS Foundation Trust staff ever had face to face contact with FC. Telephone contacts were met with responses ranging from claims of being the right person but not to know BC, having reached a wrong number, to denials of being FC. Throughout the period BC continued to want to see his child and he then told staff that his wife was eight months pregnant. The possibility of using advocacy services to enforce contact was suggested but abandoned when BC gained access to his child although his wife shouted at him and threatened to call the police. BC was allowed to see his new child so efforts to gain access through the legal route were stopped. Towards the end of the year BC was refused admission to his family home. Later in 2008 and early 2009, there are references in the notes to his ex wife but they had not divorced at that time. [An Islamic divorce was initiated in 2011 by FC.]
220 In the autumn of 2008, BC took his home leave in London although staff recorded that he was likely to be discharged in Sheffield. In November 2008, BC thought about going to Scotland as there were fewer Somalis there; though the staff felt it would be better

for him to settle in London as he had family there. But in December 2008 and January 2009 the plan then was for BC to go back to London with an initial stay with his brother. At this point BC told staff he had a GP in London SE7 and he then confirmed his home address. Staff phoned the GP surgery who confirmed that he had been on their books since November 2008 although he had no contact with them as yet. Staff also noted that BC had been quite dismissive of attempts to support him and to make plans for his discharge. It was at this point that PQ contacted the North Recovery Team based in SE7 with a view to transferring BC.

221. At an MDT meeting in late January 2009 which HC attended, BC told staff that he had spent his home leave sorting out the gas and electricity supplies to his flat. HC told staff that he did not think his brother was capable of independent living as he was chewing khat all the time on home leave and lost motivation.

222. It was at this point that efforts were begun to find supported accommodation for BC in Sheffield. He was told that for this to happen he would need to give up his flat in London. BC already had a community team in place in Sheffield. HC came to Sheffield to express his concern that his brother was going to be discharged to London and said that supported accommodation would be for the best. The process of organising admission to supported accommodation began - first with Halfway housing and then with SACMHA. Efforts were again made to ensure that BC gave up his flat in London.

223. In March the application forms for SACMHA were completed and BC met their eligibility criteria. Staff thought the scheme was suitable as he had struggled to integrate into the hospital community and, therefore, having access to workers with greater cultural sensitivity and the ability to support him in his needs to integrate with the Somali community. They stated that he would need assistance with monitoring his compliance with medication and to help structure his daily routine. With BC's khat use, he would need further education and support.

224. Within two days of making this application, BC was again talking about being discharged to London and met his uncle (who seemed to live in the Sheffield area) to say his good-byes. BC later asked for home leave to go to London to hand back his flat to the local authority, so he could stay in Sheffield.

225. Towards the end of March BC was accepted at SACMHA which he said he was happy about and that he would be applying for furniture. Ward staff helped BC complete the application forms for a community care grant and OP, his support worker from SACMHA, helped to change his GP registration within Sheffield as he was moving to a new catchment area. SACMHA helped furnish the flat so he could move in on 1st April 2009. It is not clear how long BC stayed in the SACMHA flat, it may only have been thirty-six hours, but he had left by the time of the seven day follow up visit by PQ and the CMHT consultant psychiatrist.

226. When the Service Management Review Report was completed by Oxleas NHS Foundation Trust on 11th May 2009 FC was given as the nearest relative - although the marital status was given as separated, again there is confusion over her family name. Her address is given as being in Sheffield. BC had asked on several occasions for his nearest relative to be changed to his brother's name but this never seems to have happened. It cannot be excluded that BC gave different names on different occasions.

227. There was clearly a long and tortuous series of changes of mind and plans over a period of a year covering BC's contact with mental health services following his suicide attempt in April 2008. BC's two children represented a strong family connection to Sheffield for some of this period but there seemed to have a distinct cooling towards the children after it was thought he had discovered that his wife was seeing someone else. There has never been any formal attempt by either party to separate legally or to secure a divorce; at least that it is recorded in the case notes. Though it now seems that an Islamic divorce was initiated by BC's wife in November 2011. BC often seemed indifferent to plans for his discharge and then he could suddenly change his mind. On the day of his discharge he had forgotten that he was due to leave the hospital. All those involved in BC's treatment and care seemed torn between a wish to prevent him becoming institutionalised while not knowing how he could be discharged safely. The suggestion that he should go to a rehabilitation ward does not seem to have been followed up. Perhaps BC should have been given a trial leave period with SACMHA, if that was possible, to see how he reacted to the new surroundings. BC had invariably gone to London on previous home leaves, so this might have been one way of testing his willingness to stay in Sheffield. The lure of the flat in London was always there in spite of attempts to get him to give it up. He could not be forced to do so, but his continuation of the lease should perhaps have been a warning that a move to London was still a strong possibility. It would appear that the local authority which owned the London flat did not know that BC lived in his in-laws' home in Sheffield.

The perceptions of BC's family of the level and quality of care and treatment provided

228. The independent investigation panel have been unable to establish contact with either of BC's brothers despite several attempts to do so.

229. After the homicide one of BC's brothers (SC) said that between 1998 and 2004 BC was functioning well and held down a job but he believed that in 2004 BC had stopped taking his medication because he thought he could cope without it. The brother reported that at that time BC stopped making sense and started saying that he thought people were talking about him and were doing things behind his back. GC said that at the end of 2007 the brothers noticed that BC was spending more time in London rather than with his wife and family in Sheffield and was becoming "*fixated on people*". The brothers then tried to transfer BC's psychiatric care to London to make things easier for the family but were unable to persuade the Sheffield authorities to do so. GC arranged for BC to be registered with a GP in London SE18 in 2008 and through the GP practice "*arranged a social worker*".

230 In 2008, BC stayed in SC's flat but BC would be awake all night and his other brother (HC) would have to stay up with him. GC said that BC would talk about killing this or that person - he would name a person picked apparently randomly from the local community whom BC believed was either talking or doing something about him. BC could be talked out of these thoughts. But GC said that over the last six months BC was getting worse. BC had become a lot angrier. On the last occasion when GC took BC back to hospital in Sheffield after home leave, in March 2009, he said that BC became very agitated in the car on the way back and that GC had to stop in order to settle him down. He then left BC at the hospital. On 25th March 2009, GC went on holiday to Somalia and returned on Monday 4th May, so was unaware that BC was back in London as he had not heard from him and no one had told him of BC's presence.

231. HC said that BC first showed symptoms of his illness in 1995 which he attributed to the stress of leaving Somalia. He said that when BC was discharged from hospital in 1995 he would become suspicious and paranoid if he stopped taking his medication. The two brothers would do their best to make sure BC took his medication but it was difficult and BC did not like the medication. HC said that when BC was in Nether Edge he would keep coming back to London, would stop taking his medication and the hospital would report him as a missing person. HC said that BC hated having to give blood samples to monitor his Clozapine use. HC said that on 15th April 2009 the police "*tried to take BC back to Sheffield*" (the 'safe and well check' initiated by PQ) but BC told them he could stay with HC. HC said he knew BC was only saying this to get away from the police. HC said that when the police contacted him, he told them that BC could not stay with him and that they should take him back to Sheffield. HC said that he had seen BC lunching with AD on 13th April 2009 and that the two were closer than BC was to his brothers. HC said that the two would often spends evenings together chewing khat. HC did not hear anything more of BC until GC told him about the homicide.

232. Unfortunately, the independent investigation panel has not been able to follow up the families' interpretation of events over the period leading up to the homicide.

Adequacy and appropriateness of the internal investigations and reviews

Review of internal reports

233. This independent investigation is unusual as there are two internal investigation reports to be reviewed. Both Sheffield Health & Social Care NHS Foundation Trust and Oxleas NHS Foundation Trust produced a report following their internal investigation of the homicide. As will be seen the two reports are different in orientation as each Trust focused on those aspects of the case that were relevant to them. However, the use of an audit tool allowed us to assess each against a common standard. The common standard is the 'good practice' set out by the National Patient Safety Agency in 2008.
234. The audit tool was based on work led by Health and Social Care Advisory Service (HASCAS) previously carried out in the North West of England. The HASCAS tool was developed in conjunction with mental health trusts in the North West, further refined for work carried out by Caring Solutions (UK) Ltd for NHS North West over a period of three or four years.
235. The audit tool contains standards which address how the incident was recorded, the way in which the investigation was conducted, the quality of the investigation and analysis described in the report, the actions identified and implemented, clarity over accountability and responsibility, and the structure and standard of the report. The audit tool provides both a quantitative judgement as to the extent to which each standard was met in the internal investigation report and a qualitative commentary.
236. Each Trust's report will be dealt with in turn as the internal investigation panels had different terms of reference.

Sheffield Health & Social Care NHS Foundation Trust

237. The membership of the internal investigation team had a wide range of backgrounds and expertise relevant to the task, for example, the team had both managerial backgrounds combined with areas of professional expertise.

Reporting the incident

238. Although the report's account was completed five months after the homicide it was completed well before BC's trial, so the description of the homicide is fairly brief. Most of the evidence the report contains seems to have come from conversations with Metropolitan Police officers dealing with the case in the days after the arrest. Nothing was known of the events in the days leading up to the incident (that is, between the evening of 30th April when BC left Oxleas House in the care of his cousin, AD, and the time he was arrested in the early hours of Monday 4th May). There is no comment on the reasonableness of the twelve day gap between BC going missing from his flat to the instigation of the 'safe and well check' given what was known of BC 's history of non-compliance with medication.
239. After Sheffield Health & Social Care NHS Foundation Trust had been told by the Metropolitan Police of the homicide, they prepared a management report and then initiated an internal investigation. The precise timing is not clear. There is a timeline of

the events leading up to the homicide but not one for the internal investigation process. A Level 2 report was completed in September 2009.

Establishing the investigation process

240. The internal investigation was given five terms of reference as follows, the panel was to examine:

- *Risk assessment and reviews of these in relation to harm to self or others*
- *Communication and liaison between services in Sheffield - inpatient and community teams, also with the GP*
- *Contacts with services, including Do Not Attends, missing persons*
- *Clarity of who was care co-ordinator and monitoring of treatment plan*
- *Liaison between Sheffield and London.*

241. A very precise interpretation of the second term of reference could perhaps exclude the voluntary sector in the form of SACMHA but in fact the manager of SACMHA is listed in the 'key staff' who were interviewed. A total of five people were interviewed in Sheffield and information was received from others both in London and Sheffield. The choice of interviewees was appropriate to the specific areas set out in the terms of reference. The panel was able to seek out further information in order to locate the main problems in the care delivery and provision of services for BC.

242. The sources of information were Insight (the Sheffield Health & Social Care NHS Foundation Trust's electronic record system) and medical notes, the incident file, the management report, client activity details, discharge arrangements including correspondence, and the chronology of events the panel drew up. The panel also considered local policy documents on missing persons, the admission and discharge pathway, the information sharing protocol, the CPA pathway, and the discharge plan. The panel interviewed key staff: the care co-ordinator, the team manager, the manager of SACMHA, a consultant psychiatrist, and a second team manager. They received information from a service director, a detective constable with the Metropolitan Police, a ward manager, and the deputy chief executive of Oxleas NHS Foundation Trust. This was a comprehensive information collection exercise.

243. The report states that information was received from the manager of SACMHA but it is not possible to identify precisely what evidence he provided. It would have been useful for the internal investigation panel to have found out whether SACMHA saw itself as being the appropriate organisation for a service user such as BC's and whether they had the skills and resources to cope with him.

244. There was no input from primary care which is understandable considering that BC had been an inpatient for nearly a year. BC had only been registered with a new GP in Sheffield for a few weeks when he was discharged and did not seem to have ever seen the GP.

245. The internal investigation panel stated that Sheffield Health & Social Care NHS Foundation Trust had a commitment to include carers and relatives in its policy documents but there is no evidence of any attempt to contact any one as Oxleas NHS Foundation Trust had taken on the responsibility of meeting BC's brothers. It is not clear

whether or not the panel ever considered meeting PO (BC's uncle) who visited him during his stay in Stanage ward. It is not entirely clear whether PO lived in Sheffield but the frequency of his visits to the ward seems to suggest that he did. The internal investigation panel wrote to BC's wife asking her if she wished to contribute to the investigation and to see a copy of the completed report, she did not reply. As the victim was a family member the contacts Oxleas NHS Foundation Trust panel had made covered this requirement. All of the contacts with the family followed the internal inquiries. It is not clear whether the families and carers could have added anything to the internal inquiries except, perhaps, to clarify their ability to act as carers for BC as envisaged in the discharge plans.

Understanding BC and his care and treatment

246. The internal investigation report is silent on some aspects of BC's care and treatment - for example there is no reference either to his CPA status or to his MHA status. There are some references to previous diagnoses and the report states that when the records were received from Oxleas NHS Foundation Trust BC was thought to be suffering from a paranoid illness but there is nothing to say whether or not this diagnosis was revised during his stay in Sheffield. BC's social and family background are outlined but the information about his brothers was obtained post-incident from the Oxleas NHS Foundation Trust internal investigation. There is no reference to PO, the uncle, who visited BC while in Sheffield and who might have been a Sheffield resident. There is reference to BC's use of khat and a statement that BC had no forensic history. There are no references to risk assessment and management in the internal investigation report even though it was one of the terms of reference.
247. Further explanation and elaboration of the context and objectives of the CPA would have enhanced the report. A major feature of the report is the discharge meeting taking place and information being dispatched to Oxleas NHS Foundation Trust and the GP. There is a statement to the effect that the discharge meeting papers had been addressed to the wrong part of Oxleas NHS Foundation Trust but no evidence is presented as to the address to which it was actually sent. The 'care and delivery problems' section of the report is more a statement of the facts of the case rather than a systematic analysis. There are references to BC changing his mind about his choice of location on discharge but the panel did not look at the information about BC's poor compliance record when given leave from Nether Edge, nor did they comment on his propensity to spend his leaves in London. Both of these factors might have raised questions about the realism of a discharge plan based on accommodation in Sheffield.
248. Risk assessment and risk management are both important to this case: indeed risk was at the core of the first of the terms of reference. There is no explicit discussion of risk assessment and risk management in the report. The 'contributory factors' analysis concentrates on information sharing in emergencies and the 'root causes' analysis concentrates on the choice of medication, BC's non-compliance with medication, the attempts by the care co-ordinator to re-establish contact with BC when he disappeared from Sheffield and the missing persons call to the police. The CPA review held on 28th April is described as timely and the report notes that the information as sent to the Oxleas NHS Foundation Trust, BC's GP and to HC. No comment is made about the risk

assessment remaining unchanged from that produced when BC was discharged a month previously.

249. There is no comment about child protection or vulnerable adult issues even though BC had two small children and there had been some social services involvement in the case when BC was first admitted to Nether Edge.

250. There is no mention of any needs assessments produced for BC during his time in Sheffield. The suitability of the care and treatment BC received was not considered apart from the discussion of his compliance with medication. There was no discussion of the extent to which care and treatment corresponded to national policies but there is reference to local policies on discharge processes when dealing with a service user who does not attend.

251. The panel could have discussed the 'exercise of professional judgement' in the context of contacts between the two Trusts. One issue which arises from a reading of the notes is 'what should a care co-ordinator be expected to know about their cases?' This is a general question rather than one attaching to the individual whose endeavours to provide a plan for BC are very clear from the chronology

252. The panel noted that there was a discussion amongst the MDT as to whether Clozapine was the most appropriate drug for BC to be taking due to his lack of compliance when on leave from the hospital.

253. The discussion of the 'interface, communication and joint working of those who provided care' is seen principally in terms of BC's indecision and lack of commitment about where he was going to live on discharge. BC's commitment to more than one geographical area was recognised as an essential feature of the case. But while the panel also say that support should be in place when requests are made for information from other Trusts, they do not mention the speed with which meetings are coordinated and reports are written when service users can move from one part of the country to another in a matter of hours. Nor do they mention what information should be in such reports.

254. The report looks in some depth at BC's indecision about his location but the panel do not refer to the wider issue of BC's engagement with services and any attempts to maximise engagement.

255. It is not clear whether greater involvement of the family/carers would have made any difference to the outcome. The panel did not comment on the nature of the contacts with BC's brother(s). The notes include clues about the brothers' views on BC's treatment, for example, asking why he had been let out when he was obviously ill.

256. The panel did not comment on 'staff awareness of any precipitating factors or deterioration in the patient's health and the contribution of these to clinical decision making'. When the CPA meeting took place on 28th April staff knew that BC had been without medication for three weeks and that his mental state deteriorated when he failed to take his medication. The CPA meeting is not mentioned in the chronology of events.

257. The panel looked at the existence of integrated records in the context of TU's first attempt to contact PQ on 30th April. PQ was on a home visit at the time and she was contacted by the Sheffield Health & Social Care NHS Foundation Trust bed manager who acted as an intermediary. PQ phoned TU when she returned to office but it would seem

from the later correspondence that although an electronic record system exists, there were limits to what information could be accessed remotely by comparison with staff on a ward. Staff acting as first contacts for other Trusts would have limited opportunities to share information about risk assessments with others.

Analysis of the incident

258. Internal investigation reports should demonstrate a logical connection between the facts that are drawn out and the Sheffield Health & Social Care NHS Foundation Trust panel do this. But there is a concern that the panel was wrong to suggest that the problem was the availability of information to staff on home visits. This might have been the case at one stage but PQ contacted TU again later in the day when she was back in the office and had access to more information.
259. The conclusions drawn by the panel are not linked clearly to the evidence presented nor are they related back to the terms of reference. One of the terms of references (risk assessment and risk management) is not discussed at all.
260. The panel made one recommendation - 'Clinical teams to ensure systems are in place to deal with initial enquiries' which follows from the first of the lessons learned. The other lessons about liaising with other Trusts when dealing with service users who have connections to more than one geographical area are not subject to any formal recommendations and are left as issues for discussion. The panel do not discuss contingency planning in this context.

The development of an action plan

261. The panel state that the report has been considered by Sheffield Health & Social Care NHS Foundation Trust Executive Directors Group and the Board of Directors for the development of an action plan from the recommendations. The report is to be shared with the commissioners, all CMHTs and the Quality and Risk Group. The recommendations and actions are to be picked up by the Risk Register. The action plan was to be followed up by the Quality and Risk Group and their dashboard shared with the Board of Directors.

Clarity of accountability and responsibility for action

262. The internal investigation panel decided that the principal contributory factor was a systems problem rather than a matter of individual deficiency. There was a discharge policy in place but there were no specific guidelines in place to support staff for emergency requests for information. It is questionable whether this was a contributory factor in the light of the later phone call between PQ and TU. The content and tone of their conversation were more important. Guidance should also be given about the need for information transfer to be speedy, for example, using fax or e-mail.
263. The proposal to test the organisation's capacity to direct queries to the appropriate staff through a scenario-based audit would seem to address part of the problem of emergency communications with other Trusts; but the proposal says nothing about the contents or the tone of the conversations that would then take place.

The structure and quality of the report

264. The internal investigation report is only ten pages in length but it does include an executive summary. The report follows a logical and clear structure as it follows the NPSA template. The report is carefully written in places (for example, the section on 'Involvement and support of patient and relatives') rather than clearly written. The 'story' is easy to follow until the conversation between the Oxleas NHS Foundation Trust acting bed manager and the Sheffield Health & Social Care NHS Foundation Trust care co-ordinator. That conversation was important in the development of the incident as it would seem from other documentation that vital information was communicated but not recorded or acted upon. The lack of analysis of the care and service delivery issues also leaves gaps in the report.

Positive practice identified which should be disseminated

265. The internal investigation panel state that the thorough discharge arrangements set up in Sheffield for BC's care were notable practice.

Oxleas NHS Foundation Trust

266. It is clear from the quality of the presentation of the report and the panel minutes available to the independent investigation panel that the chair and supporting team have the requisite skills to produce a comprehensive report. Although brief, the report relies on the creation of a detailed information file which is well constructed and is clearly indexed with a logically presented chronology of events. The team has a good combination of professional expertise which they brought to bear on the issues before them.

Reporting the incident

267. The circumstances of the incident were not known to the panel at the time of their investigation which they completed in August 2009 (between three and a half and four months after the event). But they do record the extent of Trust involvement with BC and there is a brief report of BC being arrested outside the flat "*where a man was found dead in suspicious circumstances*". When the report was prepared the panel knew about the arrest and the post arrest psychiatric assessments made of BC by Trust staff.
268. The panel identified factors which may have had relevance to the incident, or at least were historical antecedents, in the narrative of their report. This included presentation of behaviour prior to discharge from the Oxleas NHS Foundation Trust assessment area and the habit of using a stimulant (khat). The chaotic nature of BC's lifestyle and his state of distress on initial presentation in the Accident and Emergency Department and subsequently in the assessment area are clearly set out.
269. The incident occurred away from Oxleas NHS Foundation Trust's premises and it was brought to their attention by the Metropolitan Police. The action taken by Trust staff is clearly related by the panel as this revolved around responding to a request from the police for a psychiatric assessment of BC. This was provided by an Oxleas NHS Foundation Trust consultant psychiatrist. Immediate and correct action was taken with the objective of compiling the Service / Management Review Report. This was achieved

and was received by the Oxleas NHS Foundation Trust Critical Incident Office within one week of the date of the incident. The final report to the Board of Directors was completed within about twelve weeks (that is, August 2009).

Establishing the investigation process

270. The internal investigation report sets out clearly the commissioning process, the terms of reference and the methodology to be followed. The terms of reference are focussed on the critical period when BC was in contact with Oxleas NHS Foundation Trust. Reference is made to involvement of the family and staff. There is also reference to liaison with Sheffield Health & Social Care NHS Foundation Trust. Arrangements for sharing the reports are also set out.

271. The panel lists the thirteen people who were interviewed even though BC was in contact with Oxleas NHS Foundation Trust for a relatively short time (about twenty-four hours). All but one of the interviewees came into contact with BC on the 29th and 30th April; in addition they saw the on-call consultant psychiatrist who saw him post arrest. The panel had a written statement from LN (the clinical charge nurse on duty overnight) but they did not interview her. The panel also had access to written statements from all staff who saw BC in the assessment area. The quality of these reports varies but they do appear to provide an accurate or likely description of the procedures and processes involved from the initial admission in the Accident and Emergency Department to his discharge from the assessment area. The materials from the case files correspond with the interviewees' statements. There was also evidence of detailed and robust interviewing of the interviewees available in the form of verbatim transcripts.

272. Relevant supporting information was used and this, in turn, has captured elements required to fulfil the demands of a comprehensive Level 2 report. This information was comprised of:
    - Incident form.
    - Service Management Review Report.
    - RiO (patient information system) progress notes and documentation.
    - Level 2 observation records.
    - Discharge summary of prior admission.
    - Care plan and review of previous admission.
    - Chronology (time line).

273. Additionally, the following documents and policies were utilised to inform the investigation:
    - Greenwich Mental Health assessment team operational policy.
    - Guidelines for Emergency Department referrals to the Mental Health Assessment Team.
    - Protocol for the Assessment Area, Oxleas House.

274. There was no input from the multi-disciplinary team or other agencies (for example, primary care) as BC was not in contact with any of these during the relevant period of time. However all the staff who saw BC in the assessment area were able to contribute. The police and members of the Somali community were also involved in the later stages of the investigation process.

275. The panel stated "*in the additional terms of reference*" that BC's relatives would have the fullest opportunity to contribute to the investigation process. BC's brothers who live locally would be invited to contribute to the panel's investigation. There was no apparent contact with BC himself. BC's brothers met the panel again to discuss findings and recommendations. There have also been meetings with the wider Somali community. The nature of the family contact reflects the sensitive and highly professional approaches taken to inform the investigation process. Communication with families is a sensitive and difficult undertaking and it is, therefore, important that personnel involved with family interviews should have received family support training and venues for such interviews should be mutually agreed.
276. The letters inviting members of staff to attend interviews are not included in the documents that accompanied the report so it is not possible to say anything about their contents and approach. The transcripts of the interviews show that the process was open and transparent; a nearly complete paper trail exists for the whole investigation process.
277. The panel took a systematic and professional approach to retrieving information and formulating factual elements in a transparent process appears evident in the report. Their clear and open critique is apparent and the report has assisted the Level 3 independent investigation 'drill down' into areas of concern in the overall profile of the care and treatment of BC.

Understanding BC and his care and treatment

278. The attempt to understand the service user and his care and treatment is quite comprehensive and the panel appear to have subjected the documents available to them to a considerable degree of scrutiny. They may have been hampered in some aspects as a number of documents are either incomplete or contain a paucity of information. There is no historical CPA documentation. The overall report reflects an understanding of the pattern of BC's illness and his distressed lifestyle. The issue of compliance with medication is partially addressed in relation to the panel expressing concern regarding the risk which was presented when BC had not returned to the Sheffield address. The panel states that further exploration is required with regard to the choice of antipsychotic (Clozapine) by the Sheffield Health & Social Care NHS Foundation Trust and the risk of regression if BC stopped complying with the medication. Also, further exploration is required regarding the missing prescription / administration sheet within the assessment area of Oxleas House (Lorazepam) apparently prescribed blind by SHO on the word of nurse practitioner (AB). The independent investigation panel do not support this interpretation of events as seen above.
279. An appropriate reference is made in the report to the attempt of serious self-harm in the year prior to this presentation. The self-harm was not analysed in detail as the panel focussed almost exclusively on the twenty-four hour period within the assessment area before the homicide occurred. However, it is seen as likely that such an issue will be explored in the Sheffield Health & Social Care NHS Foundation Trust internal investigation report and will be further considered during a Level 3 investigation. The

Oxleas NHS Foundation Trust internal inquiry report does identify self-harm events in the chronology.

280. The lack of an adequate assessment being completed at Oxleas House is identified as a 'care problem'. The panel was clear and explicit in their view of the adequacy of risk assessment and management:

> *The Panel found that information about risk was neither volunteered nor sought from BC's care co-ordinator in Sheffield, despite phone contact. Within the Oxleas House assessment service, the processes for assessment and safe patient management were not sufficiently robust; this contributed to BC being discharged without a comprehensive assessment having taken place.*

281. The report provides sufficient detail on the areas of inadequacy in the care and treatment of BC. This revolves around anomalies in the assessment process and problems of communication:
    - BC was not interviewed at any length by any member of the assessment team.
    - BC was recorded as being in need of 'assessment by the duty doctor in the morning'.
    - BC was not assessed before being given medication by duty SHO during the night - the prescription was believed to have been given on the nurse practitioner's assessment.
    - There was no medication chart for BC.
    - Neither doctor on duty during the day carried out an assessment.
    - The assessment team nurse practitioner agreed that the acting bed manager would carry out an assessment in order to facilitate discharge.
    - Phone calls to Sheffield Health & Social Care NHS Foundation Trust focused on establishing who had clinical and financial responsibility for BC's care.
    - Clinical information on records relating to BC's time with Oxleas NHS Foundation Trust in 2008 were not taken into account when the discharge decision was taken.
    - The acting bed manager took the decision to discharge BC without reference to other staff within the assessment team.
    - There was no comprehensive assessment of BC documented on RiO for his contact with the assessment team on 29th / 30th April 2009.
282. No needs assessment was prepared on BC during his time in the assessment area so it is not possible to comment on the adequacy of the assessment that was made. The belief that BC was returning to Sheffield Health & Social Care NHS Foundation Trust obscured other considerations.
283. The panel looked at compliance with local policy. They raised the issue of departure from best practice that all service users should be assessed on presentation to local services and their suitability for transfer should be part of that process. Reference was made to assessment protocols. They argued that if policies and procedures had been followed the quality of the assessment would have been improved. Nothing was said about any national policy relating to these aspects of care.

284. The panel have highlighted aspects of judgement which may have precluded adequate assessment and disposal. The clinical decision-making of the SHO was examined briefly. A question was also raised about why the duty doctor in the morning did not see it as her job to assess BC - she was not asked to do so. A major issue identified was the role of the acting bed manager particularly in relation to his responsibility for moving patients through the assessment team. The criticisms the panel made are reflected in the recommendations and lessons learned.
285. The panel examined communications between various members of staff - as communication was seen as one of the principal problems. The communication between Oxleas NHS Foundation Trust and the Sheffield Health & Social Care Trust was also examined and the panel concluded that the focus was wrong - financial and clinical responsibility seen as the issues rather than BC's needs.
286. The panel discussed the intervention of AD, BC's cousin, in the process of discharge. AD agreed to take responsibility for BC without Oxleas House staff knowing anything about his ambiguous immigration status and his habit of minimising contacts with statutory authorities. This information only emerged after the homicide when contact had been established with BC's brothers who live locally.
287. The panel commented on the fact that historical information about BC was available on the Oxleas NHS Foundation Trust information system but was accessed only to obtain contact details for PQ and Sheffield Health & Social Care NHS Foundation Trust services. It is not clear whether access to more information would have prompted other actions, for example, if Oxleas NHS Foundation Trust had known about BC's non-compliance and previous khat use. Information about BC's recent psychiatric history was not explicitly sought from the Sheffield Health & Social Care NHS Foundation Trust care co-ordinator. The panel was clear that there was a need to talk to BC rather than just observe him given his delusional state.
288. One of the strengths of the report is the identification of the need for a single integrated information system in the assessment area rather than the existent white board, spiral binder and medication chart. No one was able to tell what work needed to be done and no one could say what point each service user had reached in the assessment process. The report also highlighted the local, general, and national problems associated with providing services for difficult to engage service users with chaotic and disorganised lifestyles.
289. The panel looked in some depth at issues of 'information sharing, access, communications and joint working between teams and agencies' though within team information sharing was the main focus. There was a lack of managerial control over the assessment process - no one was in charge. There were problems of hand-overs from one shift to next and how information about tasks was communicated. Communication between the duty senior nurse and the duty doctor also seemed to be an issue but was not discussed in detail. Sharing information with Sheffield Health & Social Care NHS Foundation Trust services was also seen as a major problem. The panel identified the need for a visible 'at a glance' system in the assessment team office to track every patient under the team's care at any point in time. The panel was also clear and critical in describing their concerns about the discharge process.

290. Less attention was paid to the preparation of BC for transfer between the services or to the eventual discharge from Oxleas NHS Foundation Trust. Much of the thought and activity in the assessment area was based on the belief that BC was being transferred to Sheffield on the basis of his registration with a GP there. Nothing was done to prepare BC for transfer, there was no attempt to arrange transport, and no checks were made about where he would go on return to Sheffield. The process seems to have been based on the assumption that if BC was told to go to Sheffield he would comply. The panel might usefully have looked at this aspect of the decision making processes behind the discharge process.
291. Although no specific staff training issues were identified, the report focussed on areas which shall be subject to consideration for further staff development. These revolve around:
    - Role and function.
    - Medicine prescribing or administration.
    - Record keeping.
    - Communication.
    - Discharge (care planning).
292. The panel examined the issues of team leadership and management support in the sense that there was no identifiable member of staff responsible on each shift to ensure that processes of assessment and patient management were carried out adequately. Their discussion was limited to the assessment team rather than its place in the wider structure of Oxleas NHS Foundation Trust. The role of the bed manager was also examined.
293. The internal investigation report is very clear about the root cause methodology the panel had followed and their analysis of the care and service delivery problems followed a fishbone diagram approach. This in turn increases the clarity of the report when connecting the various factors that contributed to this homicide.

Analysis of the incident

294. The internal investigation report sets out clearly the chronology of BC's time in the assessment area. The report deals with what happened to BC and also sets out what should have happened according to the 'Protocol for the Assessment Area'. The panel also looked at surrounding issues such as the pressure of work on the assessment area on the evening of 29th April. The panel presents a good assessment of what 'caused' the incident but they did not have access to what happened during the intervening few days between BC leaving their care and the homicide.
295. The panel's conclusions were clearly linked to the evidence and the recommendations and lessons learned address the terms of reference.

The development of an action plan

296. The recommendations do not contain an implicit action plan with a timescale and there is no indication of any individual being responsible for its implementation largely because the assessment teams in Bexley and Bromley have reviewed processes for managing patients through the assessment service in line with the investigation's initial findings. Both teams were in the process of putting in place an action plan to remedy

any gaps; progress was to be reported through the management teams in both directorates. The panel state that the implementation of the recommendations would be overseen by the Trust's Adverse Incident Monitoring Group.

297. The aim was for an update on the implementation of the action plan for the Greenwich assessment team and the other two Trust services were to be presented to the Board in March 2010.

Clarity of accountability and responsibility for action

298. The panel was clear in their view about which staff roles, rather than individuals, were responsible for what happened and did not happen to BC during the time he was in the care of Oxleas NHS Foundation Trust. The panel stated that there was a lack of clarity about who was responsible for assessments. The panel also said that there should be:

> *clear and immediately visible documentation charting a patients 'path' through the service to discharge, including length of time within the assessment area, who is responsible for carrying out the assessment and time and outcome of assessment.*

299. The panel said that there should be an identified staff member with responsibility for the overall management of the work of the assessment team on each shift. They went on to say that the staff member with management responsibilities should approve the discharge of every patient from the assessment team. Additionally, the role of the bed manager should be reviewed and clarified in relation to the assessment service. This means that individual staff roles were identified and their performance was placed within the context of the overall care system that existed in April 2009.

300. The transfer protocol within the assessment service would also be reviewed. The panel did not say what might follow from such a review.

301. This way of concentrating on the organisation of the work of the unit means that the role of each member of staff in the unit would be better defined in future, reducing the ambiguities which led to BC being handled the way he was. The panel recognised the importance of training to improve the performance of both individuals and the team. The panel also focussed on the need for training to improve the effectiveness of assessments, including risk assessment.

302. The internal investigation panel concluded:

> *that even if BC had received a thorough assessment during his stay in Oxleas House on 29th/30th April 2009, the incident could not have been predicted. Nevertheless, if a thorough assessment had taken place, this may have led to different management strategies being used and this may have had the incidental effect of preventing the incident taking place.*

303. It is not apparent whether "*a thorough assessment*" would have included more appropriate information from Sheffield Health & Social Care NHS Foundation Trust. But given the risk assessment in Sheffield Health & Social Care NHS Foundation Trust's discharge plan, it is by no means clear that Oxleas NHS Foundation Trust assessment area would see BC as posing a higher level of risk than he actually did in 2009.

The structure and quality of the report

304. The report is extremely well written and is well structured with both a table of contents and an executive summary. The panel have presented a complex 'story' in a concise way. The evidence available to the panel has been carefully analysed and they have separated assumptions from the facts of the case. The panel have used a root cause analysis methodology which enabled them to develop a coherent and logical report. The report avoids emotive language and is expressed in clear and comprehensible language.

Positive practice identified which should be disseminated

305. The report does not identify any positive practice for wider dissemination. However, some of the subsequent action was commendable. One is the Trust's involvement with the Somali community and the second related to the Trust's involvement of the police when engaging with the Somali community.

Conclusions

306. The two internal investigation reports were both audited against a common standard. It was clear that both reports followed the guidance on how and when to set up a Level 2 investigation. Both Trusts were able to find panel members with combinations of professional backgrounds and the necessary skills to carry out the task. The Oxleas NHS Foundation Trust report was completed more quickly than the Sheffield Health & Social Care NHS Foundation Trust report and it has a more easily discernible methodology. The two reports were completed virtually independently of each other. The Sheffield Health & Social Care NHS Foundation Trust panel received information from the Oxleas NHS Foundation Trust Deputy Chief Executive but the Oxleas NHS Foundation Trust panel did not interview any one, or receive any papers, from Sheffield Health & Social Care NHS Foundation Trust. The Oxleas NHS Foundation Trust report was completed sometime before the Sheffield Health & Social Care NHS Foundation Trust report. Each report concentrated on the issues specific to the Trust commissioning the report.

307. The terms under which the two internal inquiries were set up did require investigation of the links between the two services. The Sheffield Health & Social Care NHS Foundation Trust terms or reference refer to "*Liaison between London and Sheffield*" while the Oxleas NHS Foundation Trust's terms of reference refer to "*explore the liaison and communication with BC's host service in Sheffield mental health services*", though this is a secondary list of tasks outside the terms of reference. Neither report looks in any great detail at this aspect of the case. The Oxleas NHS Foundation Trust's report identifies as a root cause

> *12.1 Information about BC's recent psychiatric history was not sought from BC's care co-ordinator or manager in Sheffield by the Oxleas bed manager in the two telephone conversations that took place on 30th April 2009.*

308. The Sheffield Health & Social Care NHS Foundation Trust report does not consider another of its terms of reference "*Risk assessments and reviews of these in relation to harm to self or others*".
309. Both reports are limited in their explanations of the homicide as neither Trust had access to information about the days between BC being discharged from Oxleas House in the care of his cousin AD and the police arriving outside the flat where BC was arrested.
310. The reports differ in the ways they draw out and analyse care and service delivery problems in the case. The Sheffield Health & Social Care NHS Foundation Trust report produces a summary of BC's changing views about where he wanted to live on discharge. The contributory factor identified was the absence of specific guidelines to support staff when faced with emergency requests for information.
311. The Oxleas NHS Foundation Trust's report used a fishbone classification to set out the care and service delivery issues relevant to the case and identified three specific root causes for the incident. Their root causes were the failure to obtain recent information about BC from Sheffield Health & Social Care NHS Foundation Trust, the absence of a nominated staff member on each shift to ensure that the processes for assessment and patient management were carried out adequately, and the lack of a thoroughly documented assessment was not identified by staff and that BC was discharged without such an assessment.
312. The independent investigation panel found that none of the operational staff involved could remember having seen the other Trust's internal investigation report though senior managers had.

IMPLEMENTING THE ACTION PLANS

313. The independent investigation panel considered carefully the progress made against implementation of the action plans arriving from both Trusts' internal investigations of the incident; in particular the embedding of lessons learned from their investigations. To carry out this analysis, the independent investigation panel adapted a measurement framework similar to the approach adopted by the National Health Service Litigation Authority (NHSLA) which uses a set of risk management standards within Healthcare Organisations. These are set at three levels and the principle applied to each level can be applied to the action plan progress. These are:

    Level 1 - Policy: evidence has been described and documented

    Level 2 - Practice: evidence has been described and documented and is in use

    Level 3 - Performance: evidence has been described, documented and is working across the whole organisation.

314. Both Trusts provided the independent investigation panel with evidence of the actions they had taken, to date, to implement the action plans and to embed the lessons learned.

Sheffield Health & Social Care NHS Foundation Trust

315. At the end of their report the Sheffield Health & Social Care NHS Foundation Trust panel concluded:

    Lesson Learned

    Teams should ensure that there is a system in place to support when requests for information are made and they are away from their office base. Should Oxleas NHS Foundation Trust have been invited to a discharge meeting? Should Sheffield Health & Social Care NHS Foundation Trust have discharged Client [BC] *until Oxleas had fully accepted him onto their caseload. In retrospect the need for co-ordinated discharge/admission planning/handing over is vital in cases of people who are of a transient nature.*

    Recommendations

    - *Clinical Teams to ensure systems are in place to deal with initial enquiries.*

    This single recommendation is poorly written in that it fails to capture and reflect the key findings described as '*lessons learned'* in the report and does not get to the heart of what that report discovered as system failures.

    The Sheffield Health & Social Care NHS Foundation Trust panel continued:

    Arrangements for shared learning

    This report has been considered by Sheffield Health & Social Care NHS Foundation Trust Executive Directors Group and the Board of Directors for the development of an action plan from the recommendations. [This action plan was to] *be shared with the*

Commissioners [and] *internally,* [with] *all CMHT's and* [the Trust's] *Risk Group. Recommendations and actions were to be picked up by the Risk Register. The action plan* [was to] *be followed up via the Quality and Risk Group and their 'dashboard' with the Board of Directors.*

316. An action plan was prepared in early 2010 [the exact date not stated on the document] and was then updated on the 20th April 2010. It was unclear how the panel's single recommendation that "*clinical teams to ensure systems are in place to deal with initial enquiries*" was going to be accomplished. An audit was to be undertaken at points of contact and this was to be included in the 2010/11 audit plan. Testing was to be through a scenario-based audit, both in and out of office hours to test the organisation's capacity to direct enquiries to the appropriate area. The test was initially scheduled for early March 2011.
317. Under the heading of "*Lessons learned action*", the action plan stated, "*the need for co-ordinated discharge / admission planning / handing over is vital in cases of people who are of a transient nature*".
318. Sheffield Health & Social Care NHS Foundation Trust has undertaken a telephone audit in a sample of locations with the aim of finding out whether a timely response was made to an external investigation and the Trust believes that a re-audit would be beneficial. When considered against the NHSLA framework clearly that evidence has been described and documented and results from the audit should indicate the level of use in practice.
319. The independent investigation panel notes this positive outcome but would take the view that this was only part of the problem demonstrated in this case as described elsewhere in this report. The matter of accurately and effectively communicating information about the current MHA and CPA status of the individual in question, and pertinent information about risks posed, and medication history remains. Sheffield Health & Social Care NHS Foundation Trust have re-issued guidance to staff on communication. To improve the effectiveness of communication it is recognised that it is not possible to write guidance to cover all persons and circumstances in which staff will be contacted.
319. One of the problems identified in the previous policy on *Difficult to Engage Service Users* was that it allowed their discharge from CPA, this policy was replaced several years ago. The development of the Scheduled Care Pathway and the Acute Care Pathway have replaced the initial actions set out in the action plan and the Scheduled Care Pathway has been piloted in one service over a three-month period and is now being implemented across the organisation. No doubt information will be collected about the new Pathways as they become established practice.
320. Several comments have been made about the adequacy of risk assessment and management and the independent investigation panel were given evidence of the work done reviewing and updating the Trust's risk-assessment procedures, policy and screening tools. The Trust's Risk Screening Tool Group has generated a new risk-assessment tool. Training in both the Brief Risk Assessment and Management Plan (BRAM) and the Detailed Risk Assessment and Management Plan (DRAM) commenced in January 2010 and the implementation of the tool began in July 2011. The BRAM was

implemented in Mental Health Services and the DRAM has been implemented in both the Acute and Community Mental Health Directorates. The quality of the documentation is being audited regularly.

Oxleas NHS Foundation Trust

321. At the end of their report the Oxleas NHS Foundation Trust panel concluded:

15. RECOMMENDATIONS

1. The assessment team put in place a system for having an identified staff member taking on management responsibilities on each shift; these responsibilities include:

- *Allocating tasks such as assessment to team members*
- *Ensuring these tasks are completed adequately*
- *Ensuring documentation about patients that is not entered on RiO (e.g., drug chart) is secured and appropriately disposed of when the patient moves out of the assessment suite*
- *Giving overall approval for decisions about the move-on of each patient*

2. There is a visible 'at a glance' system in the assessment team office to track every patient under the assessment team's care at any point in time.

3. The assessment protocols within the assessment service operational policy be reviewed and update training provided to duty senior nurses, the bed manager and the assessment team with regard to effective assessment (including risk assessment).

4. The transfer protocols within the assessment service be reviewed and update training provided to duty senior nurses, the bed manager and the assessment team with regard to the safe transfer of patients to other trusts.

5. The role of the bed manager in relation to the assessment service be reviewed.

16. ARRANGEMENTS FOR SHARED LEARNING

The assessment teams in Bexley and Bromley have reviewed processes for managing patients through the assessment service, in line with the initial findings from the investigation. Both teams are putting in place an action plan to remedy any gaps; this will be reported through to the management teams in both directorates.

The implementation of the recommendations will be overseen by the Trust's Adverse Incident Monitoring Group and an update on the implementation of the action plan for the Greenwich assessment team and the other two trust services will be presented to the Board in March 2010.

322. Since the completion of the internal investigation report, a system has been put in place to identify a lead person for each shift in the assessment area and to ensure that all staff know who the shift lead is. The Trust provided evidence for this by stating that a white-board is in place which identifies the shift lead and lists the actions to be taken by that shift. The shift lead carries a bleep through which all referrals are made, and all referrals have to be entered into a handover book. All paperwork is then passed to administrators

for filing. This system is monitored by the assessment team. The whiteboard also allows an 'at a glance' system to track the progress of patients through the assessment process. To ensure that all assessments are carried out by competent professional staff the assessment team's operational policy has been amended. Since then, all assessors have been reviewed and have participated in a structured induction programme with supervised practice over a nine-week induction period. Samples of clinical assessments are reviewed during supervision every four weeks. The work of the limited number of bank staff is reviewed by the team manager and no bank staff are allowed to carry out reviews.

323. The transfer protocols have been reviewed to ensure the safety of patients being transferred to other Trusts has been accomplished through changes in the assessment team's operational policy. The role of the bed manager has been reviewed and changed so the bed manager is no longer associated with the assessment role, nor is the duty senior nurse.

324. When considered against the NHSLA framework, it is clear that the three recommendations are in use, and have been described and documented. The independent investigation panel could see clearly from the interviews with assessment area staff and managers that these recommendations are thoroughly embedded in daily practice.

325. In addition to the three recommendations, work has been done on risk assessment and a new guide has been introduced. In *A Guide to the Assessment and Management of Risk* (Oxleas NHS Foundation Trust 2010) there is a section on the 'Assessment of people presenting with self-harm or suicidal ideation' which might have covered BC on presentation in the assessment area of Oxleas House. The Guide begins by setting out a series of questions to be asked and the first three questions are:

- *Is the patient alert and with no reduction in conscious level?*
- *If the patient has been using drugs/alcohol are they fit for interview?*
- *If not where do they need to be? Accident and Emergency / psychiatric ward overnight for safety?*

In the discussion of dynamic risk factors the Guide mentions 'treatment adherence' which includes any failure to attend appointments, the level of engagement, and considerations about medication.

326. In the section on Violence, the *Guide*'s authors list as higher risk factors: younger age; male gender; unstable or changeable living arrangements; low educational attainment; mental health diagnosis such as schizophrenia or paranoid psychosis with paranoid delusions as a specific symptom; drug misuse and drug induced psychosis; childhood experience of violence or separation from parents before sixteen years. BC had experienced all of these factors. Poor compliance with treatment or disengagement from aftercare is listed as an additional factor affecting safety that staff should look for.

327. BC's history of violence, like his history of self-harm, varied both over time and in severity. His threatening behaviour towards fellow service users in Nether Edge caused disturbance rather than physical harm. BC's admission that he has possession of a gun when he believed his wife was unfaithful was potentially much more serious but the

episode appeared related to specific circumstances and he said that he had given the gun back. Perhaps the real longer term risk was that he knew how to access a firearm and could do so comparatively easily. Information was available about BC carrying a knife in the family home. It was never clearly established whether the purpose of this was self-protection, or self-harm, or to intimidate others.

328. The *Guide* also reports the results of research into the consequences of non-adherence to medication and states that patients with schizophrenia are up to five times more likely to relapse than those who take their medication. They are more likely to be aggressive or violent, and are four times more likely to attempt suicide. NICE recommends that depots are an option in patients known to be non-adherent to oral treatment and/or those who prefer this method of administration. BC was given depot antipsychotics in the 1990s and seemed to comply fairly readily though when offered depot again in January 2009 he refused as it made him unsteady when walking.

329. Significantly, the *Guide* looks at the process of recording evidence, and degree, of risk. The definition of 'low' risk is phrased as follows: "*Has occurred in the past but is now unlikely; precipitants, triggers or stressors not present*". If a similar definition was used in Sheffield Health & Social Care NHS Foundation Trust in April 2009, it difficult to see how it could have been used about BC when he was away from his accommodation, was out of touch with his support worker, was not complying with medication, and may well have been using khat.

330. The *Guide* is silent about service users with a connection to more than one geographical area or those from outside the area although there is a reference to collecting a collaborative history. Elsewhere, there are references to local links but not further afield, as in a case like this.

331. The independent investigation panel have seen an action plan for BC updated on 20th April 2010 but it is not clear whether there is anything before that date. GI (Executive Director of Operational Management) corresponded with JK and MN again on 28th January 2011. This correspondence mentions the layout of the action plan and the further work needed to be done on it. There is a suggestion of a scenario-based audit to test the organisation's capacity to direct queries to the appropriate area. GI would be seeking to set these up some time in March 2012. Work on CPA guidance and communication has now been superseded by implementation of the Acute Care Pathway and the piloting of the Scheduled Care Pathway.

332. Given the above, the independent investigation panel were assured that if BC were to present to the service today, as he did just prior to his offence in 2009, then he would be identified as a high risk.

RECOMMENDATIONS

333. The independent investigation panel was surprised by the fact that BC was able to register with more than one GP at the same time and was able to remain registered even though he was an inpatient for nearly a year in total. This situation needs to be investigated and resolved, if only, to prevent some of the problems that occurred in this case. These recommendations are derived from the independent investigation. Some of the recommendations are Trust specific but the first five have general application to Trusts working with mental health service users.

Recommendation 1 - Service users with more than one known address should be flagged so that other Trusts can be informed if they suddenly move to another area. Trusts should ensure that staff check the national GP registration system to see if patients have strong ties or (potentially) second homes in other towns and cities and use this knowledge when planning discharge or follow up treatment.

Recommendation 2 - There should be closer cooperation with the police so that they have access to a qualified mental health worker when safe and well checks are made.

Recommendation 3 - Full social histories should be completed with particular care taken with service users who come from cultural backgrounds where extended family networks are common; other agencies and individuals should be used to confirm the facts.

Recommendation 4 - When Trusts are communicating with each other about a client they should ensure that key clinical information is prioritised before financial and administrative issues.

Recommendation 5 - Trusts should ensure that proper policies, procedures and training are in place to allow the rapid transfer of key clinical data to other Trusts 24 hours a day in an easily accessible format to a known recipient using Safehaven principles. All relevant staff should be competent to use these systems and processes.

The following recommendations apply specifically to Sheffield Health & Social Care NHS Foundation Trust and / or their Commissioners:

Recommendation 6 - Service users with histories of long-term treatment-resistant illnesses and when there is little knowledge of their previous behaviour in the community should be discharged to appropriate supportive accommodation or via a rehabilitation ward.

Recommendation 7 - When service users are discharged to third sector or other organisations their support and care package should be formally agreed and there should be suitable robust contingency plans in place if service users go missing.

Recommendation 8 - Service users with long-term illnesses who relocate outside the Trust's area should only be discharged from CPA when a full and proper hand over has been completed with the receiving Trust.

Recommendation 9 - The Trust should audit the information systems and take appropriate steps to ensure that care co-ordinators have access to clinical information about their clients irrespective of location within the Trust.

Recommendation 10 - The Trust should revise its 'missing persons' policy and it should be tested regularly.
Recommendation 11 - Sheffield PCT should review the services commissioned from Sheffield Health and Social Care NHS Foundation Trust with specific emphasis on access to talking therapies and in-reach drug and alcohol misuse therapies.

The final recommendation is specific to Oxleas NHS Foundation Trust:
Recommendation 12 - Oxleas NHS Foundation Trust should audit the use of clinical assessments as part of monthly supervision sessions and benchmark their use against practices in other Trusts.

APPENDICES

Appendix One: Chronology of events

The Chronology which follows is very detailed for two reasons: first, because there were many twists and turns in BC's progress as an inpatient; and second, because the full reconstruction of events shows some differences from the accounts described and discussed in the internal investigation reports. The following materials are almost verbatim copies of the entries in the various patient record systems made by the health service staff who provided care and treatment for BC.

Chronology of Events (timeline)	
Date & Time	Event
03/09/2005	Married and moved to Sheffield
09/08/2007	Outpatient case notes - overdose of tricyclic antidepressant drug
12/04/2008	Admitted to the Northern General Hospital, Sheffield Teaching Hospitals NHS Foundation Trust, with an overdose of paracetamol, Co-codamol, Ibuprofen, bleach, rat poison and also tried to stab himself through the neck.
22/04/2008	Liaison Psychiatry continued to review as BC remained an inpatient on the ward. The bleach that he ingested has damaged his insides. Children and families are involved as the police made the initial referral and there are some problems with his wife and her potential mental health problems.
24/04/2008	Discharged from Northern General Hospital, Sheffield Teaching Hospitals NHS Foundation Trust
28/04/2008	Letter from Liaison Psychiatry which stated that he was medically fit for discharge when seen in the company of a member of the Somali Mental Health Team. He showed no clinical signs of depression and is only not eating well due to soreness due to drinking bleach. No evidence of disordered thinking. Able to concentrate fully. No evidence of audio or visual hallucinations while on the ward, no intention of killing himself or of harming others. He is going to return to brothers in London.
19/05/2008	Discharge summary sent to his GP at a health centre in south east Sheffield
27/05/2008	Brought to Queen Elizabeth A&E, Woolwich, by his brother due to the great concerns of his mental health. Seen later in the Oxleas House assessment area. BC had been expressing thoughts that people were making him paranoid, doing black magic on him and controlling him. He has been non-compliant with his prescribed medication, not sleeping, eating or regularly attending to his self care. Has been paranoid towards his wife from whom he is currently separated and today he is paranoid towards his brother because he has brought him into hospital. BC is currently denying this and does not feel he is paranoid. BC was offered informal admission but has declined and wants to go home. MHA assessment took place and he was placed on *s* 4 of the MHA 1983. Care Plan: admitted on *s* 4 of the MHA; to have physical investigation and

	urine drug screen to be done; to be nursed on level 2 observations; the team to liaise with his wife to gather further information.
10/06/2008	Stated he is not happy about returning to Sheffield. Wife owns the house there. He owns house in London SE3 and is registered with a GP there. BC believes his brothers are pushing for his transfer so they can steal his identity. Claims Sheffield Muslim community want to kill him as he is gay. Claims brothers have been raping him as well as giving him drugs. Advised to discuss this with ward manager next morning. Later in the day BC refused to comply with his medication as a protest against his forthcoming return to Sheffield.
10/06/2008	Transferred from Oxleas House to Nether Edge Hospital, Sheffield Health & Social Care NHS Foundation Trust. BC was admitted and assessed on Burbage ward. Tired and hungry. Has tried to get some sleep but could not because of mental distress.
11/06/2008	Saw trans-cultural worker-BC upset he knew so much about him, upset because he took notes, does not want anything to do with anyone from Somalia. That triggered paranoid thoughts about him being set up and conspired against. Tried to explain this was not the case, the trans-cultural worker was here to help him but he would not accept this.
19/06/2008	Case notes - BC refused to be on modecate. He was getting suicidal ideas. Care Plan: call London for past psychiatric medication - was on paroxetine 40 mgs. Modecate intra-muscularly 100 mg-3 weekly; chase re Disability Living Allowance; does not have bank card; commence Paroxetine
24/06/2008	Patient review in MDT Risk to self: denies thoughts of self-harm; no attempts on ward; question of serious overdose therefore risk is low to moderate Risk to others: denies thoughts of harming others; no aggressive behaviour therefore risk is low Risk of absconding: happy to stay on ward; no attempts to leave therefore risk is low Non-compliance: taking medication; believes it is helping him therefore risk is low. Care plan: to see with interpreter in 2 days' time; clarify re: GP - who is he registered with; clarify current accommodation problems; continue current med; believes the Muslim community has killed his two younger brothers. Risk of over dose and internal injury due to bleach ingestion Informal. Would be *s* 4 if he attempted to leave. Clear psychotic symptoms.
26/06/2008	Telephone call [T/C] from PQ from the Continuous Needs Team Sheffield Health & Social Care NHS Foundation Trust. Wanted to know the right team to refer BC to as the hospital he is in currently as an inpatient, is due to discharge him to London. PQ said he is registered with surgery in London SE3 and is intending to return to live with his brother. PQ given details of the Recovery North Team Oxleas NHS Foundation Trust to send a referral or

	request transfer to both the team manager and the consultant as per protocol.
30/06/2008	BC came to staff asking to be transferred to London, but was told he would have to stay in because he was registered with GP in Sheffield and not in London. Stated he was struggling with his thoughts. Does not trust the Somalis, even the interpreter used in conversation with consultant. Concerned over his lack of funds, no money for cigarettes. Given 5 mg of Haloperidol, appears more settled since.
01/07/2008	PQ now BC's care co-ordinator.
14/07/2008	Recorded this date - discharge summary from Avery ward, Oxleas House: Current status: informal Date of discharge: transferred 10 June 2008 Discharge (CPA) status: not addressed as transferred back to Sheffield Services Diagnostic formulation Schizo-affective disorder F25.0. Mental and behavioural disorders due to use of stimulants (khat) F15.2 [using the International Classification of Diseases categories] Breakdown of relationship with wife due to paranoia and lifestyle (khat misuse), refugee status. GAF ~ 51-60 at discharge [Global Assessment of Functioning (GAF) is a numeric scale, 0-100, used by mental health clinicians and physicians to subjectively rate the social, occupational, and psychological functioning of adults. A low score reflects a high level of risk of self-harm, violence to others or self neglect. This rating suggests moderate symptoms.] Risks: risks of self-harm and suicide are low. Moderate risk of violence/harm to others, and non compliance usually in the context of khat use. Risk of substance misuse, in particular khat, is high. Risk factors: non compliance with medication and use of khat are identified as precipitants leading to relapse. Mode and reason for referral: BC was brought to hospital by his brother due to concerns over his mental state. Presenting complaint: BC believed people were trying to kill and that someone was using black magic on him . . . Believes his brother was trying to kill because he brought him to hospital. Not been sleeping for several days as he was still trying to find out what had been happening to him. History of presenting complaint: BC had been non-compliant with his prescribed medication for the last 2 months. His brother reported that BC's paranoia was getting worse. His brother also reported that BC had asked him how he could kill himself the day prior to presentation. BC was recently discharged from hospital in Sheffield where he had been admitted after taking an overdose of paracetamol, with cans of bleach and rat poison and had attempted to cut his neck with a knife. Following this incident his wife was no longer able to cope with him and he was brought to London to stay with his brother.

	Precipitating factors: non-compliance with prescribed medication; disengagement with psychiatric services; has been chewing khat on a daily basis; paranoid against his wife resulting in breakdown in relationship; not sleeping or eating very well. Forensic history: nil of note Physical examination/investigations: a raised white blood cell count of 11.7 with neutrophilia of 7.9 was noted [a variety of white blood cell which is capable of killing bacteria and which provides an important defence against infection; the upper limit of the normal range is 7.5]. Progress and Treatment: BC continued to express delusional ideas about his family trying to kill him and that being the reason why he had come down from Sheffield. Complied with medication as prescribed and was observed to smoke a lot during the day. Was also observed to pace about the ward and required a lot of Lorazepam to settle.
16/07/2008	Discussed with Royal Hallamshire Hospital toxicology - khat use will show up as amphetamine on Urine Drug Screen (UDS) - but best to ask for khat scan.
22/07/2008	Multi-disciplinary Team (MDT) meeting notes on Stanage Ward, Nether Edge Hospital, Sheffield Health & Social Care NHS Foundation Trust Progress on ward: still has persecutory thoughts; still believes uncle is doing black magic; occasionally says he wants to go to London; wants to see baby with his wife, considering going back to her; ?Using khat Care Plan: UDS to test for khat use; If wants to go back to London, to be discussed by nursing staff re section appropriate; continue current med.
28/07/2008	MDT notes Progress on ward: showing some improvement, thoughts of persecution by wife decreasing; found consuming khat used on ward a day ago; wife has stated concerns about him seeing 18 month old child, unclear if she wishes for him to return; staff explained inappropriateness of khat use. Care Plan: await cardiac echo; liaise with PQ - discuss with wife re discharge.
29/07/2008	BC found about 2.00 a.m. chewing khat, it was confiscated and he was reminded of ward policy. BC talked to staff about his family trying to kill him legally - conversation did seem very similar to 3 to 4 weeks ago - no change. Talked about last night and his khat usage, he was very apologetic and said that he would not do this again. Felt he understood why he should not use khat, particularly around the ward.
30/07/2008	MDT notes Currently doing well, remains psychotic Taking medication, utilising nursing time Wants to go to London, but currently his relatives there will not accept him therefore must be treated here Continue with current medication
05/08/2008	Case notes

	MDT notes Progress on ward: still voicing desires to visit brother and child; staff unable to contact BC's wife, regarding visiting her and child. Care Plan: clarify asap whether wife could continue relationship with BC. Ask PQ to try to make contact - if yes, clarify risks, or if no, liaise with brother in London, whether BC could live with them.
08/08/2008	PQ - BC has been asking to see his wife. Need to contact her to support BC on discharge. QR explained that although a woman answered when she was calling and confirmed that she was FC, when QR explained where she was calling from the woman said that she did not know who BC was and said it was the wrong number. Agreed would need to see what could be done if BC wanted to push for access to his child. Called mental health advocacy and left message.
12/08/2008	During 1:1 with 'named nurse' spent time discussing latest urine test as he wished to know the results. Lab analysis said the sample had been diluted. Initially stated he had no idea why this had happened but then said he must have washed the lid of it. Went on to say he no longer takes drugs, he did in the past but not anymore.
14/08/2008	Case notes - seen alone by Specialist Registrar (SpR) Provided detailed family structure - father was married five times, five step-brothers as well as four full brothers. BC was born in north Somalia where he went to school until 14. Then the war broke out, stopped school. Came to UK in 1994. Social history: married for 3 years, separated for last 3 months. Has one child 17 months. Wife is 8 months pregnant. She lives in Sheffield. Care Plan: continue same medication. Seems he has no accommodation at present. That will need looking into by Nursing Staff.
15/08/2008	PQ - visited BC for the first time on ward today. WY is concerned about his use of khat but BC views it as casual and low level risk drug. Seemed to miss the point that he needed to remain drug free to carry out an assessment, rather than a moral issue on abstinence. Offered drug scheme for Black men but he does not see it as a problem. Has changed mind about where he wants to be accommodated initially said Sheffield but at MDT said London. QR will contact family in London to see if they want him there. Wanted to begin proceedings to apply for contact with his child. Medical team feel he is fit to instruct. Married but separated. PQ wondered also if it would be worth looking at counselling for BC, seeing he left Somalia in 1994 due to war? PQ - referral to SACMHA advocacy service. Will have to wait until September because of their workload. Will need to complete financial assessments to see if he qualifies for legal aid. Confirmed he is on DLA and income support. SHO contacted BC's brother to ask about accommodation in London. His brother stated that BC has own flat and support from family there. Staff need

	to liaise with London services to arrange community support on discharge. YZ contacted ward to discuss visitation with child. Staff wanted to maintain confidentiality so she will need to come to ward to see BC. MDT notes Progress on ward: issues with wife discussed; she denies that they are married, but BC claims they are married with a child. He says that wife told him child not his. Care Plan: contact brother in London (HC); PQ to clarify family situation; no change of medication at moment; explain to BC the options available (help with finding accommodation in Sheffield). (Uses khat when depressed, is depressed now and thinks that medication is not helping.)
19/08/2008	MDT notes Progress on ward: engaging in Occupational Therapy; brother and family happy for him to be discharged to London, he would rather go to London; wants to see brothers and discuss problems with them (i.e. use of black magic). When BC attended meeting told that he is not well enough for discharge. Care Plan: change medication to Risperidone 1 mg twice daily then tomorrow increase to 2 mg; reduce Olanzapine to 10 mg daily for another 4 days.
25/08/2008	Case notes Progress on ward: Much the same, still delusional about family. Thinks medication helps, more 'confident'; BC prefers HC to be next of kin. Care Plan: Increase Risperidone to 2.5 mg twice daily; for BC to decide about accommodation (London or Sheffield).
29/08/2008	Case notes BC tells me he has visited his wife yesterday because he wanted to see his child. Wife started shouting at him and told him she would call the police; however BC managed to stay with the child for 1 hour. Still convinced family are trying to kill him and older brothers are trying to kill younger brothers – but only BC knows about it. Insight: thinks he is depressed but not schizophrenic.
02/09/2008	Case notes - MDT Progress on ward: no improvement yet; not engaging well; not evident on ward; still has psychotic delusions about his family, wife, black magic etc Care Plan: drug urine screen
03/09/2008	PQ e-mail message from QR (BC's named nurse) - BC has own flat in London according to his brother, on-going concerns about his mental health. Nursing notes - BC stated that whilst at first he felt his medication was having a positive effect on his mental state this is no longer the case and he now feels as when he first came in. Continues to believe that his family has carried out black magic on him in the past.

04/09/2008	Case notes Recommendation from pharmacy to change Risperidone to 2 mg instead of 2.5 mg twice daily. Changed prescription accordingly.
08/09/2008	Case notes BC feels worse. Continues to believe that his family has carried out black magic. Used Lorazepam for past 3 days
16/09/2008	MDT notes Progress on ward: mentioned ex wife but not divorced yet; said he has stopped praying at night as this affects his physical health which in turns affects his mental health. Care Plan: BC to register with GP in London if he is planning to move south.
17/09/2008	Nursing notes - his brother HC phoned, has arranged with staff and BC to pick him up from ward on Sunday 21st, to take to London to register with GP and come back on Monday with details. Leave medication ordered.
21/09/2008	Nursing notes - BC has not been collected by his brother as was thought to be the plan. BC when asked said that he had spoken to his brother who has now arranged to collect him early tomorrow morning. Do not know whether this is correct as there have been no contact with any family members.
22/09/2008	Nursing notes - BC went out in company of his brother for 2 nights leave and is expected back on the ward on Wednesday 24th September. Case notes ECHO - normal (heart rate check) Was supposed to be collected by brother yesterday but not happened. Plan now to be collected today and will stay with HC for 2 days. Wants to visit brothers in QE Hospital - believes they are there because they used black magic. Feels unsafe in London and Sheffield - Somali community conspiring against him.
25/09/2008	Nursing notes - not yet returned from overnight leave to London, due to return today. BC's brother phoned the ward asking if he could come back tomorrow. This was agreed however was told he must return tomorrow as he will need more medication.
26/09/2008	Nursing notes - have had no contact from BC or his family and he has not yet returned from his extended period of leave. BC has just returned from leave, have spoken briefly to BC's brother who says while leave has been unproblematic "BC is not 100% and would benefit from stronger medicine".
30/09/2008	MDT notes WY explained that prescription could be changed to Clozapine. Explained that

	this will require weekly bloods. BC agreed to Clozapine. MDT Decisions and Plan States that BC registered with a GP in London whilst on leave in London
01/10/2008	Nursing notes - BC approached staff requesting advice as he is considering commencing Clozapine. Demonstrated some insight, understood his current symptoms as part of mental illness. Appeared knowledgeable regarding Clozapine although concerned about possible side effects, advised about close monitoring. He has been administered his first dose of Clozapine this evening, he did voice feeling 'scared', however given reassurance and support and was encouraged to seek a member of staff if he had any further questions.
06/10/2008	PQ - read notes for BC - he is taking leave in London so still looks likely that he will be discharged to this team.
13/10/2008	Case notes BC complaining of side effects of Clozapine - drowsy, unsteady on feet, feels restless, feels nervous and describes increased aggression with no reason. Also experiences increased blood pressure in mornings. Explained that body takes time to adjust. Agreed to continue.
17/10/2008	Nursing notes - despite an objective improvement he has voiced that he does not like being on Clozapine and would like to stop taking it. A note has been left with the doctors regarding this.
21/10/2008	Nursing notes - when BC was given his medication he attempted to secrete his medication in his hand. The nurse administering the medication (Clozapine) saw this and when BC was challenged he swallowed the medication.
24/10/2008	Nursing notes - in 1:1 time says he feels no different than when he was admitted, says that the whole of the Somali community are trying to assassinate him legally through black magic, says his brothers were killed then put in hospital for 8 months, BC said his brothers denied this. Pressed BC several times on this last point, he repeated it clearly several times, otherwise socialising and in good spirits.
31/10/2008	Case notes Progress on ward: BC feels happier; more energy, better concentration, improved appetite; better quality sleep; less focused on psychotic delusions but still believes in them; more animated during interview than usually; improvement from negative symptoms of schizophrenia. Care Plan: Increase Clozapine to 100 mg from 01/11; further increase next week.
02/11/2008	Nursing notes - Later was observed to be crying, when approached he said he was crying about his brother being shot, an issue which has arisen before but has not been continually troubling BC.
03/11/2008	Nursing notes - BC upset yesterday because his brother had been sacked not

	shot and that he would like to hurt those responsible for sacking him, though suspect this is not to be taken literally. Talked about going to Scotland because there are fewer Somalis there. Case notes Discussed increase in Clozapine. BC asked how long he would have to take it. Told it was a long term treatment - at least for a few years. He agreed to that. PQ attended MDT for BC to ascertain if there was a role for her. BC had decided to stay in Sheffield recently but has now decided that he might want to go to Scotland based on the idea that there is no one from the Somali community there. Staff feel it would be better that he settles in London as he has family there. His wife has disowned him. Explored whether he was considered ill based on the idea of black magic. The interpreter has explained that his ideas were bizarre in the framework of the Somali community but that is only his opinion. Asked whether BC was receiving any spiritual guidance which currently he is not. Agreed to contact the Sheffield Care Trust chaplain. They were not aware of what had happened to the referral to the advocacy service and the legal service - agreed to chase this up with QR. Agreed to discuss this with the trans-cultural team too.
11/11/2008	MDT notes Question of whether he had used khat last week or over weekend Care Plan: increase Clozapine to 200 mg.
15/11/2008	Nursing notes - BC got himself up and ready to go on leave. Brother collected him around 11:00 and he has gone on weekend leave. Says he intends to spend his time in company of his family while on leave.
18/11/2008	Nursing notes - not returned to ward from his weekend leave to London and has not contacted the ward about his return. Messages left with him and brother about contacting the ward. Staff unsure if he has enough medication whilst he is off ward.
19/11/2008	Nursing notes - BC has not returned to ward and has made no contact with the ward. Staff have left messages on his and brothers' phone. Due to not knowing if BC is safe and well and also the implications of him not having Clozapine since yesterday, spoke to WY and have decided to report BC as missing person. Missing persons report implemented at 17:00. Spoke to PO, his uncle and got brother's address in London which the police have.
20/11/2008	Nursing notes - BC was returned to the ward by his brothers at approximately 02:30 this morning. He said that the leave had not gone so well and that the Somali community would not have anything to do with him. Said he was relieved he was back on ward. Did tests and he was medicated given Zopiclone for sleep.
23/11/2008	Nursing notes - he had been on leave for 3 days [though he had actually been away for 5 days]. Said he did not get on well with the Somali community

	including his family who are out to kill him because of his alleged homosexuality. Asked why he had stayed out for full 5 nights if that was the case, he said they will do it by black magic so as not be implicated. He did not look perturbed, distressed or fearful about the described threat to his life. Asked about where he is going to live as London and Scotland had been mentioned recently but he was vague and unsure about where he wanted to be. Mentioned birth of child 2 days before. Phoned wife but only able to leave a message.
26/11/2008	Nursing notes - came back from leave, very fed up. Been to ex wife but she had refused to open the door. Had briefly seen his ex wife's brother but had not spoken. Wanted to see his child who he says was born last week, did not see the child. Will go again tomorrow. PQ - e-mail from QR - got somewhere with advocacy with BC. Patient advocate from SACMHA is happy to work with him. He is going to see wife to try reasoning with her about access. Thought he would benefit from referral to SACMHA. What support will there be in London if he decides to go there? Fax from QR to SACMHA - gives brother (HC) as next of kin. To arrange for advocacy - access to child. Has cultural needs the ward staff feel unable to meet.
27/11/2008	Nursing notes - BC spent time with SHO, she feels he is autistic as he had difficulty expressing himself says that his brothers isolated him from the community due to this, SHO feels this is part of his delusional beliefs, SHO feels his delusional beliefs are unchanged, BC admitted to chewing khat on leave, remains settle on the ward. Case notes Went to see new baby yesterday. Wife did not want to let him in and he became very upset because he had bought baby clothes and wanted to see his child. Went to his uncle and did not want to come back to ward as he felt low. Admitted using khat last night and said he knew it was not good for him. Also said that his wife is involved in an affair with his boss and that she claims both children are boss's. Agreed to doctor contacting his wife. Tried mobile but no answer. Informed him SACMHA can be helpful contacting his wife - BC has an appointment with them.
02/12/2008	Case notes Progress on ward: still obsessed with thoughts; wants to move to London although believes all his brothers are involved in harming him. Care Plan: Increase Clozapine further and invite brothers/uncle to MDT.
05/12/2008	PQ - conversation with QR who feels that she is getting somewhere with BC. Patient advocate is now working with him from SACMHA and she has

	supported him to get a solicitor.
09/12/2008	MDT notes BC attended MDT this am and complained of over-sedation, Zopiclone has been stopped. Wife says BC can now see child. Has now cancelled arrangements to see solicitor. Issue of him spending a lot of time asleep - ?over sedated. Stopped the Zopiclone.
19/12/2008	Case notes WY advised that because of increasing dosage of Clozapine and his physical problems better not allow him leave at present. His mental state is not good.
29/12/2008	PQ - following BC's MDT today it was suggested he be referred to a community team in London. PQ happy to go with whatever the team think as they know him so much better. Explained that there should be a letter to his GP in London, requesting booking with the appropriate team.
31/12/2008	Nursing notes - when asked about visiting his children he said he no longer wished to see them and inferred that his ex wife was seeing someone else and this had a bearing on his decision.
02/01/2009	PQ - attended BC's MDT. WY and the ward staff are finding it difficult to know what to do with BC because he is concerned about where to go after hospital. He says he feels safe here but when told he could not stay in hospital for ever, he said he was resolved to go to London. Remains completely convinced his illness is due to black magic. The team are keen to think about discharge but as the brothers seem so far to be avoiding contact. WY is concerned about discharging him to London at the moment. PQ suggested that as WY felt that Clozapine seemed not to have made any difference and as it was more difficult/risky to discharge someone on that (would need weekly bloods and be well supported by community team) perhaps he should be recommenced on a more standard antipsychotic to make his eventual discharge more appropriate. Explained that PQ had made referral to trans-cultural team. Wants to see if they can help in respect of his beliefs about the Somali community etc. BC also has an advocate who hopefully will support him in making a decision about where to live. WY wondered if there could be a CPA so that all parties involved could represent BC's views. Agreed to contact CPA secretary for date and to communicate with interested parties.
06/01/2009	Nursing notes - BC wanted to know when he would be discharged, advised him that staff needed to identify where he would be living when he goes to London, he states that he will be living with his brother for a while and states that he has registered with a London SE7 surgery, the card is in his notes, therefore staff to speak with his brother and liaise with the surgery. Stated

	that he had been annoyed yesterday because had chewed Khat weeks earlier. Has visited child but his wife refused to accept the gifts he had bought his children which upset him which is why he used khat. BC states his brother does not smoke, drink, or use khat - a good role model.
13/01/2009	PQ - CPA meeting arranged and letter sent to all parties. E-mail questions to trans-cultural worker: • BC has given mixed messages whether he feels that his brothers will support him in the community, what impressions did the team get? • The Somali community - BC feels harassed emotionally, psychologically by his community and ostracised by accusations of being gay. Expressed ideas that they are using black magic. Could this be explored - part of delusion or a cultural-spiritual belief. • Medication: BC says he feels this is helping him but that his paranoia about community is based on truth. Has implications for medication. • Khat: BC seems to realise the negative impact of taking the drug. Have noticed some positive changes from reading his notes: • Found information about his GP • Brother has tried to make contact with IJ • Has reportedly realised the negative impact of khat on mental health • Sees his brother as good role model • Thinks there is some truth in the community plotting against him but accepts there is no evidence of this • Has been making attempts to see child. Nursing notes - advised BC that his Clozapine is to increase to 400 mgs daily over the next few days. Also need to check with his brother about BC staying with him when discharged. Tried to contact brother but unable - works shifts.
14/01/2009	Nursing notes - BC contacted his brother concerning discharge and whether BC would be able to stay with him for short period whilst he settles back into London. HC said this would not be possible but BC's house is close to him anyway, should he need support. Staff stated they would contact him when all arrangements for his support were in place.
15/01/2009	Nursing notes - explained that the plan was moving towards discharge. Has made contact with GP and confirmed BC is registered there, and they are trying to contact the brother to try to piece this together.
16/01/2009	PQ - after a phone call today have left message with the Central Recovery Team (Oxleas NHS Foundation Trust) to ask formally to transfer BC to their community team. No response yet from trans-cultural worker or chaplaincy service re CPA review - continuing to chase this.
19/01/2009	Nursing notes - BC initially informed that he could not go to London tomorrow for two nights leave due to a recent increase in Clozapine and subsequent Clozapine monitoring. BC angry about this. Was reviewed by TW and after consultation with SpR he has been allowed to go ahead. Leave medication ordered.

	Case notes - allowed leave as long as he agrees to take his medication and his brother to supervise his medication
20/01/2009	Nursing notes - BC has commenced two days leave nurse asked if he could speak to his brother when he picked BC up but BC has met him off the ward. No change in BC's presentation prior to leaving.
23/01/2009	PQ - phone call from nursing staff confirming BC's address and his GP surgery. She has tried to speak to BC about his children, his discharge etc but BC has lately been quite dismissive of attempts to support him and make plans for his discharge. His brother remains difficult to contact. BC still not returned from leave. Agreed to contact community team next week. She hopes to prepare a document for the CPA review, detailing the efforts made and information learnt so far to support BC, so PQ can hopefully pass this on to the relevant team when he is transferred. Nursing notes for CPA review Presentation on ward - always been changeable, at times very tearful and at others sociable and warm in his interactions. Attempts to arrange Imam visit did not work as BC was in London when the Imam came. Declined services of solicitor in pursuit of access to children. Current - been to London and registered with GP. Has flat in London close to brother and has taken leave in London without cause for concern. Still has concerns about moving to London as still has some fears about Somali community there but feels he will be safe there. Plan is for him to be discharged to London. Realises he will need to engage with services there due to his Clozapine bloods. 'No longer considered a risk of harm to self or indeed harm to others.'
25/01/2009	Nursing notes - BC is yet to return from leave despite informing staff that he intends coming back today. Staff to consider reporting AWOL should he not return in the near future.
26/01/2009	PQ - phone conversation with trans-cultural worker who has met BC once and had established that some of his persecution and harassment from his family could be real. His brothers in law, his wife's family do not want him to have any contact with his children. He did not think that BC was at physical risk from his family but potentially at risk of psychological abuse. He said that if the family thought he was gay that would be a very serious taboo subject and was likely to be met with hostility. He will not be able to attend the review. Nursing notes - spoke to BC's GP in London and they confirmed that although he has been on their books since November 2008 they have had no contact with him as yet. This goes against what he has been telling us, that he has visited his GP and has been having his Clozapine this way. Then spoke to BC who assured me he was coming back tomorrow with his

	brother giving him a lift. However this is what BC has been telling staff for past few days. Will be phoning BC tomorrow and will tell him he will be reported as a missing person if he does not come back to the ward tomorrow. Case notes Care Plan: report him missing to the police; on return review medication and possibly start him another antipsychotic; suspend Clozapine; liaise with PQ re transfer to London. Letter from PQ to the North Recovery Team manager, Oxleas NHS Foundation Trust Wish to transfer BC to this team for aftercare. Explains circumstances of the case - delusion of belief that he is subject to a curse. In order to assess BC's situation, the ward tried to contact his brothers but this has proved very problematic - his consultant describes the brother turning up at very early hours in the morning when staff are not able to catch up with him, and he does not answer the phone when staff call. History of chewing khat which complicated assessments. Now sure he wants to return to London. Back to brother and consultant wants to refer to their area in the near future. PQ thinks he is potentially quite vulnerable and would benefit from follow up from a community team, as well as support of his GP. Ward staff have greater knowledge of him. Letter from Gastroenterologist - BC came to clinic. Has recurrent epigastric pain and heartburn. Arranged for repeat gastroscopy.
27/01/2009 13:27 20:44	Nursing notes - BC still to return from London. Phoned brother who said that BC has refused offer of lift back to Sheffield. BC has now been reported as a missing person. Nursing notes - staff attempted to contact BC to no avail. Police have contacted the ward to say they have cancelled 'the incident' report because he is no longer missing. BC is still in London at his brother's house but as far as they are concerned his whereabouts are known and they have no power to bring him back due to informal status.
29/01/2009	Nursing notes - BC returned to the ward shortly before midnight. Stated he had travelled back from London by coach, had taken him 5 hours. When asked how his leave had gone, stated not well.
30/01/2009	Discussed in Oxleas House referrals meeting. A lot of detail is needed from the referring team (core assessment, risk assessment, care plans and CPA reviews, social circumstances including discharge address, relevant contacts and brother's contact, medication). Referring psychiatrist will also need to write to the team's psychiatrist.

30/01/2009	Nursing notes - BC attended CPA meeting this morning. His brother attended. BC stated later he is frustrated that his brother was not aware his other brother is trying to kill another of his brothers. Unsubstantiated - part of delusional system. BC then stated his family is trying to hurt and do black magic on him. BC acknowledged that the increased anxiety and thoughts he was preoccupied with were related to missing 3-4 days of medication PQ - attended review at as requested. Very unclear how best to support BC and he is not able to say what he would like. Explained to staff that she could not find a risk assessment for BC anywhere on the system. Just as was leaving BC's brother arrived but PQ was unable to stay longer due to other work commitments. Feel he might benefit from discharge to supported accommodation or rehabilitation ward but BC was insistent he wanted to go to London. If this changes staff could consider Wainwright bed for a short period [an eleven bedded unit providing a city-wide residential respite resource to adults with mental health needs] and PQ thought maybe a referral to Fairlawns rehabilitation ward. Would be happy to look at referral if that is what he or the ward staff would like. Nursing notes - now been commenced on Quietiapine will be titrated up to 150 mg twice daily. Has voiced his ideas surrounding the Somali community. Made some comments about a tin lid. Another patient was concerned that BC was walking about with a sharp implement from a tin of pineapple. BC stated he would cut his throat with the sharp, noted to be laughing after making the comment. Commented this affected the other patients. Was challenged about this - disclosed he had been using cannabis in London continuing that it had affected his thoughts. Was discussed, a UDS will be needed to ascertain this. MDT notes WY wants a specific clear plan to be arrived at today. Discussion over sheltered versus supported accommodation. BC said yesterday that he had done nothing on leave but today says that he was sorting out gas and electricity in the flat. Told the team that sometimes he is confused. WY reminded him that he is lying because he told the team that his GP had been giving him Clozapine when actually he did not have Clozapine. Told him this cannot be tolerated any longer and that he cannot stay on the ward forever. BC wants to go to London and be given Clozapine. He will not have depot as this makes him unsteady when walking. Care Plan: commence Quietiapine 25 mg twice daily today; discharge date set at Friday next; PQ to give WY the name of the community consultant; WY to write to team in London.

	CPA review Care plan Medication: Due to his non-compliance with medication on leave, and the difficulties and risks when medication is stopped overnight, WY suggested a different medication. Will be discussed further with BC, who today said that he'd like to keep taking Clozapine. Notes of meeting with BC 's brother BC has flat in London - one of his friends is living there at present. Reported that BC's illness began in 1995 but denies it being associated with drug use, except chewing khat, has two brothers in hospital in London. While in London goes off chewing khat and lacks motivation to do anything. When brother tells him that people are not trying to kill him, he says HC is part of plot. Brother believes he is not capable of independent living as he goes out chewing khat all the time. Told him of plan to transfer care to London. Reports threats to kill one brother who is part of plot and believes the brother has told police that BC had killed someone. Threats to kill self.
02/02/2009	MDT notes WY - in light of information from older brother and the fact that he is still psychotic and threatening to kill people, there is no support from the brother and his flat in London is not ideal for living. Need for PQ to look for supported accommodation. Care Plan: is now to refer him to supported accommodation as he already has a community team in place.
04/02/2009	Nursing notes - staff feel he may have changed a little since he stopped Clozapine after he returned from his AWOL last week.
06/02/2009	Nursing notes - BC has spent long periods in bed and has apologised for bringing khat on to the ward yesterday. MDT notes Progress on ward: says uncle brought him khat onto ward; says his brothers do not look after him - no bedding and no heat when staying in London with them; says his brother is a liar and swore about him; believes he is medicated for depression; told he needs to stay in Sheffield and give up London flat. Care Plan: re-start Clozapine; discuss housing.
09/02/2009	PQ - e-mail from WY - after BC's brother arrived at the ward, concerns about BC being discharged to London were again raised and it is thought that finding BC supported accommodation would be best. Obtained vacancy list today.
12/02/2009	PQ met BC on ward. Said he felt bad - feels persecuted and under threat of curse still and no one believes him. Clarified that this must be difficult, will find accommodation in Sheffield where he can feel safe. He knows he will

	have to give up his London flat. PQ phoned OP who said that at SACMHA BC was unlikely to come into contact with Somalis. Requested the care plan for their file.
13/02/2009	PQ - filled in application form for Halfway housing [Community Action Halfway Home provides practical and emotional support to people with mental health problems to enable them to improve the quality of their lives]. E-mailed care team to ask if they could ensure that BC had handed back his flat in London - according to MDT notes nurse was being asked to see if she would be able to see to this. Meeting with BC - would like to work towards seeing his children, feels he always tries to remain positive and get better but got worse over time. Would like support to get back into education. Talked about risk history - said that he was naturally someone who avoids violence and confrontation but he knows that he has been aggressive in the past when he was really, really upset. Nursing notes - BC woke early this morning and had altercation with another patient - no apparent reason for this. Had 1 mg of Lorazepam for agitation and aggression. BC was talking about the Somali community coming for him, and there is a man on Burbage who is connected to the Somali community, he became quite distressed, reassurance given. Later given another 1 mg of Lorazepam. Nursing notes - night staff handed over that there was suspicion that BC had been smoking cannabis with another patient last night. A UDS could be collected from BC to confirm this.
13/02/2009	The North Recovery Team manager (Oxleas NHS Foundation Trust) phoned PQ regarding more information about referral and left message.
14/02/2009	Nursing notes - BC asked his named nurse when he would be discharged, it was explained that this would be asap but he needed to give up his flat in London and he would be assisted in finding somewhere else to live. Was reminded that discharge would have been a few weeks ago if he had been compliant with medication. BC acknowledged and agreed to remain complaint as he wants to leave hospital.
16/02/2009	MDT notes More unwell this last week. Delusional ideas more evident. Currently out on leave so not able to attend the ward - at mosque. Care Plan: increased Quietiapine from today to 600 mg.
20/02/2009	Nursing notes - BC continues to voice persecutory ideas surrounding the Somali community. BC also mentioned that since Quietiapine he feels much worse.
24/02/2009	PQ - returned from leave to find message from the North Recovery Team manager at Oxleas NHS Foundation Trust. Returned call and left message on

	answer machine. Case notes Care Plan: To reduce Quietiapine to 150 mg bd. Clozapine to re-start tomorrow
25/02/2009	Letter from Gastroenterologist stating that BC had failed to attend camera test for his stomach but notes that he has heliobacter pylori and should get antibiotics.
26/02/2009	Nursing notes - BC has been out to the shops this evening with another patient. There are some suspicions that a few of the patients are smoking cannabis and so will be carrying out UDS tests tomorrow.
01/03/2009	Nursing notes - BC seen to help him fill in a form to SACMHA for housing. Was clearly experiencing paranoia and admitted to staff that he was being given cannabis by peers during the last few weeks. Firmly told this was exacerbating his mental state. Appeared to agree. Told to say no and then to tell staff. Been keeping low profile this evening.
03/03/2009	MDT notes Progress on ward: more settled and less aggressive; still some paranoid thoughts Care Plan: accommodation - has been accepted; pre-discharge meeting in two weeks. Application for accommodation to SACMHA When setting out eligibility criteria mentions - 'long term mental health problem'; 'will require extensive programme of support best met in a supported accommodation based service'; and, 'applicant needs extensive support in order to maintain a tenancy'. Scheme suitable because he has struggled to integrate into the (hospital) community and therefore having access to workers with more cultural sensitivity and are able to support him in his needs to integrate with the Somali community. Will need assistance with monitoring for medication compliance and to help structure the daily routine. Due to khat use, he will need further education and support around this. NB this document gives London GP as a contact along with brother.
05/03/2009	Nursing notes - has been speaking of seeking discharge to London and appears to accept that this is what he is going to do next. BC visited his uncle today to say goodbye. At approximately 19.30 he was discovered chewing khat and had also given some to one patient and possibly to a second. Has been informed of the rules especially regarding supply to others. Says he feels guilty about it and does appear genuine. Reported as remorseful about involving others in his khat use.
06/03/2009	PQ attended BC's interview at Halfway housing. He spoke really well – very

	open about his problems (with limited insight). Talked about finding out about his wife's affair and buying a gun. PQ was unaware of this so will request that it is added to risk assessment. Forms completed for SACMHA. The ward to set up a discharge plan.
07/03/2009	Nursing notes - named nurse read care co-ordinator's report which stated that BC had purchased a gun when he found out his wife was having an affair and asked BC about this. He said that a friend had given it to him but BC had no intention to use it or to hurt anyone so he returned it to his friend. BC continues to voice paranoid beliefs that the Somali community want to kill him and they think he is homosexual.
08/03/2009	Nursing notes - BC reporting that the Somali community was after him and he was afraid for his brother. Prescribed Lorazepam given. Risk management care plan Risk to self: admitted following an overdose; no attempts since nor ideation. Used khat which affected his mental health. Has used it occasionally on the ward but it is a heightened risk when discharged. Risk to others: no forensic or criminal history. Has fixed belief that the Somali community are trying to kill but never acted on these beliefs. Recently disclosed that friend gave him a gun when he found that is wife was being unfaithful but had no intention of using it and gave it back to the friend. Not considered a risk of harm to others at the present time.
09/03/2009	Letter from Halfway - not able to offer accommodation with the level of support he requires.
10/03/2009	MDT notes Progress on ward: accommodation now agreed; would need a CPA prior to discharge Care Plan: CPA in two weeks
12/03/2009	PQ visited the ward to see BC as arranged but he was fast asleep. Had T/C from OP - SACMHA has accommodation for him but he will need money for furniture etc. Need to apply for community care grant. Enquiring about the best person to do this.
13/03/2009	Nursing notes - named nurse phoned SACMHA to enquire what furniture will be in his flat so a community care grant application can be completed but they have not returned the call.
15/03/2009	Nursing notes - BC stated that he was bored and that he has been attempting to cope without the use of prescribed medications.
16/03/2009	PQ discussed risk with QR over e-mail correspondence re the gun which BC mentioned. QR records that she has explored the issue with BC and he has clarified that a friend gave it to him but he had no intention to use it and he has returned it to his friend. QR had recorded this and feels that there is no cause for concern. Both QR and PQ have documented this information.

	QR also explained that she is waiting for SACMHA to call back about what is needed for the flat so PQ can start the Community Care Grant.
17/03/2009 12:12 13:47 21:00	The North Recovery Team manager T/C to PQ. Message left for her to contact Oxleas NHS Foundation Trust regarding BC's referral. PQ - phone message from the North Recovery Team manager at Oxleas NHS Foundation Trust. Returned call - they had received the referral but had no other details. Explained that BC was now planning to stay in Sheffield. The North Recovery Team manager said to call and let them know if this changed in the future. Nursing notes - BC asked if he could have leave for 2 days to go to London as he has a house in London that he is paying rent for and also has a house in Sheffield that he is paying rent for. BC would like to give the house in London back to the Council and says he wants to stay in Sheffield Nursing notes - 1:1 time with BC to discuss the phone call from his brother in which he stated BC had voiced idea to commit suicide. BC was surprised to hear this and said he has not said anything of this nature to his brother and does not know why he said this to staff.
20/03/2009	MDT notes Progress on ward: paranoid at times; has had cannabis on ward; told brother he wants to kill himself, but later denied this; denies telling brother about self-harm; says someone who is not his brother is phoning the ward. Care Plan: continue Clozapine; encourage Occupational Therapy. MDT Review advance preparation - PQ having difficulty in closing current property as there are no details / information about it. RS is assisting her with that.
21/03/2009	Nursing notes - weekly review - is trying to 'team split' telling one member of staff something he later denies to another.
23/03/2009	PQ - visited BC on the ward. Accepted her visit but did not seem to want to talk and did not have anything he wanted me to address. Said he is happy with his flat and happy about applying for furniture. Agreed to continue to work with the hospital towards his discharge to SACMHA. In the office spoke to nursing staff who explained that BC had been verbally threatening to QR whilst she was helping him by filling in his forms. May have been due to being wound up by other patients. Staff believe that he may still chew khat and that this can make him unpredictable. Letter of introduction to the community team from PQ Sees role of community team as overseeing his care package and perhaps also helping him to challenge some of his paranoid thoughts about being under a curse. ". . I guess it is too short notice for anyone from your team to attend (CPA).

	However the minutes for this review will shortly be available, he has an up to date risk assessment on Insight and the admission summary from 27/05/2008 is helpful." "As I have only met BC on 4-5 occasions I feel that it would be most beneficial for him if he is able to meet with someone from your team as soon as possible. ."
24/03/2009	Nursing notes - continues to believe that the Somali community are wanting to end his life. After reassurance and further explanation on how this diagnosis can make him believe that the persecutory thoughts he is having are real. Accepted this reassurance and appeared a lot brighter. No further concerns voiced or noted. MDT notes Progress on ward: mixed reports; still voicing paranoid thoughts at times. Care Plan: provide short paragraph for CPA on Friday.
27/03/2009	Nursing notes - BC had to be prompted out of bed to attend his CPA. Settled throughout. The decisions from the CPA have not yet been ascertained. No concerns voiced or noted. BC has been allocated a GP; his client details have been updated. OP (SACMHA) informs me that he had located some basic furnishings for BC until his grant is finalised. BC will need to have Clozapine bloods taken on 6th April as an outpatient at the Michael Carlisle Centre. OP is unable to attend this with BC, note placed in diary to inform PQ on Monday to make arrangements for the blood monitoring. CPA meeting notes Progress on ward: staff feel he could be discharged; still not registered with GP in the area he is moving to; could attend as outpatient for bloods; care co-ordinator would see him weekly; OP could help with GP registration; went through recent review - may still be psychotic but had improved, no untoward incidents reported on leaves, functioning better; PQ recommended that he be given 7 days discharge medication at least. Care Plan: OP will register with GP today; PQ will ensure he has consultant in Community Mental Health Team (CMHT), she would review him weekly until he is transferred to another CMHT as per his new accommodation; OP will ensure regular bloods following discharge, will also help him with finances and will let family know about his discharge; agreed discharge for Tuesday 31st March 2009. Care plan record sheet completed by QR Is now off titrated dose of Clozapine and will be ready for discharge. Awaiting care grant, needs to register with GP.
30/03/2009	PQ - will visit him 06/04/2009 at 10.00. CMHT consultant psychiatrist will visit BC at home in April

31/03/2009	Nursing notes - due for discharge today although when spoken to regarding his discharge he said he was not aware that it was today but was happy for it to proceed. Received message from SACMHA, they have managed to find all items required for BC to move in (bedding etc). BC will be required to pay them £40 once the community care grant is received. Left a message for OP following conversation that BC will need to attend outpatients for Clozapine bloods. This may change when BC is registered with a GP, but care co-ordinator will be aware of any changes. PQ update: • Have passed details of the case to CMHT consultant psychiatrist who is happy with the plan so far and will visit BC in April at home. • Spoken to the referral secretary at the Yews and passed over BC's address and GP details. Suggested that joint work from as early as possible as PQ does not know BC herself so would be best for him to build up a rapport with his new worker. She will speak to today's duty worker and will get back to me. • Spoke to OP who has registered him with GP. OP has pots and pans for BC. Explained how to get practical details of discharge from ward. • Spoke to pharmacy. Will contact GP about blood tests. Will attend the ward to arrange BC to be discharged with the right medication and enough to allow him to settle into his new home before attending for bloods. • Will visit on 06/04/2009 at 10:00. PQ - T/C from pharmacy with an update: he has spoken to GP practice who are happy to carry out the blood tests. Happy to facilitate this and although they are only able to offer early appointment, pharmacy has spoken to OP who is happy to support BC and work round their timetable. The pharmacy and SACMHA are also happy for the medication to be delivered to OP and have arranged this. Provision made for unusual blood test reading. Last MDT notes Progress on ward: discharge today; no thoughts of harming others, chews khat occasionally but knows it does not help; finds it difficult to manage hygiene Risk assessments: low to self-harm, sexual vulnerability, aggressive behaviour to others, non-compliance, but medium to self neglect and use of drugs. Care Plan: bloods tests at GP; Clozapine for pharmacy; SACMHA accommodation; 7 day follow up from PQ; SACMHA follow up. Short term leave prescription: aspirin for 14 days and Clozapine for 28 days, Omeprazole

	Discharge plan: Enhanced level CPA - follow-up care • SACMHA, OP - support worker will initially provide an intense level of support until BC settles into his new accommodation/routine. • Care co-ordinator PQ • Crisis - relapse in mental health - phone numbers etc for SACMHA, PQ and Accident and Emergency MDT decisions and Plan - Reviewed prior to discharge, no current risk to self or others evident. Letter covering copy of CPA review and care plan. BC discharged from Nether Edge Hospital, Sheffield Health & Social Care NHS Foundation Trust.
01/04/2009	Discharge Summary Briefing Risk assessment: Risk to self: low; risk of sexual vulnerability: low; risk to others / aggressive behaviour: low; risk of non-compliance: low; risk of self neglect: medium; risk of taking illicit substances: medium.
02/04/2009	Sheffield Health & Social Care NHS Foundation Trust internal investigation report states that SACMHA had identified that BC was not in flat at this date.
06/04/2009 09:59	PQ - attempted 7 day follow up visit to BC. Phone call to OP, his support worker, reported that BC had settled into his flat well and OP had made sure he had everything he needed to live comfortably. OP went to visit BC today for his first blood test as arranged and found that BC was not in. OP phoned BC who was with his brother on the way to London, returning Sunday night. OP spoke to the brother and explained BC had missed his test. At the last CPA review PQ was present when WY made it clear to BC that he would need to attend for blood tests in order to get his medication. Care Plan: feel that have done everything that can be done to support BC to take his medication safely in the community, but cannot prevent him going to London. Will speak to CMHT consultant psychiatrist. Wonder whether if he does return to Sheffield, that he could be supported to take an alternative antipsychotic as he does not appear to have taken any medication routinely prior to being commenced on Clozapine and Clozapine is so difficult to take in the community if the person has no insight / is not willing to attend for blood tests.
10:12	PQ - T/C to pharmacy. BC's last result on 30/03/2009, tablets last dispensed on 31/03/2009. People have 10 day window. So he has until 10 April to get blood test. His medication will run out on 10th as well. The only options have left to try and help him is to try and get in contact with him and suggest that he attends a local hospital or GP for full blood test. They can then contact the surgery who will arrange to have the medication delivered to him somehow. Would need to be with enough time to allow for

	postage.
10:37	PQ - T/C to BC's brother. He spoke very quietly and it was sometimes difficult to understand him. Think he asked us why he was allowed to go to London? Explained the situation. HC said he saw his brother in London yesterday. PQ explained that Sheffield services had tried to arrange a blood test for him but he left without warning. Explained the purpose of blood tests. Says his brother believes people want to kill him, asked if this could be true. Brother says not. Asked if BC had suffered problems like this in Somalia and told that they only began in 1996/7. Unsure whether he was saying that BC had not suffered any trauma during war in Somalia. Did not feel able to push it at this stage but agreed to send BC to psychologist. HC pointed out that BC had been on medication for nearly a year in hospital and still had these beliefs so perhaps he needed more. Explained need for blood test. Will go to local GP and ask them. Offered to call GP to explain situation. Brother trying to support BC.
16:30	PQ - discussed the situation with ST today. He agreed with the current plan and added that a call to his GP in London would make them aware, remain in contact with BC's family, put a plan in place for how to help them seek help. PQ phoned SE3 GP surgery and spoke to administrator as advised by ST. He put out an automatic major alert on his case to indicate that if he comes in he will need a full blood test with results sent to pharmacy.
17:02	PQ - T/C to OP - BC had called him later in the day to say that he was coming back to Sheffield. Passed on information from pharmacy that if he gets his blood tests done at GP by Wednesday he should still be able to get his medication. OP said that this would not be a problem and he should be able to get BC to the GP. Letter from CMHT consultant psychiatrist arranging home visit on 28/04/2009 at 16:00 to be accompanied by PQ.
07/04/2009	PQ - T/C from OP. Has been to BC's flat but he is not in. Has called his number and his brother's and both phones switched off. BC's support package is set up for twice daily visits. OP will try again tonight and keep in touch with me. Discussed his risk history as per the CPA minutes - signs to look out for and what to do. BC's brother will also have his risk plan from the CPA minutes.
09/04/2009 11:00	PQ - T/C OP - he had been to BC's flat but he had not been there, had called and been told that BC was on the way back. Explained that the latest he could make his blood test was Friday 10th. Agreed that BC does not seem to understand that he needs to attend for bloods.

	PQ - T/C to pharmacy. Said that if BC could get to them they would do a blood test and send them off in the 16:00 van. After that he would need to be re-titrated [incremental increase in drug dosage to a level that provides the optimal therapeutic effect] back on the medication. Has already run out of medication. Called OP back he agreed to try and get BC to Nether Edge but he finished at 15:30. No chance of cover over the Bank Holiday. Agreed that he would call BC at 13:00 to give him last chance for bloods. Next visit will be Tuesday 14th.
11:15	PQ - T/C to BC - no answer - called BC's brother - left message. Called GP surgery - closed. Called Crisis team to make them aware of the situation. Agreed to call back at 13:30 when known if BC had been in time for his last medication.
13:30	Called duty nurse at East Glade [the location of the South West sector CMHT] to update. Agreed that all that could be done was being done. PQ called OP - BC still not at home. Called duty nurse at East Glade to update her. Services are aware in case the situation breaks down over the weekend.
14:28	PQ - T/C to KL - BC not attended for blood test so pharmacy unable to dispense medication, arrangements made for BC to attend GP surgery but he did not attend. OP from SACMHA to ring at 13:00 to take BC to pharmacy but not at home. Crisis Resolution and Home Treatment Team made aware of situation due to high risk of relapse and risk factors, GP also made aware.
14/04/2009 10:21	PQ - T/C to OP. On his way to visit BC today. Their team have decided to move him to an address closer to their office so that they can monitor and support him more closely. Agreed to keep in touch and visit together at 16:00. Conversation with duty consultant (covering for BC's assigned CMHT consultant psychiatrist): • Have still not seen BC but know that has a history of rapid deterioration • Had not had medication for several days now • Is not likely to attend bloods if he remains without insight • Will be unable to re-start him on Clozapine in the community • Needs a full review of his previous treatment to determine if he has tried other medications and whether Clozapine is any more effective than any others and consider if treatment on Clozapine is viable in the community. • BC needs to be referred to the Crisis Team for either home treatment or admission. Phone call to Crisis team - hopes that someone from their team will be able to visit with PQ this afternoon at 16:00 and will get back to PQ before 15:30.

Time not stated	PQ - attempted joint visit with OP from SACMHA. BC was not in. OP was able to use the communal keys to get as far as his personal door but they do not open the resident's rooms unless serious cause for concern so he did not have the keys at the time. Went outside and checked for signs of him. OP and PQ discussed the plan. Explained that she did not feel safe entering his flat because they had no idea how unwell BC was. Was last seen 02/04/2009 which was when he last took medication and the pharmacy has confirmed that he has run out. Discussed that BC was in theory high risk due to his last suicide attempt and the fact that he has not been seen for some time. The information PQ had from the ward was that he rapidly deteriorated without medication and could become very scared. He has in the past held a knife to his brother's throat and carried a loaded gun. Agreed that if they were going to enter BC's property then they needed to do it with the back-up of services such as an Approved Mental Health Practitioner.
18:20	PQ - T/C to Crisis team to feed back situation to them as requested. Spoke to Community Psychiatric Nurse R who advised me to contact police for a 'safe and well check' based on the risk to self and others. T/C to the police. They were reluctant to attend without a member of mental health service, and without the key holder. T/C to SACMHA who agreed to be on call to provide the keys rather than use the police. SACMHA then phoned back to say they were going to visit BC's flat with the back-up of another person. Phoned back to say they had visited BC's flat and found it empty and in a tidy state. Cigarette ends looked recent and no signs of someone living in distress. Were still unable to contact his family so agreed to call the police back and report BC as missing.
18:30	PQ - T/C to the police and explained situation. Passed over his and brother's number. PQ - T/C to Crisis Team to update. PQ unsure of BC current mental state as he has not been seen for a week.
15/04/2009 11:41	T/C from Sergeant K to inform Sheffield Health & Social Care NHS Foundation Trust that BC has been found safe and well in London. She gave PQ contact details for Metropolitan Police. PQ - T/C to Metropolitan Police. One of their officers has attended and found BC safe and well yesterday at his flat in London SE3. Did not have any immediate concerns regarding his mental state. They spoke to a brother who informed them that he was going to bring him to Sheffield for an appointment at Michael Carlisle Centre today. PQ - T/C to pharmacy which informed her that BC does not have an appointment with them but he does require bloods taken for Clozapine.

	PQ - T/C to brother - no answer and left message for him to contact me. PQ - T/C to inform SACMHA that BC has been found safe and well and are awaiting his return. They will call when he returns to them. PQ - T/C to GP in London - spoke with administrator; BC is no longer registered with their practice. Crisis Resolution & Home Treatment (CRHT) - T/C to PQ to inform her of a joint visit with CRHT to Sheffield accommodation on Thursday 16th April to assess whether BC requires home treatment or admission to recommence antipsychotic medication. To inform CRHT of above information. T/C to another brother's mobile but no answer. Care Plan: await BC's return to Sheffield. Has visit planned with PQ and CRHT on 16th.
12:43	CE - T/C to KR to update. It would appear that BC is making his way back to Sheffield today. Requested that PQ ring tomorrow morning to confirm BC is back in Sheffield prior to the home visit at 15:00, CE planned to phone PQ back today and request that she calls.
16/04/2009 09:32	KR - T/C to PQ - she has not heard that BC has definitely returned to Sheffield, therefore agreed that he would be kept as on-going triage, and when PQ has confirmation that he is physically in Sheffield she will contact the team, and arrange assessment date and time then.
15:22	PQ - T/C phone for OP - BC has not returned so cancelled appointment with Crisis Team. OP will contact as a soon as BC returns. KR will keep file open for BC but close the referral for a visit today.
21/04/2009	PQ - T/C from OP. Has been to visit BC today who was still not there and he is not answering his phone nor are his brothers answering theirs. Explained that the plan was currently that they would contact as soon as BC turned up again. And that everything had been done that was possible to support him. They discussed what they should do: PQ suggested that OP consult their policy on whether they can sustain a support service if someone is repeatedly not in. And beyond that what their policy would be on how long they keep a flat for him. OP said he would talk to their team and get back to her.
23/04/2009	PQ - consultation with 'loss of contact with services CPS policies'. In accordance with policy document section 24.2 - SACMHA, the police and PQ have all attempted to make contact with the service user's family, and both his registered GP and his potential GP in London, his housing service SACMHA are aware, the police located him safe and well at his brother's last week, but he has not returned to Sheffield. He has not answered his phone today, his brother's phone says he is not able to accept calls. SACMHA

	continue to try to contact him and his brother. Have contacted the police who are aware. PQ has had an informal interview with SACMHA on the phone and CMHT consultant psychiatrist and PQ are due to meet 28/04/2009. Care Plan: e-mail CMHT consultant psychiatrist to make aware, contact CPA manager in accordance with 24.3.
18:30	Crisis Triage - T/C to PQ - BC missed his Clozapine bloods on Tuesday as he has been in London visiting family. East Glade (i.e. PQ) and SACMHA have been in touch and apparently he is making his way back to Sheffield. PQ unsure of his mental state as he has not been seen for a week. However has history of relapsing quickly, and there have been significant risk issues in the past. PQ will ring back later in the day when hopefully the situation will be clearer and someone has seen him. Can then discuss options re input from CRHT over weekend. Crisis Triage - T/C from PQ - SACMHA has been round to flat and could not find him but there was no signs of distress, PQ has now reported him missing to the police and would like a joint visit if found on Thursday at 15:00
24/04/2009	PQ discussion with CMHT consultant psychiatrist. Agreed to have a review in line with policy. Review booked for 28/04/2009 PQ agreed to contact SACMHA. Still no reply on BC's phone. Phone call to SACMHA to explain that Sheffield Health & Social Care NHS Foundation Trust was holding a review on Tuesday which they were welcome to attend but if this was short notice they could provide a report. PQ - e-mail received from IJ. Suggested should continue to follow policy and agreed with the need to balance the past risk with a need to avoid institutionalising someone who may not want or need follow up. PQ - T/C from OP - he has informed SACMHA service manager and they continue to review the care. OP is going to visit BC again to see if he has returned. He will try to attend the review on Tuesday at 10:30 but it is short notice as was agreed. Their plan is to monitor the situation.
27/04/2009	PQ received fax from pharmacy confirming discontinuation of Clozapine
28/04/2009	PQ - T/C from new SACMHA support worker - explained that BC had been discharged from this team as he appears to be staying in London. The SACMHA team will shortly be receiving the minutes of the CPA review meeting which decided to discharge BC. CPA Review and Care Plan Documentation BC is now in London and has not had any contact with Sheffield services. This review is a discharge meeting. BC's last review was when he was in hospital. He was discharged on 31/03/2009 and was already in London before his 7 day follow-up visit.

	Was last seen by services on 15/04/2009 in a safe and well check. Was assessed as being well. If BC's mental health deteriorates he should visit his London GP. BC's prescription for Clozapine has now run out - if BC becomes unwell his mental health and medication should be reassessed. BC was last seen at his brothers in London. He has family in London - would be referred to the appropriate team by his GP if needed. Copy of care plan sent by PQ to BC's London address Formal risk assessment for BC on 28/04/2009 by PQ Risk to self: medium; risk to others: low; risk of abuse by others: low; self neglect: low. Risk assessment by PQ Safety strategies: very difficult to ascertain what BC's coping / safety strategies are. Seems that he can become agitated and fearful and responds well to reassurance and being in a safe environment. Understood that his wife has no contact with BC but his brothers are supportive. Safety issue 2: BC's mental health deteriorates. Circumstances 2: If BC becomes distressed, if he stops taking medication. Warning signs: irritability, aggression, paranoia. Plan 2: BC should report to his GP and Accident and Emergency if his health deteriorates. Person responsible 2: BC, his family.
29/04/2009	Seen by Oxleas NHS Foundation Trust see main report pages 35-6
30/04/2009	Seen by Oxleas NHS Foundation Trust see main report pages 37-40
04/05/2009	(Bank Holiday Monday) AD was found dead.
06/05/2009	The North Recovery Team manager - Oxleas NHS Foundation Trust - received Sheffield Health & Social Care NHS Foundation Trust CPA review, care plan and risk assessment dated 28th April 2009 by post from Sheffield Health & Social Care NHS Foundation Trust. Post marked 30/04/2009.
11/05/2009	SUI Service Management Review Report received by Critical Incident Office Oxleas NHS Foundation Trust. States that he has diagnosis of paranoid schizophrenia. "*Staff support: support and time given to Bed Manager and Assessment Team after learning of the incident. Reflective practice session to be arranged*."
24/06/2009	Letter from Oxleas NHS Foundation Trust MHA office informing GP that BC is detained at Wathwood Hospital RSU under *s* 3 of the MHA. His Consultant is KM.
07/07/2009	Forensic social worker from Wathwood visited BC's flat in Sheffield and found all his medication there.
23/11/2009	Letter from Oxleas NHS Foundation Trust MHA office informing GP that BC's section was changed from *s* 3 to *ss* 48/49

16/09/2010	Central Criminal Court imposed *ss* 37/41 order detaining BC indefinitely.

Appendix Two: Abbreviations and acronyms used in the report

Initials	Role / Job Title
AB	Assessment nurse, Oxleas House assessment area, Oxleas NHS Foundation Trust
AC	Person thought by Metropolitan Police to be BC's carer probably, in reality, BC
AD	BC's second cousin and victim
BC	Subject of the inquiry and perpetrator
CE	Community mental health nurse/senior practitioner Nether Edge Hospital
DF	Service manager, SACMHA
EF	Liaison psychiatrist, Oxleas House assessment area, Oxleas NHS Foundation Trust
EG	Mental health nurse practitioner, Oxleas House assessment area, Oxleas NHS Foundation Trust
FC	BC's wife
FG	Community consultant psychiatrist, Sheffield Health & Social Care NHS Foundation Trust (BC's responsible clinician when an outpatient)
FH	Health care assistant, Oxleas House assessment area, Oxleas NHS Foundation Trust
GC	BC's youngest brother
GI	Executive director of operational management, Sheffield Health & Social Care NHS Foundation Trust
HC	BC's brother (4th of the 5 younger (full) brothers)
HI	Health care assistant bank staff, Oxleas House assessment area, Oxleas NHS Foundation Trust
HJ	Health care assistant, Nether Edge Hospital, Sheffield Health & Social Care NHS Foundation Trust
IJ	Deputy ward manager, Nether Edge Hospital, Sheffield Health & Social Care NHS Foundation Trust
JK	Head of Integrated Governance, Sheffield Health & Social Care NHS Foundation Trust
KL	Community mental health nurse, Sheffield Health & Social Care NHS Foundation Trust
KM	Consultant forensic psychiatrist, Wathwood Hospital Regional Secure Unit, BC's current responsible clinician
KR	Approved social worker (based in the Crisis Team), Sheffield Health & Social Care NHS Foundation Trust
LM	CPA manager, Sheffield Health & Social Care NHS Foundation Trust
LN	Night shift duty senior nurse, Oxleas House assessment area, Oxleas NHS Foundation Trust
MB	Mental health nurse practitioner, Oxleas House Assessment Area, Oxleas NHS Foundation Trust

ML	Day shift duty senior nurse, Oxleas House Assessment Area, Oxleas NHS Foundation Trust
MN	Audit and knowledge management manager, Sheffield Health & Social Care NHS Foundation Trust
NO	Senior house officer (Year 2 trainee in psychiatry), Oxleas House assessment area, Oxleas NHS Foundation Trust
OP	BC's support worker, SACMHA
PO	BC's uncle
PQ	BC's care co-ordinator, Sheffield Health & Social Care NHS Foundation Trust
QR	BC's named nurse, Stanage Ward, Nether Edge Hospital, Sheffield Health & Social Care NHS Foundation Trust
RS	Health care assistant, Stanage Ward, Nether Edge Hospital, Sheffield Health & Social Care NHS Foundation Trust
ST	Health care assistant, Stanage Ward, Nether Edge Hospital, Sheffield Health & Social Care NHS Foundation Trust
TU	Acting bed manager, Oxleas House, assessment area, Oxleas NHS Foundation Trust
TW	Nurse, Stanage Ward, Nether Edge Hospital, Sheffield Health & Social Care NHS Foundation Trust
UV	North recovery team manager, Oxleas NHS Foundation Trust
VW	BC's GP at a health centre in south east Sheffield
WY	Consultant psychiatrist, Stanage Ward, Nether Edge Hospital, Sheffield Health & Social Care NHS Foundation Trust (BC's responsible clinician when an inpatient)
YZ	Health care assistant, Stanage Ward, Nether Edge Hospital, Sheffield Health & Social Care NHS Foundation Trust
ZA	BC's patient advocate, SACMHA

Acronyms used in the report

CMHT	Community Mental Health Team
CRHT	Crisis Resolution and Home Treatment
CPA	Care Programme Approach
DLA	Disability Living Allowance
DSN	Duty Senior Nurse
Insight	Electronic patient administration system used by Sheffield Health & Social Care NHS Foundation Trust
MHA	Mental Health Acts 1983 and 2007
RiO	Electronic patient record system used by Oxleas NHS Foundation Trust
SACMHA	Sheffield African and Caribbean Mental Health Association
SHO	Senior House Officer
SUI	Serious untoward incident

T/C	Telephone call
UDS	Urine Drug Screen

Appendix Three: Documents reviewed

Oxleas Incident form
Oxleas Service management report
Oxleas patient record progress notes dated 27/05/2008 - 08/05/2009
Oxleas Core assessment overview - patient record report
Oxleas Risk overview - patient record report
Oxleas Referral assessment monitoring documentation for statutory work for the MHA 1983
Oxleas Assessment and shared care team social work report for statutory work under MHA 1983
Avery ward, Oxleas House discharge summary
Oxleas Care plan and review (previous admissions)
Oxleas Level 2 observation record in assessment area
Oxleas House protocol for the assessment area (working draft)
Oxleas Staff statements
Oxleas Staff interview minutes
Oxleas Panel meeting minutes
Oxleas Chronology (tabulated timeline)
Oxleas Board of Directors inquiry report
Oxleas Terms of Reference
Oxleas Miscellaneous correspondence E-mail dated 21/01/2011 update to Action Plan
Primary care records May 1995 to March 2009
A Guide to the Assessment and Management of Risk (April 2010)

Sheffield Health & Social Care NHS Foundation Trust Internal Inquiry
Sheffield Health & Social Care NHS Foundation Trust Action Plan updated 20/04/2010
Sheffield Health & Social Care NHS Foundation Trust Internal Inquiry draft
Sheffield Health & Social Care NHS Foundation Trust BC Incident Chronology
Covering letter from Oxleas dated 21/10/2009
Sheffield Health & Social Care NHS Foundation Trust Urgent matter regarding systems for sharing information
Sheffield Health & Social Care NHS Foundation Trust Meeting regarding incident BC 70348
Sheffield Health & Social Care NHS Foundation Trust Notes of meeting with WY 17/07/2009
Metropolitan Police Service Medical disclosure form
Sheffield Health & Social Care NHS Foundation Trust Formal risk assessment for BC on 28/04/2009 assessed by PQ
Sheffield Health & Social Care NHS Foundation Trust meeting re BC (undated)
Sheffield Health & Social Care NHS Foundation Trust Further information regarding BC 28/05/2009
Sheffield Health & Social Care NHS Foundation Trust Report of Telephone Call with bed manager on 30/04/2009
Sheffield Health & Social Care NHS Foundation Trust activity detail for client
Sheffield Health & Social Care NHS Foundation Trust Internal Inquiry papers

Sheffield Health & Social Care NHS Foundation Trust Meeting regarding incident BC 70348 dated 15/05/2009
Sheffield Health & Social Care NHS Foundation Trust E-mails re internal inquiry
Sheffield Health & Social Care NHS Foundation Trust incident report form
E-mail from Oxleas NHS Foundation Trust about incident inquiries
E-mail from Sheffield Health & Social Care NHS Foundation Trust about joint inquiry
Sheffield Health & Social Care NHS Foundation Trust Serious Incident Report Request
Sheffield Health & Social Care NHS Foundation Trust E-mails relating to discovery of body
Sheffield Health & Social Care NHS Foundation Trust Note from Assistant Service Director of the Recovery, Rehabilitation and Specialist Directorate 06/05/2009 re BC
Sheffield Health & Social Care NHS Foundation Trust Note of Telephone Call from PQ's line manager
Sheffield Health & Social Care NHS Foundation Trust Draft e-mail re joint investigation
Sheffield Health & Social Care NHS Foundation Trust 11.30 note about arrest
Sheffield Health & Social Care NHS Foundation Trust Inpatient Admission front sheet for Burbage Ward
Sheffield Health & Social Care NHS Foundation Trust activity summary for client
Sheffield Health & Social Care NHS Foundation Trust admission history for client
Sheffield Health & Social Care NHS Foundation Trust Client summary sheet
Sheffield Health & Social Care NHS Foundation Trust BC inquiry notes
Sheffield Health & Social Care NHS Foundation Trust Insight documents
Sheffield Health & Social Care NHS Foundation Trust Risk assessment
Sheffield Health & Social Care NHS Foundation Trust Internal Inquiry - notes (no name)
Sheffield Health & Social Care NHS Foundation Trust CPA Review and Care Plan Documentation
Sheffield Health & Social Care NHS Foundation Trust discharge summary
Sheffield Health & Social Care NHS Foundation Trust Continuation case notes
Sheffield Health & Social Care NHS Foundation Trust Insight No: 239920 Insight Daily Records
Sheffield Health & Social Care NHS Foundation Trust Primary care records (PCR)

Sheffield Health & Social Care NHS Foundation Trust - Adult Mental Health CPA Policies and Procedures 2002
Sheffield Health & Social Care NHS Foundation Trust - Policy - Domestic Abuse (ratified 11 December 2008)
Sheffield Health & Social Care NHS Foundation Trust - Prevention and Management of Violent Behaviour Policy (ratified 11 December 2008)
Sheffield Health & Social Care NHS Foundation Trust - Policy: Difficult to Engage Service Users (including non-compliance with treatment and non attendance (ratified 7 May 2009)
Sheffield Health & Social Care NHS Foundation Trust - Prevention and Management of Violent Behaviour Policy (issued February 2006)

Official Publications

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Appendix Four: Khat

In December 2005, the Advisory Council on the Misuse of Drugs (ACMD) recommended that, on the basis of evidence, khat should not be a controlled substance under the Misuse of Drugs Act 1971. The use of the substance was very limited to specific communities within the UK, and, in the Council's view, was unlikely to spread to the wider community. However that was not to say that the use of khat is without detrimental effects and its use should be discouraged. In the light of that recommendation the Council made a number of other recommendations relating to educating and informing users of the harms associated with khat use, ensuring effective advice was available, and restricting supply to children.

Khat is a herbal product consisting of the leaves and shoots of the shrub catha edulis. It is cultivated primarily in East Africa and the Arabian Peninsula, harvested and then chewed to obtain an amphetamine-like stimulant effect. Khat causes excitement, lack of appetite and euphoria but has been classified by the World Health Organisation as a drug of abuse that can produce mild to moderate psychological dependence. Khat use has been reported for centuries, there are Arab reports that it was being used in Yemen in the sixth century. Ethiopians may have brought it to Africa after conquering Yemen, and its use spread from there in the fifteenth century.

Khat is not currently controlled under the Misuse of Drugs Act 1971 but the two main psychoactive component chemicals, cathinone and cathine, are classified as Class C drugs under the Act. An offence is committed if cathinone or cathine are extracted from the plant. Khat is licensed under the Medicines Act 1968. It can be imported legally into the UK when declared as vegetable.

The British Crime Survey reported, for the first time, in 2010 that around 0.2% of adults in the general population reported last year use of khat (Hoare and Moon 2010). Most of the earlier epidemiological data reported that khat use was prevalent among the Somali, Ethiopian, Kenyan and Yemeni communities. The ACMD reported that research conducted for them among a sample of the Somali community living in London showed that 78% had used khat at some time, 67% had used it in the week prior to interview and 6% were using khat on a daily basis. High usage of khat was predominantly a male activity.

Khat imports arrive daily via European airports and there is an efficient distribution system to the khat using communities across the UK. Most khat users buy khat at a meeting place where khat is bought and chewed. It can also be bought in small shops within the ethnic community to be used at home or with friends. An alternative supply of khat is available via 'mobile traders' who sell khat from the back of a car or van on the street.

Stored khat rapidly loses activity, becoming psychologically inactive after about 36 hours. Cathinone and cathine are isolated from the leaves of the catha edulis plant by action of enzymes in saliva. Chewing has been shown to be an efficient way of extracting cathinone and cathine. Khat has less reinforcing properties than other stimulants such as amphetamine and

cocaine as it takes long time to reach maximal concentrations. Drugs that have a fast onset of action have a high addictive potential.

The ACMD reported evidence from animal studies that cathinone causes dopamine release and also the release of neurotransmitter at serotonergic synapses and peripheral noradrenergic sites. These biochemical properties are similar to those of amphetamine, especially its sympathomimetic properties. Chronic administration of khat extract or cathinone caused a depletion of serotonin in the basal ganglia of rat brain. The authors of report suggest that low levels of serotonin and possibly the release of dopamine produced by cathinone may be the mechanism for an increase in aggressive behaviour measured in the laboratory animals.

In the social research quoted by the ACMD khat use was seen as causing problems for the family. Women were more likely than men to report that khat use was responsible for family breakdown and violent behaviour. Moreover, some women felt that their partners spent too much money of khat and that it hampered their employment prospects. Khat use is associated in some cases with mood swings. The ACMD were keen to point out that khat use may just be a convenient scapegoat for family disruption.

Very low offending rates were reported by the ACMD. Of the three individuals who reported having committed violent offences, all were recent khat users. There does not seem to be a link with acquisitive crime. The rates detected are particularly low considering the financial status, social situation and location of many of the khat using communities.

Users of khat report increased levels of energy, alertness, self-esteem, sensations of elation, enhanced imaginative ability and capacity to associate ideas when chewing. However over stimulation of the central nervous system can lead to psychiatric disorder and there are cases of people developing psychosis after use of khat. There are few controlled studies investigating the possibility of a causal link between khat use and psychosis.

A study, reported in 2005, surveyed inhabitants of Hargeisa involved in the civil war in Somalia, for the presence of psychiatric morbidity. Unusually high levels of psychiatric morbidity were found (8.4% severely disabled). Those who displayed positive psychiatric symptoms had an earlier age of onset of khat use and used greater quantities of khat. However those who were former combatants also displayed a higher vulnerability to psychiatric symptoms. There was also an association between the experience of traumatic events, amount of khat use and psychosis. The authors thought it likely that the combination of trauma, psychosis and khat use is linked, although it is not possible to determine cause and effect.

A large study in Yemen found there was no association between khat use and psychiatric symptoms. In fact use of khat appears to be inversely associated with phobic symptoms. The ACMD thought that the quantity and frequency of khat use and experience of trauma may contribute to the development of psychosis.

The ACMD concluded that it is evident that khat use is widespread amongst communities in East Africa and the Middle East and here it causes little morbidity. However, khat may

contribute to psychiatric morbidity in those vulnerable through traumatic life experiences. Unfortunately, many of those settled in the UK from khat using communities may have suffered such trauma and are now subject to considerable stress during the process of migration to a new country and culture. Khat use outside its usual social context may further contribute to this problem.

All abused central nervous system stimulants also stimulate the cardiovascular system. In normal non-khat using volunteers, chewing khat leads to a significant increase in systolic and diastolic blood pressures persisting for between 3 and 4 hours after the onset of chewing. Other studies have found the same increases in blood pressure and also significant increase in heart rate. There is evidence that tolerance develops to these sympathomimetic effects in chronic users.

Residual pesticide on khat leaves is a cause of concern for khat chewers. In Yemen, khat production and the use of pesticides have increased over the years. High levels of the pesticide dimethoate have been found in some samples. High levels of pesticide residue have been associated with complaints of weakness, runny nose and congestion.

Reports to the ACMD Khat Working Group suggested that some khat users were reluctant to wash khat in the belief that it would cause the plant to lose its potency. Men tend to use khat in communal areas which tend to be poorly ventilated rooms in which there is a great deal of tobacco smoke as well.

In the period up to 2005 the ACMD stated that the consequences of the use of khat were not well recognised by health professionals. There were no specific pharmacological agents available to treat khat dependency. Addiction services with experience of treating individuals with dependency on stimulants would be able to use such a model for the treatment of khat dependency. They would be different from the majority of people seeking treatment with addiction services as they are highly unlikely to use other drugs or alcohol.

Khat use is rarely perceived as a problem and it is not seen as a drug. For these reasons khat users are unlikely to attend for treatment at current treatment facilities. The ACMD suggest that community education would be more effective provided culturally sensitive personnel could be found to deliver health advice and harm reduction strategies.

The ACMD stated that there were only two published case studies available to them of the pharmacological treatment of khat dependence. In both cases bromocriptine was used. Bromocriptine is a direct agonist of dopamine receptors and is occasionally used in the treatment of stimulant addiction although the effectiveness of dopamine agonist has not been proved by large scale clinical trials.

More recently, Anderson and Carrier (2011) report that khat currently retails in the UK at £3 to £6 per bundle and now that VAT is imposed on khat imports into the UK some £2.9 million was raised in 2010 when some 3002 tonnes of khat entered the UK. This figure apparently

represents a large increase since the late 1990s when about 364 tonnes were imported annually.

Anderson and Carrier write that the ACMD's advice was accepted by the Home Office in early 2006, leaving the legal status of khat unaltered. The World Health Organisation carried out a full review of khat in 2006 and assessed its medical harms and concluded that there was no evidence that khat should be brought under international control. There has been some discussion among the Somali community that khat use should be taken more seriously by the majority community, some argue that consumption should be made illegal in the UK as it is in other countries - the current legal situation in the UK is anomalous.

Many of the studies reviewed by Anderson and Carrier emphasise that khat consumption helps maintain 'culture' and 'identity' for diaspora communities, a point made by commentators and by consumers themselves. Identifying khat as a cultural practice does not imply approval. Religious opinions have largely been ignored in previous research and it is know that Muslims are divided as to whether or not khat is forbidden.

Anderson and Carrier conclude their review by saying that much of the literature which is based on survey and focus group data drawn from the relevant diaspora communities demonstrates that there is concern about a link between khat consumption and social harm. But none of the literature in their review provides a clear causal relationship between khat consumption and the various social harms, for example, unemployment, crime, public disorder, violence, family breakdown, income diversion, and lack of integration.

Appendix Five: The independent investigation panel

Dr Tony Fowles is a senior associate at Caring Solutions UK Ltd and is a specialist in criminal justice with a background in research and university teaching; including being Dean of the Law School at Thames Valley University. He was recently the lead reviewer for the NHS London project, 'Learning from Experience - report of consultancy to support the compilation and analysis of learning from the 2002-2006 London mental health homicide reviews and analyses'. For eight years Tony was a criminologist member of the Parole Board of England and Wales which is responsible for the early release of prisoners. This work involved assessments of risk, for example, further violent offences as well as reputational risk. He was Chair of the Lancashire Probation Board between 2002 and 2007. Tony has published several books on criminal justice, and is one of the Editors of the *Howard Journal of Criminal Justice* which is Britain's main criminal justice policy journal.

Dr Michael Rosenberg is a retired Consultant Psychiatrist, who worked as a general adult psychiatrist from 1981-2009 for the NHS in Brighton. Between 2003 and 2006 Michael was the Chief Executive and Honorary Consultant Psychiatrist at South Downs Health NHS Trust; a Trust where he had previously been the Medical Director between 1998 and 2003. Michael was responsible for the Psychiatric Intensive Care Unit at Mill View Hospital from 1999 to 2005 (a modern 10-bedded unit caring for acutely mentally ill patients, requiring short-term intensive treatment). From 2006 to 2009 he worked as an inpatient triage consultant. He is approved under Section 12(2) of the Mental Health Act 1983. Michael has extensive experience of the investigation of critical incidents and advised on the management of complaints in his Trust.

Mr Tony Thompson has extensive experience representing mental health and learning disability nursing and services. He has published numerous professional books and journal articles in the area of inter-professional working. His career has spanned decades in the statutory services. This includes positions as Inspector of Training schools (General Nursing Council for England and Wales). He is the former Education Officer and Professional adviser for the English National Board. He has held senior lectureship in Higher Education and an external examiner to several UK Universities. Previous service positions held include director in NHS and the Independent sectors. He is currently a senior associate at Caring Solutions UK Ltd and a Director of Bridge R&D UK Ltd. and Bridge International.