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INVESTIGATIONS – REVIEWS – INQUIRIES

An independent investigation into the care and treatment of MO

A report for NHS London

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1. Introduction

1.1 Mohammed Osman (MO) stabbed Camille Remy to death in December 2006. MO admitted manslaughter on the grounds of diminished responsibility and was ordered to be detained indefinitely at Broadmoor Hospital, where he remains.

1.2 East London and the City Mental Health Trust (now East London NHS Foundation Trust) and Barnet, Enfield and Haringey Mental Health NHS Trust commissioned a joint internal investigation into the care and treatment they had provided for MO. MO had briefly been an inpatient at North East London Mental Health NHS Trust (now North East London NHS Foundation Trust) two weeks before the killing. However, the other two trusts did not know this, so North East London NHS Foundation Trust was not made a party to the internal investigation.

1.3 NHS London commissioned this independent investigation into the care and treatment of MO as part of its responsibilities for performance managing the NHS locally. It was commissioned in accordance with guidance published by the Department of Health in circular HSG (94) 27 "*The discharge of mentally disordered people and their continuing care in the community*" and the updated paragraphs 33-36 issued in June 2005.

1.4 MO is Somalian. He was 31 at the time of the killing and had been living in England for about five-and-a-half years. His first language is Somali. He also speaks French and some English. From about October 2005 until the end of August 2006 MO was housed as a homeless vulnerable person by Newham council. He then spent a number of months travelling and went to Belfast, Dublin and Stranraer. Newham council re-housed him at the beginning of December 2006.

1.5 MO had contact with many different services and agencies. In addition to the NHS trusts mentioned and Newham council's housing services, these included the British Transport Police, the Metropolitan Police, Whipps Cross University Hospital NHS Trust, North Middlesex University Hospital NHS Trust, and Dumfries and Galloway council's social services department. At the request of NHS London, Newham council and the Metropolitan Police have also cooperated with the independent investigation process. They have shared information and their records of their involvement with MO with us.

1.6 The investigation team met with Camille Remy's family on 30 May 2008 to share the terms of reference of the investigation, to explain the investigation process and to listen to their concerns. We were told by Madame Mireille Cluzeaud, Camille's mother, that she had not heard the full story of events leading up to her daughter's killing. In order to give as full a picture as possible of those events we have developed an extensive chronology.

1.7 In compiling our report we have taken into account that Camille's family live in France that their first language is not English and that services and arrangements for mental health care and treatment may differ between France and England. We have provided written explanations of terms and services that are likely to be unfamiliar to Camille's family. We have arranged for this report to be translated into French.

1.8 We also met with MO at Broadmoor Hospital to explain the independent investigation procedure and to hear his evidence in relation to his care and treatment in the period leading up to the killing.

2. Terms of reference

2.1 Our terms of reference, were agreed by the commissioners of the investigation and also Newham council and the Metropolitan Police. The terms of reference are set out below.

2.2 The aim of the independent investigation is to evaluate the care and treatment of MO and to identify what, if any, contributory factors led to the homicide of Camille Remy and whether they were avoidable. The investigation will also review the trusts' internal investigation report and the progress that the trusts have made in implementing the action plan arising from it. Where appropriate recommendations based on best practice in mental health care will be made.

Specifically, the independent investigation will:

1. Compile an accurate chronology of events from MO's first point of contact with psychiatric services and any other services which may have impacted on his care and treatment up to and including the events immediately following the homicide.

2. Investigate and comment on the mental health care and treatment offered and provided to MO.

3. Assess the adequacy with which MO's risk was assessed and the adequacy of any actions consequent upon the assessment(s).

4. Review the extent to which organisations and agencies whose work impacted on the care of MO, including police and housing was appropriate and adhered to statutory obligations, relevant national guidance and local operational policies in the way which they worked with the PCT.

5. Review the actions taken by the trusts in response to the death of Camille Remy and comment on the way in which the trusts managed this incident, including the quality of any contact that the trusts had with the families of MO and Ms Remy.

6. Review the trusts' internal investigation and assess the adequacy of its findings and recommendations and the progress made in the implementation of those recommendations.

7. Establish and make reference to any other relevant investigations relating to MO and his family which are being and have been undertaken by organisations outside the trusts such as the police and housing.

8. Make clear, sustainable and targeted recommendations based on the contributory factors/root causes of the events leading to the homicide of CR and aimed at ensuring that any lessons are learned, acted upon and shared.

9. Provide a written report including recommendations to NHS London.

3. Executive summary and recommendations

Executive summary

Introduction

3.1 NHS London commissioned this independent investigation into the care and treatment of MO as part of its responsibilities for performance managing the NHS locally. It was commissioned in accordance with guidance published by the Department of Health in circular HSG (94)27 *"The discharge of mentally disordered people and their continuing care in the community"* and the updated paragraphs 33-36 issued in June 2005.

3.2 MO stabbed Camille Remy to death in December 2006. He admitted manslaughter on grounds of diminished responsibility and was ordered to be detained indefinitely at Broadmoor Hospital, where he remains.

Overview of MO's contact with services

3.3 MO was in contact with many different public service organisations between October 2005 and 20 December 2006, when he killed Camille Remy. These services included a number of different NHS trusts, police forces, and local authority social services and housing departments. Most of these organisations had only brief contact with MO, but three of them, (East London and the City Mental Health NHS Trust – now East London NHS Foundation Trust (ELC NHS trust); Barnet, Enfield and Haringey Mental Health NHS Trust (BEH NHS trust); and Newham council's homeless persons unit (HPU)) dealt with MO for longer. Although East London and the City Mental Health NHS Trust is now East London NHS Foundation Trust we continue to refer to the trust as ELC NHS trust in the report as this was the name of the service when MO received care there.

3.4 The first known contact between the services and MO was in October 2005. MO was living at Anchor House, a homeless persons' hostel in London, where he chased another resident with a knife. He was arrested and taken to Newham police station. He received a caution, and the forensic medical examiner (FME) at the police station told MO that he

needed a psychiatric assessment. MO was asked to leave the hostel and became homeless.

3.5 MO went to the ELC NHS trust's south east Newham community mental health team (SE CMHT). He was seen and assessed and it was decided that his mental state should be monitored in ELC NHS trust's outpatients' department. The SE CMHT also undertook a vulnerability assessment on the basis of which Newham council's housing department gave MO emergency accommodation.

3.6 In November 2005 MO went to Plaistow police station and told the police he had been drugged and raped. The police referred MO to the SE CMHT and MO was seen and assessed the same day. The assessment revealed a range of psychotic symptoms and MO was started on anti-psychotic and anti-depressant medication. A follow-up appointment was made and the SE CMHT continued providing support for MO until March 2006. MO told the SE CMHT he had stopped taking his medication and was fine. He did not want further help from mental health services. He was offered outpatient follow-up but he refused. His case was therefore closed.

3.7 In April 2006 MO went to the accident and emergency (A&E) department of Whipps Cross Hospital complaining of a pain in his anus and that someone was trying to poison his food. A psychiatric liaison nurse saw him and an appointment was made for him to return to the hospital the next day to be seen by a psychiatric senior house officer (SHO). MO failed to keep that appointment.

3.8 Newham council moved MO to temporary accommodation in early May 2006 but he requested a review of that decision on the grounds that his new accommodation was on the ground floor. He said this was unacceptable to him because "*over one hundred people*" were pursuing him day and night and someone with a lot of money was trying to "*eliminate*" him.

3.9 At the end of May 2006 MO went to the A&E department of the North Middlesex Hospital. He alleged that he had been put to sleep by some kind of anaesthetic gas while in his own room. He believed that he had been sexually abused and was complaining of pain in his anus.

3.10 Newham council's agents inspected the property where he was staying and found that electric fittings and lighting had been tampered with and pulled out, the kitchen sink had been damaged and was leaking. Newham council's agents concluded that the damage had been caused deliberately by MO.

3.11 In June 2006 MO presented at the A&E department at North Middlesex Hospital. This time he complained about pain behind his eyes but he left before he could be examined by medical staff.

3.12 The day after this visit to A&E MO had a fight with Mr A, a fellow resident at the property where he was living. The police crime report of the incident discloses that the scene was heavily bloodstained, and that two knives were recovered. MO had several stab wounds to his chest and was admitted to North Middlesex Hospital. Mr A had knife wounds to his left shoulder and right arm. MO gave a brief account of what had happened. He said Mr A had come to his door armed with a knife, but he could not explain how Mr A was injured. Mr A's version of events was that MO had jumped out of his door as he was passing and had lunged at him with a kitchen knife and a violent struggle had ensued.

3.13 While MO was in North Middlesex Hospital he was agitated, asking to be transferred to another hospital and refusing some treatments. A doctor who carried out a mental health act assessment concluded that MO was suffering from paranoid psychotic experiences in that he felt he was being persecuted and pursued. MO was detained under section 5(2) and then section 2 of the Mental Health Act 1983 and transferred to Northumberland ward at St Ann's Hospital part of the Barnet, Enfield and Haringey Mental Health NHS Trust.

3.14 MO applied for a Mental Health Review Tribunal (MHRT) hearing to appeal against his detention under section 2 of the Mental Health Act 1983. On 18 July 2006 the MHRT concluded that there was no evidence that MO was suffering from mental disorder, although he may have previously suffered from a psychotic episode induced by taking khat, the leaves of a shrub which is chewed like tobacco and acts as a stimulant. The MHRT discharged MO's section.

3.15 Newham council gave MO bed and breakfast accommodation when he left St Ann's Hospital on 25 July 2006. However, within a few days he was moved to different accommodation after complaining that "*some people*" had been "*spraying something*" on his door. In the following weeks MO had to be moved again on a number of occasions, including once when he was involved in an argument with a neighbour and once when he set fire to curtains because the hostel manager would not give him a different room.

3.16 Following a request from the HPU, the SE CMHT saw and assessed MO on 7 August 2006. The SE CMHT offered him a follow-up appointment for the end of August but before that date MO left his accommodation and travelled to Ireland.

3.17 He went first to Dublin where he stayed at a refugee reception centre. He exhibited signs of paranoia and was seen by a GP who prescribed medication. On 10 October 2006 he assaulted a fellow resident at the reception centre by punching him in the mouth and threatening him with a knife. As a result MO was detained in hospital under Irish mental health legislation until 31 October 2006.

3.18 At the beginning of November 2006 MO travelled to Belfast where police detained him for slapping a woman on a train. From Belfast he travelled to Stranraer where social services gave him emergency accommodation and assessed him as fit to travel. He was put on a train to travel back to London. Police files show that during his journey he assaulted a deaf man on a train travelling to Sheffield. The victim did not want to pursue the matter with the police.

3.19 On 15 November 2006, almost immediately after he arrived back in London, MO was arrested for punching a passenger on a bus and charged with assault. He appeared at the magistrates' court on 17 November and was bailed until 7 December.

3.20 On 30 November 2006 MO visited a housing options centre in Lewisham in order to find accommodation. He smashed a window and police detained him.

3.21 MO went to the A&E department at Whipps Cross Hospital on the evening of 2 December 2006 and was assessed by a psychiatrist. MO was thought to have persecutory delusions and delusions of reference. He was transferred to Naseberry court, an acute psychiatric unit that is part of the North East London NHS Foundation Trust.

3.22 In the morning of 3 December 2006 MO demanded to go home. He was seen by the duty doctor who concluded that MO was not sectionable under the Mental Health Act 1983. MO discharged himself against medical advice.

3.23 On 4 December 2006 MO went to the HPU and was offered emergency accommodation at the Metropolitan hostel in Hackney. An appointment was made for an assessment officer to interview MO at the HPU on Friday 8 December. MO failed to attend. The assessment officer who was to have seen MO agreed with his principle officer that they would extend MO's booking at the Metropolitan hostel over the weekend until 11 December. On that day the HPU extended MO's booking at the Metropolitan hostel indefinitely.

3.24 MO was arrested on 12 December for possessing a knife. He was held in custody and seen by a FME who said he was not fit to be interviewed. A few hours later, however, police did interview him. He was charged and he appeared before magistrates the next day. The case was adjourned and MO was released.

3.25 On 19 December 2006 MO went to the HPU saying that his neighbours were spying on him and attacking him. After discussions between the HPU duty manager and the manager of the Metropolitan hostel, MO was told he would not be given another room. He became abusive and left the HPU offices.

3.26 On 20 December MO fatally stabbed Camille Remy at the Metropolitan hostel. Camille Remy was a French student who had recently travelled to England. She was staying at the Metropolitan hostel and had booked through a company specialising in accommodation for foreign students.

3.27 MO's case presented particular problems to the services that had contact with him. He is an intelligent man, able for a period to mask his symptoms. He has periods of lucidity. English is not his first language. He was homeless and did not have a family or other network that could have helped with his diagnosis and care. Above all, no one service or practitioner had the chance to observe MO over an extended period nor were they able to build up a full picture of his mental health.

3.28 We find a number of weaknesses relating to the management and procedures of the services that had most contact with MO. These include the fact that the staff of both the ELC NHS trust and the BEH NHS trust had to contend with challenging workloads and this may have affected patient care. They had no formal opportunity to reflect as teams on their practice and patient care. There were weaknesses in information sharing and record-keeping.

3.29 We also find that in dealing with MO the staff of the SE CMHT and the BEH NHS trust did not implement the care programme approach (CPA) appropriately and did not undertake proper risk assessments. This meant that they missed the opportunity to build up as full a picture as possible of MO's mental state and to devise appropriate care plans for him.

3.31 Opportunities were missed to assess MO and to devise better care for him. However, given the nature of MO's illness and the circumstances of his contacts with services we cannot say that the killing of Camille Remy could have been avoided.

Recommendations

R1 The ELC NHS trust should keep the staffing levels of the SE CMHT under review to ensure that casework pressures do not adversely influence the way patients are managed and to ensure that individual caseloads are manageable and allow staff to fulfil all their professional obligations, including record-keeping, satisfactorily.

R2 The SE CMHT should consider holding regular team meetings to discuss and review individual case-handling and any issues and lessons arising.

R3 ELC NHS trust should review the effectiveness of its arrangements for ensuring and verifying that consultants appropriately fulfil their responsibilities for supervising and appraising other medical staff.

R4 ELC NHS trust should ensure that all staff with responsibility for the care of patients are subject to compulsory and ongoing training in risk assessment and risk management.

R5 ELC NHS trust should amend its clinical risk assessment and management policy to set out the requirement for training of the kind recommended in recommendation 4 above.

R6 BEH NHS trust should keep the patient numbers of individual medical staff under review to ensure that they are at all times manageable and allow staff to fulfil their professional obligations, including allowing them to have an appropriate grasp of the issues relating to their patients.

R7 BEH NHS trust should keep the occupancy rates of its wards to the levels recommended by the Royal College of Psychiatrists and other professional bodies in order to ensure a safe environment.

R8 BEH NHS trust should ensure that staff have regular planned opportunities for in depth consideration of and reflection on issues and challenges relating to their professional practices and the care of individual patients.

R9 BEH NHS trust should devise a system for ensuring that each patient has a named nurse who is available to:

- provide comprehensive nurse assessment
- share and communicate that assessment appropriately
- ensure appropriate nursing care planning and management.

R10 Where the named nurse is not available for a significant time or is unable to fulfil the requirements referred to at recommendation 9 above, another named or associate nurse should be appointed.

R11 The BEH NHS trust should continue to monitor the implementation of the internal inquiry recommendations with regard to the need for compulsory and continuing training in risk assessment and risk management.

R12 Newham council's housing services should develop a multi-agency memorandum of understanding setting out the terms on which they can share information about clients thought to pose a risk to themselves or others with other relevant agencies and bodies, (including landlords), so that appropriate CPA and risk management plans for such clients can be devised and delivered.

R13 The HPU should develop a process under which a pivotal person or persons within the HPU ensures on an ongoing basis that relevant information about clients' mental health needs is gathered and reported back (in accordance with the suggested memorandum of understanding) to CMHTs, and any other relevant agency, as well as to Newham's accommodation team and other staff in Newham council's housing services.

R14 In discussion with the CMHTs, Newham's housing department should review the risk documentation that it receives in respect of clients with mental health needs to ensure that it encompasses and focuses on relevant housing issues, including:

- the suitability of certain types of accommodation
- risks that the client might pose to housing workers, landlords, their employees and other tenants
- the oversight or other input to the client's care plan that is required from housing workers
- the need to share information.

R15 The HPU should amend its '*procedure for mental health clients*' document to require that the risks relating to housing a client are reassessed in the event of a significant change in the client's circumstances, such as a period in hospital, or a lengthy unexplained absence.

R16 The ELC NHS trust should ensure that all staff caring for patients undertake robust care planning in line with current policy and best practice in relation to the care programme approach, which includes risk assessment and risk management, and that they understand where responsibility for such assessments and plans lies.

R17 The ELC NHS trust should amend its clinical risk assessment and risk management policy to reflect the fact that the risk assessment and management process begins the moment a person is first assessed and not merely when they are registered for CPA or are deemed to be receiving specialist mental health care.

R18 Adherence to the requirement for proper CPA planning (see recommendation 16 above) and the need to begin risk assessment and risk management from the time a person is first assessed by services (see recommendation 17 above) should be monitored through

regular audits undertaken as indicated in the ELC NHS trust's response to the internal investigation.

R19 The ELC NHS trust should continue to monitor the implementation of the internal investigation recommendations in relation to patient discharge.

R20 The BEH NHS trust should ensure that risk assessments and risk management plans are discussed in multidisciplinary team meetings so that all professions can contribute relevant information and understand any plans devised.

R21 North East London Mental Health Foundation Trust should ensure that medical staff carry out a physical examination on patients as part of the admission procedure.

R22 ELC NHS trust, BEH NHS trust and the HPU should remind all staff of the need to keep a full record of the contacts that they have with a patient and all significant discussions that they have in relation to a patient.

R23 BEH NHS trust should ensure that staff required to prepare reports or give evidence before a MHRT are informed immediately of any application to the MHRT and of any date fixed for a MHRT hearing so they can prepare for the hearing.

R24 BEH NHS trust should ensure that trust staff required to prepare reports or give evidence to a MHRT are adequately:

- trained
- supervised
- supported
- updated on new developments

in relation to the practice and procedure of the MHRT, report writing for the MHRT and presenting evidence and argument to the MHRT.

Part 1 - background information

4. The method the investigation team used

4.1 NHS London commissioned Verita, a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations, to undertake the independent investigation.

4.2 The investigation team consisted of Kate Lampard and Chris Brougham. Kate Lampard is qualified as a barrister and is former chair of Kent and Medway Health Authority and of Invicta Community Care NHS Trust. Chris Brougham was a nurse and has held senior management positions in the National Health Service and the National Patient Safety Agency. Dr Jayanth Srinivas, a consultant forensic psychiatrist at the Hatherton centre in Stafford, provided professional advice.

4.3 The investigation team worked in private and gathered documentation and written evidence from East London NHS Foundation Trust (ELC NHS trust), Barnet, Enfield and Haringey Mental Health NHS Trust (BEH NHS trust), North East London NHS Foundation Trust, Newham council's housing services, the British Transport Police, the Metropolitan Police, Whipps Cross University Hospital NHS Trust, North Middlesex University Hospital NHS Trust and Dumfries and Galloway council's social services department. We also interviewed staff from these organisations. Good practice was adhered to by, for example, offering interviewees the opportunity to be accompanied to their interviews and to comment on the factual accuracy of transcripts of their interviews.

4.4 We have analysed the evidence received and made findings and recommendations based on our interviews and the information available to us.

4.5 It was intended that the independent investigation would build on the internal investigation, not replicate it. However the quality of the interview transcripts from the internal investigation was poor and they did not provide a reliable or complete record. This meant that we had to interview some people who had already been interviewed for the internal investigation in order to obtain a full and accurate record of their evidence. Our

findings sometimes overlap with those of the internal one.

4.6 Our findings from interviews and documents are set out in ordinary text. Comments, opinions and explanations are in bold italics. Quotations from interviews and evidence are written in italics and indented.

4.7 We have reviewed the trusts' internal investigation report and the progress that ELC NHS trust and BEH NHS trust have made in implementing the action plans arising from it. We comment at relevant points throughout this report on the progress the trusts made. We attach a full copy of the trusts' action plans in appendices A and B.

5. The services that had contact with MO

5.1 Between October 2005 and 20 December 2006, when he killed Camille Remy, MO was in contact with many separate public service organisations. These included a number of different NHS trusts, police forces, and local authority social services and housing departments. As we describe in the chronology in chapter 7, most of these organisations had only brief contact with MO, but three of them, East London and the City Mental Health NHS Trust; (ELC NHS trust) Barnet, Enfield and Haringey Mental Health NHS Trust (BEH MHT); and Newham council's homeless persons unit (HPU), dealt with MO over a longer period. In this chapter we give relevant background information about them.

South East Newham community mental health team of East London and City NHS Foundation Trust (ELC NHS trust)

5.2 ELC NHS trust's operational policy for community mental health teams (CMHTs) was drafted in September 2005 and revised and amended in April 2006. Under the policy the CMHTs provide a service for adults with mental health problems and of working age, normally 18 to 65 years.

5.3 Paragraph 2.3 of the operational policy states:

> *" People requiring treatment, care and monitoring may include the following:*
> *1. Severe and persistent mental disorders often associated with significant disability and poor quality of life, predominantly psychotic disorders.*
> *2. Longer term conditions of lesser severity but which are characterised by poor treatment adherence or requiring proactive follow up.*
> *3. Any disorders where there is significant risk of self harm or harm to others or where the level of support required exceeds that which primary services are able to provide.*
> *4. Disorders requiring skilled or intensive treatments not available in primary care.*
> *5. Complex problems of management of engagement such as presented by service users requiring interventions under the Mental Health Act.*
> *6. Severe personality disorders where there has been shown to be benefit by continual contact and support."*

5.4 ELC NHS trust set up the CMHT that serves the south east region of the London Borough of Newham (the SE CMHT) in 2004. The SE CMHT serves patients from the 12 GP practices in its catchment area. It is based at Passmore Edwards building, Shrewsbury Road, Forest Gate, London E7 8QR. The SE CMHT is made up of four community psychiatric nurses (CPNs), including CPN 1 who had contact with MO, four social workers, a senior practitioner social worker, a clinical nurse lead, an occupational therapist, a psychologist, a support worker, and a clinical nurse lead. The team manager CA, a registered mental nurse (RMN).

5.5 Medical input to the SE CMHT is provided by two consultant psychiatrists who act as the responsible medical officers (RMOs) for the team's patients, the consultants' two senior house officers (SHOs), who work part-time for the CMHT, and two associate specialist psychiatrists. Patients are allocated to one of the consultant-led sub-teams of the SE CMHT according to which GP practice they are registered with.

5.6 The SE CMHT's team manager told us that the team's consultants were contracted to work two sessions per week with the team, and spend the rest of their time dealing with ELC NHS trust's inpatient service users. She told us that the consultants attended the SE CMHT each Thursday afternoon for a clinical multidisciplinary team meeting when all cases open for assessment were discussed. They attended for a further session for care programme approach (CPA) meetings and medical reviews of patients who had been allocated to a care coordinator.

5.7 Whatever the practical arrangements for consultants to attend to CMHT work, the ELC NHS trust's operational policy for community mental health teams in fact states that the consultants will undertake a further session on a flexible basis for "*clinical reviews as required,1:1 meetings with care coordinators, senior nurses/[social worker] and CMHT manager, admin work*".

5.8 Throughout the time that MO was in contact with the SE CMHT, the consultant responsible for him was Dr F and the associate specialist was Dr G. SE CMHT staff told the investigation team that Dr F had chosen to spend more of his time at their offices than the contracted two sessions. Dr G described Dr F as there "*most of the time*". Dr F left the ELC NHS trust during 2007. We believe he returned to Spain, his native country, but it has not been possible to trace him and he has not given evidence to us. Dr G is still with the SE CMHT.

Referral and assessment

5.9 The SE CMHT screen any referrals to the service. Some patients are taken on for assessment, while others may be referred to psychological treatments the team cannot provide. Patients not taken on for assessment by the SE CMHT can be seen as outpatients at the clinics the team's two associate specialist psychiatrists run for the ELC NHS trust. These clinics are held at a health centre in Canning Town and in the Shrewsbury clinic in the building next to the one the SE CMHT occupies.

5.10 Paragraph 11 of the operational policy states:

> *"11.1...all referrals thought to require an assessment by CMHT will be discussed at the weekly allocation meeting.*
> *11.2 Referrals for assessment will be allocated to a worker, who will take a lead on the assessment, and another worker will be identified to jointly assess.*
> *...*
> *11.6 Users who do not meet the criteria for CPA will be referred to other services or will be passed back to the original referrer. Any advice or recommendation as to the future action will be clearly documented and feedback will be given to professional referrers. All decisions will be reviewed if additional information comes to light that informs the risk assessment."*

Northumberland ward at St Ann's Hospital

5.11 Between 10 July and 25 July 2006 MO was an inpatient on Northumberland ward, St Ann's Hospital in St Ann's Road, London N15 3TH. The hospital is part of BEH NHS trust. We understand that Northumberland ward was set up in about May 2005. At the time that MO was an inpatient there were three consultants on the ward and each had responsibility for a different part of the trust's catchment area. Each consultant also had responsibility for providing medical input to the CMHT for their patch.

5.12 In about May 2006 Dr L, the consultant with responsibility for the Tottenham area went on long-term sick leave. In June 2006 Dr V, who covered the Hornsey and Highgate area, agreed that he would give up most of his community work for that area and take on Dr L's

Tottenham inpatient and community workload. Dr V was assisted in dealing with that Tottenham area workload by Dr N, a trust grade senior house officer (SHO), and another part time SHO. As the consultant responsible for patients from the Tottenham area, Dr V became the RMO for MO.

5.13 Dr V told us that he used to spend Tuesdays doing an all-day ward round at St Ann's Hospital and would then visit the ward again either on a Thursday or a Friday, sometimes both. At other times Dr V dealt with community patients. On Monday mornings he and Dr N attended a meeting of the Tottenham area CMHT.

5.14 In July 2005 SA was appointed temporary ward manager of Northumberland ward, a post he held until October 2006. Two charge nurses worked under SA. He told the investigation team that the ward had been without a manager for quite some time before he joined and there had been many staff changes. Sickness among staff was high. We were also told that although Northumberland ward was a 19 or 20-bed unit, it had about 28 patients while MO was there, and some patients had to "*sleep out*" on home leave.

5.15 In autumn 2006, Northumberland ward was moved into specially refurbished premises in the main St Ann's Hospital building. At the same time BEH NHS trust restructured its patient care and staffing so that all the patients on the ward were under the care of one consultant.

Newham council's homeless persons unit

5.16 At the time that MO was first provided with accommodation by Newham council, the provision of accommodation was managed through what was known as the homeless persons unit (HPU). The HPU was responsible for assessing whether the council had an obligation under the Housing Act 1996 as amended to accommodate individual applicants for housing. In March 2006 the council merged its homelessness response service with its homelessness prevention and advice service and the HPU became part of a larger service team called the housing options service. We refer to it throughout this report as the HPU. Its offices have always been at 3 Pragel Street, Plaistow, London E13 9HB.

5.17 Newham council's obligation to accommodate an applicant arises if he or she is

eligible, in terms of their immigration and financial status, and has a priority need such as dependent children or is deemed vulnerable because, for example, they have mental health problems.

5.18 Newham council's housing staff explained to us that an applicant who appeared to be entitled to accommodation would be offered emergency bed and breakfast accommodation while their application was investigated and assessed. Where an applicant is eligible for emergency bed and breakfast accommodation but has a vulnerability, such as mental health problems, which makes it inappropriate for them to share facilities, they can be offered a self-contained studio or small flat. Once it has been determined that an applicant meets the criteria for being housed by the council, they can be offered long-term temporary accommodation. We were told that in Newham, where demand for local authority housing is the highest in London, it can take many weeks for such accommodation to become available. Once in temporary accommodation, the tenant can apply for permanent accommodation as it becomes available.

5.19 The process of finding suitable emergency and temporary accommodation for a particular applicant and managing the letting process is undertaken by Newham council's accommodation team. That team is housed in separate premises from the HPU.

5.20 In the period up to March 2006, when the HPU combined with the homelessness advice and prevention service, the HPU staff was divided into a number of teams each under its own team leader. One of the team leaders, AC, acted as the mental health coordinator. She had particular experience of dealing with mental health issues and took responsibility for liaising with local mental health services. Other members of the HPU staff would refer mental health queries and assessment matters to her. After the housing options service was set up the number of teams in the service reduced to two - one dealing with homelessness prevention and advice and the other with the assessment of homelessness. The role of mental health care coordinator was taken on by MT who is also a homeless assessment officer and AC remained as a team leader.

5.21 Newham council's "*HPU casework procedure manual*" refers to mental health under paragraph 2.9. That paragraph states:

"For the purposes of sec189 (1)c Part VII of the Housing Act 1996, a person is considered vulnerable if s/he has long and enduring mental illness and has no accommodation s/he is entitled to occupy.

Newham homeless persons unit will require the following information before accepting referrals from hospitals.

1 The reason s/he was admitted to hospital. Was s/he sectioned-Formal or Informal.

2 Length of time spent in hospital.

3 Reason why s/he cannot return to their accommodation...

...

5 Nature and extent of illness which may render the applicant vulnerable.

...

7 Has the patient been referred to any of the community mental health teams?

...

10 If the patient is known to be violent, has a risk assessment been carried out?

..."

5.22 In October 2006 Newham council adopted a new procedure for mental health clients. It states:

"All clients who approach as homeless following discharge from hospital have to provide the following:

1 Risk Assessment/Care Plan

2 Vulnerability Assessment

...

It is imperative that a risk assessment is provided so we can determine whether a client is a risk to others in terms of violence, aggression or at risk to themselves i.e. self harm, suicidal tendencies. We need to be satisfied that our other clients will not be at risk from mental health clients placed in bed and breakfast accommodation.

The same applies if applicant has been referred by local service centre/community mental health teams

...

Where possible all cases should be allocated to mental health coordinator.

...

All cases where clients have stated mental health issues an appointment will need to be made with the community mental health for a vulnerability assessment to be carried out."

6. MO's personal history

6.1 Our only available source of information about MO's personal history before May 2001 is what he told the various agencies with which he had contact after that time. The accounts are not consistent. The facts that appear most regularly in them are that he was born on 8 December 1975 in Somalia, he has a number of brothers and sisters, his father was killed during the war in Somalia and MO and other members of his family fled Somalia to Ethiopia. MO has said he was married in Somalia and had two children, but he was divorced and his children live with their mother in Ethiopia. At some stage MO travelled to France where he said he obtained a university degree. MO has also said that he has brothers and sisters living in France but his mother still lives in Ethiopia. MO has spoken of chewing significant quantities of khat, the leaves of a shrub that acts as a stimulant, over a number of years.

6.2 According to the chronology the police compiled during their investigation into the killing of Camille Remy, on 22 May 2001 MO attended at the Home Office's immigration centre in Croydon to claim political asylum. During an interview with Home Office officials on 20 June 2001 he said he had arrived in the UK on 16 May 2001. The police reports state that on 26 June 2001 MO's asylum application was refused but on 28 June 2001 he was granted exceptional leave to remain in the UK valid until 28 June 2005.

6.3 We do not know for certain what MO's immigration status was after 28 June 2005. MO told the SE CMHT that in or about August 2005 he had been granted indefinite leave to remain in the UK. In any event, on 19 October 2007, the judge who ordered him to be detained under section 37 Mental Health Act 1983 for the killing of Camille Remy also recommended that MO should be deported at the appropriate time.

6.4 MO told the mental health services that dealt with him from autumn 2005 that once in the UK he had made contacts and friends within the Somali community in London. He said he had found work in a warehouse and as a teaching assistant for a homework project for the Somali community in Newham. He had lived in a studio flat but when he could no longer afford the rent he had moved into a hostel.

7. Chronology of MO's contact with services

October 2005 to 23 June 2006

7.1 At the beginning of October 2005 MO was living at Anchor House, a homeless person's hostel in Barking Road, London E16.

7.2 On 3 October MO was arrested for affray at Anchor House. He had tried to force his way into the room of a fellow resident and had then chased the other resident along a corridor armed with a knife. MO was detained overnight at Newham police station. The police detention log shows that MO claimed that the reason for the disturbance was that his fellow resident "*had attempted to implant 'probes' into [MO's] nose*". MO also claimed that Anchor House was full of cameras that were being used to monitor him.

7.3 Forensic medical examiners (FMEs) saw MO twice during his detention at Newham police station. At 11.55pm on 3 October 2005 he was seen by Dr T. The detention record shows that Dr T told police he believed that MO was suffering from "*some kind of mental illness*" and needed to be referred to his doctor when the police investigation finished. Dr T noted on the forensic examination form kept as part of the police records that MO was fit to be detained but not fit to be interviewed at that time. We contacted Dr T by telephone and wrote to him requesting an interview but he did not make himself available.

7.4 MO was examined again at about 8.00am on 4 October 2005, this time by Dr R. She told us that her notes of her interview with MO show she had found nothing to indicate mental illness in MO. Dr R noted on the forensic examination form that MO was fit to be detained and fit to be interviewed.

7.5 The police interviewed MO on 4 October 2005 and released him with a caution.

7.6 On 5 October 2005 MO presented at the offices of the SE CMHT at Shrewsbury Road, Newham. MO was seen first by CPN 1, a CPN who was the duty worker that day, and then by CPN 1 and Dr G, associate specialist with the SE CMHT. Both CPN 1 and Dr G recalled that MO had claimed that the police had told him to go to the SE CMHT to get help. MO had had a letter with him with a police heading which did not identify any particular police station.

Neither CPN 1 nor Dr G could remember what the letter said. MO took it away with him. No one at the SE CMHT photocopied it.

7.7 CPN 1's note of the interview with MO on 5 October 2005 sets out a few details of MO's personal history and also records that MO:

> *"Feels paranoid and believes this started when the relationship with his girlfriend-a married woman-ended. Denies any illicit drug/alcohol use and admits to chewing khat during weekends only approximately £10 only..."*

7.8 She also noted the fact that MO's communication in English *"was not clear"* and that she and Dr G had agreed that they would see MO again on 10 October with a French speaking interpreter. In the referral information document CPN 1 completed on 5 October 2005 she recorded:

> *"States he was involved in an incident at the hotel he has been living at ...chased another resident with a knife. Thought the person wanted to harm him. Taken to police station and cautioned. Now homeless. Has no history of mental illness...states that he has not slept [for] past 3 weeks. Keeps himself awake drinking lots of coffee, this is because he fears to be attacked by others*
> *Would like to see Doctor to find out whether there is something wrong with him.*
> *Fearful of his actions and reactions.*
> *Does not consider himself a risk to others at the moment."*

7.9 CPN 1 told us that during the interview on 5 October MO:

> *"...was quite guarded in the way he presented, it was very difficult to get any information from him, he wasn't forthcoming. When he presented the letter and then we started asking questions he spoke a lot but he said nothing"*.

7.10 CPN 1 explained that she and Dr G had not been able to make up their minds about whether MO was suffering from a mental illness. They doubted that the police had told MO to present to the CMHT rather than follow the usual course of having him assessed and referred to services via an FME. CPN 1 told us that at that stage she had believed that MO had probably

presented in order to get his social rather than his mental health needs addressed.

7.11 Later on 5 October 2005 MO went to the offices of the HPU at Pragel Street in Newham. He told the duty worker there he had been "*evicted*" from his accommodation. He also appears to have told the duty worker about his appointment with the SE CMHT scheduled for 10 October 2005. The duty worker spoke on the telephone with the manager of Anchor House who told him about the incident in which MO had chased a fellow resident with a knife. The manager said that as a result of that incident MO's licence agreement at Anchor House had had to be terminated. The duty worker's hand-written note of the conversation with the manager of Anchor House records the manager as having said:

> *"The behaviour was totally out of character. He is not known with [sic] such behaviour. But it is not tenable for him to continue his stay at the hostel."*

7.12 The note also records:

> *"12ins knife being used. He was slightly agitated"*

7.13 The duty worker discussed MO's case with his manager and they agreed that MO appeared to have some mental health problems and they would need a vulnerability report from the SE CMHT before they could consider offering him accommodation. They advised MO to keep his appointment with the SE CMHT and in the meantime they referred MO to a night shelter.

7.14 MO was late for the interview with the SE CMHT on 10 October 2005. The interpreter had left by the time he arrived. The interview was rearranged for 12 October. MO attended at the CMHT on 12 October but no interpreter was available. CPN 1 noted in the contact record that MO had told her that he was sleeping on the streets, going to the mosque to get food and attending college twice a week. He spoke about having difficulty sleeping, paranoid ideas and low mood. CPN 1 also noted that MO was to be given a vulnerability assessment report to present to the HPU in support of his housing application and that a further appointment would be made for him to be seen with an interpreter.

7.15 The vulnerability report CPN 1 compiled for MO at this time was dated 13 October

2005 and is on the HPU's standard form. CPN 1 made reference on the form to the incident that had led to the termination of MO's licence at Anchor House, including the fact that it had involved MO using a knife. CPN 1 assessed MO as vulnerable for the purposes of the Housing Act 1996. She gave the following reasons:

> *"MO has suffered several losses ...this has led him to becoming low in mood (depressed) and having paranoid thoughts. Although he is not an allocated case to this team, his mental state is being monitored and he is required to attend this office. His current situation is affecting his depressive/paranoid mental state"*.

7.16 CPN 1 recommended that local accommodation would be preferable because MO had connections in the area.

7.17 On 13 October 2005 MO returned to the HPU with the vulnerability report. The duty senior officer who dealt with MO's case that day decided to contact CPN 1 to ask her to provide more information about the psychiatric assessment of MO's mental health and a risk assessment that clearly stated whether or not MO posed a risk to himself or others. CPN 1 was not available on the telephone and a message was left for her to ring back. In the meantime the duty senior officer authorised accommodation for MO for seven days in self-contained annex accommodation "*for his/others safety*". The caseworker who undertook to find the accommodation made a file note which states *"Having considered this applicants circumstances the nearest most suitable accommodation available from the list of vacancies today is 73 Fairlop Road, E11... [MO] agreed to accept the offer of interim accommodation"*. Fairlop Road is in Leytonstone, outside the borough of Newham.

7.18 It appears that the booking at Fairlop Road was extended on 20 October and then again on 26 October and 3 November 2005 because the HPU had received no further assessment of MO. A note in the HPU file for 3 November suggests that a member of HPU staff was to pursue the CMHT to provide the assessment sought but no note appears in the CMHT file of any request for CPN 1 to ring the HPU at this time or for the SE CMHT to provide a further assessment of MO. There is no evidence that the SE CMHT gave the HPU any further assessment of MO's mental health or the risks that he posed to himself or others. On 11 November 2005 MO's booking for his accommodation was extended "*indefinitely*".

7.19 It appears from the SE CMHT file that an interpreter was booked for an interview with MO scheduled to take place on 24 October. There is no entry in the contact record about that meeting. However, given the further details about MO in the full needs assessment and the discharge letter that CPN 1 subsequently prepared, including the fact that Dr G had prescribed the antidepressant Citalopram for MO at about this time, it seems likely that he and CPN 1 did conduct a further interview with MO on 24 October 2005.

7.20 CPN 1 completed ELC NHS trust's standard full needs assessment form for MO at the end of October 2005. CA, the SE CMHT manager, told us that there was no requirement to complete such a form because MO was still only being assessed and had not been accepted for treatment under the CPA. The form that CPN 1 completed is dated 28 October 2008. In it she records what she knew of MO's history at that time, including, under the section headed 'contact with police':

> *"Taken to police station and released with a caution, following an incident at the hotel he was living at. The incident was that he chased another resident along the hotel corridor with a 12 inch knife."*

7.21 In completing the form CPN 1 did not indicate any identified needs or the need for any further assessments.

7.22 Under the section headed 'thought content', CPN 1 recorded that MO:

> *"...thinks he talks to himself when sitting alone, hence people are running away from him because of his mental problem. The Somali community have no respect for him. When outdoors thinks he is hearing voices talking to him when nobody is around. Believes these problems are due to stress and being away from his country".*

7.23 Under the section headed 'service user views of mental health state', CPN 1 noted: *"Believes he is depressed and needs help"*. In respect of MO's drug use CPN 1 recorded: *"Denies use of illicit drugs. Admits to chewing Khat on a daily basis for 4 years and for past 1.5 months only uses it sporadically"*. The section for recording a care plan notes:

"1. To start to commence citalopram 20mg mane

2. To follow up at the outpatient clinic

3. Case to be closed to the CMHT"

7.24 On 28 October 2005 the senior practitioner with the SE CMHT noted in the contact record that the case of MO had been closed to the SE CMHT. On the same day Dr G wrote a discharge letter to MO's GP, Dr B referring to the incident on 3 October 2005 at Anchor House as well as to MO's accommodation arrangements, his history and family background. Under the heading 'mental state examination', Dr G stated that MO was: *"low in mood, mildly depressed, difficult to assess, as his command of English is poor"*. Dr G also stated in relation to thought content*:*

> *"Depressive themes in terms of negative cognitions, lack of confidence and low self esteem. No suicidal ideation or homicidal ideas could be elicited. No psychotic psychopathology could be elicited. Intact cognitive functions and good insight."*

7.25 Dr G concluded his letter by saying:

> *"In terms of the paranoid symptoms he has expressed on a few occasions, I feel that they were Khat related."*

7.26 Dr G also set out the care plan referred to under paragraph 7.23 above.

7.27 Dr G, CPN 1 and CA told us that the decision to close MO's case to the SE CMHT and for him to be followed up merely by appointments with an SHO in the outpatients' clinic would have been discussed and agreed by them and the SE CMHT consultant Dr F as a multidisciplinary team. This discussion does not appear to have happened in any formal meeting. CPN 1 told us:

> *"These are people who are on assessment, not people who are allocated* [for care under CPA to a care coordinator]. *In an allocated case it would be a formal meeting, but this is...just an assessment"*.

7.28 Dr G suggested that the decision to close the case would have been discussed in the SE CMHT's Thursday afternoon clinical meeting. In any event there is no record on file of the parties involved in that decision, or the terms of their discussions about it.

7.29 In a letter dated 7 November 2005, Dr B, the GP to whom Dr G had addressed the discharge letter of 28 October, told MO that he would have to find another doctor because he was now living outside the GP's catchment area.

7.30 On 14 November 2005, MO reported to police at Plaistow police station that he had been drugged and raped on the night of 5 October 2005. MO suggested that the alleged suspect was connected with a man called BB, a Somalian whose brother had been in dispute with MO's brother in Somalia. MO also alleged to the police that members of Mr BB's 'gang' followed him wherever he went and had members living in the property occupied by MO at Fairlop Road. MO said during subsequent interviews with police that he had received treatment from the SE CMHT.

7.31 On 21 November 2005 Plaistow police referred MO to the SE CMHT with his consent. It appears that CPN 1 and Dr G saw MO later that day. Dr G's typed note of the interview shows that MO repeated the allegations that he had made to Plaistow police. Dr G also recorded:

> *"It seems that he is also hearing voices...*
> *He said that he has not used Khat for nearly 45 days. He was distressed by the whole experience and tearful.*
> *When asked about how he knew about the rape. His answer was suggestive of delusional misinterpretation....He also believes that some police officers are colluding with the persecutor...*
> *He has not been eating properly due to the persecutory delusional beliefs.*
> *He denied experiencing either suicidal or homicidal thoughts.*
> *Plan:*
> *Commence Aripiprazole 10mg mane and should continue on citalopram 20mg od."*

7.32 CPN 1 also noted that MO needed to be registered with a GP and needed help applying for a Freedom bus pass. On 28 November CPN 1 saw MO and helped him to complete his application.

7.33 An HPU file note shows that AC, the mental health coordinator for the HPU, considered MO's case on 2 December 2005. She noted her agreement that MO was vulnerable and therefore entitled to be housed by Newham council and that he needed to be given low-rise accommodation. In a separate file note she wrote "*2 officers to visit at all times*". AC told us:

> "*The reason I put that is accommodation officers had to go and visit them and they didn't have much information, they didn't have access to the vulnerability report, they wouldn't know what to look for so, for safety reasons I would put down that two officers should really visit, just in case.*"

7.34 On 5 December the HPU formally accepted a duty to provide MO with accommodation under the Housing Act 1996 as amended by the Homelessness Act 2002.

7.35 Dr G and CPN 1 together with a French speaking interpreter saw MO again on 5 December 2005. Dr G's note of that meeting says:

> "*[MO] said he was compliant with the prescribed psychotropic medication. Complained of feeling slow and drowsy at times.*
> *He admitted chewing Khat 10 days ago following his last appointment with us. He appeared more cheerful and relaxed. There has not been a significant change in his mental state....*
> *Plan:*
> *To continue on Citalopram 20 mg od and Aripiprazole 30 mg mane*
> *To be reviewed in two weeks time.*"

7.36 CPN 1 telephoned MO on 12 December 2005 to give him the contact details for GP2, a GP who was taking on patients in Leytonstone.

7.37 Dr G and CPN 1 saw MO again, in the presence of an interpreter, on 19 December 2005. Dr G's note of the meeting records that MO was preoccupied by paranoid delusions and police investigations of his allegations but his paranoia appeared to be lessening. Dr G prescribed the same medication as before. During the meeting MO also told Dr G and CPN 1 that he had an appointment arranged for the next day with the GP CPN 1 had suggested. We

found no evidence that MO saw a GP on 20 December and it was not until 4 January 2006 that MO was registered with GP3, a GP with a separate practice but occupying the same building as GP2.

7.38 On 11 January 2006 the management at Fairlop Road hotel cancelled MO's licence to occupy interim accommodation there because other residents said he had been causing fights. MO denied the allegations and the HPU were able to negotiate the continuation of his licence.

7.39 On 7 February 2006 MO went to see the GP, GP3. MO was first seen by a nurse who recorded a family history of depression and diabetes. MO asked GP3 for an HIV test. GP3 also gave MO a blood test. All results were normal. GP3 noted that MO was taking aripiprazade and citalopram but he did not detect signs of depression or psychosis.

7.40 On 21 February CPN 1 contacted MO to arrange for him to attend an interview with the SE CMHT. On the same day she completed a CPA registration form for MO. CPN 1 explained to us that this meant that MO was officially allocated or taken on as a patient. However she said she had taken this step only in order to comply with the ELC NHS trust's requirement that all patients are treated under CPA within three months of the beginning of the assessment process. We have found no reference in the CPA policy to the three-month standard. CPN 1 told us she had not made arrangements to draw up a CPA plan at the time because she had not been sure that MO should be taken on as a patient. She said that in this respect she had been "*influenced by the fact that we were still assessing*".

7.41 CPN 1 saw MO on 28 February 2006. At that meeting she told MO that she wanted to complete some forms for his file but according to her note, MO told her:

> "*...he did not want further input from the CMHT. Believes he is well and stopped taking medication [one] month ago and has been fine since.*"

7.42 MO told CPN 1 that he had stopped the medication because he had mistakenly taken an excessive dose of Aripiprazole. She asked MO if he would attend for one more appointment with Dr G and he agreed. The appointment was arranged for 22 March 2006.

7.43 On 1 March 2006 CPN 1 completed a risk checklist form for MO. She made entries

under the headings 'aggression/violence to others', 'substance misuse' and 'poor nutrition', but did not indicate whether these were current risks. She did, however, identify "*non-compliance with medication*" and "*disengagement from mental health services*" as current risks. Further, although she indicated on the form that she was "*lacking appropriate information or unable to fully assess for other reasons*", she answered "*no*" to the question "*Is a detailed risk assessment indicated?*" When asked about the apparent errors and omissions in the form she completed, CPN 1 told us that although the risk checklist form had been in use for some time, she and her colleagues had not been trained how to use it and found it confusing.

7.44 According to CPN 1's record of the meeting that took place on 22 March between herself, Dr G and MO:

> *"[MO] stated that he is fine, stopped taking medication 1 month ago and has been able to continue with his studies.*
> *Denies hearing voices or having paranoid thoughts, added that he has learnt to distinguish between his ideas about other people and reality....*
> *Believes he needs to get on with his life and does not wish to engage with the CMHT at this stage. Aware of what to do should he need help. He was offered outpatient follow up but he also refused as he does not intend to continue taking medication*
> *Stated he has stopped chewing khat since this has an impact on his mental health*
> *Plan:*
> *Close case to CMHT*
> *Letter to GP and consultant*
> *We agreed to close case to team."*

7.45 Dr G told us he had considered with MO the possibility of changing his medication to a depot Risperdal Consta or lower dose of Aripiprazole to see if it made MO less drowsy but MO was "*adamant*" that he would not continue with medication.

7.46 The SE CMHT staff told the investigation team that the decision to close MO's case would have been taken at an informal meeting between them to which the consultant Dr F would also have been a party. CPN 1 said the thinking behind the decision to discharge was that MO:

"...had by then moved out of the area and he decided that he wasn't going to have any treatment. But I think what swayed us, and it was very important, is that at that stage he was not sectionable."

7.47 Dr G confirmed that at the time he had not detected signs of paranoia, nor had MO appeared acutely psychotic. He told us:

"I felt he wasn't sectionable...he wasn't acutely psychotic...There wasn't much you can do at that stage"

and

"I offered him an outpatient appointment but he wasn't interested, so what we decided, there wasn't much we can do..."

7.48 On 3 April 2006 CPN 1 wrote a letter addressed to GP2, the GP who shared premises with GP3, MO's registered GP. She enclosed a copy of Dr G's discharge letter to MO's previous GP dated 28 October 2005, referred to in paragraph 7.24 above, and gave an update on the history of MO's involvement with the SE CMHT. She concluded by saying:

"In view of MO voicing that he will not engage with the services his case will now be closed to this team. He is aware of the self-referral procedure and has been advised to contact you in the event of needing CMHT help, since he is out of our catchment area."

7.49 On 4 April 2006 MO went to the A&E department of Whipps Cross Hospital complaining of a pain in his anus and that someone was trying to poison his food. He was seen by PLNA a psychiatric liaison nurse. PLNA made an appointment for him to return to the hospital the next day to be seen by a psychiatric SHO, but MO failed to keep that appointment. PLNA then wrote to MO's GP giving him a summary of his assessment of MO including his risk assessment. The summary stated that MO:

"...reported that a rich Somalian man BB has been using people to poison his food thus causing pain in the anus...He said that his brother and BB's brother were working

together…in Somalia. They were both…charged with stealing…His brother was set free but [BB's] brother was sent to prison and had subsequently died…As a result BB is using his wealth to pay other people to poison his food. He said BB does not want him dead but only wants to torture him."

7.50 The summary went on to state that MO had denied suicidal thoughts, intent or plans and that he posed no immediate threat to himself or others. Under the heading 'plan of care', PLNA noted that when he had phoned MO after his failure to attend for the appointment on 7 April 2006, MO had said that he was feeling fine and no longer believed that people were trying to poison him and he had rejected the suggestion of a further appointment. PLNA noted that the GP was to follow up and MO had been "*discharged from a psychiatric point of view*".

7.51 PLNA told us that:

> "*MO was lucid at the time…there was nothing to make me think it was necessary to alert the GP by phone at that point in time. He did not give me cause for great concern.*"
>
> "*He didn't seem psychotic-more suffering with paranoid ideas.*"

7.52 On 28 April 2006 a member of Newham council's housing department visited Fairlop Road and found that MO had removed the lock from the door to his accommodation there and that the door was kept open while MO was out. The staff member wrote in a file note that Veni properties, the agents who managed lettings on behalf of Newham council, had been made aware.

7.53 A note on the housing department's file shows that on 2 May 2006 an officer from Glasgow city council contacted the HPU to say that MO was at their offices making a housing application. On being told that MO had a live housing application with the HPU the officer in Glasgow agreed that she would direct MO back to the HPU. We have received no evidence about the circumstances of MO's trip to Glasgow.

7.54 On 8 May 2006 MO was given temporary accommodation at a ground-floor studio at 20

Howard Road, London N15, South Tottenham, outside the borough of Newham. MO immediately requested a review of the decision to re-house him at Howard Road. On his application form, which was written in French and translated, MO said he was seeking the review because "*over a hundred people*" were pursuing him day and night and that someone with a lot of money was trying to "*eliminate*" him, so he had asked not to be accommodated on a ground floor.

7.55 He also said he did not want to deal with Veni properties "*because some of the staff working for them have connections with my enemy. At the present time he already has a copy of my keys as well as his camera in my studio flat*". The medical assessment officer who considered the suitability of Howard Road as accommodation for MO noted that, given MO's mental health history, it would be best if he were placed "*where appropriate supervision can be given*" and that "*N15 might not be the best place for him given the nature of his previously established support*".

7.56 Newham council told MO on 30 June that his application for review had been successful and that the HPU would contact him as soon as they had found alternative accommodation.

7.57 On 29 May 2006 MO went to the A&E department of the North Middlesex Hospital. The handwritten notes of the doctor who saw MO on that occasion record:

> *"- Alleged to have been put to sleep by some kind of anaesthetic gas while in his room and believes to have been sexually abused*
> *-Now complaining of pain in anal region...*
> *Examination not done to avoid interference with forensic evidence*
> *Plan*
> *Patient has been advised to report matter to police"*

7.58 The letter subsequently sent to MO's GP states that the treatment given was "*advice only*" and MO had been discharged.

7.59 An inspector from Veni properties visited the property at Howard Road on 22 May 2006 and found it was dirty. The inspector visited the property again on 5 June 2006 and found