

HUNDREDFAMILIES CASE REVIEWS AND RELATED NEWS ARTICLES: EAST MIDLANDS

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1. Khalid Peshawan

Summary: In April, 2007 Khalid Peshawan, originally from Iraq, visits his GP complaining of low mood and anxiety stemming from a situation at work. He has suffered an injury and his employer is pressuring him to return. His GP prescribes Sertraline (Straline/Lustral/Zoloft) 50 mg with other meds. Two weeks later KP reports that the antidepressant is not helping so the GP doubles the dose. May 24 the dose is doubled again to 200 mg and Diazepam is added. KP's mood does not improve but he becomes suicidal and angry. He states that he is "worried that he might 'lose control and hurt his close friends'". Some time in the summer he drinks, almost hits a police cruiser, is verbally abusive and has his driving license revoked. By Oct, KP is not doing well. He has serious financial problems and he wants to return to work now but his employer refuses to allow him to, because of his medication. It appears the concern is about Diazepam. On Oct 1 he sees a Consultant Psychiatrist at the Trust and admits that he has suicidal thoughts. The psychiatrist decides KP needs to change antidepressants, and the plan is to add venlafaxine and wean KP off the sertraline. Zopiclone is added and the Diazepam continued. After this he breaches his Community Order (which he got in 2003 after he stabbed a man in the leg during an altercation at a night club), fails to keep appointments with his care coordinator, and is scheduled for a mental health assessment in mid-Oct. KP continues to be suicidal. By Oct 15 he has successfully weaned himself off the sertraline and is taking venlafaxine but needs the Diazepam to make him feel better. On Nov 26 his friend sees him, and he is suicidal - drinking and taking tablets. When KP leaves, his friend calls police but KP kills his former girlfriend and hangs himself. The news article reports that the killing was preventable but there is no mention of the SSRIs that appear to have caused suicidal thinking.

The Investigation report considers the following areas for better management of KP's case:

- 14.1. Diagnosis, Medication and Treatment
- 14.2. Post Traumatic Stress Disorder
- 14.3. Risk Assessment and Forensic Risk History
- 14.4. The Care Programme Approach, Assessment and Care Planning
- 14.5. Use of the Mental Health Act (83)
- 14.6. Cultural Diversity
- 14.7. Adherence to National and Local Policy and Procedure
- 14.8. Competence and Experience of the Clinical Team
- 14.9. Clinical Supervision
- 14.10 Documentation

- 14.11. Lone Worker Issues
- 14.12. Management of Clinical Care and Treatment
- 14.13. Clinical Governance Processes

Under Diagnosis, Medication and Treatment, pages are devoted to whether KP's diagnosis was correct. They also note that: "Between the period of the 12 April and the 28 June 2007 Mr. X's anxiety and depression appeared to grow worse".

They also noted: "The Independent Investigation Team believes that the GP prescribed medication was appropriate and fell within clinical guidelines. The change to Mr. X's medication appears to have been made on reasonable grounds as he did not appear to be responding to Sertraline...The decision to continue with Valium [Diazepam] could be questioned as it was apparent that it made Mr. X drowsy and unable to go about his daily business. "

The report also records that: "It is not clear how well Mr. X understood the medication that he was prescribed. Nowhere in his clinical records is it recorded that the benefits and possible side effects of his medication were explained to him."

It was not just KP that does not appear to understand the potential effects of the medication. Both the Trust and the investigation team noted that KP (Mr. "X") got worse on sertraline and other drugs. It is not clear why they assumed that venlafaxine (Effexor) would help where sertraline had made the situation worse, and why they did not even consider the potential connection between the SSRI/SNRI, the suicidality that emerged when KP started these medications, and the tragedy.

Killing 'could have been stopped' – (BBC News)

http://news.bbc.co.uk/2/hi/uk_news/england/derbyshire/7664352.stm

18:46 GMT, Friday, 10 October 2008 19:46 UK

A trust has been set up in memory of Halimah Ahmed

The death of a 19-year-old woman suffocated by her ex-boyfriend could have been stopped, a coroner has ruled.

Khalid Peshawan, 33, killed Halimah Ahmed at his Derby home in November 2007 before hanging himself.

Coroner Dr Robert Hunter said mental health professionals should have properly assessed Mr Peshawan.

It also emerged that in 2005 the former asylum seeker was granted indefinite leave to remain in the UK, despite a stabbing conviction two years earlier.

Halimah remains and has always been a source of inspiration for us - Ashtiaq Ahmed, victim's father
Derbyshire Mental Health Trust said it would review the coroner's findings.

Mr Peshawan had told friends life "was not worth living" and he felt suicidal because he could not continue a relationship with the woman he loved.

Mr Peshawan failed to be fully assessed for possible detention under the Mental Health Act on three separate occasions.

It was either because a social worker was unavailable or Mr Peshawan could not be found, the court heard.

Just a few days before Miss Ahmed was killed, community psychiatric nurse Karen Stone assessed Mr Peshawan, an Iraqi Kurd, as a "significant risk to others".

She said he had talked of harming himself.

Refused asylum

Summing up, Dr Hunter said "on the balance of probabilities", the events of 26 November could have been avoided had a full assessment of Mr Peshawan been carried out.

Miss Ahmed's father, Ashtiaq Ahmed, said he hoped the findings would prevent anything similar happening again.

Speaking after the inquest, he said: "Halimah remains and has always been a source of inspiration for us.

"Her vision will be realised through the Halimah Trust."

Mr Peshawan was refused asylum in 2000.

In 2003 he was convicted of stabbing someone outside a nightclub and given a community service order.

But in 2005 he was granted indefinite leave to remain in the UK, the hearing was told.

[An Independent Investigation into the Care and Treatment of a person using the services of Derbyshire Mental Health NHS Trust](http://hundredfamilies.org/wp/wp-content/uploads/2013/12/PESHAWAN_K_EMid_10.08.pdf)

http://hundredfamilies.org/wp/wp-content/uploads/2013/12/PESHAWAN_K_EMid_10.08.pdf

Undertaken by the Health and Social Care Advisory Service

Ref 2007/13112

January 2010

Excerpts (Complete Report is 148 pages)

4.1. Incident Description and Consequences

The following account has been taken from the transcript of evidence heard at the Inquest into the deaths of Mr. X and Ms. Halimah Ahmed.

On the afternoon of the 26 November 2007 19 year old Ms. Ahmed rang her mother at 3.30 pm to inform her that she was going to visit friends from university. At this point it is assumed that Ms. Ahmed left the family home where she lived, in her car, to pursue the visit she planned to make.

A little later that same afternoon Ms. Ahmed's mother tried to call her on her mobile telephone and was diverted through to voicemail. When Ms. Ahmed missed the family meal that evening her parents grew increasingly concerned and at around 9.30pm Ms. Ahmed's father telephoned the police, but declined to report her missing at this stage as he hoped that she would return home. At around 11.30 pm, when she had still failed to return home, Ms. Ahmed's father telephoned the police again, this time to formally report her missing.

On the 26 November 2007 thirty-three year old Mr. X went to see his GP, on this occasion he was described by both his GP and his friends as being calm and relaxed. Following this appointment Mr. X went to a solicitor's firm in order to make a will. He was informed that his will would be finalised the following day.

At 4.30pm Mr. X met up with his brother outside of the shop that he (his brother) owned. Mr. X's brother stated to the Coroner that on this occasion Mr. X appeared to be 'normal' in his presentation, although he was a little tired and decided that he was going to go home.

Later on that afternoon at around 5.00 pm Mr. X telephoned a friend saying that he had a 'problem'. Mr. X went to this friend's house and was described by him as looking uncomfortable: his eyes were red and he was shaking. The friend was concerned because Mr. X was drinking and appeared to be swallowing tablets. Mr. X ran away out of the house and his friend telephoned the police because he was worried about Mr. X's wellbeing. Mr. X was not seen alive again.

The following day Mr. X's brother was unable to contact him via his mobile telephone as it appeared to be switched off. Mr. X's brother went to Mr. X's home. The front door was not locked and he entered the house. Mr. X was found dead hanging by the neck and a young woman was also found dead on the floor directly next to the body of Mr. X. Later that same day the young woman was identified as being Ms. Halimah Ahmed. Dr. Robert Hunter Her Majesty's Coroner for Derby and South Derbyshire found that Mr. X 'had taken his own life by ingesting a quantity of Paracetamol and Aspirin and had hung himself...and died as a result of the hanging' and that Ms. Halimah Ahmed had been unlawfully killed by Mr. X.

At the time of Mr. X's death he had been in receipt of community-based mental health services from the Derbyshire Mental Health Service NHS Trust. He had received his care and treatment from this organisation for a period of some fifteen weeks. His diagnosis had been determined as depression with

symptoms of Post Traumatic Stress Disorder. Mr. X was 33 years old at the time of his death and was member of the Kurdish Iraqi community in Derby.

12. Chronology of the Events

This Forms Part of the RCA First Stage The chronology of events forms part of the Root Cause Analysis first stage. The purpose of the chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external factors that may have impacted upon the life of Mr. X and on his care and treatment from mental health services.

During the course of this Investigation it was not possible to speak to the friends and family of Mr. X and so it has not been possible to draw up a comprehensive chronology in the context of his life history. Mr. X was only known to Derbyshire Mental Health Services for a period of some fifteen weeks, during this time attempts were made to get to know Mr. X. However Mr. X was often reluctant to talk about himself and the subsequent information held within the clinical record is often incomplete and may not be entirely accurate. The following information has been taken from Mr. X's clinical records, probation service records and the transcript of the Coroner's Inquest.

Background Information Mr. X was of Kurdish ethnicity born on the 24 August 1974 in Iraq. It is unclear how many siblings Mr. X had, but it would appear that at the time of his death both of his parents were still living and domiciled in Iraq, and that he had one brother living in the United Kingdom at an address close to Mr. X's home¹¹.

It would appear that Mr. X's life in Iraq was turbulent. When talking to his CPN/Care Coordinator at the Trust he described an event in 1983 when he had witnessed people being killed. The history that the CPN/Care Coordinator took gave a very brief account of Mr. X's childhood, however it would appear that bombings and violence were a day-to-day part of his life as a child and young person. In 1986 Mr. X stated that one of his brothers died at the family home as a result of shrapnel wounds and that he had witnessed this event¹²

Mr. X left Iraq to live in the United Kingdom, it is not clear exactly when this was, but it was likely to have been sometime in 1999 or early 2000. The clinical records suggest that his decision to leave Iraq was the direct result of an unsuccessful love affair. It is not possible to understand fully Mr. X's decision to leave his home and family behind from the clinical records alone, and it must be borne in mind that many other factors may have influenced his decision to move to the United Kingdom¹³.

30 March 2000. Mr. X made a formal application for asylum in the United Kingdom. He was served Form ISI51A, which was a notice to a person liable to removal as an illegal entrant and was given temporary admission to the United Kingdom pending a decision on his asylum claim¹⁴.

5 June 2000. Mr. X registered with a Medical Centre so that he could receive primary care health services¹⁵.

6 July 2000. Mr. X's application for asylum was refused, however he was granted exceptional leave to remain in the United Kingdom until 6 July 2004. Mr. X had the right to appeal. There is no trace in the Home Office Records that an appeal was lodged¹⁶.

9 September 2003. Mr. X was convicted at Derby Crown Court of stabbing a person in the leg outside of a nightclub. Mr. X was given a Community Punishment Order of 150 hours. The person whom Mr. X stabbed was also Kurdish and known to him and both men had been involved in a previous altercation, when Mr. X had been assaulted. On the occasion Mr. X committed this offence there was evidence brought to bear that he had been provoked. Neither the Courts nor the Probation Services felt Mr. X to be dangerous and no Supervision order was sought. ¹⁷.

28 April 2004. The Home Office received an application from the Immigration Advisory Service for indefinite leave to remain in the United Kingdom on behalf of their client Mr. X¹⁸.

22 August 2005. Mr. X was granted indefinite leave to remain in the United Kingdom. Mr. X's former conviction was noted and it was judged not to be sufficient to warrant the refusal of Mr. X's application. Full security checks were conducted into Mr. X's background, all of which proved to be negative¹⁹.

22 August 2006. The Home Office received an application from Mr. X for naturalisation as a British Citizen²⁰

16 November 2000 – 23 February 2007. Between the 16 November 2000 and the 23 February 2007 Mr. X attended his GP surgery a total of 39 times for the treatment of minor skin conditions and injuries

12 April 2007. On this day Mr. X presented at his GP surgery with 'low mood and anxiety++'. It was estimated by the GP who saw Mr. X that he had probably been feeling this way for a period of some six months. It appeared that Mr. X's anxiety at this stage stemmed from an injury he had received at work. Mr. X felt that he could not return to work and he was coming under increasing pressure from his employer to do so. He was worried about paying his mortgage and meeting his financial commitments. He was prescribed Sertraline tablets 50mg once daily.

26 April 2007. Mr. X visited his GP surgery again. It was recorded that he had not noticed much benefit from the Sertraline and that he was still very anxious about returning back to work. The GP decided to increase the Sertraline tablets to 100mg once daily and that Mr. X would need to be seen again in two weeks time. The diagnosis at this stage was depression anxiety.

28 April 2007. Mr. X nearly hit a police vehicle whilst out driving his car. Mr. X appeared to smell of alcohol and he became verbally aggressive when asked to supply a sample of breath which he refused to do. He was arrested and charged with failing to supply a sample of breath²⁴.

10 May 2007. Mr. X was seen at the GP surgery once again. He discussed his low mood with the GP and explained that he felt isolated from his family.

24 May 2007. Mr. X was seen once again at the surgery. The GP who saw Mr. X on this occasion wrote 'depression + post traumatic stress'. The GP increased Mr. X's medication to Sertraline 100 mg twice

daily. It was also noted that Mr. X was due to see his Occupational Therapy doctor at his place of work the following week²⁶.

28 June 2007. Mr. X was referred to the Derby City Community Mental Health Team by GP 1 at a Medical Centre. The referral letter stated that Mr. X was a 32 year old man with depression and post traumatic stress disorder. The letter outlined Mr. X's symptoms and sought some psychological intervention from secondary care services. It was noted that Mr. X's medication comprised Sertraline 200 mg and Diazepam 5 mg²⁷.

3 July 2007. On the 3 July 2007 Mr. X was sent a letter inviting him to make an appointment with the Derby City Community Mental Health Trust. Between the 12 April and the 3 July 2007 Mr. X was also seen on nine other occasions for minor injuries and pain at his GP surgery.

10 July 2007. Mr. X was written to by mental health services confirming that an appointment had been made for him to see a Community Psychiatric Nurse (CPN) who had been allocated as his Care Coordinator at St. James House on the 16 August 2007²⁹.

16 August 2007. Mr. X was seen at St. James House by the CPN. Mr. X's history was taken and an initial assessment was commenced. It was noted that there was no evidence of paranoia or of persecutory beliefs. It was also noted that Mr. X was very angry and could not control his feelings when talking about his experiences in Iraq, Mr. X acknowledged that he was often angry and was worried that he might 'lose control and hurt his close friends'. Mr. X explained that he experienced flashbacks of traumatic events and that when this occurred he lost concentration and was vulnerable to accidental injury. Mr. X said that the antidepressant he was taking helped his mood, but that he found it difficult to sleep at times and was often tearful. This initial assessment was recorded on Trust Cognitive Behaviour Therapy Documentation, not on the Trust Care Programme Approach documentation.

29 August 2007. The CPN saw Mr. X at St. James House and continued the assessment process.

5 September 2007. Mr. X did not attend the appointment with the CPN that had been offered to him

Later on the same day the CPN spoke to a member of the Crisis Team who agreed to meet with Mr. X. However Mr. X changed his mind and refused to be seen. The CPN discussed this with her line manager and the notion of a Mental Health Act (83) assessment was explored, however it was felt that this should not be pursued due to a lack of Approved Social Worker or Medical recommendation. The CPN once again contacted the Crisis Team

26 September 2007. Mr. X met with the CPN at St. James House in order to continue his assessment. It was recorded that Mr. X continued to struggle with his mood and that he had 'blackouts' and lapses in concentration. During this session he confessed that he often felt suicidal and that he had attempted to take his life on two previous occasions, Mr. X refused to elaborate. He did however go on to say that he definitely planned to kill himself and that the CPN would read about it in the newspapers. Mr. X was very reluctant to talk about things further but agreed to the CPN's plan to discuss his situation with the Crisis Team.

27 September 2007. The CPN saw Mr. X at his home, on this occasion she was accompanied by a member of the Crisis Team. Mr. X no longer wanted to be seen by the Crisis Team citing the reason that he found it too distressing to talk about his problems. The CPN did however get Mr. X to agree to see the Consultant Psychiatrist to review his mental state and medication³⁴.

28 September 2007. The CPN arranged for the Sector Consultant Psychiatrist to see Mr. X on the 1 October 2007 for an Outpatient review. The CPN also arranged to visit Mr. X at his home on the 3 October 2007³⁵.

1 October 2007. The CPN collected Mr. X from his home in her car and accompanied him to see the Consultant, the Sector Consultant Psychiatrist. The Consultant learnt from Mr. X that he was very low in mood and had suicidal ideation. Mr. X told the Consultant that his concentration was poor and that he was worried about his financial situation. He also admitted to having angry outbursts resulting in 'black outs' with a loss of time. He alternated between not sleeping well and sleeping for excessively long periods of time. The Consultant did not think that Mr. X was psychotic and judged him to have significant depressive, anxiety and post traumatic stress disorder symptoms. Mr. X admitted to suicidal ideation, but he would not elaborate further. The Consultant assessed him as presenting a low to moderate risk of harm to himself and a low risk of harm to others. It was noted that Mr. X's compliance with medication had been variable and The Consultant decided to wean him off Sertraline and to commence him on Venlafaxine 37.5 mg twice daily. It was also decided to commence him on Diazepam 5 mg twice daily and Zopiclone 7.5 mg at night. The Consultant made another appointment to review Mr. X in two weeks time at the Outpatient Clinic.

3 October 2007. The CPN went to Mr. X's home for her scheduled visit however he was not in. The CPN tried to contact him on his mobile telephone but it was switched off and left a message on his answer machine requesting that he contact her. When the CPN returned to the Community Mental Health Team offices she discussed Mr. X with the Service Manager and a decision was made to request a 'safe and well' check from the local police service. The police agreed to carry out a check. Shortly afterwards Mr. X telephoned the CPN and apologised for not being in explaining that he had been in Court. The 'safe and well' check with the police was cancelled and the CPN arranged to meet Mr. X at his home the following week.

9 October 2007. On this day Mr. X's Probation Officer telephoned the CPN to ascertain the formulation regarding Mr. X's mental state. The Probation Officer informed the CPN that Mr. X's driving license had been revoked that summer following an incident when he had a near miss with a police vehicle. On this occasion Mr. X had smelt of alcohol and became verbally aggressive towards the police officer when asked to provide a sample of breath. Mr. X refused to provide a sample of breath and was subsequently arrested and charged. Mr. X had suggested that if the Probation Services needed to know more about 'his circumstances' then they should contact the CPN. The Probation officer also told the CPN about Mr. X's previous conviction when he was involved in a stabbing outside of a nightclub in 2003. The Probation Officer and the CPN agreed to liaise one with the other as required³⁸.

10 October 2007. Mr. X's application for naturalisation as a British Citizen was refused on the grounds that he did not know enough about the British way of life.

11 October 2007. The CPN visited Mr. X at his home. He continued to present as being low in mood and flat in affect. Mr. X stated that he still planned to kill himself but that the medication was helping. The CPN was concerned that he was taking twice the prescribed dose of his medication at night and warned him about the effects of this when combined with alcohol which she was certain Mr. X was drinking. It was clear that Mr. X was worried about his financial situation and that he wanted to return to work. However because of his prescribed medication his employer would not allow him to. It was agreed that the CPN would ascertain whether or not he was eligible to claim benefits. The CPN recorded her intention to accompany Mr. X to his scheduled Outpatient appointment on the 15 October 2007⁴⁰

15 October 2007. Mr. X was reviewed in the Outpatient Clinic by the Consultant. It was reported by Mr. X that he had successfully weaned himself off of the Sertraline and that the Diazepam made him feel slightly better. The CPN who accompanied Mr. X, disclosed that a close friend of his had died in Iraq over the weekend. Mr. X was close to this friend and did not want to talk about it. Mr. X told the Consultant that he was currently living at a friend's home and that his own property was under offer and in the early stages of being sold. Mr. X appeared to deeply resent being asked about his mood and suicidal thoughts stating that he only wanted medication to be prescribed. The Consultant discussed the possibility of a Mental Health Act (83) assessment with him and noted that he appeared to be a very angry young man who did not want to be questioned. Mr. X felt that his voluntary presence and request for medication should indicate that he did not need any further action to be taken. At this meeting the medical opinion was that Mr. X had significant depressive and post traumatic stress disorder symptoms. He was assessed as being a moderate to high risk of harm to himself and a low risk to others. The impression was:

1. Post traumatic Stress Disorder 2. Social problems in crisis 3. Recent bereavement 4. Unresolved psychological issues with some unhelpful personality traits

Directly following this review the CPN approached the Consultant to inform her that Mr. X had declined her offer to drive him home and had also refused her offer of a lift to his next Outpatient appointment. The CPN was very worried that Mr. X would disengage and the Consultant decided to complete a recommendation for Section 2 of the Mental Health Act (83) in order to assess Mr. X as an inpatient and to get a better idea of his mental health problems. An urgent request was made to the Approved Social Worker to facilitate a Mental Health Act (83) assessment that very evening⁴¹.

16 October 2007. The Consultant was informed that the Approved Social Worker had been unable to find Mr. X at either of his known addresses the day before. The same Approved Social Worker had informed the police of his concerns, the police had been able to contact Mr. X on his mobile telephone, and he told them he was well. The Consultant passed the request for the completion of the Mental Health Act (83) assessment to the Community Mental Health Team⁴²

The CPN collected Mr. X and his friend in her car and drove them to St. James House to be seen by the Consultant and GP 1. The purpose of the assessment was explained to Mr. X and the reasons why it was

felt to be necessary. Mr. X's recent history was reviewed for GP 1's benefit, this included his suspension from work, financial problems, need to sell his house, and recent bereavement. During this meeting Mr. X did not want to talk about his problems and refused to discuss his childhood as it made him feel worse when he did.

18 October 2007. A Mental Health Act (83) assessment was planned for this day. The CPN and her Service Manager had spent the previous two days trying to locate an Approved Social Worker to input into the process but were unable to do so. The Consultant had arranged for GP 1, Mr. X's GP, to be present.

During the assessment meeting it appeared that Mr. X had very good support from the friend who had accompanied him. He told GP 1 that he had attended the meeting because he wanted medication and that he no longer had active thoughts about killing himself. During the meeting Mr. X's financial problems were discussed and it was felt that his Care Coordinator could help him to sort things out. It was noted that his sleep was improving and that he was eating well. It was felt that Mr. X's mood was a bit low but that he had no thought disorder. Mr. X appeared to have some degree of depression and anxiety but stated that he had good levels of social support to help him.

It was decided that Mr. X was not detainable. The plan was for Mr. X to continue with his medication and for another appointment with the Consultant to be scheduled in four to six weeks time. The CPN was to continue supporting Mr. X in the community once a fortnight and more frequently only if required. The meetings with the CPN were to be set on a fortnightly basis as Mr. X felt that more frequent meetings exacerbated his condition. It was agreed that that CPN would next meet Mr. X on the 31 October 2007⁴³

25 October 2007. On this date Mr. X appeared at South Derbyshire Magistrates' Court. The charge was failing to provide a specimen of breath. The date of the offence was 28 April 2007. The Court report refers to his one previous offence in September 2003 of Section 20 wounding for which he was sentenced to 150 hours Community Punishment. The Probation Service recommendation (citing Mr. X's mental ill health) was that Mr. X should be made subject to a Community Order with the following requirements:

At this time the probation area (Derbyshire) was one of four areas participating in a pilot intervention that would mean that should he fail to comply with the terms of the Community Order and be returned to court for a breach of the order, the Benefits Agency would be informed and should the breach be proved, his benefits would be withdrawn for a four week period.

The Magistrates made a Community Order for 12 months with a condition of 80 hours unpaid work despite the Probation Service citing Mr. X's mental ill health. October 2007. Mr. X failed to attend his initial appointment relating to his Community Order for induction with the Probation Service. He attended three hours late because he had overslept.

31 October 2007. The CPN telephoned Mr. X first thing in the morning to remind him of his appointment, the CPN was not able to get through to Mr. X and left a message on his answering

machine. Mr. X did not attend his appointment. The CPN informed both the Consultant and her Service Manager. The CPN offered Mr. X another appointment.

1 November 2007. On this date the CPN completed a Care Programme Approach (CPA) Review and Care Plan. A FACE Risk Profile assessment was also undertaken. These processes were completed in the absence of Mr. X who had not been seen by the CPN since the 18 October 2007. The CPA records that Mr. X had been placed on Enhanced CPA47.

5 November 2007. A letter was sent to Mr. X advising him that an appointment had been arranged for him to see the Consultant on the 7 December 2007.

13 November 2007. The CPN received a telephone call from Mr. X who was in 'a state of panic'. The CPN recorded that Mr. X had breached his Community Service Order and that his case was due to go back to court. Mr. X had been advised by his Probation Officer to ask his Care Coordinator to write a letter providing evidence as to why he was unable to comply with the terms of his Order. The CPN told Mr. X that she would discuss this with his Probation Officer. Mr. X also demanded that the CPN assisted him with his financial difficulties as his debts were mounting on a daily basis. The CPN advised him to seek help from the Citizens Advice Bureau. Mr. X became angry when he understood that the CPN was not going to help him.

The CPN telephoned Mr. X's Probation Officer who informed her that she did not need to write a letter for the Court as Mr. X had previously agreed to the terms of the Community Order in the presence of an interpreter. It was felt that Mr. X had fully understood what had been required of him and that no mitigation could be put into place.

15 November 2007. The CPN saw Mr. X at St. James House. Mr. X presented as being very angry and spent most of the time explaining his current social difficulties. He had not approached the Citizens Advice Bureau. The CPN offered to accompany Mr. X but he declined her offer. The CPN explained that she had spoken to his Probation officer and that she felt a letter was not required from her. The CPN recorded that she 'attempted to validate Mr. X's anger'. He refused to discuss his mental state or the intensity of his suicidal ideation. He reluctantly agreed to meet with the CPN again on the 29 November 2007.

26 November 2007. Mr. X went to visit his GP and saw GP 1. GP 1 provided a letter for Mr. X for the Court explaining that he had slept through his Community Service Order due to the effects of his medication. Mr. X was recorded as feeling better and a repeat prescription was given for a further two weeks of medication.

Later on this same day Mr. X visited a solicitor in order to make a will. At 4.30pm Mr. X met up with his brother outside of the shop that he (his brother) owned. Mr. X's brother stated to the Coroner that on this occasion Mr. X appeared to be 'normal' in his presentation, although he was a little tired and decided that he was going to go home.

Later on that afternoon at around 5.00 pm Mr. X telephoned a friend saying that he had a 'problem'. Mr. X went to this friend's house and was described by him as looking uncomfortable, his eyes were red and he was shaking. The friend was concerned because Mr. X was drinking and appeared to be swallowing tablets. Mr. X ran away out of the house and his friend telephoned the police because he was worried about Mr. X's wellbeing. Mr. X was not seen alive again.

Mr. X was due to appear in court for the breach on this day. He had failed to attend three of six appointments offered to him and had completed eight of the 80 hours of the order imposed by the Court. The Probation Officer preparing the report for the breach appearance recommended that the unpaid work order should be revoked in view of his inability to attend in the mornings and that the Court should resentence with a supervision requirement to enable the Probation Service to closely monitor him and "access the interventions he is so obviously in need of".

27 November 2007. Mr. X was found hanging from a light fitting at his home with the body of Ms. Halimah Ahmed on the floor beside him.

2. Karl Tett

Karl Tett, 35 has been seen by mental health services for 16 years, and for most of this time he has taken antipsychotic medications, apparently prescribed for anxiety. He is functioning well up to October, 2004. Probably on this date, but possibly after, he is prescribed sertraline with the plan to reduce his risperidone. KT is an ODP. In Feb 2005 he interrupts an operation saying the consultant should be arrested. For this he eventually loses his job and eventually his license. By the time he is seen next by mental health services, in April 2005, he has deteriorated markedly and has become extremely paranoid and has developed odd beliefs. After an incident in a pub Aug 11 in which he announces the drinks have been poisoned and refuses to leave, he is sectioned and admitted to hospital the next morning. There, they decide he should not take any medication other than Lorezepam until after the weekend so that the psychiatrist can "conduct a full and proper assessment of his mental state". Thus, KT has not had his usual medications for at least 1 ½ days – and possibly longer - when he stabs fellow patient Michael Green to death with a pen on Aug 13. The investigation team never considered the potential role of the drugs / withdrawal in KT's troubles, and concluded that it was not possible to know if the incident was preventable.

Police investigate patient death – (BBC News)

http://news.bbc.co.uk/2/hi/uk_news/england/nottinghamshire/4174392.stm

Last Updated: Monday, 22 August 2005, 16:07 GMT 17:07 UK

A patient at a mental health unit in Nottingham has died after he was assaulted by another patient.

Michael Green, 60, died at Nottingham's Queen's Medical Centre on Friday after the attack on 13 August.

A post-mortem examination was carried out at Leicester Royal Infirmary on Monday but the results have not yet been released.

Nottinghamshire Police are investigating the incident at the Wells Road Centre.

Independent review

Notts Healthcare NHS Trust has offered its condolences to Mr Green's family and is offering them support.

The other patient involved in the incident has been relocated to a secure unit and the trust is working with the police to investigate the incident.

The Wells Road Centre is used by patients with severe mental health problems who need help with substance abuse.

It has a 20-bed acute admission ward and a 13-bed in-patient unit used by the Nottingham Alcohol and Drug Team.

The trust said there would be an independent review of the circumstances surrounding the death.

An independent investigation into the care and treatment of Mr C and Mr M –

A report for NHS East Midlands

http://hundredfamilies.org/wp/wp-content/uploads/2013/12/TETT_K_EMid_08.05.pdf

January 2011

DATE	REPORT PAGE	INFORMATION
1989 - 2004	9	Mr M 3.8 Mr M was 19 when he first had contact with mental health services in 1989. He was admitted to an acute admission ward in Norfolk and was diagnosed with agitated depression. 3.9 In the period between 2001 and 2005 Mr M received inpatient and outpatient care principally in West Sussex, from West Sussex Health and Social Care NHS Trust1. A number of his admissions were under sections of the Mental Health Act, 1983 (MHA) including removal to a place of safety under section 1362. 3.10 Mr M is a qualified operating department practitioner (ODP) (though not now registered as an ODP).
1989 -	10	Diagnosis

DATE	REPORT PAGE	INFORMATION
		3.14 Since Mr M's first contact with mental health services there has been uncertainty over his diagnosis. Diagnoses have included post-traumatic stress disorder, acute psychotic feature, drug induced psychosis , and generalised anxiety symptoms.
May, 2004	9	3.10 ...In May 2004 concerns about his behaviour led to Mr M being referred to occupational health services [HPC] by his employer in Brighton. As part of this referral Mr M disclosed his previous mental health problems. He had not previously disclosed these as part of his pre-employment questionnaire. He was signed off as not fit for work. In May 2004 his employer referred him to his regulatory body the Health Professions Council (HPC)3.
May 2004	10	Diagnosis 3.15 In May 2004 Mr M's consultant in West Sussex referred him to the National Psychosis Unit (NPU) at the Maudsley Hospital for a second opinion. He was seen on three occasions and his last appointment was in April 2005. 3.16 By 2005 the team at the NPU had come to the view that he was paranoid and psychotic but he had none of the typical symptoms. He did not hear voices, did not have cognitive impairment and he did not have negative symptoms characteristic of schizophrenia5.
July 9 2004	33	6.49 The specialist registrar told us that at the first appointment on 9 July 2004 Mr M was accompanied by his girlfriend. He presented as having anxiety and he believed that people had been tampering with his locker at work and with his motorbike and that somebody had been moving some furniture around his flat. His girlfriend said she had witnessed what had happened to the motorbike. The specialist registrar told us: "He did not describe any auditory hallucinations or visual hallucinations; he was not talking about a big plot against him. So there was nothing that was overtly paranoid, in that sense. In his mental state, he presented really well, very coherent, one was able to have quite a good interaction with him. I had quite a good rapport with him, as I have said here, he was not distractible or anything like that. His mood appeared to be good. I did not detect any other abnormal thoughts at the time. He talked about having had an acute psychotic episode in the past and we talked a little bit about his anxiety as well, which he acknowledged".
October 22 2004	34	6.50 At Mr M's second appointment on 22 October 2004 his girlfriend was not in attendance. He had no delusional beliefs, and was functioning well. The plan was for him to start an antidepressant and to gradually reduce his antipsychotic drugs. In an interview with us the doctor from the NPU did not recall having any detailed information about the incident that happened in Corfu which led to his admission to a psychiatric ward. Note: this is the first reference in the report to "Mr M" taking medication. Obviously these meds were prescribed at some time after 1989.
January, 2005	25	6.9 The West Sussex staff ensured that a planned transfer was put in place and Mr M was first seen by his Nottingham care coordinator on 9 May 2005. He was then seen by the consultant psychiatrist on 23 May for review and CPA. Mr M was prescribed risperidone 2mg daily, sertraline 150mg daily and diazepam 2mg prn.

DATE	REPORT PAGE	INFORMATION
		<i>The above appears to be describing the drugs he was on at that time, which he was prescribed prior to his move to Nottingham from West Sussex and his first visit with the care coordinator and psychiatrist there. Sertraline is probably the antidepressant referred to in the note above re: Oct 22, 2004. The risperidone is probably the antipsychotic. If these medications are not the anti-psychotic and antidepressant referred to in Oct, 2004, then the report contains no information about what these earlier prescriptions might have been.</i>
		3.11 In January 2005 Mr M was employed as an agency ODP in Wrexham. On 14 February 2005 he interrupted an operation saying the consultant should be arrested. Diagnosis 3.16 By 2005 the team at the NPU had come to the view that he was paranoid and psychotic but he had none of the typical symptoms. He did not hear voices, did not have cognitive impairment and he did not have negative symptoms characteristic of schizophrenia5.
April 20, 2005	25	6.51 At the third appointment on 20 April 2005 [6 months after his last appointment] Mr M's presentation was completely different to the previous two appointments. He was very paranoid. He was certain that he had had a brain haemorrhage and that in Wales he had seen an abnormal scan. The doctor at the Maudsley was clear that Mr M was suffering some kind of psychotic episode. A letter written to the consultant psychiatrist in West Sussex makes this clear.
May, 2005	9	The HPC hearing [arising from the May 2004 complaint] was held in May 2005.
	38 – 39	During the three months from 9 May to 9 August Mr M was seen 14 times by a variety of clinicians... Risk assessment and management - community 6.68 The clinical risk management/risk indicators form completed on 28 June by Mr M's community psychiatric nurse records incidents of violence, intent to harm others, dangerous impulsive acts and paranoid delusions about others together with signs of anger and frustration. It is also recorded that Mr M did not accept that his previous behaviour had presented a risk to others.
July 20 2005	28	6.17 On 20 July 2005 Mr M was seen by a clinical psychologist. At the time Mr M felt his main difficulty was the anxiety he felt about being attacked. The fear increased the more people there were around him and this affected everyday activities such as using public transport and going to the pub. He also mentioned to the psychologist that occasionally when watching the news he would worry that he was to blame for the incident that was being reported.
Aug 2 2005	28	6.18 He was seen again by the psychologist on 2 August and a further appointment was made for 16 August which Mr M was unable to keep due to his admission to hospital.
Aug 9	28	6.19 On 9 August Mr M was offered and accepted the tenancy of a council flat.

DATE	REPORT PAGE	INFORMATION
2005		<p>Events prior to admission</p> <p>6.20 Mr M was making arrangements to move into his own accommodation, organising for furniture to be delivered and applying for increased housing and council tax benefits.</p> <p>6.21 His care coordinator summed up his assessment of Mr M just prior to the incident as: "At the last point when I saw him, I did not feel that he presented a risk to other people. He came across as very rational, there had been no evidence of the intensity of the previous discussions we had. He seemed to me to be looking ahead in the sense that he was building his future, setting his new flat up and that was specific to that particular meeting."</p> <p>6.22 Mr M told us that while outwardly he was giving the impression of coping he was increasingly becoming paranoid, believing that he was under threat from paramilitaries and other terrorist organisations.</p>
Aug 11, 2005	29	<p>6.26 On 11 August, whilst drinking in a pub during the afternoon and early evening, Mr M was detained under section 136 of the MHA. He was taken to a police station. It became clear that he had not been taking his medication and he was concerned about the dust in his flat being radioactive. He also believed he had been charged with terrorist activity. He had been unwilling to talk to the police surgeon and accused him of killing innocent people in Palestine. At the police station he claimed he could hear whipping and cries of pain from women. A Mental Health Act assessment was undertaken. The notes of the assessment record a risk of aggression when unwell. He was visited by his mother whilst at the police station.</p> <p>Admission to ward - midnight Friday 12 August 2005</p>
Aug 12, 2005		<p>3.23 ...on 12 August Mr M was admitted to the acute admission ward as described below. On admission to hospital he was placed on ten minute observations which were appropriate as he was obviously seriously ill and therefore a potential risk to himself and possibly others. Up to 10 August and prior to this sudden relapse Mr M had appeared to be coping quite well and was supported by a range of professionals of whom none had assessed him as a risk to others.</p>
Aug 12, 2005		<p>3.25 On admission to the ward the plan was to nurse Mr M on ten minute observations and to undertake physical assessment to include analysis for drugs as Mr M had felt that his drink had been spiked in the pub the previous day. The consultant psychiatrist and approved social worker who had assessed him at the police station and arranged for his admission decided that Mr M should not be given anti-psychotic medication over the weekend. This was to ensure they could conduct a full and proper assessment of his mental state.</p> <p>6.30...He was written up for "lorazepam prn only and should he need haloperidol duty doctor needs to assess." Mr M was to be transferred to the locality ward on Monday.</p>
Aug 13,		6.74 One of the trust managers we interviewed was also part of the trust

DATE	REPORT PAGE	INFORMATION
2005		investigation panel. She told us that the observation records for 13 August had not been completed. The staff on duty at the time of the incident gave evidence in Mr M's trial that they had carried out the observations but not recorded them. 6.75 The trust investigation report says: "Mr M was convinced that Mr C posed a threat to female patients and was being nursed on 'medium' observations at ten minute intervals. It is most unfortunate that the attack on Mr C seemed to have taken place during an intervening period, prior to the next check on Mr M being performed."
October 2007	9	[Mr.M's] name was removed from the HPC register in October 2007
Jan, 2011	41	C5 Because of the conflict in the evidence between the staff who were on duty and Mr M about whether observations were carried out and the failure of the trust investigation panel to examine in any detail the immediate period prior to the homicide we are unable to determine whether this incident was preventable.

3. David Young

Diagnosed with paranoid schizophrenia in 1995, David Young has a history of assaulting people despite showing up to take his fortnightly depot injections. He assaults a nurse, and attacks his brother with a knife, following a medication reduction, a crime for which he is not charged. In 2004 he grievously wounds a neighbour and is sent to prison for this until June, 2006. By the time he stabs his brother to death, DY has been on Depixol for 6 years. Prior to that he took Flupenthixol Deconate since 1994. He has always held odds beliefs related to being watched, including that he has a transmitter implanted in his body. DY cannot read. Nottinghamshire Healthcare Trust apparently does not understand that regularly taking his medication does not mean that DY's unusual ideas and voices are gone, or that he will not become violent again. This may be a misunderstanding on their part about what so-called "antipsychotic" medication does. However, the review report makes it clear that this is what they assume. They are focussed on medication compliance instead of knowing of the person. After he kills his brother, DY tells the assessing forensic psychiatrist "that the depot medication did nothing for him and that he was only telling him so much information "because I'll probably never get out of jail"...Mr S believed that "no medicine will take away my voices and that the only thing that will take them away is an operation to remove the bugging device"." The news article in this case is brief and mentions neither mental illness nor medication.

Man charged over stabbing murder in Nottingham– (BBC News)

http://news.bbc.co.uk/2/hi/uk_news/england/nottinghamshire/8456178.stm

Winchester Court in Sherwood

David Young has been remanded in custody, charged with murder

A man has been charged with the murder of another man, who was found stabbed to death at a flat in Nottingham.

The body of Michael Young, 51, was found by police at Winchester Court in Sherwood on 8 January.

David Young, 47, of Belconnen Road, Bestwood, who is accused of the murder, has been remanded in custody by Nottingham Magistrates' Court.

He is due to appear before Nottingham Crown Court on 26 January to answer the charge.

An independent investigation into the care and treatment of a person using the services of Nottinghamshire Healthcare NHS Trust

Undertaken by Consequence UK Ltd Ref Mr S

<http://hundredfamilies.org/wp/wp-content/uploads/2013/12/YOUNG -D EMid 01.10.pdf>

October 2012

EXECUTIVE SUMMARY Incident overview and intention In 2010 Mr S confessed to the unlawful killing of a male known to him. Because Mr S was a service user of Nottinghamshire Healthcare NHS Trust at the time the incident occurred, there was a requirement for the care and treatment Mr S received from that service to be scrutinised under the auspices of health circular guidance HSG 94(27).

2.0 AN OVERVIEW OF MR S'S CONTACT WITH MENTAL HEALTH SERVICES

2.1 Mr S's past psychiatric history (1994 – 2005) Mr S first came into contact with mental health services in Scotland. Prior to Mr S's admission into hospital, he had reported hearing voices. Following admission, he: **Absconded from the mental health unit; and Assaulted a nurse.**

This led to his spending some time in a high-secure mental health hospital. It was during this period that **Mr S was diagnosed with paranoid schizophrenia.**

In 1995 Mr S was transferred from the high-secure services to the mental health service in Nottingham.

At the time of transfer, Mr S's medication comprised oral medication and long-acting 'depot' injections of Flupenthixol Deconate.

Following his discharge into the community, Mr S was managed successfully in the community with regular 'depot' injections until 1998, when a reduction in the dosage of his medication led to a

deterioration in his mental health. During this period of deterioration, Mr S attacked his brother with a knife. No charges were brought against him following this.

Mr S's medication was increased and consequently, between mid-1998 and 2001, he remained stable in the community.

After September 2001 Mr S was noted to have become preoccupied with terrorist attacks. He became threatening to his family and is reported to have taken to carrying a knife around with him. By 2002 his behaviours had become overwhelming for his family and mental health services were alerted to a range of high-risk behaviours Mr S was exhibiting.

As a consequence of the deterioration in Mr S's mental state, he was admitted to a Psychiatric Intensive Care Unit on 23 August 2002, where he remained until January 2003.

During this admission, Mr S revealed that:

- he had a microphone in his throat;
- he had a transmitter in his bowels;
- there was a war going on between Scotland and Ireland against the English;
- he would lose his soul and go to hell if he did not fight the English.

When Mr S was discharged back into the care of consultant [1], he was on enhanced CPA and also had a care co-ordinator, in addition to his consultant. He remained stable in the community, complying with his treatment regime of fortnightly depot injections of 100mg Depixol. However, in 2004 he grievously wounded a neighbour following an incident he found provocative. Mr S was sentenced in January 2005 to three-and-a-half years in prison. He was released back into the community in June 2006.

2.2 Overview of Mr S's contacts with mental health services in Nottingham during the three-and-a-half years leading to the incident. Mr S was released back into the care of consultant [1] in July 2006 on standard CPA.

His first face-to-face appointment with consultant [1] was on 29 June 2006, which he attended with his sister. The plan at this time was for Mr S to attend at outpatient appointments with consultant [1] and to attend for his Depixol 100mg medication by injection every other week.

Mr S was reliable in attending for his medication for the entire three-and-a-half years (June 2006 – 24 December 2009). He was not, however, very reliable at attending for his outpatient appointments.

Between July 2006 and December 2009 Mr S was offered 13 outpatient appointments, of which he attended four. On each of the appointments he attended, his sister was present with him.

Throughout the three-and-a-half years after his release back into the community, Mr S presented as well, and although his voices were noted to remain present from time to time, Mr S reported that, with his medication, he was managing these. The 'depot' clinical records show that at no time did any member of staff identify any signs of mental ill health in Mr S. Furthermore, at not one of the outpatient

appointments that Mr S attended with his sister did she raise any concerns about her brother's behaviour.

The only factor of note between 2006 and 2010 was the reconfiguration of mental health services across Nottinghamshire which required Mr S to change community mental health teams and therefore his long-standing consultant psychiatrist (consultant [1]). The manner with which this transition was managed by the community mental health team staff involved was exemplary, and there is no discernible difference in Mr S's pattern of engagement/non-engagement with outpatient appointments pre or post his transfer to a city-based community mental health team.

Mr S's last outpatient appointment was on 21 December 2009, where he was assessed by a locum consultant psychiatrist. The records of this assessment raise no concern about Mr S's presentation and the plan regarding his management remained unchanged.

Mr S's last depot injections were on 7 and 24 December respectively. Again, the staff involved did not detect anything of concern about Mr S's presentation and he revealed nothing to them that could have alerted them to any deterioration in his mental state.

The incidents that occurred in the days leading to the incident appear to have come 'out of the blue' to Mr S's sister and to the mental health professionals. However, at the time of Mr S's arrest, it came to light that Mr S's housing provider had been concerned about Mr S's behaviour in March 2009, and again in November 2009. However, the CMHT to which Mr S was attached was unaware of the incidents giving rise to this...

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On a number of occasions in the clinical records it is clearly documented that Mr S had a habit of throwing away correspondence without reading it. This was as a consequence of his reading difficulty. His sister was noted as the person to whom correspondence should be sent and she would make sure that Mr S was aware of it.

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The pre-sentencing psychiatric report, which was prepared on 23 August 2010, revealed the following:

- That there was no evidence that Mr S had been using drugs and/or alcohol in the antecedent period leading to the death of his brother.
- That Mr S believed that he had a bugging device inside of him that had been put inside him when he was at HMP Lincoln.
- That Mr S believed that the bugging device had been planted "to fight the other side of the world". The report's author also recorded that Mr S told him that "the SAS was fighting the other side of the world through him in order to gain control of heaven". And that now his brother had died, "it all finished".
- That Mr S reported that "it was either him or his brother, and his brother had to die, otherwise the conflict would carry on". And that since his brother's death "he hears only good voices".

The pre-sentencing psychiatric report also set out that Mr S reported believing that:

- “he was the chosen one and that members of the IRA had prayed for him to come down to earth in the 1950s and 60s before he was born”; ☐ “when he dies the aliens will come down and kill all the police and the army”;
- “his life was more or less over anyway after what had happened”;
- “no one else has to die now that his brother is dead ... we’ve won; that’s it”.

Mr S was also reported as telling the assessing forensic psychiatrist (the author of the report) that the depot medication did nothing for him and that he was only telling him so much information “because I’ll probably never get out of jail”. The report also noted that Mr S believed that “no medicine will take away my voices and that the only thing that will take them away is an operation to remove the bugging device”.

The pre-sentencing psychiatric report also noted Mr S’s report that he had told others about the voices he heard but that no-one believed him. The report also set out Mr S’s recall of his last psychiatric assessment on 21 December 2009, at which he was accompanied by his sister. The report said: “At the time he was hearing voice but it was ‘no good telling people’ as they simply would think he was mad.”

The assessing psychiatrist’s perspective as set out in the pre-sentencing report was that:

- Mr S was mentally unwell;
- On more than one occasion during the interview he clearly laughed in response to hearing something;
- Mr S’s speech was normal, his mood appeared to be normal and reactive and there was no evidence that his thoughts were being blocked or interfered with in any way; ☐ The diagnosis of paranoid schizophrenia was a “robust diagnosis”;
- Mr S’s symptoms had remained present “while he had been taking an adequate dose of injected anti-psychotic medication, which was thought by those following him up to be keeping him well”; and
- “There is compelling evidence that immediately following his arrest Mr S had delusional beliefs involving his brother, whereas he either did not have these beliefs, or was concealing them, when reviewed on 21 December ... and on 10 and 24 December when he attended to have his medication administered. It is perhaps most likely that Mr S was concealing his abnormal beliefs and his experience of auditory hallucinations from those who were assessing him.” The consultant in forensic psychiatry noted that in the lead-up to his last notable relapse in 2002 Mr S had not been able to conceal his symptoms from others. He also noted that it was possible that an acute stressor had occurred after Mr S’s assessment on 21 December 2009, and that his sister would not have been able to tell mental health services if there was anything of concern at the time he was assessed or afterwards.

The Independent Team has already noted that Mr S’s sister was at a loss to know what had triggered Mr S’s attack on his brother. This information underlines the final conclusion of the consultant in forensic

psychiatry that, in the absence of any information supporting a sudden deterioration in Mr S's mental state, "it is more likely that he had been concealing his ongoing symptoms from those around him".

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Predictability

With regards to the predictability of the incidents that occurred, the Independent Team does not believe that the mental health services could have reasonably predicted that Mr S would act as he did. Mr S had attended reliably for his medication by injection between July 2006 and the end of December 2009. Although Mr S had been erratic in his attendance at outpatient appointments, bar 2007, he was seen at least annually and on these occasions he was also accompanied by his sister. Although asked about his voices and hallucinations, Mr S did not divulge to any professional that he continued to believe that he was bugged, or that he had a special mission to carry out. Mr S's sister did not raise any concerns with the mental health services about her brother over this same period. In fact, Mr S's sister had no information to provide as she was not at all aware that her brother continued to harbour these unusual beliefs.

Preventability

The only information that might have alerted mental health services to a possible deterioration in Mr S's mental state was held by Mr S's housing provider. The Independent Team considers that reasonable effort was made by the housing provider to determine whether or not Mr S was in receipt of mental health services in March 2009. The housing provider reported to the Independent Team being informed by the mental health service that Mr S was not in receipt of mental health services. The lapse of information transfer to the housing provider meant that Mr S's community mental health team was not aware at any stage of the concerns that prompted Mr S being discussed at a vulnerable person's panel in April 2009.