Report of the Independent Inquiry into the Care and Treatment of Mr. Glaister Earle Butler

COMMISSIONED BY
THE WEST MIDLANDS STRATEGIC HEALTH AUTHORITY

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CHAPTER 1

INTRODUCTION

1. Background

Following the conviction of Glaister Earle Butler for the manslaughter through diminished responsibility of Detective Constable Michael Swindells, this Inquiry was commissioned by what is now NHS West Midlands[1], as Strategic Health Authority, responsible of the oversight of Birmingham and Solihull Mental Health NHS Trust.

2. The Terms of Reference of the Inquiry are set out in Appendix 1.

3. The Members of the Panel of Inquiry were:

Robert Francis, QC (Chairman)	A Barrister specialising in medical law.
Bernadette Hennigan	At the time of appointment Director of Nursing of a large London Mental Health NHS Trust, now a self employed Management Consultant.
Linda Metcalfe	Mental Health Service Manager (Policy and Practice) employed by a local authority Social Services Authority and lay member of the Mental Health Review Tribunal.
Dominic Makuvachuma-Walker	A mental health survivor who now works for the East London Foundation Trust. At the time of the Inquiry he was the Project Development Manager for the Catch-a-Fiya Network at the Afiya Trust.
David Ndegwa	a Consultant Forensic Psychiatrist and Clinical Director in forensic psychiatry of a London NHS Trust.

[1] *Formerly Birmingham and Black Country SHA*

4. Mr. Butler's Consent and his Rights

Before the Inquiry started Mr. Butler was asked for, and kindly gave, his consent to the disclosure of his records to enable the Inquiry to undertake its work, and we are grateful to him for helping us in this way. It has been necessary to include a considerable amount of material derived from his records in this report. We have, at all times, been mindful of his right to privacy and have balanced that against the public interest in being assured that this Inquiry has been thorough and has reached evidence based conclusions. Accordingly, we have only included information from the records where we consider it necessary in the public interest. We considered whether it was possible not to name Mr. Butler in this report, but concluded that the homicide of which he stands convicted is so well known that no purpose would be served by anonymisation.

5. We invited Mr. Butler to meet us as we thought it would have been extremely helpful to the Inquiry to obtain his perspective on the care and treatment provided to him. He declined to do so. Helpful though it would have been to see him, his response is perfectly understandable.

6. Evidence

The Inquiry gathered a large quantity of documentation including, so far as possible, the entirety of Mr. Butler's records, police witness statements and other relevant material. A summarised list of this material is at Appendix 2. We also referred to a number of other reports and publications; a list of the principal references is at Appendix 3. The Inquiry sat in private and interviewed witnesses who agreed to see the panel in response to an invitation. A list of the witnesses we interviewed is at Appendix 4. They were given the opportunity to be accompanied by a friend or a representative of their choice. Each such witness provided information to the Inquiry on the understanding that this would be kept confidential except to the extent the panel deemed necessary to inform this report. All oral evidence received was transcribed and a copy sent to the witness for agreement

or amendment. Although the panel had no powers of compulsion, all those we invited to meet us, with the exception of Mr. Butler himself and certain members of his family, agreed to do so, and we record our gratitude to all of them for their co-operation.

7. The Perspective of DC Swindells' Family

In the course of our inquiry we had the privilege of meeting DC Swindells' mother and step-father, Mr. and Mrs Taylor. They were highly impressive people, who in spite of the clear difficulties, and obvious and understandable emotions about the situation, shared with us their constructive and objective views about this tragedy and what they wanted to come out of this Inquiry. We hope they will not mind our quoting some of the things they said to us which we have kept to the forefront of our minds while preparing this report.

"…we always felt that as well as Mick, GB was let down by the system. Both were let down by the system in different areas .. we are here not to condemn anything…just to try and stop these things happening"[2]

Mr. and Mrs Taylor raised a number of questions. The matters they raised, listed here in no particular order, included:

- Why was no-one helping Mr. Butler with his rent and other financial difficulties?

- Was enough thought and support given to the community among whom Mr. Butler was housed?

  "We have had care in the community, I know, but my concern at that time would be care of the community rather than just care in the community… care of the community should be as important as care in the community".

- Had the team taken Mr. Butler's background and history fully into account in the care and support they offered him?

- Was the team hindered in their knowledge of Mr. Butler by poor record keeping and management?

[2] *As Mr and Mrs Taylor were seen by us together and adopted each other's remarks we have taken what each said as a joint statement by both.*

- How did he come to have a knife on him in a public place when his mental state was such that he could have "snapped" at any time?

- Had Mr. Butler been able to fool the team into thinking he was getting better because they had become complacent in their dealings with him?

- Why was there no external monitoring of Mr. Butler's care planning and management?

  "They just seem to be self-monitored. I would not do that in a small business. I would expect it to be monitored and reviewed on a 12 month basis, minimum, by an outside organisation. You cannot monitor yourself…"

They also expressed the view that the nursing and clinical leadership of the team was to blame for what occurred. They felt that a number of people there were not doing their job. They expressed concern that someone like Mr. Butler could not be compelled to take prescribed medication, and they could not understand why he was not provided with sheltered accommodation.

8. The questions they have were very understandably and reasonably raised are ones which we will, to the extent that they are within our terms of reference, seek to address in this report. It will be seen that in many instances the concerns underlying their questions are ones which we share.

9. Mr. and Mrs Taylor also expressed concern about the police operation which led directly to the death of DC Swindells:

"I do feel, while I want the full coverage, that probably the Mental Health people are getting the full responsibility of this when I feel the police should be sharing the blame… you just get stonewalled by the police. You don't get an open meeting like this."

"*It does not take eight policemen and a dog handler to arrest someone in that state. And if you have got a fear, you've got to snap. But obviously having a knife in his pocket, or in his trousers at the time, it could have happened at any time."*

We record these comments because it is right to point out that our Terms of Reference do not permit us to investigate the rights and

wrongs of the police operation. Therefore, of necessity, our investigation on its own cannot provide the complete consideration of the sad events that led to the death of DC Swindells and the conviction of Mr. Butler, which Mr. and Mrs Taylor and the public have a right to expect. We understand that the police authorities may have undertaken some form of Inquiry but we have not been informed or its nature, or whether it has been concluded, and, if so, with what result. We have restricted our consideration of the police to the issue of liaison with mental health services.

10. Records

Given the length of Mr. Butler's history it has been necessary to receive and examine a large collection of mental health and other records. Given the period of time over which they were prepared, and the later involvement of the police, it is perhaps not entirely surprising that they are not in very good order. However, it remains of concern to us that the records presented to us by the Trust appear to be significantly incomplete as compared to the copy records made available to us by the police who had them as exhibits for the purpose of Mr. Butler's trial. Just as importantly, the records that were presented to us were in a state of disorder. This made the task of disentangling what had happened and the order of events particularly difficult. This disorder was not wholly attributable to their use in the police investigation. We were told more than once by mental health service witnesses that the notes had been difficult to use and to locate. It is of serious concern to us that the state of the notes was such as to prevent them being the useful management tool that they should have been. As suspected by Mr. and Mrs Taylor this must have had an impact on the standard of care, supervision and support available to Mr. Butler.

11. General approach

11.1 **Preparation of report:** In this report we consider first the incident that has brought about the need for this Inquiry. Then we consider in a

more or less chronological narrative the services provided by mental health services to Mr. Butler in the years leading up to the incident. In these chapters we identify a number of areas of concern at the practices adopted. We then take up several themes, team management, social care, liaison with other agencies, culture and race issues, and confidentiality. Each member of the panel has contributed to the writing of this report, bringing to it their own perspectives – accordingly readers preoccupied with such matters may note that there are differing styles at various points of this report. However, the report is agreed by all members of the panel.

11.2 **Apportionment of responsibility:** It will become apparent in the chapters that follow that the panel has serious concerns about the level of care and supervision provided to Mr. Butler by the Small Heath Assertive Outreach Team. The panel considered carefully the extent, if at all, to which they should attribute the failings identified to individuals. In the end we decided that to do so would not be constructive. We were mindful of paragraph 4 of the terms of reference which enjoins us to look for the lessons to be learned rather than the apportionment of blame. We also had regard to the several accounts we had from members of the team which suggested that from the date of this tragedy they have been anxious about being singled out for responsibility for it. Neither of these factors would have dissuaded us from singling out individuals whose personal professional performance gave us serious concern. We have not done so, although it will become apparent that we have found significant areas of unsatisfactory practice in this case. In the end, however, we have come to the conclusion that these are more to do with a problem with the culture and practice within the team as a whole, abetted by a failure in management at all levels, as well as team supervision and review. All these issues need to be addressed collectively rather than for individuals to be singled out. To do the latter would, we think, be unfair to such individuals and unlikely to be productive in terms of ensuring a better standard of service in the future.

11.3 **Learning the lessons:** We have been told of the Trust's own inquiries since the incident and of the changes made in policy, management and practice as a result. We considered it would be something of a sterile exercise to lengthen this report with a review of that process rather than to express our conclusions on the facts as we found them. We make a number of recommendations based on our findings. It may be that it will be said that some of these have already been implemented, but we hope that those concerned will consider whether the steps they have taken have gone far enough in the light of our findings. The case, tragic as it is, should be a catalyst to a review of the provision of assertive outreach care.

12. Publication

12.1 The terms of reference make it clear that the Strategic Health Authority [SHA] wishes to receive a report for publication and this is what we have intended to produce. We understand and accept that the SHA has a responsibility to review the report and make a decision as to whether it should be published, and, if so, in what form. While recognising that this responsibility is the SHA's, and not the panel's, we think it will be helpful to give our view on publication.

12.2 Publication of our report as it stands will inevitably bring into the public domain information about Mr. Butler and his family which is private and confidential. Generally a health authority owes a duty to patients and service users to keep their personal information confidential, both at common law and under the Data Protection Act. Further as a public body the SHA has a duty to respect Mr. Butler's private life in accordance with Article 8 of the European Convention on Human Rights as incorporated into domestic law by the Human Rights Act 1998. Additionally, the right of freedom of speech under Article 10 must also be considered.

12.3 The applicable principles have recently been considered by the Administrative Court in *Stone v South East Coast Strategic Health Authority and others*[3]. In that case Davis J said:

> The questions that have to be asked are whether Mr. Stone's rights under Article 8 of the Convention have been breached; whether the decision to publish the report is an interference with his right to privacy which is not justified under Article 8(2). … As has been emphasised in the European Court of Human Rights, the protection of personal data, and the need for appropriate safeguards, is of fundamental importance to a person's enjoyment of the right to respect for private and family life provided by Article 8: and that is particularly so in the case of medical data…
>
> Moreover, it seems to me of importance that in the present case Mr. Stone is not seeking simply to assert his private rights and private interest (although he is doing that): he is also himself asserting a matter of public interest. That consists not only of the upholding of the general principle of a right to privacy but also the upholding of a wider matter of public interest: viz. that a person can freely and frankly discuss sensitive matters with his or her doctor, probation officer and social worker etc. and, further, can co-operate with an Inquiry of the present kind without being deterred by the risk of subsequent disclosure…
>
> Any restriction of the right to freedom of expression must be subjected to very close scrutiny. But so too must any restriction of the right to respect for private life. Neither article 8 nor article 10 has any pre-eminence over the other in the conduct of this exercise.
>
> ... Article 8 is not the only Convention right that has to be considered. As Campbell v MGN Ltd makes clear, Article 10 also has to be considered and given due weight. In the present case, it is now (albeit it was not in the original grounds) accepted on behalf of Mr. Stone that – even though the three Defendants, as public bodies, cannot themselves directly invoke the provisions of Article 10 – such Article comes into play: if only because of the general corresponding right of the public to be free to receive information where it is sought to be published…
>
> And in a case such as the present an ultimate balance has to be struck not only by weighing the considerations for and against a restriction on the right to privacy by reference to Article 8 itself but also by weighing the considerations for and against a restriction on publication by reference to Article 10.

12.4 In *Stone*, the court recognised that the patient had a right to confidentiality and privacy; not only was this a right in which he had a private interest but there is a public interest in patients being able to confide freely in medical advisers and mental health workers without fear that their disclosures will be published. In order for publication to be justified those factors have to be outweighed by pubic interest factors such as the protection of public health. That interest can include the protection of public confidence in the management of the health service, and allowing the public to know sufficient of the facts to

[3] *[2006] EWHC 1668 (Admin) 12 July 2006, Davis J*

enable them to judge whether the conclusions reached by an Inquiry such as this are justified. The court held that the public had a "true public interest" in knowing what treatment and care were provided and to be able to reach an informed assessment of the failures identified. As the judge put it:

> The existence of potentially dangerous persons at liberty in the community affects the entire community. That community has a reasonable and justified expectation that an Inquiry undertaken after such a high profile case as the present will be publicised in full, so that the public is not left in the dark (or in the shade) about how it happened or left to speculate about the lessons that have been or should be learned and about the recommendations made, with a view to implementation, to reduce the risk of such occurrences in the future.

Such objectives are not met merely by circulating the report among health professionals. Where public agencies are criticised the public have a right to know about it and an expectation of being able to consider the details. Finally, the court suggested that much of the substance of the information is already in the public domain by reason of the criminal court proceedings.

13. In the view of the panel the public interest in the sense identified in *Stone* outweighs Mr. Butler's rights to confidentiality and privacy for the information about him included in this report. Our reasons are as follows:

13.1 The killing of DC Swindells by Mr. Butler and the facts about it disclosed at the trial caused widespread and justified public concern, about the standard of mental health service provision to dangerous patients in the community and as to the risks to which the public were exposed.

13.2 The purposes of the process under which this Inquiry was commissioned included an investigation and reporting of the facts about the treatment and support provided to Mr. Butler, whether there were deficiencies in that provision, and an identification of lessons to be learned in order to reduce the risk of such tragedies occurring in the future. Those purposes would be defeated if publication of the Inquiry's report is not permitted.

13.3 In order for the public to assess whether there has been an appropriate investigation of the matter they need to have access not merely to a summary of conclusions and recommendations, but to the full detail of the findings of fact on which these were based. The public cannot otherwise judge whether the report's conclusions and recommendations are well founded.

13.4 Unhappily we suspect that many of the problems we have identified in this Inquiry are not confined to one Assertive Outreach Team in Birmingham and that there may be a case for a review of practice elsewhere. Unless the report is published in full this benefit may be prejudiced.

13.5 If things have gone wrong in the provision of mental health services by the State, the public are entitled to know what went wrong and why it did so. Given the policy of having inquiries after events such as this, there is a legitimate expectation that their reports will be published.

13.6 As in the Stone case the principal facts are already in the public domain in any event; in particular detailed psychiatric evidence was given at Mr. Butler's trial in public. From this it is already a matter of public record that Mr. Butler had been suffering from a mental illness for a long period and was under treatment for it.

13.7 In preparing this report we have constantly had in mind the question of whether what we have included was necessary to inform our conclusions. We do not believe we have retained any unnecessary or irrelevant material.

13.8 For the sake of completeness we should add that we consider that publication of the report is not prevented by the *Data Protection Act 1998* for reasons analogous to those considered in the Stone case. Section 4 of the Act provides that processing of sensitive personal information, including medical information, is permitted if one of the conditions in each of Schedules 2 and 3 of the Act are satisfied. Schedule 2 paragraph 5(2) refers to the processing of information

"necessary for the purpose of any … functions of a public nature exercised in the public interest by any person". Publication of this report could be for such a purpose. Paragraph 7(b) of Schedule 3 refers to the processing *"being necessary... for the exercise of any functions conferred on any person by or under an enactment".* It was held in Stone that publication of a homicide inquiry report such as this was an exercise of a function under section 2 of the *National Health Service Act 1977.* In any event under paragraph 8 of the same Schedule publication is permitted if necessary for medical purposes which include *"the purposes of preventative medicine, medical diagnosis, medical research, the provision of care and treatment and the management of healthcare services."* The judgment in *Stone* supports the proposition that publication of this type of report falls within that condition.

14. Our thanks

The Inquiry panel has been assisted throughout by its secretary, Pearl Green. We would like to express our heartfelt thanks for her diligent and efficient support.

15. Recommendations

15.1 We consider it is essential that the Trust now reviews the records of Mr. Butler and ensures that a properly ordered and as complete as possible a set is collated for future use. Further, given the complexity of his case, an accurate summary should be drawn up of the salient points of the history for use in the future, should Mr. Butler ever require outpatient mental health service in future. Accordingly, we recommend that the Trust undertake such a review.

15.2 This report should be published in its entirety, but that before doing so an opportunity is given to Mr. Butler to make representations on the subject so that these may be taken into account in the SHA's decision-making process.

15.3 The Trust and the Strategic Health Authority should consider whether the issues in this report require a review of policy and practice in community mental health services generally in their respective areas and, to the extent that they consider that such a review is necessary, ensure that it is carried out and publish the results.

15.4 The Trust and the Strategic Health Authority should produce and publish a statement indicating the extent to which they accept the findings and recommendations in this report and the action taken to implement those recommendations which they accept.

CHAPTER 2

EXECUTIVE SUMMARY

1. The Incident

On 21st May 2004, on a canal towpath in Birmingham, Glaister Earle Butler lethally stabbed a police officer, Detective Constable Michael Swindells, who was, with a large number of other officers, trying to detain him. At the time Mr. Butler was a patient under the care of the Small Heath Assertive Outreach Team [AOT], following his discharge from in-patient treatment at Highcroft Hospital in October 2001.

2. At the time of this tragic incident a number of factors came together which resulted in Mr. Butler being able to commit such violence. Some of these factors were known to the AOT, some were not. The AOT believed, wrongly, that Mr. Butler was in a stable state and posed no appreciable risk to himself or the public.

3. The matters that were known to the team included the following:

3.1 Mr. Butler was a patient with a longstanding diagnosis of paranoid schizophrenia.

3.2 His paranoia included deluded beliefs that the police, MI5 and others, including the mental health services were intent on ruining his life and stealing money from him. His experience of the police suggested to him that they would look for ways to have him taken to hospital under the Mental Health Act.

3.3 In the past, when unwell, he had engaged in violent behaviour, albeit not at a very serious level, and, had on one occasion been suspected of setting fire to his flat.

3.4 He was also known to have neglected himself and his finances when unwell.

3.5 He was continually reluctant to engage meaningfully with the AOT and they were concerned that if they insisted on more interaction than he was willing to accept he might disengage altogether.

3.6 When in hospital he had been extremely reluctant to accept anti-psychotic medication but in the end accepted it.

3.7 He showed little evidence of accepting that he was or had been unwell.

3.8 In the period leading up to the incident there had been a number of occasions when he had not answered the door or was not in.

3.9 On one occasion when the consultant psychiatrist and a nurse were able to gain access to Mr. Butler's flat he was observed to have a large knife on his sofa and there appeared to be damage to a door. They were satisfied by his explanations that there was no cause for concern.

3.10 They regularly delivered prescribed anti-psychotic medication to Mr. Butler which he assured them he was taking.

3.11 Some members of the team had concerns about his compliance with the medication regime prescribed.

4. Unknown at the time to the AOT were the following matters:

4.1 Mr. Butler had been taking none, or hardly any of the medication delivered to him for well over the past 12 months. After the homicide the police found 432 daily doses of medication in his flat.

4.2 He had failed to apply properly to renew his housing benefit with the result that this had stopped.

4.3 He was in arrears of rent on his flat.

4.4 Neighbours were concerned about the noise he was making in his flat.

4.5 In retrospect while Mr. Butler appeared to be relatively stable on a superficial assessment, in reality he was unwell and vulnerable to react adversely to a sudden encounter with a party of police officers.

5. On 21 May a number of events occurred which could well have destabilised an already fragile mind:

5.1 A Council carpenter appeared in the morning to repair the gate leading to Mr. Butler's flat. Mr. Butler emerged from his front door waving a knife at the carpenter and generally behaving towards him in an aggressive and threatening manner.

5.2 A short time later a Council representative left a notice of intention to seek possession of Mr. Butler's flat on the grounds of non-payment of rent. Mr. Butler was seen by a neighbour to react in a distressed manner when he opened this notice, before walking away.

5.3 Following receipt of a report about the incident with the carpenter, 11 police officers and a police dog were assembled at a rendezvous point in the road round the corner from Mr. Butler's flat preparatory to calling on him to investigate the report. Mr. Butler, returning from a trip to the shops, unexpectedly came upon the police.

5.4 As soon as the police saw Mr. Butler, he was asked to stop so that they could speak to him, but he fled, pursued by the officers and the dog.

5.5 When the dog caught up with him he turned, drew a large knife and waved it at the dog, before resuming his flight.

5.6 The officers gave chase, calling in reinforcements.

5.7 We have no doubt that these events led Mr. Butler to be in a state of great fear, possibly even being afraid that he was about to be killed. In these circumstances a highly dangerous situation developed in the course of which DC Swindells was fatally wounded.

6. Mr. Butler was eventually arrested, but not before he had resisted the effects of CS gas and being struck by rubber bullets. When examined by psychiatrists at the police station later that day he was found to be acutely unwell.

7. Before embarking on their attempt to investigate the complaint, the police had sought information from mental health services, but through no fault of their informant were not given more than the briefest details of Mr. Butler's history. They were not informed that there was a history of physically violent behaviour or that Mr. Butler had carried a knife in the past. The state in which the records were kept was such that it would have been very difficult for any member of staff unfamiliar with Mr. Butler's case to access essential information efficiently and accurately.

8. The events of 21 May give rise to a need to examine the following themes:

8.1 The history of the care and support given to Mr. Butler by mental health services since he first came to their attention in 1994.

8.2 An overview of the performance of the AOT.

8.3 A review of the medication prescribed to Mr. Butler and the monitoring of compliance.

8.4 A review of the liaison between the AOT and other agencies and members of the public.

8.5 The general functioning and management of the team

8.6 The level of social care provided.

8.7 The impact of cultural and racial issues

8.8 The impact of the perceived need for confidentiality.

9. Mr. Butler's Background and the Care provided

Mr. Butler is of African Caribbean descent and was born in September 1953. He was therefore 50 years of age at the time of the incident. Before he became unwell he had a record of achievement. He had obtained a university degree and skilled employment as a design draftsman in a geographical area in which racial prejudice was

common. He was made redundant in 1982, he believed because of his race. Thereafter, he was unsuccessful in obtaining long-term employment and does not seem to have had paid work after 1985. By the time he came to the attention of mental health services in Staffordshire in 1994 he was socially and financially isolated and suffering from the paranoid beliefs described above.

10. He was admitted to an acute unit in Stoke-on-Trent on 17 March 1994 under sections 2 and then 3 of the *Mental Health Act 1983*. He had a history which included an attack on a neighbour, and spitting at other neighbours. He was also in a state of self-neglect which included failing to pay his bills or claim benefits and allowing most services to be disconnected at his accommodation.

11. In December 1994 he was thought to have recovered sufficiently to be discharged to Servol, a community hostel in Birmingham designed to serve the needs of service users with an ethnic background similar to his own. Mr. Butler remained at Servol until November 1997 when he left of his own accord. During his time at this community the AOT established contact with him on a regular basis and tried various methods of engagement, none of which were particularly successful. On occasions during his time there staff suspected that he was not taking his medication.

12. After he left Servol Mr. Butler lost contact with mental health services, until a chance encounter in March 1999, when the police arrested him on 12 August 1999. It was alleged he had thrown a brick through a neighbour's window and had been found in possession of a knife. He expressed a belief that MI5 had broken his windows and doped his food, and that the police had stolen money. He was admitted to Highcroft Hospital, and subsequently Small Heath Hospital, under section 3 of the *Mental Health Act 1983*. Later in August he absconded and was detained by the police with the assistance of CS gas. He expressed the belief that the police wanted to kill him and all Black people. By October he was thought to have recovered

sufficiently for supervised discharge under sections 25A to G. His discharge was revoked in November because Mr. Butler had stopped taking his medication, was confronting his neighbours, and was disengaging from the AOT. He continued to deny he was ill and complained to the Jamaican High Commission. There were suspicions that he was only pretending to take his medication. There were incidents of an assault and other threatening and violent behaviour.

13. Once he became more compliant Mr. Butler was discharged, in January 2000, again under statutory supervision. A clear and structured discharge plan was formulated and then implemented by the AOT. The principal contact with Mr. Butler was by a support worker from a similar ethnic background who appeared to be more successful at engaging with him than others. However, in retrospect it can be seen that the intervals between visits were greater than provided for in the plan, and records of monitoring his mental state became increasingly perfunctory. Despite this the year was one of relative stability until January 2001 when contact was lost with Mr. Butler again.

14. Eventually Mr. Butler was found at home on 28 February 2001, but was clearly unwell. After an assessment the following day a warrant for his detention was obtained, but he evaded an attempt to execute it. He was eventually arrested by the police on 5 April for suspected arson and after a struggle was taken into custody. He was then re-admitted to hospital.

15. On this occasion Mr. Butler remained compulsorily in hospital until October 2001. He resisted being given depot injections of anti-psychotic medication and had to be restrained for this purpose. He demonstrated little or no insight into his illness and was thought to mask symptoms. When he developed side effects of the anti-psychotic medication he agreed to take atypical anti-psychotics orally. A Mental Health Review Tribunal in June 2001 refused to order Mr. Butler's discharge on the ground that he continued to lack insight

and would not be likely to consent to medication if his compulsory admission were ended.

16. Thereafter, he began to co-operate more with his treatment, and preparatory steps were taken to allow him to return to the community, including assistance from the AOT in obtaining council accommodation. A CPA care plan was prepared. There was no note as to why discharge was appropriate as a baseline against which to assess future progress.

17. From October 2001 until the date of the incident Mr. Butler was under the care of the Small Heath Assertive Outreach Team. The general standard of the care and supervision gave the Inquiry cause for concern in a number of respects:

17.1 If Mr. Butler was not in when a team member called his supply of medication was often posted through his letterbox. No reason for this questionable practice was recorded.

17.2 CPA documentation during this period was sparse and did not detail sufficiently Mr. Butler's needs or what support for them was planned.

17.3 Little consideration was given to the means of monitoring compliance with the prescribed medication regime in spite of a previous history of non-compliance and suspicion, while in hospital, of deception. Mr. Butler's assurances that he was taking his medication were accepted without question.

17.4 Social support offered failed to take into account Mr. Butler's particular interests and aptitudes.

17.5 The frequency of visits fell below the level to be expected in assertive outreach.

17.6 The team too readily accepted brief interaction and superficial contact with Mr. Butler on his doorstep rather than ensuring that they gained access to his accommodation for a longer interview.

18. In the period of five months leading up to the incident, the causes for concern referred to above continued, but in particular:

18.1 CPA planning and risk assessment was inadequate

18.2 There was little reaction to the evident reluctance of Mr. Butler and his frequent absence from home or unwillingness to answer the door to engage other than repeating visits until he was seen.

18.3 Although on 26 April 2004 a knife on the sofa and marks on the back of Mr. Butler's door were seen, the explanation that he was pursuing martial arts (or sharpening pencils) was accepted without any follow-up or any consideration of the implications of the explanation for the management of his care and support.

19. In addition, there were other matters evidencing practice that should have been better:

19.1 A clinical assessment, if performed on 27 April was not recorded by the consultant psychiatrist.

19.2 Some visits by the team were not recorded.

19.3 There was no completed review of the risk assessment by the team following the visit on 27 April.

19.4 Team discussions at which matters concerning Mr. Butler may have been discussed were not recorded.

20. Overview of Care

20.1 We accept that Mr. Butler was unwell and suffering paranoid delusions about figures of authority throughout 2004.

20.2 Throughout his time in the community he struggled to occupy himself constructively and lost contact with his family. Consultant Forensic Psychiatrist (B) told us Mr. Butler *"was living the bare bones of existence."*

20.3 The support provided by the team failed to detect the depth of his illness, his non-compliance with medication, his increasing financial and social difficulties, or the significance of what in retrospect were overt signs of disturbance, such as the appearance of the knife.

20.4 The team was oversensitive to the risk of disengagement and failed to apply the assertive outreach model of care, relying instead on a passive and reactive model, applying routine and formulaic measures to a service user who was unusual, but above all an individual with his own abilities, interests and needs.

20.5 They did not pay Mr. Butler the attention he needed, in part because of their assessment of him as being low risk, thus ignoring the fact that he had a high level of need which if not satisfied could lead to relapse and increase in risk.

20.6 The team failed to have regard to the significance of Mr. Butler's history.

20.7 Mr. Butler was failed by the team not because of individual incompetence but by a collective acceptance of difficulties as being insuperable, the loss of will to be assertive, and a failure to persist in a systematic, co-ordinated and thoroughly documented programme of care and support.

21. Prescription of Medication and Monitoring

21.1 A concerning degree of reliance was placed on the efficacy of medication to the effective exclusion of other forms of therapy and support. While it is not suggested that the prescription of anti-psychotic medication was inappropriate, the subsequent visits to Mr. Butler by the team was largely focussed on delivery of medication.

21.2 The monitoring of Mr. Butler's compliance with the prescribed regime of medication failed to detect that he had not taken and had stored well

over a year's supply of the Olanzapine.

21.3 The team allowed themselves to rely on the efficacy of medication in controlling Mr. Butler's illness, without retaining even basic means of monitoring compliance.

21.4 The team relied on Mr. Butler's presentation in brief encounters and on his own assurances.

21.5 While the team was aware of the difficulties in effective monitoring, they took no steps to improve their capability in this regard by searching for more effective means.

21.6 The team harboured some doubt about Mr. Butler's true compliance, as the existence of such doubts was communicated to the police on 21 May 2004 and to a psychiatric SpR after the incident on that day, but they did not act on these doubts,

21.7 The team could have, but did not consider:-

21.7.1 Laboratory testing of drug levels.

21.7.2 Active monitoring of possible side-effects, such as weight gain and drowsiness.

21.7.3 More intense questioning of Mr. Butler.

21.7.4 Requesting Mr. Butler to produce his supplies and the containers.

21.7.5 The use of a staged approach to monitoring.

22. The team allowed the unacceptable practice of delivering medication through the letterbox as opposed to personal delivery without documenting any reasons for such a practice, or without due regard to at least some concerns about the practice expressed within the team.

23. The team failed to keep or maintain adequate records of medication dispensed in the community by delivery to a service user.

24. Liaison with Others

24.1 The team failed to detect Mr. Butler's problems with housing benefits and rent arrears. The local authority appeared to have no record that Mr. Butler was a service user of mental health services even though the Assertive Outreach Team had facilitated the allocation of a council flat to him. There was inadequate liaison and exchange of information between the team and the housing authority

24.2 The team was unaware that Mr. Butler's gas supply had been disconnected. If known to them this would have suggested to them that Mr. Butler was neglecting himself again. A periodic review of Mr. Butler's financial welfare would have brought this problem to light.

24.3 The team was unaware that neighbours were concerned at anti-social behaviour on the part of Mr. Butler. The team did not make any contact with neighbours. While there are difficulties with regard to disclosure of confidential sensitive personal and clinical information, there is no reason why some form of contact with neighbours cannot be fostered, particularly in the case of a service user who is socially isolated.

25. Team Management

25.1 The assertive outreach service in Birmingham was one of the first in the country and was highly regarded as being a role model to follow elsewhere. Pioneering work in Birmingham led to the wide acceptance of this model of care.

25.2 By the time of the events under consideration by this Inquiry there were obstacles in the way of the team maintaining a standard of excellence:

25.2.1 The post of service manager had been vacant for some time before 12 April 2004.

25.2.2 The team manager was part time.

25.2.3 A history of a rapid turnover in consultants developed.

25.2.4 The consultant who was finally appointed was required to devote a considerable proportion of his time to other duties and, having been a junior doctor with the team previously, might have lacked status among team members.

25.2.5 Major changes in the corporate structure of mental health services in the West Midlands resulted in senior management having little time to monitor the performance of teams about which there had been no expressions of concern - the merger of Trusts in Birmingham.

25.2.6 The team lacked the support of a psychologist.

25.3 The combination of a reputation for excellence and pioneering work, a low turnover of team members, with the exception of the consultant, and the above mentioned issues may have resulted in the team becoming complacent about their task, and to lack a clear sense of purpose or a desire to be self-critical about their standard of practice.

25.4 The result was a focus on a medical model of care rather than a social one and a failure to devise exit strategies and targets for each service user. They did not seek out new ways of tackling difficult cases such as Mr. Butler's. They failed to make sufficient time to discuss patients about whom they felt little cause for concern and concentrated to their effective exclusion on the rest. Once a service user had fallen into the lowest category of case, it was unlikely that subtle signs of deterioration would be picked up.

25.5 The emphasis was on the delivery of medication as opposed to seeking out support measures which might have encouraged Mr. Butler to engage more with services and the community.

25.6 The maintenance and keeping of records fell to a low standard.

25.7 The team did not follow adequately the principles of the Care Programme Approach in their care planning or risk assessment. In particular:-

25.7.1 They did not formulate or record a full account of relapse factors as opposed to a brief list.

25.7.2 They did not undertake or record a review of relapse or risk factors for an unacceptably long period after the initial discharge care plan.

25.7.3 Such assessment and review as there was consisted predominantly of mechanistic completion of a pro-forma and there is no evidence of an attempt to manage risk with express reference to Mr. Butler's actual life and social context.

25.7.4 There was no recorded attempt as part of the care plan to consider liaison with other agencies, such as the housing authority or Mr. Butler's general practitioner.

25.7.5 There is no evidence of involving Mr. Butler in the preparation of a risk assessment.

25.7.6 Mr. Butler's desire to study and to return to work was never highlighted in a care plan.

25.8 There were deficiencies in the process of team learning after the incident:

25.8.1 Team members were not encouraged to discuss the incident after the event in detail for fear of contaminating evidence.

25.8.2 There was confusion about the preparation of internal reports and a failure to distribute them to the managers and others who needed to take them into account in improving practice.

25.8.3 Staff support offered to the perceived to be unhelpful by team members and failed to dispel fears about a culture of blame.

26. Social Care

26.1 The social care model was not followed in a case in which it was clearly needed.

26.2 Planned weekly visits were changed to fortnightly visits without any recorded team discussion, in a case in which a more intensive engagement was required.

26.3 The care plan did not contain any effective strategy for reducing Mr. Butler's social isolation.

26.4 It is not clear that sufficient was done to support Mr. Butler in attempts to obtain training places or employment.

26.5 The team acquiesced in Mr. Butler's desire for privacy without taking into account the possibility that this amounted to a wish to disengage and an indication of relapse.

26.6 There is no evidence that the needs of Mr. Butler's brother were considered.

26.7 There was no consideration of offering an advocate to Mr. Butler.

26.8 There was little or no consideration of Mr. Butler's social framework and in particular his relations with neighbours.

26.9 There was no contact with the housing authority after Mr. Butler's placement in a council flat.

26.10 There is no evidence that Mr. Butler's voice was sought or heard as part of the process of support and partnership.

27. Race and Culture

27.1 Any problems identified in the delivery of appropriate mental health care to members of minority groups in Birmingham are not unique to that city but are symptomatic of a nation-wide issue. It is not suggested that staff in Birmingham were racist or other than trying to do their well-intentioned best for members of minority communities.

27.2 This is strong evidence to show that nationally members of the Black community come into contact disproportionately with mental heath services and, once in contact are subjected to more restriction and coercive measures. This experience has to be seen in the more general context of the perception of oppression harboured by many individuals from this background.

27.3 It is well recognised that there is discrimination both direct and indirect in mental health care and that members of the Black community have disproportionately adverse experiences of it.

27.4 Mr. Butler comes from an African Caribbean background and, before becoming unwell had a record of achievement in education and skilled employment. Even after becoming unwell he retained and wished to use his intelligence and experience. He may well have, as highlighted in the evidence from clinicians who worked with Mr. Butler during his time in the Potteries, suffered racial discrimination in the context of his employment and social life, and had adverse experiences with the police in the context of the various episodes of statutory admission to hospital.

27.5 A principal and appropriate purpose of Mr. Butler's transfer from Staffordshire to Birmingham was to take advantage of Servol a community designed to support members of the African Caribbean Community, given that his history suggested a negative experience of services and society, on the basis Mr. Butler perceived to be due to his racial identity. This did not succeed and after his initial discharge into the community Mr. Butler received support in the first place from a

support worker from a similar background who was able to form a productive relationship with him.

27.6 The team did not build on the potential success of this relationship by considering why it seemed to work. Instead they resorted to formulaic, routine and unimaginative measures which failed to meet Mr. Butler's personal cultural needs. They did not consider support informed by Mr. Butler's adverse experiences in life which arose out of his race, or were perceived by him to do so.

27.7 The lack of communication and interaction with Mr. Butler on his own level may have reinforced a negative self-image, based as it would have been on his oppressive experiences of society and authority.

27.8 The team had its own culture in which practice was driven by routine as opposed to addressing specific cultural needs of the user. Members may have perceived the team as delivering a high standard of care, having been widely regarded as being at the forefront of the field. They had a culture of applying a medical as opposed to a social model of care.

27.9 The evidence did not suggest that the team had taken adequate advantage of racial and cultural training made available by the Trust, and there was no evidence of this being consciously applied to address Mr. Butler's needs.

27.10 It is the conclusion of this Inquiry that Mr. Butler became subject to a *"spiral of oppression"* in which negative perceptions on the part of the team reinforced a reluctance to seek help, an uncertainty on the part of the service as to how to engage, leading to an increased risk of worsening distress, a reinforcement of the negative perceptions and a continued reluctance to engage. This *"spiral"* is recognised as a result of a failure to address the specific needs of an individual by adequately taking into account his race and cultural background and experience. This is a matter of looking at the real life experiences of the individual, not applying a stereotype.

28. Confidentiality and Sharing Information

28.1 There is no indication in the case notes that the disclosure or sharing of personal information or the need to do so was considered or discussed with Mr. Butler or that consent to do so was sought.

28.2 It is a fundamental role of care co-ordinators to initiate and maintain contact and partnership with other agencies providing care and support to service users.

28.3 Arrangements about the sharing of information with other relevant agencies should have been put in place before Mr. Butler's discharge from hospital. If necessary, consideration should have been given to making such arrangements part of the conditions for discharge, and for this to be documented in the care plan.

28.4 The team did not engage with Mr. Butler's neighbours. Such contact is possible without compromising confidentiality and provides opportunities for obtaining information which the community are often willing to offer.

CHAPTER 3

THE INCIDENT

1. Background

1.1 The background leading up to the day of the index offence will be dealt with in detail elsewhere, but what occurred on 21 May 2004 involved a combination of circumstance that would have been implausible to predict and constituted an accumulation of incidents which could almost have been calculated to provide the maximum chance that someone with Mr. Butler's background and mental state would be likely to react in an extreme fashion. In short, whatever criticisms should be made about the care received by Mr. Butler before that fateful day – and we will have many criticisms to make – what occurred involved a considerable amount of ill fortune.

1.2 Mr. Butler had had a diagnosis of paranoid schizophrenia for many years. He was under the care of the Small Heath Assertive Outreach Team. It was intended at the time of the incident that his illness would be controlled by the medication, Olanzapine, which he was being prescribed, and which was being delivered to his flat on a fortnightly basis. He had lived independently in the community with what was believed by the mental health services to be success, since October 2001, a period of nearly 2½ years. He maintained his accommodation in a neat and tidy fashion without any assistance or encouragement. He admitted to no financial difficulties. There was no obvious evidence of self-neglect. Mental health service staff noticed no paranoid ideation. He declined offers of joining in special activities offered by mental health services and appeared to lead a solitary life, but, as far as the team knew or asked, he appeared to them to be appropriately occupied in pursuing his interests in engineering design, and, latterly, keeping fit.

1.3 Unfortunately, as will be seen, the reality was different. He had never come to terms with his illness and lacked any real insight into or

acceptance of this. His paranoid beliefs that the police and other organs of state authority intended to ruin or destroy him persisted, albeit hidden below the surface. He remained vulnerable to reacting abnormally to the inevitable adverse experiences to which a solitary, unemployed, mentally ill individual - particularly one of African-Caribbean origin – was likely to be exposed. Undetected by mental health services, Mr. Butler was not taking medication as prescribed; if he was taking it at all, which is open to doubt, he was doing so only on an occasional basis as and when he believed he needed to calm down or get a good night's sleep. From the quantity of medication found after the index offence at his flat, this cannot have been very often. His neighbours had been concerned about his behaviour, although they had not complained to anyone about this. It would also appear that he had got into financial trouble, in particular arrears of rent without reporting this to anyone or seeking help. For some reason he had believed he needed to protect himself, against threats real or imagined. It appears he started practising some form of martial arts, and was keeping a knife readily to hand in his flat, presumably in case he needed to protect himself.

1.4 Given this background it would not have been very surprising, had the true facts been appreciated, if Mr. Butler reacted adversely to the events which occurred on 21 May. What would, however, have been difficult to predict was the severity of that reaction. Mr. Butler was essentially a law-abiding citizen, capable in the past of impressive personal achievement, notably being the first employee of Rolls Royce from his ethnic background and someone who retained demonstrable skills in engineering draftsmanship. When ill in the past he had not been violent to any serious degree. Such incidents as had occurred, although of sufficient concern to warrant appropriate and proportionate steps to prevent repetition, could not be described as very serious in themselves: he was recorded as having thrown a brick through a neighbour's window, and head-butted a nurse while particularly unwell in hospital. There was a possibility that he had set fire to a previous

flat, although the full facts of what occurred had never been established. Such actions indicated that he was liable to behave unpredictably and violently when unwell and there was always a risk that such behaviour could be dangerous to others. However, this was not a man we consider anyone would, before the events of 21 May 2004, have described as being a serious danger to the public or someone who was likely to perpetrate lethal violence. Crucially, though, Mr. Butler's belief systems dictated to him that he was under threat from state agencies, and that he had a need to protect himself. It was his perceived need to defend himself against what he may well have believed was a threat to his life that led to the tragedy of the death of DC Swindells.

1.5 The events of 21 May involved a number of separate incidents involving Mr. Butler which retrospectively led cumulatively to the tragedy: the apparently unheralded visit to Mr. Butler's front gate of a carpenter sent by the housing authority, leading to a disproportionate and threatening reaction by Mr. Butler, service by the housing authority of a notice of intention to seek possession of his flat, an unpredicted encounter between Mr. Butler and large force of police officers assisted by a dog in the street, followed by an unplanned pursuit and, finally, the heroic but tragic attempt of DC Swindells to bring the incident to a close without apparent regard to his own safety. All this was experienced by a man who suffered from paranoid delusions that agents of the state were intent of doing him physical and financial harm and, it can now be confidently asserted, who was suffering from illness without the benefits of either the medication his RMO thought was necessary, or any form of effective therapeutic or social assistance.

2. The Carpenter's Visit

2.1 Mr. Butler lived at 376 Long Acre, Nechells, in a 1st floor flat owned by Birmingham City Council. The downstairs flat, was occupied by a retired couple. Mr. Butler's flat had a separate entrance door, but he

shared with the downstairs flat a path to a common front gate. Mr. W, a carpenter employed by the Council, was instructed to attend the premises to repair or replace the gate. Our inquiries have not conclusively revealed whether any notice of these intended works was left at Mr. Butler's flat.

2.2 Mr. W arrived to undertake the work at between 8.30 hours and 9.15 hours in the morning. He did not attempt to call on Mr. Butler, but simply set about his task. He had not been there for long before Mr. Butler came out of his front door brandishing a large knife and threatened Mr. W with it. An understandably terrified Mr. W pulled a crowbar out of his tool bag and held it in a defensive position in front of him. Mr. W believed that if he had not done this Mr. Butler would have stabbed him with the knife. In any event Mr. Butler retreated into his flat and closed the door.

2.3 Mr. W very sensibly decided that it was unsafe to continue working and withdrew, but not before alerting the downstairs neighbour to what had occurred. For reasons which are not entirely clear, the police were not contacted immediately about what had occurred, either by Mr. W, whose mobile phone did not pick up a signal, or by the downstairs neighbour, who, instead, telephoned her daughter, who responded by offering to come round to pick up her mother.

2.4 Thus, Mr. Butler had been, quite innocently, confronted with what he may well have perceived as a threat to his security and peace of mind, namely the arrival of someone he might have seen as an agent of the state, who was, in his eyes, interfering with a symbol of his security and independence, namely "his" front gate, without his having been asked for permission or warned that this was to occur. His reaction was clearly completely disproportionate to the situation, and indicates that even at this early stage of the day he was suffering from a serious degree of illness and, in particular, enhanced persecutory beliefs.

3. The Eviction Notice

3.1 According to the downstairs neighbour, while she was waiting for her daughter to arrive, she saw a council official arrive in a van, and deliver a brown envelope through the letter box of Mr. Butler's flat. That Council official, Mr. L, confirmed later to the police that at 9.30 am on 21 May 2004 he had delivered a notice of an intention on the part of the Council to seek possession of the flat from Mr. Butler on the grounds of non-payment of rent. He recalled knocking on the door and getting no reply; he had then posted the letter through the letter box.

3.2 Mr. Butler had been a tenant of 376 Long Acre since 8 October 2001. Council records show that by 21 May 2004 he was in arrears of rent in the sum of £266.35. Until 2004 Mr. Butler's rent had been entirely funded by housing benefit and there had been no history of arrears. The arrears had started to build up when Mr. Butler's housing benefit had been stopped on 3rd April because he had not provided proof of income at a benefits review on 26 January 2004. A letter informing Mr. Butler of the amount he then owed was sent to him on 28 April. Such a letter is apparently automatically generated when the arrears exceed £50. A notice of intent to seek possession is generated automatically when the arrears reach £150, and this is what was delivered on 21 May. Thus in a period of less than 2 months Mr. Butler's status went from that of a good tenant from the point of view of rent payments, to that of a candidate for eviction.

3.3 The tenancy had originally been arranged with the assistance of a Registered Mental Nurse (RMN), one of the Assertive Outreach Team's support workers, and through that the Council would have been aware that Mr. Butler was a client of the mental health services. However, there appears to have been no record of this held by the Council, whether in the Housing Department or the Benefits Office. Further no information about Mr. Butler's rent problems or the fact that a notice of possession was to be served was passed to the Assertive

Outreach Team. Mr. Butler did not seek help from the Team, nor, on the evidence available to us, from anyone else.

3.4 Therefore, Mr. Butler was allowed to fall into increasing arrears without receiving the housing benefit to which he was probably entitled, and eventually to receive a possession notice without any official taking into account his mental health history or his engagement with the Assertive Outreach Team. Thus Mr. Butler was not only deprived of assistance in regularising his position and avoiding an even notional liability to be evicted, but steps were taken which can only have reinforced his paranoid thought processes: such action would have appeared to confirm his beliefs about activities by state agencies directed at him. It would have been understandable if Mr. Butler had believed before receiving the notice that the authorities would sort out the problem without his intervention. The delivery of the possession notice in these circumstances can only have adversely affected his mental health.

4. Police Inquiries

4.1 Mr. W returned to his depot and spoke to a Mr. G who telephoned the police at about 10.00am. In a police statement he said that he dialled a 0845 number as he did not consider the matter to be urgent. However both men attended Queens Road Police Station at about 10.20am where, according to them, they waited for some two hours before they were seen by an officer. According to Inspector U's statement, he became aware of the incident from his presence in the incident room at about 10.45am. There was also an awareness that Mr. G and Mr. W were at the station, but they could not be seen for some time because of other demands on police resources.

4.2 At between 11.20am and 11.45am the husband of the downstairs neighbour who had been out at the time of the incident telephoned the police about it. He had earlier assumed that the incident had been reported by the carpenter and that police would be arriving, but, as they had not, decided to report the incident himself. Inspector U was

aware of this call as well, and at about this time asked his sergeant, WPS H, to obtain the services of a police dog as the risk assessment had increased.

4.3 Sergeant H had been instructed by Inspector U to prepare to deal with the reported incident. It was her first day working at Queen's Road police station. At some point an officer established by consulting police computers that Mr. Butler had been taken into custody on two previous occasions and that this had been in connection with mental health issues. This information was conveyed to Sergeant H. She wanted to find out more and she telephoned Highcroft Hospital to establish whether Mr. Butler was known to the mental health services. She was directed to the Harry Watton Centre. It appears she was unable to speak to Mr. Butler's key worker, but was able to ask another mental health worker, to obtain the file. The Inquiry seems to have been passed on to Approved Social Worker (A); it was arranged that the case worker would ring the Sergeant back on her mobile telephone when the file had been located.

5. Police Arrive at Long Acre

5.1 At about 12.30pm Inspector U became aware that the available police dog would cease to be available for operational reasons at 11.30am and therefore he advised Sergeant H that they would have to take action while the dog was available. Thus a degree of urgency was injected into the case that would otherwise have been absent; although Sergeant H told us that she had made it clear that the police dog would have to be retained as long as it was needed. They decided to designate the corner of Elliott Street and Long Acre, a very short distance from Mr. Butler's flat, as a rendezvous point for officers who were summoned to assist. Inspector U and Sergeant H set off from the police station and arrived at the rendezvous point at between 1.10pm and 1.25pm.

6. Mental Health Information supplied to the Police

6.1 After arriving at the rendezvous Sergeant H received a call on her mobile telephone from someone identifying himself as a mental health worker by the name of Approved Social Worker (A).

6.2 Approved Social Worker (A) told the Inquiry that he did not know anything about Mr. Butler except that he was a client of the service, so he had gone to the files "*and more or less read off the care plan*". He recalled:

> *"It was the care plan. I can remember saying to the police officer at the time and I was quite apologetic to him... "there's quite a thick file there". So if I'd have had another fifteen minutes to pick through the file, I might have found something like social history reports and some sort of context."*

> *"This is my personal bugbear… I'm quite suspicious of care plans because they don't give you any context.. If you read a care plan often it can just be three or four lines, or three or four paragraphs. So I could tell the police officer probably what medication he was on, I could probably tell the police officer who his mum was, that sort of stuff. What I couldn't give him is some recent sources. That's not having a go at the team because I can pick up any file in this area or the country and that would be the same. And I did actually say to the police officer at the time", "Well look, I can only tell you what I've got in front of me."*

6.3 He recollected telling the officer about medication, but couldn't remember exactly what. He was sure that medication was mentioned in the care plan and something about the frequency of visits as well. There was also something about verbal aggression when Mr. Butler's mental health was deteriorating. It had taken him some time to find "*the right piece of paper*".

6.4 Sergeant H's recollection is different. She told us she was informed that the team had struggled to keep contact with Mr. Butler and were not able to monitor his medication. This confirmed what she had written in a witness statement dated 3 June 2004, only two weeks after the incident. Although she was unclear in her recollection of the identity of the person giving her this information, she was very confident that her account of what she was told was correct. She had made a note of the information at the time. She was also told that Consultant Psychiatrist (F) might be able to provide more information but was not available at that time. Approved Social Worker (A)

described a suggestion that he had said anything about a failure to maintain contact with him or an inability to monitor his intake of medication as "*nonsense*". He commented that looking at what was in the records he probably would not have been able to say "*one thing or the other about* it".

6.5 According to Sergeant H, Approved Social Worker (A) told her that Mr. Butler was a schizophrenic who was verbally but not physically abusive. Sergeant H did not have the chance to follow up the suggestion of contacting Consultant Psychiatrist (F) because at that moment Mr. Butler appeared as described below. Inspector U recalled being told that the information received from the health service had come from Consultant Psychiatrist (F) but we are satisfied that this is likely to have been a misunderstanding or misrecollection of what was said. There is no evidence of any contact with Consultant Psychiatrist (F) in which he provided information for the police.

6.6 Community Psychiatric Nurse (CPN) (C) and Mr Butler's key worker recollected that she had become aware that Mr. Butler was said to have threatened a council worker and that information had been received from the police that they intended to take Mr. Butler in for questioning. She had informed Consultant Psychiatrist (F), the team's consultant psychiatrist, who had been surprised: he planned that CPN (C) and he should visit Mr. Butler at the police station once he had been taken there, to find out what was going on. She had thought that Mr. Butler would have tried to run away from the police as he had done so in the past, but erroneously assumed that the police already had Mr. Butler in their custody and were on the way back to the police station.

6.7 As will be seen, the information that Mr. Butler had not been physically abusive in the past was not correct. However it is likely that the manner in which his records were kept did not ensure that someone unfamiliar with his case would have been able to find that out easily and quickly. Further, the police were not told that Mr. Butler harboured

beliefs that the police, among others, were out to get him. They were not told that Mr. Butler had apparently, as we shall see, become involved in martial arts. They did not know that Mr. Butler was known to believe that the police *"had it in for him"*. Sergeant H told us that, had she known all this at the time, it would have altered her approach to the planning of what she was going to do. Such information would have increased her perception of risk and all officers involved would have been equipped with shields. However, the inadequate information did not lead the police team to deal with the case as not involving risk: after all what had been reported was that Mr. Butler had threatened someone with a knife. Her approach and that of the force was not to take unnecessary risks and to be prepared for the worst.

6.8 It is difficult for us to come to a conclusion about precisely what Sergeant H was told by Approved Social Worker (A) about Mr. Butler in view of the conflicting accounts they have given. The importance of this issue is not so much whether the information had an effect on the police operation – we do not consider that it did – but rather in the light it might shed on the Assertive Outreach Team's thinking at the time. If they appreciated there were difficulties in monitoring Mr. Butler's medication then they did remarkably little about those difficulties. We accept that both Approved Social Worker (A) and Sergeant H have done their honest best to offer an accurate recollection. We accept that Approved Social Worker (A) had no significant knowledge of Mr. Butler's case before he was asked to look at the file on 21 May 2004. Nothing we have seen in Mr. Butler's records, offer a far more detailed perusal than Approved Social Worker (A) could have made, has disclosed any record suggesting there was perceived in May 2004 to be any actual difficulty in monitoring Mr. Butler's medication. However, a quick glance at the Care Programme Approach [CPA] documentation in the file at the time would have given the impression that there was at least the potential for difficulty in monitoring and for non-compliance. Thus:

6.8.1 A Community Care Plan Summary prepared before

Mr. Butler's discharge from hospital in 2001 included among the list of his needs the need to ensure compliance with medication and this was confirmed in the section 117 discharge plan, dated 4 October 2001.

6.8.2 CPA relapse and risk management plan forms, dated 29 August 2001 and 5 December 2003, list "*disengagement from AOR Team*" and "*cessation of prescribed medication*" as signs, symptoms and behaviour suggestive of possible risk or relapse.

6.8.3 In a partially completed risk assessment signed by CPN (C) and dated by her as at 30 April 2004 "*Non-Compliance with medication*" and "*Unplanned disengagement from services*" were ticked as being risk related factors, but the written summary noted that Consultant Psychiatrist (F) and herself had been welcomed in to his flat on 30 April and that there as no paranoia present.

6.9 It is possible that these notes were interpreted on a quick read by Approved Social Worker (A) as indicating there had been recent monitoring difficulties. It is also possible that he mentioned that cessation of medication and disengagement were signs of relapse and that this was understood by Sergeant H to mean that there were current difficulties in monitoring. We are, however, satisfied that Sergeant H believed at the time that this was what she was being told. Not only did she make statements and notes to this effect at or near the time, but also it is clear that someone told the psychiatrists who examined Mr. Butler after his arrest that there had been such difficulties. In notes of his examination of Mr. Butler at the police station on 21 May, Consultant Forensic Psychiatrist (A) included as part of the history "*doubts about compliance*". He could not initially recall who had told him about that, although he then said that his colleague, Psychiatrist (Training Grade), had done so. Psychiatrist (Training Grade) had looked at Mr. Butler's notes before leaving Harry

Watton House for the police station and had discussed the case with members of the team. What Psychiatrist (Training Grade) told us about this is set out in full later in this chapter.

6.10 He was unsure whether the information came from a doctor - whom he named - on the Team at the time but who had not been seeing Mr. Butler. However, he had obtained all his information about Mr. Butler from a meeting lasting about half an hour with three or four members of the team. From speaking to the team he received the impression that there had been a suspicion that Mr. Butler had not been complying with his medication. He appears to have been told by at least some members of the Team that:

"There was some suspicion at least from some of the team members that compliance was not as good as it could be – not that he was not taking his medication at all."

6.11 We conclude from our consideration of this evidence that there were at least some members of the Team at Harry Watton House in May 2005 who considered that there were difficulties in monitoring medication. It is therefore far from implausible that this impression was gained not only by Psychiatrist (Training Grade), but also Approved Social Worker (A), and that he conveyed this impression to Sergeant H.

7. Police Pursuit of Mr. Butler and Fatal Assault on DC Swindells

7.1 By 13.25 hours, 11 officers and a police dog had assembled at the rendezvous point. At first sight, this might seem a rather large number of officers to call in the first instance in relation to the investigation of an alleged incident which in any view had ended hours before. Sergeant H explained that it was preferable to have a sufficient team to deal with any contingency and not use them, rather than to have inadequate numbers to deal with a developing incident.

7.2 There seems to have been an assumption that Mr. Butler was still at home, but at this time no specific plan had been formulated as to how he or his home were to be approached. However, before any plan could be devised the police were overtaken by events. It will be

recalled that in fact Mr. Butler had been seen leaving his flat having looked at what can now confidently be said to be an eviction notice. Now, without any warning, he appeared at the junction of Elliott Street and Long Acre on his way home. When he saw the group of police officers he stopped and looked at them. Something about his manner or appearance suggested to officers that he was or may be Mr. Butler, and, as an automatic reaction, two of them moved towards him indicating that they wished to talk to him. Mr. Butler's immediate reaction was to run away. The police team's reaction was to pursue him.

7.3 The terms of reference of this Inquiry do not require us to undertake an investigation into the police operation and the panel neither possesses the expertise, nor has received the evidence to enable it to do so. We have only interviewed one police officer, Sergeant H, and it is apparent from considering the witness statements of the officers as a whole that it would be a formidable task to piece together the precise detail of what occurred and that this could not be done without interviewing a number of witnesses in detail. Therefore, what follows is not intended to be more than a summary of what seems to have occurred largely derived from what Sergeant H told us and the Crown Prosecution Service Summary attached to the police witness statements.

7.4 It appeared to Sergeant H that there was "*something not right*" about Mr. Butler's behaviour. According to her, a group of police officers does not normally attract people to stop to pass the time of day. She told us that he put his arms out and was almost calling the officers to him, but, this soon changed and he appeared to her to be scared. Inspector U instructed two officers to speak to him. It appears that as officers approached Mr. Butler he waved his arms at them aggressively and then ran off. The police dog was released to pursue him. Mr. Butler's reaction was to turn round, draw out his knife from his trouser pocket and "*slash*" it at the dog, missing the dog's face by inches. The dog was then called off and put back on its lead. Another

officer approached Mr. Butler who turned and ran at him brandishing the knife in a threatening manner. The officer retreated and Mr. Butler ran off on to Cuckoo Bridge and down on to the canal towpath. He did not go particularly fast and "*was just jigging around*", "*swaying from side to side*". He went in the direction of Salford Circus. It then became Sergeant H's priority to take whatever action was necessary to contain and arrest Mr. Butler, but also to take care of the safety of officers. Information would have gone out over the police radio network that assistance was needed and that a knife had been seen. At some point Mr. Butler turned back towards a group of pursuing officers again brandishing the knife in a threatening manner. These officers were obliged to retreat for their own safety. At some point after this CS gas was deployed against Mr. Butler but to no apparent effect. Sergeant H recollects shouting to the pursuing officers that they should *"back off"*. On several occasions during the pursuit on the towpath Mr. Butler turned and waved the knife at officers who stopped or retreated temporarily for their own safety. Mr. Butler was described as looking angry.

7.5 Through radio contact other officers learned of the developing situation and attended the scene from various directions to assist, including CID officers. One such officer was DC Swindells, who had been seen in the CID office at Queen's Road Police Station at about 13.20 hours. He appears to have responded to a call for assistance, but the information in our possession does not permit us to say when this happened, how he arrived at the scene, or what information he had about Mr. Butler before his encounter with him.

7.6 After at least some CID Officers had arrived on the towpath Mr. Butler was observed confronting a group of officers who were shouting at him to put his knife down. He was making slashing motions at the officers and swearing at them. According to PC J, Mr. Butler's eyes were "*quite visibly staring and appeared fixated on us*". Two officers then sprayed Mr. Butler with CS gas, but he did not react at all. The cloud of spray

drifted back towards the officers, at least one of them being affected by it. Mr. Butler started to jog away again and was followed by officers. Every now and then he would stop and advance towards them and they would retreat, before the pursuit was resumed.

7.7 The number of officers in the pursuing group dwindled as the pursuit took its physical toll on them. By this time DC Swindells was at the head of the group. He shouted to a colleague, PC J, to hand him a baton and having been given it went closer to Mr. Butler shouting "*Stop Police!*" at him. Mr. Butler stopped and turned round and immediately stabbed DC Swindells in the chest and then again in the stomach. Tragically one of the blows penetrated the upper abdomen and lacerated the heart. DC Swindells appears to have gone swiftly into cardiac arrest and in spite of the best efforts of paramedics and doctors at the scene and in hospital, his life could not be saved.

7.8 PC J resumed the chase but for obvious reasons kept his distance from Mr. Butler. At one point PC J was in fear of his own life because of the threatening posture of Mr. Butler. Other officers took up the chase.

7.9 At this stage the deployment of a baton gun was authorised and firearms officers made their way to the canal. The officer with the gun challenged Mr. Butler with the call "*Armed Police, put down the knife*" more than once, but Mr. Butler continued running. He finally stopped and turned round to face the officer, saying *"I've done nothing, I've done nothing*". As PC M, the firearms officer, pointed out in his statement this was a puzzling thing to say as Mr. Butler was standing there holding a large knife and had been chased by police from the scene of the stabbing. PC M fired his weapon at Mr. Butler and saw the baton round strike him in the lower back and arm. Mr. Butler showed no reaction and did not deviate from the path or release the knife: he just carried on running. The officer caught up with Mr. Butler again when he turned to face him once more. The officer once more appealed to him to put the knife down but to no avail. The officer fired

a second baton round, this time striking Mr. Butler in the same area of his body. Again he ran off.

7.10 PC M then observed a group of plain-clothed officers approaching Mr. Butler from the opposite direction. He was very concerned for their safety and decided to draw his handgun. He shouted at Mr. Butler that he was armed and had a gun. He carried on running, and the other officers moved away. PC H re-holstered his weapon and gave chase. Eventually Mr. Butler appeared to tire and slowed down. Two officers approached him with drawn handguns and challenged him to put the knife down. After a short hesitation he placed the knife on the ground and stepped away from it. He was then physically detained and arrested, albeit after a struggle. Police records time the arrest as having occurred at 13.45, and Mr. Butler's arrival at the police station at 14.02 hours.

8. Discussion

8.1 As we have described, in the course of the pursuit along the canal various unsuccessful attempts were made to detain Mr. Butler. There were a large number of entries to and exits from the towpath; this made containment very difficult if not impossible. The police were equipped with telescopic batons but these were of no assistance in the situation facing them. Mr. Butler seems to have shrugged off CS gas and baton rounds. The police did not have taser guns which in Sergeant H's opinion could have brought the incident safely to an end. When Mr. Butler was standing on the path at one end of an underpass beneath a bridge, and some officers were standing at the other, DC Swindells bravely but without protection took a colleague's baton, and on his own ran towards Mr. Butler, presumably with a view to detaining him. Mr. Butler's tragic reaction was to stab DC Swindells with fatal consequences. Even then Mr. Butler did not stop and continued alternately to run and to threaten officers. He appears to have been subdued only when he became physically exhausted, in spite of a very large number of police officers being deployed to capture him.

8.2 Asked for her retrospective reaction to these terrible events Sergeant H told us:

"I just think it was a tragic accident. I don't think any one person or any one authority is to be blamed for any of this. It was just a tragic death and a police officer was killed. But jobs like this are dealt with every day in the police service, every single day. Thank God, they don't all end like this. If you say lessons to be learned, I feel that that is very much like somebody needs to take the blame for this, and I don't think that they should in this case. I think it is very sad. If we can change things to pre-empt that it could happen again then good. I think the main issue would be the mental health markers [available as part of police data] just a little bit more information. But as for anything else, this will happen today and tomorrow."

8.3 We have no doubt that, suffering as he was from a severe paranoid illness, Mr. Butler acted as he did in the belief that he was being attacked and that his own life was in danger. This is not to seek to challenge the correctness of his conviction for manslaughter through diminished responsibility but to emphasise that Mr. Butler's disproportionate and escalating reaction to the unfolding events of that day were due to his illness and that he is highly unlikely to have acted in this way had he not been seriously ill at the time. His likely state of mind was described graphically by Consultant Forensic Psychiatrist (B), who is Mr. Butler's RMO in Ashworth Hospital:

"He is not engaging with anyone because he is paranoid that the neighbours are in the plot, they are all part of MI5 historically, he is probably popping in and out of shops very quickly because he does not like being around all these strange people and he is just not talking to anyone. He has lost contact with the family, he thinks his brother is dead, there is nobody in his life at all. I think he is really quite ill but he is quite a determined and competent fellow. He knows what he can and cannot do, that there are limits and he has learned what behaviour gets him admitted, so he is not doing that. Then it all blows apart when 20 police are in front of the door, he thinks this is when they are going to do it, they are going to take all my goods, take whatever is in my bank account and I shall disappear. I believe that he is really quite ill and what he sees is the worst possible thing for him: a whole load of policemen on his doorstep. "

"Therefore, while it seems like a very big deterioration in a period of a month, he is really quite ill and at the end of the month, he is surrounded by prison officers and being interviewed by police and people he thinks are going to kill him any second."

"I would say that every time Mr. Butler is confronted by the police, he tries to run away. He is not a naturally aggressive man. He is a man who would try to discuss, reason and rationalise and talk it through and, if he cannot do that, he either isolates himself so that he does not have contact with the problem areas, or he runs away. He keeps going abroad to run away at times and when the police appear he jumps out of first floor windows rather than attack them. It is only when they pursue him and he cannot get away and there are loads of them chasing him and firing gas at him that he turns round and then it is only one stab wound. It is incredibly unlucky in many ways."

8.4 Sadly, through no fault of the police dealing with this incident, they had no detailed knowledge of Mr. Butler's illness and did not have available, any assistance from mental healthcare professionals who might have been able to advise them on how to approach Mr. Butler safely. While we have heard of liaison between mental health services and the police at a number of levels, such as MAPPA, we have not been able to discover that there was any systematic exchange of risk related information between them, or any workable facility for police to obtain risk related information about a mental health service user as a matter of urgency. This case demonstrates the need for such a facility and for accurate information to be available to the police when undertaking their law enforcement duties, as well as when acting to assist implementation of the Mental Health Act.

8.5 Sergeant H was asked by us whether such information or assistance would have made any difference to the police operation. She gave us the distinct impression that it would not. Her priority was and would in any event have been to detain Mr. Butler as soon as possible in order to protect the public from danger. She would not have permitted anyone other than a police officer to approach him on safety grounds. It is intended as no criticism of the Sergeant herself that we find her professional reaction to be of concern. While clearly the safety of the public, including healthcare professionals is the priority, and it is the duty of the police, which they perform bravely day in and day out, to protect the public, it must be in the interests of public safety that incidents involving the mentally ill are brought to an end wherever possible by de-escalating them and maximising the prospects of bringing the patient safely into custody. We believe that the chances of this occurring are likely to be enhanced if police not only receive training in how to deal with persons known to suffer from mental illness, but have available assistance and advice from healthcare professionals on the best, safest and most culturally and therapeutically constructive way to approach and detain such patients. Where time permits we see no reason why, in situations as potentially

serious as this one, the police should not be able to call for such assistance and advice. We rather doubt that any experienced mental healthcare professional would have advised the police to seek to detain Mr. Butler by hot pursuit with a large team of officers and a dog as opposed to an attempt to surround him and contain him in the least apparently threatening manner. We cannot emphasise too strongly, however, that this observation is not intended as a criticism of the police team in general, or of Sergeant H, or least, of all, DC Swindells. They were faced with an urgent and dangerous situation which they were under a duty to bring to an end as soon as they could. We do believe, however, it would have been easier and safer for them to perform their duty with appropriate training and assistance, even though it had never been their intention to have to pursue Mr. Butler in a public place.

9. The Search of Mr. Butler's Flat

9.1 The police executed a search of 376 Long Acre at 00.30 hours on 22 May. They discovered the following items material to this Inquiry:

9.1.1 A large quantity of Olanzapine, 423 tablets, some on, or in a fridge freezer in the kitchen, others beneath the kitchen work surface in the corner of the kitchen.

9.1.2 A number of knives, including a "Prima" knife and a meat cleaver, in a knife case, and, later, a 12 inch "Prima" knife.

10. Mr. Butler's Mental State after his Arrest

10.1 Mr. Butler was examined at the Queen's Road station at about 15.45 by Dr. R, a police surgeon. The doctor found injuries: a ½ inch long skin deep cut to Mr. Butler's right eyebrow, and two abrasions on his right upper arm which had been caused by the baton rounds. Dr. R judged him fit to be detained. Mr. Butler was transferred to Rose Road police station at about 16.40 hours, and another police surgeon was called. Dr. S arrived at just after 18.00 hours and confirmed that Mr. Butler was fit to be detained interviewed and charged.

10.2 Subsequently, he was seen by two Specialist Registrars, Psychiatrist (training grade) and Consultant Forensic Psychiatrist (A), who arrived at the police station at about 19.30 hours, some five and a half hours after the arrest. Some of the information they received before attending the station on 21 May has been considered above. Psychiatrist (Training Grade) worked in general adult psychiatry for Birmingham and Solihull Mental Health Trust in its Early Intervention Team. This was based at Harry Watton House, but was separate from the Assertive Outreach Team. Consultant Forensic Psychiatrist (A) had a post at the Raeside Clinic in forensic psychiatry. Where a patient known to general adult services or someone who appears mentally ill is arrested for a serious offence the forensic team is available to be asked to attend and make a forensic psychiatric assessment.

10.3 After Mr. Butler's arrest the police had contacted mental health services and in due course, Dr. Neil Deuchar, Medical Director of the Trust, called Dr. G, on-call consultant at Raeside, to request a forensic assessment. It was suggested that a specialist registrar in forensic psychiatry should see Mr. Butler jointly with a specialist registrar in general adult psychiatry. Thus Dr. Deuchar also called Psychiatrist (Training Grade), who looked at Mr. Butler's notes and talked to staff on the Assertive Outreach team before setting off to the police station. Psychiatrist (Training Grade) had copied a report and a few pages of Mr. Butler's records but did not take the whole file with him.

10.4 We asked Psychiatrist (Training Grade) about his interpretation of the information he had of Mr. Butler's history as obtained from the Assertive Outreach Team notes and his discussion with the team. As a psychiatrist, albeit in a training grade, coming fresh to the case, we found his impression, which we did not consider was unduly influenced by hindsight, illuminating, and we consider it is worth setting out in full:

Q. You had read the running record, which included the reference to the knife and a little bit of irritability and so on, but that apart there was a series of visits in which nothing untoward occurred at all.

A. *Except the fact that he was not available most of the time and people were just dropping the medication off through a letterbox. He was often not at home and*

in spite of repeated reminders to attend for his reviews, he was not responding and that resulted in the consultant having to see this person at home on one of the visits.

Q. You and your colleague at the police station advised that olanzapine should be prescribed?

A. *Yes.*

Q. Presumably on the basis that it had been prescribed before?

A. *Yes.*

Q. Did you have any idea at the time that in reality Mr. Butler had not been taking his olanzapine?

A. *Reading through the notes, a couple of weeks prior to this happening, the staff had gone to deliver his medication and he had said, "Why are you still bringing the medication? I've already got it." There was a clear inconsistency between what Mr. Butler was saying and what the team knew. The team was sure that he did not have the medication when staff had gone to deliver the two-week supply of medication. That created a doubt about whether he was compliant. Speaking to the staff on that Friday, some of them doubted his compliance with medication. The history from the past was that he had never developed an insight into his mental illness throughout the times he had been in hospital previously. He had not voluntarily complied with medication, based on the tribunal report. He had not developed an insight, in spite of being in hospital for months, so there were doubts about the reason why he would take the medication. But speaking at the review, he said he had no side effects from the medication, so he was giving the right answers when asked by the treating team.*

Q. What were you told by the staff about the nature of the doubts they had?

A. *This was prior to me going to see Mr. Butler. I was having a discussion with the staff who were there. I cannot remember their names, but some of them were not sure that he was fully compliant with his medication. I can't put my finger on what he said, but I was looking at my handwritten notes and before going they said there was variable compliance. That is what I heard from the staff.*

Q. That is what you wrote down?

A. *Yes, before I went to see him. I don't know who said that.*

Q. The same sort of comment is made in Consultant Forensic Psychiatrist (A)'s note, but I imagine he would have got that from you.

A. *Possibly from me.*

Q. The reason I asked you to give as much detail as you can is because we do not see in the notes written by the multi-disciplinary team any expression of that doubt at all.

A. *The only entry was that when staff went to deliver medication he said that he had been delivered medication already, which probably was not true because it was in the diary for the staff to deliver the two-week supply of medications. That was the only doubt in the last few months going through the notes.*

Q. I cannot understand why that might have raised a doubt to you, looking at the notes, because it was not written down as though it was a doubt, was it?

A. *No, it was not. I cannot put my finger on which of the staff it was, but the Outreach Team doctor who was there, although he might have been part of the discussion that happens on a weekly basis, was not the doctor who was seeing Mr. Butler.*

Q. No, but can you remember who the doctor was?

A. *Dr. M... was on the staff of the Assertive Outreach Team at the time. He was at the office with the staff because of what had happened. There were at least three or four staff there in the Assertive Outreach Team base, so I went up to have a chat with them and I spoke to them for about half an hour about what had happened and just to get some background to Mr. Butler. I would assume that was where the information came from that there were some suspicions about compliance.*

Q. Going back to your general understanding of the recent history before 21 May, was the message you were getting from the people you spoke to in the team that there had been a little, but not very much, concern or were you hearing a message that there had been a deterioration?

A. *The majority of the information we were hearing was that there had been no change. The only thing that I picked up was the last entry by a different team member who had seen him a few days prior to the index offence. There was nothing to indicate that this patient was someone who needed to be seen more frequently because of concerns. He was not highlighted as at risk. We normally have a list of patients about whom we are concerned and they would be put on a red zone or something, showing that you need to see the patient more frequently. That was not the flavour I got from speaking to the team or by reading the notes.*

Q. But there was some flavour of suspicion that he was not complying with his medication.

A. *Yes, there was.*

10.5 Both doctors made notes of their visit to Rose Road police station where Mr. Butler was by then being detained. Not surprisingly, some of the information turned out not to be entirely accurate. For example, Consultant Forensic Psychiatrist (A) noted that Psychiatrist (training grade) understood that Mr. Butler had complained "*at the local Housing Department and was confrontational. The police called and attend at his home*." In fact there is no evidence of any such incident at the Housing Department: this is probably a garbled version of the incident that had occurred in the morning with the Council carpenter. Consultant Forensic Psychiatrist (A) recalled that the Custody Sergeant did not have a great deal of information available.

10.6 Both doctors saw Mr. Butler together. Consultant Forensic Psychiatrist (A) told us that there was a paranoid flavour to the content of his thoughts which touched on matters concerning his neighbours and the

police, and he was difficult to engage in conversation. Mr. Butler told them he would prefer to talk to his own psychiatrist and nurse and indicated that he did not regard himself as mentally ill. He told them that he believed that the police were always arresting him and arranging his detention under the Mental Health Act. He also stated that his neighbours were in some way conspiring to arrange his admission to hospital. He said he had recently received a letter alleging wrongly that he was in arrears with his rent. When asked about his arrest, he said that he had been out shopping and on his return he saw a large number of police officers in the street. He went to find out what they were doing and some officers and dogs confronted him. He was then chased and, he alleged, assaulted causing him injuries. He claimed he could not remember clearly because he had been hit on the head. He initially denied having a knife but subsequently said he might have bought one while shopping. He did not admit to having stabbed anyone. Consultant Forensic Psychiatrist (A) said that his conversation was difficult to follow because of the level of irritability he displayed and because he switched from topic to topic; it was difficult for the doctors to form any rapport with him. Consultant Forensic Psychiatrist (A) found him to be frightened, irritable and suspicious. However he did not elicit any overt psychotic symptoms. He accepted that the mental state in which he found him at the police station might have been different from that apparent event earlier in the day. He may well not have been floridly unwell previously, but had become more unwell as a result of the stress of arrest and detention.

10.7 Psychiatrist (Training Grade) noted that Mr. Butler kept on claiming that the police had been using the Mental Health Act in collaboration with MI5 to detain him in hospital on various occasions. His impression was that Mr. Butler was having a relapse of his paranoid schizophrenia. He understood that he had been charged with serious offences but denied that he had done anything wrong. He considered at the time that Mr. Butler was fit to be detained and interviewed,

although he has changed that view since.

10.8 Consultant Forensic Psychiatrist (A)'s initial clinical impression was that Mr. Butler was suffering from a relapse of his illness, but that the extent of this was unclear. In his opinion, Mr. Butler was fit to be detained by the police and to be interviewed. It is necessary to record, given the critical cross-examination to which Consultant Forensic Psychiatrist (A) was subjected at the criminal trial about this opinion, that he told us that he had not felt under any pressure from the police to conclude that Mr. Butler was fit to be interviewed. He told us that they were very careful and "*proper in their response to a difficult situation*."

10.9 Arrangements were made for Consultant Forensic Psychiatrist (A) to visit Mr. Butler again the following day to assess him. The police custody record suggests this was to be before any interviews. In spite of this arrangement an interview in fact took place, with the agreement of Mr. Butler's solicitor, at 23.16 hours. Mr. Butler declined, as was his right, to answer any questions. During the night Mr. Butler refused medication, which had been brought to the police station by the Home Treatment Team. He also refused drinks and food. On one occasion his solicitor brought a bottle of cola to the station for him at his request, but he refused to accept a drink taken from it by an officer, as he did not trust the police. He also refused to accept medication, Olanzapine, which had been prescribed on Consultant Forensic Psychiatrist (A)'s authority, stating that the police did not have the right to give medication to him. The police were sufficiently concerned about this to contact Consultant Psychiatrist (F) at the Assertive Outreach Team, to ask if he could reassure Mr. Butler. Consultant Psychiatrist (F) is recorded as advising the police that there would be:

> *"no problem with [Mr. Butler] missing his medication tonight as he was taking his medication up to today – Consultant Psychiatrist (F) states that there could be a problem if he misses tomorrows dosage and he can have it in the morning if he agrees to have it and it will not affect interview..."*

10.10 Consultant Forensic Psychiatrist (A) attended the police station again

at about 8.00 hours. He found Mr. Butler's condition had deteriorated and concluded that he was unfit for interview. Indeed, with the benefit of hindsight he doubted that he had been fit for interview the previous day.

11. Discussion

11.1 It is not within the remit of this Inquiry to investigate the care provided to Mr. Butler following his arrest, but his mental state then is relevant and possibly helpful in establishing what it might have been before and at the time of the homicide and as to what, if anything could have been apparent on a careful assessment in the period leading up to this tragedy.

11.2 It is clear that the extreme stress of the events of 21 May may have caused a sudden deterioration in Mr. Butler's mental condition. As discussed above we consider it likely that the combination of events, which, to him, were threatening, and confirmatory of his previous experiences, led to his believing that his life was in danger. Following his arrest he expressed openly his beliefs that the police and other state agencies were intent on sending him to hospital. He showed no insight into his condition, refused medication and other help because he did not trust the source and became floridly unwell. Therefore, it cannot be assumed that the signs which were so obvious to Doctors Consultant Forensic Psychiatrist (A) and Psychiatrist (training grade) would have been present, even on a careful assessment, in the weeks leading up to 21 May 2004. However, it is apparent, even from the account above of the events of that day, that a great deal was not known about Mr. Butler that could have been discovered earlier. The matters which are particularly striking are:

11.2.1 Mr. Butler's long-standing and persistent non-compliance with the medication regime prescribed for him.

11.2.2 His retention of over a year's supply of medication.

11.2.3 His failure to ensure continued receipt of housing benefit.

11.2.4 The rent arrears.

11.2.5 The Council's intention to serve an eviction notice.

11.2.6 Mr. Butler's mental state as described by Consultant Forensic Psychiatrist (B).

11.3 As will be seen when we examine the care, supervision and support provided to Mr. Butler while he was living in the community, the level of engagement with him was such that such matters were likely to be missed. We cannot say all or any of them would have been detected if a higher quality of interaction and engagement had been achieved, but at the very least there must be a possibility that such matters would have come to light.

12. In the chapters which follow we shall examine the standard of care provided in accordance with the themes prompted by the events of 21 May. These are:

12.1 A chronological account of Mr. Butler's contact with mental health services since 1994.

12.2 An overview of the performance of the Assertive Outreach Team.

12.3 A review of the medication prescribed and of monitoring of compliance.

12.4 Liaison between the Assertive Outreach Team and others.

12.5 The general functioning, management and working of the team.

12.6 The level of social care provided.

12.7 The impact of cultural and racial issues.

12.8 The general impact of the perceived need for confidentiality.

13. Recommendations

We will make a number of recommendations in connection with each of the themes we explore in the relevant chapters below, but certain

points arise out of the specific events of 21 May as follows:

13.1 Mental health services in Birmingham should review with West Midlands Police the advice, support and training available to the police for dealing with the mentally ill, in particular in relation to techniques of engagement, detention and reduction of risk.

13.2 Mental health services should seek to open a dialogue with West Midlands Police to explore methods of improving engagement with persons with differing mental health needs and cultural backgrounds consistent with the protection of the public.

13.3 The Trust and the Strategic Health Authority should review with the police procedures and resources whereby advice could be made available to the police in relation to incidents involving known mental health service users.

13.4 The Trust should review record keeping policies to ensure that a document is constantly available in an easily accessible form to enable important information relevant to a service user's mental state, needs, and risk to be available to professionals who do not have a personal knowledge of the case. This could take the form of the new computerised CPA documentation that has been brought in, but the Trust should review the type of information kept in this form in the light of the history in this case.

CHAPTER 4

BACKGROUND LEADING UP TO APRIL 2001

1. Mr. Butlers is of African-Caribbean background and was born in Jamaica on 14 September 1953. His family came to the United Kingdom in his early childhood. His parents separated in the early 1970's and contact with his father was subsequently lost. His mother latterly returned to the Caribbean before she died. Mr. Butler has two siblings resident in the United Kingdom. His education culminated in his obtaining a degree in engineering. In 1979 or 1980 he became the only graduate trainee of African-Caribbean origin at Roll Royce in Stoke-on-Trent where he worked as a design draftsman. He was made redundant in 1982. Thereafter he obtained other employment of a less rewarding nature, but it is not thought he had any further employment after 1985. By the time he came to the attention of mental health services he was unemployed. Throughout the late 1980's it is thought that he lived alone in a council flat in Newcastle-under-Lyme, depending on his savings. It is not thought he made any claim for state assistance and spent his time studying in the library. He had some contact with his family. Little is known of any social contact or friendships with others. It is probable that for most, if not all, of the time since he was made redundant from Rolls Royce Mr. Butler has led a socially isolated life.

2. Mr. Butler first came to the attention of mental health services when he was admitted for the first time on 17 March 1994 to the Acute Care Unit in Stoke-on-Trent, initially under section 2, then section 3 of the Mental Health Act 1983. There was a history which included an unprovoked attack on a neighbour on the previous day, spitting at neighbours prior to this, suspicions on his part that Special Branch were behind his detention, not paying bills or indeed claiming benefits for some two years, allowing most services to be disconnected and facing an eviction order. He was sure he was targeted because of his race. A diagnosis of a paranoid psychotic illness was made.

3. Following his admission Mr. Butler was thought to have improved and he was allowed to go to the Servol Community Trust, a hostel in Birmingham designed to serve the needs of service users with a background similar to Mr. Butler's, on 22 December 1994. Mr. Butler wanted to move to the area. This had been arranged before Consultant Psychiatrist (E) took over his care as consultant responsible for rehabilitation on December 5. He initially remained under her care as RMO to ensure he settled in over the assessment period, and was subject to section 3 until 21 February 1995. Consultant Psychiatrist (E)'s retrospective view is that:

"this man simply could not come to terms with what had happened to him or accept that he was ill. So it seemed to me that the greatest risk was acting on his denial, just simply vanishing from services, getting back into this picture of gross social isolation, living without electricity, not eating, self neglect."

4. This picture is confirmed at the Servol six week assessment review, it was noted that he was settling in but was anti-social and uncommunicative, doing very little on his own initiative[4].

5. On 18 March 1995 he had agreed to see Consultant Psychiatrist (A). He considered that Mr. Butler should have sheltered support and that he should continue to take medication for life. Information from his brother had indicated that he had been ill for some time and his presentation at Servol showed he had negative symptoms including lack of drive and energy. Consultant Psychiatrist (A) noted a profound paranoid element to his condition. Mr. Butler had been "*somewhat shaken*" by this consultant's confirmation of his diagnosis and challenge to his complete denial.

6. Consultant Psychiatrist (E) wrote to Clinical Psychologist (A) in Birmingham, for an assessment and intervention if possible. In the letter, she noted that Mr. Butler was a gifted African-Caribbean man – and had experienced racial hostility, possibly of a quite severe kind. There was no doubt, however, of the diagnosis of paranoid psychosis. There were four

[4] *A Consultant Psychiatrist at St. George's Hospital, London with a particular interest in the issues of the African Caribbean community.*

consultations, after which Clinical Psychologist (A) wrote on the 21 July that there were indications that Mr. Butler was actively hallucinating. Questions on his past or current mental state were said to be met with an angry silence or complete denial, although he gave an account of his education and employment. The staff at the hostel had reported to her that he seemed agitated and distracted.

7. Consultant Psychiatrist (B) in the Homeless team and in July 1995 accepted Consultant Psychiatrist (E)'s referral to take on Mr. Butler's psychiatric care. By 3 August, he referred Mr. Butler to Dr. S for a Mental Health Act assessment. Mr. Butler had shown considerable deterioration at Servol in the prior two months with self neglect, further withdrawal, and not going out; he had pushed over an elderly care worker over a minor issue. There was a note that Servol staff suspected that he had not taken his oral medication for some months.

8. On 2 October, Dr. A, a locum Consultant Psychiatrist who had taken over Mr. Butler's care, reviewed Mr. Butler at Servol Hostel. He had presented as secluded - sitting alone - and there was information suggesting that was how he usually spent the day. Mr. Butler was composed but it was difficult to engage him. He appeared very guarded towards key questions and there was a low emotional response. His nails were unkempt and he appeared rather neglectful towards self-care. Staff reported concern about weight loss, that he was not taking his medication and that Mr. Butler was living a very unstructured life. The carers at Servol reported that Mr. Butler had never shown any aggression towards any of the residents. The conclusion was that Mr. Butler had developed negative symptoms and, given his known non-compliance with the management plan, it was not certain what the mental health team could offer him. However, Mr. Butler readily agreed to ideas about structuring his day and a referral to the Archer Centre.

9. Mr. Butler was assessed by the local Assertive Outreach Team on 10 October 1995. There is no evidence of a written care plan but a detailed visiting regime was commenced by the team. The risk

assessment form was completed to suggest that there was no current serious risk to self, harm to others or self neglect, but that there was a history of violent incidents, incidents involving the police, self neglect, and violence to staff, patients and general public.

10. It is evident that the Assertive Outreach Team used various approaches to engagement. There were regular visits to Mr. Butler at Servol, initially three times weekly. They offered one to one games of snooker, visits to the theatre, support for self care such as visits to the hairdressers, support to obtain maximum benefits, trips to the shops, work programmes to structure his days which include daily living skills such as cooking and employment advice at the Job Centre. CPN (E), referred Mr. Butler to Archer Centre for rehabilitative activities. However, due to restructuring, this was not accepted as a referral.

11. Whilst the assertive outreach regime involved a team approach, the two staff mainly engaged with him were the RMN and CPN (E). This approach fits very clearly with the evidence from one expert witness, Dr. S:

"Assertive Outreach teams should be to provide a long-term personal investment in individuals. That is usually achieved by individual working."

12. However, despite this, progress was sporadic. In one record on 7 November 1995 it was noted that Mr. Butler was guarded when talking about a previous hospital admission, but appeared more responsive when engaging on a social level. He did not feel medication helped in anyway although apparently complying.

13. A feature of many visits through the rest of 1995 was that Mr. Butler was often still in bed, often changed his mind about an activity or had not kept to his work programme. However, at times, he had shown enjoyment and pleasure in the activities. On 27 December 1995, Mr. Butler had seemed subdued and reported his brother had not visited when in fact he had according to the Servol hostel staff. It also appeared that the staff there expressed concern about his lack of motivation and isolation. Dr. A saw Mr. Butler regularly, including on 25 January 1996 and on 22 February.

At this point, he was spending most of his time in bed, showing little interaction with other people, and if pushed a bit he tended to get irritable. Dr. A noted that Assertive Outreach Team staff had made persistent and vigorous attempts to involve him in a more structured rehabilitation programme, but with little success.

14. Assertive outreach efforts to engage continued and included continuing to encourage him to attend the Warwick Training Centre for computer training. It is notable how on many occasions he had to be persuaded to go despite professing interest and how he struggled with his concentration when there. In an Assertive Outreach report in April 1996 to review the previous six months, it was noted that he remained guarded, reserved and appeared a private person. Mr. Butler had not presented with any positive psychotic symptoms in that time. A Beck Inventory had indicated that Mr. Butler was very happy with his life although the team had thought he might be depressed. It is noted that there was a review on 12 April but no record of this could be found. Through April to July 1996, there is evidence of reviews of Mr. Butler's medication in out patient clinics. Dr. A wrote that he was now being taken over by the negative symptoms of schizophrenia. The Assertive Outreach Team continued to visit, quite often with Dr. Ak, and to work as well as they could with Mr. Butler, although by November it was being reported by Servol hostel staff that there was little improvement. He remained subdued and uncommunicative and continued to present as hostile and aggressive if prompted to attend to his personal hygiene.

15. On 7 January 1997 Dr. Ak met Mr. Butler at Servol Hostel with a team member: staff reported great improvement – "*7 out of 10*". His mood was brighter and he took an interest in self-care. This was confirmed in another review by Dr. Ak in February: his self care had continued to improve: he was doing own shopping and preparing his own drinks and snacks. However, *"he rarely smiles or interacts with other residents*." Assertive Outreach visits had reduced to weekly at this point. They continued to try to take him out – for instance to pubs for pool - and he seemed to enjoy these occasions and was more talkative. He took the

initiative in going to Aston University to check on IT courses. In April, however, he had refused his medication for a time.

16. At a review on 1 May 1997 Mr. Butler had become irate and shouting at Servol staff for inviting his brother without informing him. He was not amenable to reasoning, and the review was postponed. He said he was not happy taking medication as he has no need for it and "*he has never been ill, the police kicked his door down without reason to do so*." He was also going to press charges against the police force. Mr. Butler apologised later.

17. From this time, a slightly different pattern developed of Mr. Butler not being in for some of the Assertive Outreach weekly visits. He stated that he himself was applying for courses. He refused Servol staff help with finances, spending most time out at the library, isolating himself and becoming more hostile and verbally aggressive. He told Dr. Ak at a review in August that he wanted to live independently and look for a job. He was rational and spontaneous. At this review, he had agreed to see the social worker as he wanted alternative accommodation. He had been offered a university place at the University of Central England (UCE) in engineering but it appears either that he did not take this up or he left almost straightaway. There is a letter on the file from a solicitor that seeks information to enable advice on his rights in relation to mental health treatment, accommodation and contact with the team. This demonstrates very clearly the challenge of engaging with Mr. Butler and at that stage, his increasing overt hostility to and avoidance of mental health services.

18. A Servol Hostel Progress review report in October 1997 mentioned such exceptional progress in all areas of his adult living skills, that he refused any support from staff team. The contradiction inherent in this summary extended to the rest of the report where it was noted that Mr. Butler denied he had mental health problems and now thought Servol was also part of the conspiracy by the medical team and the police and expressing complete contempt for the Servol staff. He still stayed out all day at the

university despite leaving the course; he was hostile towards the RMN on 25 October 1997 and did not want him to visit as he thought he did not need it. He was seeing a social worker by this time about accommodation.

19. There were two more entries in the records by Community Psychiatric Nurse (A). On 2 November Mr. Butler was hostile on the telephone and on 11 November it had become clear that he had left Servol. The final note was for staff there to encourage Mr. Butler to contact the Assertive Outreach Team. She confirmed this to the GP in a letter dated 11 December 1997. In the letter she stated that there had been no concerns about Mr. Butler's mental state at the time, but that the manager of Servol had believed he had not taken his medication since about August. His brother and the GP were requested to inform the team if he made contact. The reported non-compliance may appear at variance to some of the reports in the preceding months. It is also notable how very positive support over the preceding 3 years, in the face of varying response from Mr. Butler, was not followed by a more assertive effort to find him. There are no attempts noted to contact the Housing Department, Benefits Agencies, his solicitors and only one letter to his brother.

20. The next record is on 13 March 1999 when the RMN noticed Mr. Butler in a barbers, but when he tried to talk with him, Mr. Butler ignored him and walked away. Mr. Butler had managed, at some level, in the community for 18 months without contact.

21. It appears there was no further contact until August 1999 when a detailed report by an approved social worker, dated 12 August, noted that Mr. Butler had been arrested by police after throwing a brick through a neighbour's window and that he had been found with a knife in his possession. Mr. Butler was reported as saying that the police had stolen money from him and that as Special Branch had broken his windows he had broken theirs. He was detained under section 3 of the Mental Health Act and admitted to the psychiatric intensive care unit at Highcroft

Hospital. It seems he had been living in council accommodation since he had disappeared, but had had no contact with his brother. He claimed he was not on benefits but had earned money writing engineering computer programmes. He was described as hostile, paranoid and aggressive, assuming that the mental health team was part of the police. Dr. H's notes indicate particular paranoia about the police – that they threw the brick, that they were military police and part of MI5, had taken money from him and doped the food in his house. He denied past mental hospital treatment.

22. Mr. Butler, in an admission report, talked of having a family in South Africa and a good business, being the best at computer programmes. The summary was that he was experiencing persecutory delusions – mainly about the police - and grandiose delusions, with no insight. There is no evidence the meaning of the illness was discussed with him or that any investigation was conducted into what, if any, factual experiences underlay his paranoid ideas. After initial hostility particularly about medication, Mr. Butler appears to have quickly settled. An in-patient risk assessment on 25 August 1999 noted the facts surrounding his admission, assessed the risk of harm to others as stable but significant.

23. His brother had visited by 19 August 1999, but Mr. Butler remained without insight, saying he did not have a mental illness. He denied that he had housing arrears when this was raised with him and was certain that he could not be evicted. The arrears were later confirmed in a letter from the Housing Department stating that he owed £661.39. It referred to several letters having been written to him before that which were copied to the RMN. This practice is notably different from that in 2004 when there was no communication between the mental health team and the Housing Department about his arrears.

24. On 25 August 1999 a risk assessment form was completed in which the incident of throwing a brick at a neighbour's window and being found in possession of a knife were recorded under the risk history. The presence of current risk symptoms was noted as was a history of non-

deliberate self-harm. Given the risk history it was surprising that no history of harm to others was formally registered.

25. On 22 August 1999, Mr. Butler absconded for six days. It is noteworthy that his brother had his flat key so was involved at this stage, and that the police had to bring him back, using CS gas sprayed onto his face, perhaps thereby providing him unwittingly with confirmation of his adverse views about the police. He stated that the police wanted to kill him, as well as all black people and people from the West Indies. He became more settled but remained isolated, eating apart from his peer group, often watching TV. It does not appear that there was any effort to understand further the nature of his beliefs about the police perhaps because of his reluctance to communicate.

26. On 8 September 1999, Mr. Butler was transferred to Small Heath in-patients ward. He seems to have initially been settled there, contacting his brother and talking more openly about a recent trip to South Africa, his past employment and qualifications, and how he was looking forward to a new job. He also mentioned a wish to return to Jamaica. He remained angry at the way the police treated him. It was decided on 15 September 1999 to commence home leave periods, initially for two weeks, when he would be visited by the Assertive Outreach Team. The RMN had visited Mr. Butler throughout his in patient stay to deal with matters such as his flat security and presumably to rebuild a relationship. He took Mr. Butler home on leave and was the main Assertive Outreach Team member visiting. He dealt with practical matters such as benefits, visiting twice or more a week, occasionally having no reply but usually finding Mr. Butler at home, once gardening. His role was also to drop off the medication which Mr. Butler stated he was taking.

27. On 13 October 1999 at a ward round the leave was extended to a month, and at this point, Mr. Butler was informed that he would be placed on supervision under section 25 of the Mental Health Act upon discharge. Sections 25A to G provide for the discharge of patients from hospital under supervision. The statute enables the service to require the patient

to comply with certain requirements as to place of residence, attendance for treatment, occupation, education and training and that access be given to the patient at his place of residence[5]. Such supervision can only be imposed if various grounds are satisfied, including an opinion that there would be a "*substantial risk of serious harm to the health or safety of the patient or the safety of other persons*" if he did not continue to receive after-care[6]. Initially the supervision under these provisions will last for six months unless ended earlier, but may be extended if the statutory procedure is followed. This includes a requirement that the RMO examines the patient within the period of two months leading up to the expiry of the supervision, and is satisfied, among other things, that the substantial risk referred to above would continue[7].

28. During the second half of October and November 1999, there were many occasions on which attempts by the RMN and other team members were met with no reply. On at least one such occasion medication was put through Mr. Butler's letterbox. At a visit on 17 November 1999, Mr. Butler was reluctant to let them in, refused to accept that he had rent arrears or discuss an issue about access to the garden for an upstairs tenant – about which there had been a complaint – and he refused to answer when asked about medication. He was quite loud and appeared perplexed and distracted.

29. It is clear from the records at this time that the RMN was in frequent contact with housing officials and was also prepared to exchange information with neighbours for Mr. Butler's benefit. This is to be contrasted with the lack of such communication evident in 2004.

30. On 18 November Dr. H wrote to Mr. Butler stating that he had been informed that:

"you have stopped taking your medication, have had increased confrontation with the neighbours and have been increasingly confrontational and disengaging with the AOR Team."

[5] *Section 25D(2)*
[6] *Section 25A(4)*
[7] *Section 25G(1), (4)*

31. His section 17 leave was revoked. A warrant under section 135 of the Mental Health Act was required to effect Mr. Butler's return to the ward on 30 November – and the involvement yet again of the police. He denied there was anything wrong with him and stated that even if there was he would not come to the hospital but go to his GP. This was also the third time in Mr. Butler's history that issues with neighbours were a concern, although any untoward incidents were prevented by the team's actions on this occasion.

32. On 1 December at a ward round Dr. H records that Mr. Butler had stopped taking his medication when he had been discharged and this had led to a deterioration. He became hostile during the ward round and accused the staff of destroying his career.

33. During December, Mr. Butler contacted the Jamaican High Commission on at least two occasions to say he was a Jamaican national being held against his will by the Home Office. He still refused to accept he had rent arrears, remained isolated and refused his depot, becoming angry and agitated when asked about it, but he did appear to comply with oral medication. On 13 December a Dr. F of the Mental Health Act Commission certified that Mr. Butler was incapable of understanding the nature, purpose and likely effect of either the oral or depot medication prescribed for him and that the treatment ought to be given, under section 58 of the Mental Health Act. He had to be restrained by three nurses for 30 minutes on 22 December 1999 in order to try a test depot dose of Piportil despite attempts to de-escalate the situation. Later in the month, it was indicated that nurses had observed him concealing oral medication and probably spitting it out as "*he goes straight to the bathroom*." It appears both nurses and doctors spent considerable time discussing why medication was required but when he agreed to take a depot injection on 30 December 1999, he then threw a punch at a nurse. On 31 December at least a three man control and restraint was required to administer the depot. During the incident Mr. Butler threatened to harm female nurses and their families and to set their homes on fire.

34. These events are given in some detail because they indicate both Mr. Butler's continuing lack of insight on many levels, his propensity for violence when resisting medication, and his ability at times to deceive – although he was very frank verbally about his views of medication.

35. By mid January 2000, after a change of medication to Depixol, it was noted that Mr. Butler was more accepting of medication – both oral and intra-muscular - and had become "*much more approachable and friendly*." His leave was being kept at a few hours because of previous unwillingness to engage with the Assertive Outreach Team. However by 19 January 2000, he was being granted overnight leave. On 26 January 2000 Dr. H explained the plan that he be discharged under section 2 supervision and Mr. Butler is recorded as having accepted that. He was discharged on this basis on 11 February 2000, and the depot medication was stopped. Dr. H wrote to him on 9 February 2000 to confirm the provision under section 117 of the Mental Health Act of:

- Weekly contact with the Assertive Outreach Team to monitor and support with any practical issues.
- Support with benefits and anxieties with interpersonal relationships.
- Medication delivered on a weekly basis.

The requirements expected of Mr. Butler under section 25 were:

- To allow access to the Assertive Outreach Team at least once a week.
- To attend for blood tests, out patient appointments and reviews as required.

36. The medical recommendations for supervised discharge under section 25 are instructive. Both Dr. H and Dr. P certified that supervision was

necessary because there were serious risks of harm to the patient's health and safety and to the safety of others if he did not receive section 117[8] after-care. Dr. H stated that the risks were because of "*relapse due to non-compliance and a tendency for conflict with the community.*" Supervision would "*secure treatment compliance.*" Dr. P wrote that "*the structure imposed under section 25 should facilitate his continuing contact with services and attendances at outpatient appointments and compliance with medication.*" The recommendation was supported by the Approved Social Worker (B), on the ground that in the past Mr. Butler had refused to receive care which had led to isolation, self neglect and psychotic symptoms which in turn had led to behaviour of concern to the safety of himself and others. She thought that supervision was likely to ensure structural and regular contact with the Assertive Outreach Team and that his treatment plan was complied with.

37. The clear, structured care plan set out by Dr. H was followed in practice as is borne out by the visiting pattern which followed – usually by the RMN - and the relationship he had with Mr. Butler, which was such that Mr. Butler was able to be open about electricity debts. However, by April, problems began to appear. He said on two occasions that whilst he was taking medication he did not need it. He tried to get work but failed; then he considered a teacher-training course but decided not to pursue this. There was mention of his visiting his brother. In May 2000, despite the apparently promising, if tentative, relationship with the RMN, he questioned the frequency of visits saying he was "*fed up*" with them and was "*not ill*". It was thought he was "*quite rational about it*" and the visiting routine was promptly changed to fortnightly. However, the records suggest that the gaps between visits were often longer than that. We have been shown no record of this change being discussed in the team or in supervision.

[8] *Under section 117 of the Mental Health Act 1983 it is the duty of the relevant Trust and local social service authority to provide after care to a patient discharged from statutory detention in a hospital. In practice the meeting at which post discharge care is planned is called a section 117 meeting. As can be seen such aftercare can be associated with supervision and requirements under section 25.*

No formal change was made in the requirements under section 25. Apart from no psychotic symptoms being detected there was no recorded objective evidence of whether or not he was taking medication. He was seeing Dr. H every three months. He enrolled on a course, although it came to nothing as it was cancelled. He turned down a proffered alternative. Many of the entries in the records at this time described him as "*not doing much*." The RMN seems to have largely stopped recording whether Mr. Butler was confirming that he was taking his medication.

38. On 11 August 2000, the supervisory period under section 25 was extended. Dr. S wrote:

"This patient has improved significantly in his mental state and his ability to care for himself because of the authority of the section 25. He is likely to disengage from psychiatric services if another six months of stability are not maintained."

This year of relative stability raises two questions:

38.1 Was it the combination of the Section 25 supervision and requirements, and a reasonable relationship with one Assertive Outreach Team member that maintained this stability? If this had been the perception later on, after his discharge post 2001, then the fact of having no legal structure or a particularly good relationship with anyone after the RMN left, could and perhaps should have triggered a more thorough review of Mr. Butler's care in the community and, in particular, of the methods employed to engage with him. It might have been considered worthwhile using section 25 again.

38.2 Despite this stability, was there not more opportunity to work with Mr. Butler on supporting him out of social isolation and a life without occupation? Employment or training were obviously important to him, but there is no indication that anyone tried to work with him on his level and with a focus on his abilities and particular interests. This may have been the start of the view that the priority was to avoid the risk of him disengaging from the service – at cost maybe to other possible interventions.

39. On 22 December 2000 the RMN tried to visit Mr. Butler only one week after his previous visit, presumably in order to deliver medication. There was no reply; as a result the RMN returned twice more before succeeding in seeing Mr. Butler at the fourth attempt on 1 January 2001. The RMN's persistence enabled him to observe at this visit that Mr. Butler might be becoming unwell. Over the next 10 days three unsuccessful attempts were made to see Mr. Butler. Then, on 10 January, he was seen: he was hostile at first and talked about visiting Jamaica. On 16 January Mr. Butler left a note to say he had gone abroad for three weeks at a time when he was due to be seen for review in out-patients. The RMN spent a considerable amount of effort throughout the rest of January and February in checking whether he had returned by visiting regularly, and also through contacts with his brother. A neighbour approached him about Mr. Butler's behaviour as he had stuck two fingers up and sworn at her when she had seen him outside her window. This was followed up by a call from the Housing Department about the complaint which now included an issue with loud music. This was the fourth recorded instance of confrontational behaviour with neighbours.

40. It is of note that during this period of lost contact, the section 25 period expired and could not be renewed because Mr. Butler could not be assessed as required under section 25G(4).

41. On 28 February 2001, two team members finally found Mr. Butler at home; he was angry at the intrusion but calmed down and let them in, repeating he did not want to be aggravated. He could not clarify what this meant. He did not see why he needed to see a doctor as there was nothing wrong with him. The next day, Consultant Psychiatrist (F) and two team members visited, but Mr. Butler became verbally aggressive as he wanted to be left alone; he said he was leaving the country, and was nothing to do with them. He said that if he needed medication he would see a doctor. He told them to leave or he would throw them out. The team informed the Housing Department of what had occurred and of the intention to perform a Mental Health Act assessment.

42. On 4 March 2001 an unsuccessful attempt was made to execute a warrant under section 135 of the Mental Health Act with the Approved Social Worker, key worker, Consultant Psychiatrist (F) and the police present. After opening the door, Mr. Butler was able to run off and could not be caught. It is worth noting that there is no evidence that he offered or threatened violence on that occasion. The Housing Office informed the team on 13 March that Mr. Butler had set fire to his flat at 2.30am the night before. He had been seen leaving with two bags. It is right to record that we have seen no direct evidence in relation to this allegation of arson. Subsequently, it seems that Mr. Butler claimed he was out of the country at the time and he was certainly never charged with any offence arising out of this incident. However, whether or not the allegation was capable of proof it is part of Mr. Butler's history and is a matter that needed to be taken into account when assessing risk.

43. Mr. Butler was picked up by the police apparently after returning from Jamaica and was admitted under section 3 of the Act to Meadowcroft Hospital on 5 April 2001 from Queens Road Police Station. He had been arrested for the suspected arson and was alleged to have spat in the arresting officer's face and was then additionally arrested for assault. He denied all knowledge of the fire at his flat and felt he was victimised by the police. He would not accept medication.

44. One of the doctors who made the formal medical recommendation for Mr. Butler's admissions summarised the grounds as follows:

"This man has a history of suffering from severe mental illness… He tends to disengage with health services, stop taking medication when he becomes ill. He has done so in the last 4 weeks. He is also paranoid, sleeping rough and has reportedly set fire to his own flat. He refused to talk or look at us during the interview and kept his eyes closed."

45. The approved social worker included in her reasons for supporting the recommendation that:

Earle repeatedly disengages from services and is non-compliant with medication despite its effectiveness.

46. By the time of this admission, the team might have had some clarity on Mr. Butler's presentation:-

- He did not believe he was ill.
- He took medication sporadically even as an in-patient and was capable of deception, pretending to take medication.
- He had little by way of family to offer support, was socially isolated and not fully functioning in the community.
- He always preferred no contact with the mental health services, or if that were not possible, minimal contact.
- He responded better to some individuals with whom he had formed a relationship than others.
- Part of his belief structure was that he was being persecuted by State agencies because he was black, a belief that may have been reinforced by some of his experiences in life. As a result he had a fear of police and authority in general.
- As he could cover symptoms well for a time, the main initial signs of relapse tended to be arrears with the Housing Department and issues with neighbours. The former had happened at least twice, the latter on four occasions.

These were all areas which could be monitored, and in respect of which constructive interventions could be planned. These points should have been carried through into planning his discharge and care in the community after this admission.

CHAPTER 5

CARE APRIL 2001 TO DECEMBER 2003

1. Re-admission to Hospital - April 2001

As seen in the preceding chapter Mr. Butler was re-admitted to hospital on 5 April 2001. The property found on him when he was searched by ward staff comprised £90 in cash, a passport and a cheque from a Jamaican bank for £3,007. He was noted to be staring out of the window, mumbling to himself. He was thought to present a risk of absconsion and was placed on one to one observations,

2. The care plan prepared on 5 April by a named nurse recorded that Mr. Butler had been detained under section 3 of the Mental Health Act because he:

"appeared to be relapsing and [to] present a risk to his own health and safety as well as the safety of others as he tends to set fire to property (arson), verbally and physically aggressive, especially when he disengages with the services."

3. We find the suggestion of a *tendency* to set fire to property surprising. We have seen no evidence to suggest that there was more than one such incident, as described above. It is important that notes such as these record as accurately as possible the known facts and not speculation. At this stage there was only an allegation that Mr. Butler had set fire to his flat, an allegation the evidence for which, in our opinion, was never satisfactorily sought by mental health service staff to establish whether in fact there was substance to it.

4. When reviewed the following morning he said he did not know why he had been brought to the hospital and said:

"Every time I come back to this country you do this to me."

5. He said he had been doing engineering work in Jamaica and had come back after about a month there to buy equipment, which was the reason he had the cheque. He had visited his brother and had bought a car. The police had picked him up while he was sitting in it. This might suggest that Mr. Butler was motivated to find a means of supporting himself

financially, and that this might also have lain behind his failure to apply for benefit in 1994 when living in the Potteries.

6. He expressed the feeling that:

The police and doctors do this to him every time he returns to the UK – does not know why - "they write whatever they want"

7. He did not recall a previous incident when he was supposed to have been found in possession of a knife. He expressed concern that the cheque and his money would be stolen by staff. He was not willing to answer questions and stated he would not come to them for any physical or mental problems:

"I have my own doctors… You are white… I know you employ some blacks and Asians... but that's none of my business."

8. He was thought to be guarded and distressed rather to have clear persecutory delusions, but to possess no insight. He was visited by his brother and Mr. Butler asked for his property to be given to him.

9. On 7 April. Mr. Butler was recorded to have told a nursing auxiliary that he was not being rude by not talking with others, he was:

"keeping his head down and serving his time on the unit and keeping out of trouble to get off as soon as possible"

10. On 10 April, he was seen by a Dr. B who noted that Mr. Butler was still medication free – this was an intentional part of the assessment – and that there was no objective evidence of a psychotic illness. After reviewing the history and seeing Mr. Butler, who presented as very angry and as shouting at staff, he concluded that he had only been in Jamaica for three weeks, had set fire to his flat before leaving, and had visited his brother on his return. He ordered the reinstatement of the previous medication, by starting Amilsulpide, to be titrated upwards to 400 mg twice daily.

11. Between 10 and 14 April Mr. Butler refused medication, asserting that he did not need it and would not engage with staff. On 14 April there was an incident in which he is recorded as having become "*extremely*

aggressive and violent" and head-butted an auxiliary nurse during a routine search of his room, causing a minor injury. He was restrained and given intra-muscular medication. From 14 to 18 April he continued to isolate himself from contact with others. On 18 April in the course of a medical review Mr. Butler repeated the account of his movements he had given on admission, denied he knew anything about the fire, and complained that Amilsulpide stopped him going to sleep and was a dangerous drug.

12. On 20 April, a tremor of his lower lip and jaw was noted. On 24 April a doctor wondered whether this was early tardive dyskinaesia, a known side effect of Amilsulpide. The doctor could find no clear evidence of psychosis and requested that Mr. Butler be reviewed by his own team. The doctor gave permission for Mr. Butler to have escorted leave to the bank to pay in the cheque for £3007, which the patient had been requesting for some time. This leave took place on 28 April, but he was unable to withdraw cash, presumably from the funds represented by the cheque, because Mr. Butler was unable to produce a proof of address at the bank. Thereafter, he continued to be reluctant to engage but presented no management problems.

13. On 30 April, Mr. Butler was visited by his brother who stated that he had tried to cancel the cheque, although he would not elaborate on the reason. On 1 May 2001 a doctor reviewing Mr. Butler recorded that he was still saying that he had never been physically or mentally ill, and that the police "*target people [in?] conflict*" leading to use of the Mental Health Act. The doctor authorised escorted leave within the hospital grounds and a transfer to an open unit. As a result Mr. Butler was transferred to the Small Heath Inpatients unit on 3 May. It is clear from the records that both the inpatient staff and the Assertive Outreach Team expressed concerns about managing Mr. Butler on an open ward and his being medication free. They were reassured by Meadowcroft staff that assistance would be provided if enforced medication was required.

14. Consultant Psychiatrist (B) reviewed Mr. Butler on 4 May. Mr. Butler told him he had gone to stay with his mother in Jamaica on 14 March, which was the day after the fire in his flat, but he maintained his denial of any knowledge about the fire, or that he suffered from any mental illness. He repeated his feelings that he had been victimised by the police but denied there was any specific conspiracy against him. He denied ever suffering from psychotic symptoms. He became extremely agitated when Consultant Psychiatrist (B) tried to probe this denial. He refused to accept any medication.

15. From then on the pattern of isolative behaviour, refusal to accept medication and denial of illness persisted. He tended to become angry and walk out of psychiatric assessments and reviews when asked probing questions. However, no psychotic symptoms could be elicited. Very occasionally members of staff were able to engage him in conversations about his ambitions to settle abroad.

16. A crisis occurred on 6 June. In the course of a ward round by Consultant Psychiatrist (B), Mr. Butler became extremely agitated and hostile; he walked out of the room when medication was suggested. It was decided to administer intramuscular medication in the form of a depot injection of Clopixol Decanoate. Consideration was given to transferring him back to Meadowcroft for this purpose; it was not felt possible to impose medication on Mr. Butler at the Small Heath unit for safety reasons, presumably associated with the numbers and training of staff there. Consultant Psychiatrist (F) and other members of the outreach team including CPN (C) saw Mr. Butler on 13 June: he appeared agitated and again walked out of the room when medication was mentioned. He remained hostile to staff and on 15 June was recorded as having kicked another patient, although it was unclear whether this was accidental or intentional.

17. On 22 June Mr. Butler was given intra-muscular Zuclopenthixol 200mg, Lorazepam 2mg, and Haloperidol 5mgs with the use of minimal force. By 24 June he was showing signs of extra-pyramidal

side effects for which he was offered Procyclidine, but he refused to accept it. He continued to refuse to engage and a further depot was administered under restraint on 29 June. He continued to refuse Procyclidine because of the side effects. On 4 July Consultant Psychiatrist (B) decided to attempt to persuade Mr. Butler to take atypical anti-psychotics in the form of Olanzapine, and on 6 July Mr. Butler agreed to take oral medication. Consultant Psychiatrist (B) in turn agreed that if Mr. Butler took this consistently the depot medication could be discontinued.

18. Consultant Psychiatrist (B) told us that he remembered that:

"he was quite a difficult patient to manage, because he had a tendency not to display clear symptoms of mental illness. I feel that he probably had the ability to mask symptoms to a certain extent. He would always deny symptoms on direct questioning, as I have highlighted in my report. He would become irritable and hostile easily, particularly when unwell – not when well, but particularly when unwell. I know that there were problems with compliance with medication and engagement. The history is also suggestive that he had a tendency to self-neglect, and also sometimes to become hostile and aggressive."

19. With regard to risk he felt his case was related to his poor engagement with services and poor compliance with treatment. He had a tendency to self-neglect and become socially isolated and withdrawn. He was rather unpredictable in relation to hostility and aggressive behaviour.

20. He was uncertain about the extent of the fire said to have been caused in the flat, but did not believe it was a very serious incident, probably damage to a room. He did, however, consider the incident was significant with regard to the assessment of risk.

21. On 5 July Mr. Butler appeared before a Mental Health Review Tribunal. The Tribunal received reports from Consultant Psychiatrist (B), the RMO, and Approved Social Worker (B), as well as a nursing report:

22. Consultant Psychiatrist (B's) report, which became a useful source for those seeking information about Mr. Butler in later years, gave a very complete history and in particular noted that he had graduated in mechanical engineering from Aston University.

22.1 He had worked at Rolls Royce for 3 years.

22.2 His first admission to a psychiatric hospital had been in 1994 when he was reported to have made an unprovoked attack on a neighbour the previous day; there was a known two years history of self neglect at the time.

22.3 He was facing an eviction order for failure to pay his bills.

22.4 He was reported to have been verbally abusive to neighbours and to have spat at them.

22.5 He had gone to Birmingham to claim £500 when there was no debt apparently owed.

22.6 He contacted the Jamaican High Commission to claim that he was being persecuted and that others were trying to kill him.

22.7 He had not claimed benefits for the previous two years and was trying to live on savings.

22.8 He had no close friends and seemed to live a reclusive life

22.9 The troubled period residing at Servol was described as was his 18 month *"disappearance"*.

22.10 The episode in 1999 when he had broken a window was described as were his beliefs expressed on admission to hospital that officers from Special Branch and MI5 were trying to kill him, that medical staff were involved in this conspiracy, that they had taken £10,000 from him and that the police had taken a valuable computer. He had believed that the food in his house had been doped. No mention was made of the report that he had been found in possession of a knife. He had been treated under section 3, discharged under section 25 and followed up by the AOT but had not gained any insight.

22.11 Consultant Psychiatrist (B) confirmed that during the current admission Mr. Butler had persistently refused to co-operate with any

treatment and had been started on depot medication only after a great deal of difficulty.

22.12 Consultant Psychiatrist (B) was of the opinion that Mr. Butler suffered from paranoid schizophrenia and that his illness was characterised by paranoid beliefs, hostility with aggressive behaviour, loss of insight, social withdrawal and isolation. He had no insight at all and was not complying with his treatment. He recommended that it was inappropriate to discharge Mr. Butler at this stage.

23. The social worker's report gave a brief summary of the history and concluded that in her opinion Mr. Butler would engage with services to pursue his housing and financial needs but would not see the need for continuing medical input or treatment.

24. The Tribunal accepted that Mr. Butler was suffering from a mental illness. They found that the nature of his illness:

"is characterised by a continuing lack of insight. He has steadfastly refused to consent to medication during his admission although recent injections against his will have led to a reduction of his symptoms. We find that he would not be at all likely to consent to medication if the order were cancelled and without it we are sure that there is likely to be a rapid relapse in his condition to the detriment of his health."

25. The Tribunal found the evidence about the fire in the flat *"far from satisfactory"* and concluded they were not in a position to reach a clear finding as to the risk to others on this basis. They recorded that Mr. Butler had spoken to them politely and indicated that he wished to co-operate in the community and take Procyclidine. They found this encouraging and an indication that community care might have a part to play once the recent improvement had been consolidated.

26. It is not surprising that the Tribunal took the view that it did. The changes that were beginning to be apparent just before the hearing had not had time even to percolate through to the reports before it, and it was entirely reasonable to conclude that more time was required to see if the progress could be consolidated. It is quite possible that Mr. Butler, being a very intelligent patient, realised that a second opinion under section 58 of the Mental Health Act was likely to be sought soon

(the three month period since medication was first administered in this admission being on the point of expiring) and that there was a prospect of his being compelled to accept medication indefinitely. For this reason, as well the appearance before the Tribunal he might have seen apparent co-operation with medication as giving him the best chance of discharge without his having developed any genuine acceptance that he was ill.

27. Over the following period Mr. Butler's apparent change of attitude appeared to be associated with a marked change in presentation. On 11 July Consultant Psychiatrist (B's) ward round noted that Mr. Butler had been "*notably more sociable*" with "*no episodes of aggression*". He was "*pleasant and calm*" and agreed to accept Procyclidine for the continuing side effects of the depot medication, which Consultant Psychiatrist (B) discontinued. He said his first priority was to find somewhere to live (by this time his flat had been taken from him) and asked for help in sorting out his benefits. However staff remained cautious on 9 July a nurse noted:

"Appears to be compliant with oral Olanzapine although staff need to be aware that Earle has in the past secreted medication when given in oral formation."

28. Mr. Butler continued to comply with taking oral Olanzapine throughout the rest of his time in hospital. Consultant Psychiatrist (B) recalled that it was given in the form of Velotabs, which dissolve very quickly and thereby make it easier to ensure compliance. He remembered him getting much better on this treatment: more pleasant, communicative with an absence of hostility. He accepted that the medication helped him and he was willing to continue with it.

29. By 28 July Mr. Butler reported that the side effects were decreasing and he was continuing to engage with staff in a pleasant and constructive manner.

30. However, he continued to deny he had been or was mentally ill. On 1 August he told Consultant Psychiatrist (B) that he was willing to continue medication on discharge from hospital, and he was visited by

two housing officers to begin the arrangements for finding him accommodation. On 6 August he received an offer of accommodation, but after visiting it two days later he declined the offer. A care plan drawn up at the inpatient unit on 7 August 2001 noted that Mr. Butler was very settled and noticeably more sociable. He was said to be showing no signs of aggression, but still lacked insight into is condition. He was considered to be ready for discharge shortly and therefore needed to be prepared. However, we have seen no note suggesting any analysis of his current mental state of why discharge was now appropriate. That is not to say that, given appropriate support, discharge was not a justifiable course of action. However, that support needed to be informed by a continuing awareness that Mr. Butler's apparently more compliant attitude might well not have been motivated by a genuine acceptance of his illness or of a need for medication.

31. Preparations for Discharge and the Search for Accommodation

With the assistance of the RMN temporary accommodation was identified in Erdington into which Mr. Butler was prepared to move pending more permanent accommodation being found. He was given leave from hospital for this purpose from 7 September, and also as preparation for discharge into the community. He was allocated a bed at the unit in Chester Road. In preparation for this Community Psychiatric Nurse (A), of the Assertive Outreach Team, prepared a relapse and risk management plan dated 28 August 2001. This listed as signs and symptoms suggestive of possible risk or relapse:

- Disengagement from the team.
- Cessation of prescribed medication.
- Verbal aggression.

32. On 10 September the RMN contacted the Nechells housing office informing them that they needed to start looking for somewhere for Mr. Butler to live. On 14 September a review at Chester Road was informed that Mr. Butler was doing well there. It was agreed that staff would give Mr. Butler responsibility for taking his medication. On

19 September Mr. Butler told the RMN that he was having problems with his benefits and asked for help which the RMN offered to give. Both attended a review meeting at Chester Road on 21 September. Staff agreed that Mr. Butler was doing well, and the RMN chased up leads in relation to finding accommodation for Mr. Butler. He recorded contact with the Nechells Housing officer, whom he named, and another officer from Handsworth. On 25 September the Nechells housing office contacted the team with news that a bed-sit had been found. This does not seem to have been pursued, presumably because Butler did not want it. On 1 October the RMN was contacted by the Nechells housing office with news that accommodation had been found at Long Acre, Nechells. The following day the RMN took Mr. Butler to see this. His note reads as follows:

"Took Earle up to Long Acre to view a property. Earle liked the flat and signed the tenancy agreement there and then and also completed a housing benefit form. His tenancy will start on Monday. Afterwards dropped him off in town."

33. Community Psychiatric Nurse (C) also met Mr. Butler while he was looking at this flat. She recorded that he appeared to be settled and was talking appropriately about the work that needed to be done to it.

34. It is apparent from this summary of the records, confirmed as they were by the RMN when we met him, that there was considerable contact between himself, on behalf of Mr. Butler, and the Housing Department. His records of what he did are exemplary. It must have been apparent to the officers with whom he was discussing Mr. Butler's case that Mr. Butler was a mental health service user. It is therefore quite remarkable that the Housing Department has been unable to find any records of their own in which this information is noted. The question of liaison with other agencies is considered later in this report.

35. On 26 September Mr. Butler was seen by Consultant Psychiatrist (F). Mr. Butler reported that he was *"fine"*. The extra-pyramidal side effects were much better.

36. Discharge into the Community

On 4 October a formal review and section 117 discharge meeting took place at Chester Road attended by Consultant Psychiatrist (B), Community Psychiatric Nurse (A), and Approved Social Worker (B). Consultant Psychiatrist (B) noted that Mr. Butler continued to deny any problems and that no psychotic symptoms were elicited. There was still no full insight into his illness. However Mr. Butler felt that his current medication (Olanzapine).

"suits him very well and he is happy to continue with this. He is willing to see the team regularly."

37. It was agreed that Mr. Butler should be discharged from section 3 admission. Consultant Psychiatrist (B) pointed out to us that this decision would not have been taken unless there had been unanimous agreement between members of the ward team and AOT. The following arrangements were to be put in place:

37.1 There was to be regular input from the Assertive Outreach team "*which will be once weekly at least.*"

37.2 There were to be "*regular*" outpatients appointments at Harry Watton House.

37.3 The AOT would help Mr. Butler with his social and other daily needs. Mr. Butler stated that he was not keen on any immediate help with social activities as he was going to be busy decorating his flat.

37.4 A further record of the same meeting added that the weekly visits would also be for the purpose of monitoring mental state and compliance with medication.

38. We asked CPN (C) to describe what the plan was. She told us that:

"We would monitor him for any deterioration, which is what we do with all the clients – looking for relapse signatures from previous relapses. I understand that in the past his self-care had gone down, he was not eating or washing and his house was in a terrible state. These were all little things that we would be looking for. We would watch to see if he was hallucinating or if there was any increase in the aggression towards the team. These are all subtle things. Even to the point that the team would

look to see if he was wearing a different hat…. Obviously we would ask him "Are you taking your medication?" and he would say. "Yes"

"You never know whether to believe any of the clients. We discussed as a team different ways of delivering medication to Mr. Butler in the same way as we do with every client – whether we should put it into medi-dose boxes or venalink containers. It was discussed with Mr. Butler as well and he said he wanted his medication to be delivered fortnightly. At the time we made that decision we could not get his medication put in a venalink anyway because pharmacy were refusing to do it… We felt that the risk of losing contact with Mr. Butler was such that we wanted to make sure we could engage him and if he was willing to see us fortnightly for medication, it was a team decision that that was the best option…"

"Underlying our thoughts was that we wanted to maintain contact with him and that it was better to see him even if it was only to deliver medication fortnightly than for him to take off and for us not to monitor him at all."

39. She agreed that it would have been possible to negotiate with Mr. Butler before his release from hospital the way in which his compliance with medication would be monitored.

40. Consultant Psychiatrist (B) said he would have had at the back of his mind the risk that Mr. Butler could mask symptoms if not taking medication, but he would have expected there to have been clear warning signs of his becoming unwell in those circumstances, showing hostility, self neglect, and social isolation. In any event he felt that they had to take into account Mr. Butler's status as a private person and his wishes with regard to how much intrusion was reasonable. He would have expected the AOT to be monitoring for signs of relapse and would have been worried if Mr. Butler was not letting anyone into his flat, or was only seeing them on his doorstep. Blood testing for drug levels would have been theoretically possible, but the analysis could only have been performed by a specialist London hospital. He would have expected the team to have asked direct questions about Mr. Butler's beliefs, experiences and anxieties as part of the assessment of whether he was suffering psychotic symptoms. He would have anticipated that Mr. Butler would have become hostile in the face of such questioning if he was unwell but when he was well he would not have had such a worry. If Mr. Butler had started to mind being asked that sort of question he would have become concerned.

41. Again there was no note of any analysis of Mr. Butler's mental state or

of the reasons why discharge was appropriate. Thus no baseline was documented against which to assess future progress. The section 117 meeting did not result, as it should have done, in a set of formal CPA documentation. CPN (A) had prepared a risk and relapse risk management plan before this meeting but there is no indication that it was re-visited after this meeting. We have been unable to locate a formal care plan other than the notes of the section 117 meeting itself. CPN (A) told us that although the forms were provided collectively the only using parts of them. This is of concern as the Trust had in its possession at the time appropriate forms for documenting CPA arrangements. They do not seem to have been used as they were intended. We are satisfied that this is not something for which any one professional had responsibility, but was an aspect of the normal practice of the AOT. As will be apparent it was an approach which lay at the heart of the team's failure in this case to adopt a systematic and genuinely assertive approach to the care and supervision of Mr. Butler.

42. On being discharged from hospital, Mr. Butler may have appeared to be in a stable mental condition, and he had been found appropriate accommodation. However, it was clear from his history to this point that he lacked real insight into his illness, and remained highly reluctant to engage with mental health services. His behaviour in hospital suggested that he could be reluctant to comply with his medication regime. There was at least a possibility that he agreed to take the prescribed Olanzapine as a means of getting released from hospital: in other words he was prepared to go through the motions and to co-operate to the minimum extent necessary to avoid more than minimal contact with mental health workers. It was also clear that his illness provoked paranoid beliefs about the organs and agents of the State. Many of these beliefs, such as his conviction that the police were out to do him harm, may have been reinforced by the adverse experiences some in the black and ethnic minority community commonly have. However, sadly, little if any investigation of his real experiences as a member of that community seems to have taken

place, so it is impossible to know whether that was the case. What was clear was that Mr. Butler was likely to present a challenge to the Assertive Outreach Team charged with his care and support, one to which, as will be seen, they failed to rise effectively.

43. Initial Support in the Community

On 16 October, the RMN visited Mr. Butler at his flat and found him painting it. Mr. Butler said he had received a grant from the DSS with which he had bought some essential items. The RMN advised him about a loan for which he could apply. Mr. Butler asked him to get an application form. They also discussed arrangements for a forthcoming review meeting. Mr. Butler asked for the date to be changed. On 24 October CPN (A) visited Mr. Butler and found him in "*extremely good spirits*" and he reported that he "*was enjoying himself*". Medication was left with Mr. Butler.

44. On the following visit, on 6 November 2001, CPN (A) received no reply. She has recorded that she left a letter asking him to come to Harry Watton House to see Consultant Psychiatrist (B) on 19 November. She also put the medication through the letterbox.

45. This was the first occasion following the discharge in October when medication was left at Mr. Butler's accommodation rather than it being handed to him personally. This had occurred on occasion in 1999. We asked CPN (A) about the practice of leaving medication in this way, and she told us that the policy of putting medication through the letterbox had been discussed in the team and, she thought, taken to the Assertive Outreach Forum as an issue. They were aware it was "*not ideal practice*", but:

> *"We felt that it was important that people got their medication rather than not. Our policy certainly was that if we put medication through the door, we would do a follow up visit to make sure they had got it and to find out if there were any side effects and so on. That was happening with a number of clients of the Trust so far as I am aware."*

46. The RMN also told us that the issue had been discussed in the team "*as one way of ensuring that he got his medication*". He thought he

had asked Mr. Butler on one occasion and that Mr. Butler had suggested he put it through the letterbox if he was not in.

47. There are a number of reasons why this was very questionable practice:

47.1 This occurred only a month after his discharge from section 3 admission.

47.2 Mr. Butler had a long standing and well established history of non-compliance with medication and close supervision of his progress in this regard was required.

47.3 Impersonal delivery may unwittingly have given Mr. Butler the impression that little importance was attached to his compliance by the team, perhaps reinforcing his belief that he did not need the medication.

47.4 There were no means of knowing whether anyone other than the intended recipient would have an opportunity to pick up this medication before Mr. Butler did so.

47.5 By not retaining the medication until Mr. Butler was seen the capacity to monitor his behaviour and engage him was reduced.

48. There is no documented evidence that the practice of delivering medication in this way was approved or planned.

49. Mr. Butler was next seen two days later on 21 November by the RMN. The notes of this visit do not record whether Mr. Butler was asked to confirm that he had received the medication delivered previously. There was a conversation about a proposed outpatient's appointment, his thoughts about a trip to Jamaica, and his need for money to buy furniture. Further medication is recorded as having been delivered on this occasion.

50. On 28 November Consultant Psychiatrist (B)reviewed Mr. Butler. He

continued to deny involvement in the fire at his former flat, but he expressed agreement to taking the prescribed medication and seeing the AOT regularly. He also verbally agreed to Consultant Psychiatrist (B) disclosing information about him to the police, but was not prepared to sign an authority for that purpose. Consultant Psychiatrist (B) told us such disclosure would only have been considered if the police had contacted him about the incident. He recollected there had been some form of communication about it with the police but could not recollect the detail. There were no records of any such contact available to us.

51. Care 2002 – 2003

Thereafter members of the team, usually the RMN but quite often CPN (C), attempted to visit Mr. Butler once a fortnight. It would serve little purpose to describe in detail each of these occasions but the following table summarises them:

TABLE 1 : CONTACTS RECORDED IN MULTI-DISCIPLINARY NOTES ~ 2002-2003

DATE	CONTACT	COMMENTS
19.12.01	RMN	Complaint of back pain.
04.01.02	CPN (C)	
08.1.02	RMN	
01.02.02	RMN CPN (C)	Discussion re holiday plans and finance, activities.
18.02.02	CPN (D) RMN	Looked edgy would not let team in. Said had received no medication; said could not go to outpatients appointment next day.
19.02.02	Con Psychiatrist (B) CPN (C)	Outpatient review: “Fine”; no problems; hoping to do some writing; keeping fit by jogging, stopped due to back problems, now relieved; no paranoid thoughts well kempt, polite, euthymic. *“happy to continue”* Olanzapine.
01.03.02	CPN (D)	Appeared well, but bit busy.

DATE	CONTACT	COMMENTS
08.03.02	CPN (C)	Said he was going on holiday to Jamaica, requesting medication for 2 weeks; medication delivered; no problems observed.
11.04.02	CPN (C) RMN	"Relatively settled"
30.03.02	Team Manager (A)	Seen on doorstep of flat; pleasantly talkative about holiday.
25.04.02	RMN	Relatively settled; back better; discussion re activities.
24.05.02	RMN CPN (C)	No reply; medication through letter box.
07.06.02	RMN CPN (D)	2 attempts: no reply.
08.06.02	CPN (D)	No reply; note left.
09.06.02	CPN (D) L B	No reply.
10.06.02	CPN (C) RMN	Answered door after delay; said been away for few days; accepted medication and said it still suited him.
21.06.02	CPN (C) RMN	Invited in: flat clean and tidy; discussion about interests, travel plans, and feelings.
25.06.02	Review (Con Psychiatrist (B))	Feels well, no problems; copes well; sees brothers occasionally. Occupying self with writing, housework and hobbies. Feels sweaty and sleepy on medication but no other side effects.
19.07.02	CPN?	No reply.
02.08.02	CPN (C) RMN	Took medication but said was busy and did not let in; appeared relaxed.
17.08.02	CPN (D)	No reply.
18.08.02	CPN (D)	No reply.
20.08.02	RMN	No reply: medication through letter box.
21.08.02	CPN (C) RMN	Window open but no reply.
24.08.02	RMN	No reply.
25.08.02	RMN	Appeared settled; said he had picked up medication.
03.09.02	Service Manager (B)	Said was fine and shut door.

DATE	CONTACT	COMMENTS
01.10.02	CPN (B)	Appeared settled, denied any problems.
15.10.02	CPN (C)	No reply.
16.10.02	CPN (C)	Appeared well and chatting appropriately; expressed interest in trip to Blackpool.
01.11.02	CPN (C) Student	Appeared settled and said he was cooking.
15.11.02	CPN (C)	No reply.
16.11.02	CPN (C)	No reply.
17.11.02	CPN (C)	Answered door straightaway.
26.11.02	CPN (C)	Given outpatient\appointment; said he would attend.
	Con Psychiatrist (F) CPN (C)	Review at Harry Watton House: remains well, cooperative.
01.12.02	CPN (C)	No reply: medication through letter box.
15.12.02	CPN (B)	Opened door after few minutes; appeared settled, smiling appropriately; said might attend Christmas party if nothing else to do.
23.12.02	CPN (C)	Given present: said had been too busy to come to Christmas party.
27.12.02	CPN (D)	No reply.
11.01.03	CPN (C) Student	Reluctantly let them in; discussion re back problems, activities holidays; said would be interested in trip to France; evidence seen of his drawing; appeared a little suspicious of student.
25.01.03	CPN (C)	Answered door promptly; relaxed, smiling; said it was “going OK” taking medication.
08.02.03	CPN (B)	No reply.
09.02.03	CPN (B)	No reply: medication through letter box.
10.02.03	CPN (B)	Seen on returning from shopping.
11.02.03		Attended for outpatients appointment but sent away through administrative error. Came back and offered alternative but was angry and refused.
23.02.03	CPN (C)	Relaxed; happy to wait unto Reid’s return for outpatients review.

DATE	CONTACT	COMMENTS
08.03.03	CPN (B)	Accepted medication on doorstep; appeared relaxed.
22.03.03	CPN (C)	No reply.
24.03.03	CPN (C)	Invited inside; said he is taking medication without problems.
01.04.03	Dr G	Reported he was fine and no psychotic symptoms.
07.04.03	CPN (C)	Accepted medication at door: said had no problems.
20.04.03	CPN (C) RMN	Spoke on door step; appeared settled.
04.05.03	RMN CPN (B)	Appeared settled.
18.05.03	RMN	Appeared settled; expressed interest in client holiday to Weymouth; no problems observed.
01.06.03	RMN CPN (B)	Appeared on edge; changed mind about interest in holiday.
14.06.03	CPN (C) RMN	Seen briefly; said did not fancy sharing room on client holiday.
19.07.03	CPN (D)	Appeared OK.
21.07.03	CPN (C)	No reply.
26.07.03	CPN (C) Service Manager (B)	Appeared at door stripped to waist and sweating; said was working out.
25.07.03	Con Psychiatrist (F) CPN (C)	Outpatient CPA review: no symptoms, coping. Say s he is happy to take Olanzapine; busy with work n mechanical engineering. Risk of self harm, harm to others and self neglect assessed to be nil.
09.08.03	Team Manager (A)	Appeared well; said had changed mind about trip previous week.
16.08.03	Approved Social Worker (A)	Appropriate behaviour.
30.08.03	RMN	Appeared settled'; no problems observed; discussed voluntary work and chance to use computer; said he is not interested and has a lot to do.

DATE	CONTACT	COMMENTS
11.10.03	CPN (C)	No reply.
12.10.03	CPN (C)	Very chatty and sociable.
08.11.03	CPN (B)	Settled, pleasant and chatty.
22.11.03	RMN	Appeared settled; no problems noted.
05.12.03	Con Psychiatrist (F) CPN (C)	Review at Harry Watton House; remains well; happy with medication; coping well, no symptoms; finances OK.
	CPN (C)	Care plan.
09.12.03	CPN (C)	Bare chested and sweating; did not invite in. Said he wanted to attend party on 18/12.
22.12.03	CPN (C) CPN (A)	Appeared settled; gift given to him.

52. CPA documentation during this period was very sparse. There are review summaries dated 25th June 2002, 1 April 2003 and 25 July 2003. The first set out a plan:

- To continue with medication.
- To continue engaging with AOR Team with … work at educational opportunities.
- Continue with regular outpatients appointments four monthly.

53. The second plan was to:

- To continue with the Olanzapine
- For AOR team to see Mr Butler fortnightly <u>to deliver medication"</u> [our emphasis].
- To encourage Mr Butler to participate in social activities.
- To give Mr ButlerEarle a full medical review in three months.

54. The third document, formulated by Consultant Psychiatrist (F), set out a plan:

- To continue with Olanzapine.

- For Mr Butler to continue to occupy himself with his studies
- For Mr Butler to be given support living in the community as required.
- For Butler to be medically reviewed three monthly.

55. Finally there is a form dated 5 December 2003, the date of the review by Consultant Psychiatrist (F)noted above.

- Two needs are listed: *"ongoing support as required. Monitoring of Earle's mental health".*
- The care services to be provided include fortnightly monitoring and delivery of medication.

56. Signs and symptoms suggestive of the possible risk of relapse or trigger risk behaviour were:

- Disengagement from AOR Team.
- Cessation of prescribed medication.
- Verbal aggression to AOR Team and neighbours.

57. There are a number of features giving rise to concern about these plans and their content:

57.1 It is striking that very little emphasis is given in these plans to the method of monitoring medication. When it is mentioned there is no description of the means of monitoring. Thus opportunities were lost to review the effectiveness of monitoring and the techniques being used. In particular no consideration was given to the desirability or otherwise of delivering medication via the letterbox.

57.2 There is also a striking lack of any form of target to be achieved before the next review. There seems to have been an implicit acceptance that Mr. Butler would continue as a user of the Assertive Outreach Team's services without much thought about an exit strategy for him.

57.3 Social activities are continually referred to, and indeed were offered from time to time without any consideration of the obvious reluctance of Mr. Butler to participate in what was offered. While he might have displayed such an attitude to any suggestion, no consideration was given to whether his somewhat unusual background of educational and technical achievement meant that insufficiently interesting and stimulating activities were being offered.

57.4 No consideration was given to the nature of the visits being conducted, in particular, to the fact that many visits were taking place on Mr. Butler's doorstep and not in his home. Thus they accepted superficial contact when genuine engagement was needed.

57.5 As with so much of the record keeping disclosed by this case it is now, and would at the time, have been very difficult to work out at a glance what the current state of play was with regard to the care plan, risk signs and so on, because the CPA documentation was not arranged in one properly updated bundle.

58. Turning to the significance of what was observed during this period certain features occurred commonly:

58.1 It was frequently noted that Mr. Butler was "*settled*"

58.2 He was often seen only on the doorstep of his flat, producing an excuse for not letting the team in, such as having a shower or going out.

58.3 Medication was recorded as having been left through the letterbox on four occasions in this two year period. When this occurred it would only infrequently be recorded at the next successful visit that he had confirmed receiving it.

58.4 Whenever it is recorded he was asked about medication he stated he was taking it or happy to do so.

58.5 Generally if there was no reply at an attempted visit, follow-up visits

would be made until he was seen, but no consideration is recorded as having been given to the possible implications of his absence or unwillingness to answer the door.

58.6 The level of observation and support took insufficient account of Mr. Butler's non-compliant behaviour in hospital, and failed to explore what might have been the reasons for the sudden change at around the time of the Mental Health Tribunal hearing.

58.7 While the notes record discussions about interests, activities etc, on many occasions the details of such discussion are not noted.

58.8 Mr. Butler would often express an initial interest in a proposed outing, party or holiday, but he would never actually attend.

58.9 There is no evidence of any analysis or consideration of whether any progress was being made. Mr. Butler, according to these notes, remained in social isolation.

59. The impression is of routine visits at which little of substance was discussed. There is little suggestion of seeking means of improving Mr. Butler's mental condition or quality of life; rather there appears to have been an acceptance that his being "*settled*" was a satisfactory state of affairs.

CHAPTER 6

CARE JANUARY TO MAY 2004

1. Summary of Care in 2004

In relation to period leading up to the homicide in 2004 it will be necessary to examine a little more closely what happened on some of the occasions when contact was had with Mr. Butler. However it may be helpful to the reader to set out in a table a summary of the occasions on which there was contact or attempted contact. The description of events is largely taken from the team's multi-disciplinary notes.

TABLE 2 : SUMMARY OF CONTACT WITH MR. BUTLER January – May 2004

DATE	CONTACT	EVENTS
20.01.04	CPN (C)	Visited Earle at home. Given 2 weeks medication; chatted and appeared settled in mood.
26.01.04		Housing benefit review: Mr. Butler said not to have provided proof of income (unknown to the team).
02.02.04	CPN (C)	Visited but no answer in spite of knocking several times.
02.02.04 15.30	CPN (C)	"I visited Earle at home and gave him his two weeks medication. Earle answered the door at the first knock. He was smiling and pleasant. He said he had been out this morning and" He had no problems to report."
16.02.04	CPN (C)	Attempted to visit Earle but no reply. "*I will try later.*"
17.02.04	CPN (C)	*"I visited Earle at home and gave him his week's supply of medication: little interaction apart from saying he is well and has not problems at present."*
?March 2004	neighbour	Saw Gas Board men break into GB's flat to take meter away [Team not aware of this at the time].
01.03.04	CPN (C)	Attempted visit: no reply.

DATE	CONTACT	EVENTS
02.03.04	CPN (C)	Attempted visit: no reply.
03.03.04	CPN (C)	Attempted visit: no reply. Note asking him to contact the team left.
04.03.04	CPN (C)	"I visited Earle at home. He answered door immediately and accepted his 2 weeks medication. He apologised for missing me the past few days.
01.04.04	CPN (B)	"Called today to dispense further supply of oral medication. No reply obtained but medication left through letterbox. Will try to contact tomorrow."
01.04.04		Housing benefit stopped owing to lack of proof of income at review on 26/1/04. [Team not aware of this at the time].
19.04.04	[Clinical Team Meeting]	"*Seen last week but no 'warmth' or social contact. May be relapsing slowly. To be seen by Thilak and Hilary during this week."*
21.04.04 11.15	CPN (C)	Attempt to visit Earle at home to tell him about his outpatient appointment but there was no answer despite knocking several times. Letter left informing him of this.
22.04.04 12.00?	CPN (C)	Attempt to "*remind Earle about his OP appointment but there was no answer at his flat. The upper window was shut. This was open yesterday.*"
23.04.04		*Appointment for psychiatric review: did not attend.*
24.4.04 or 25.4.04	Team Manager (A) Support Worker (C) Support Worker (A)	Home visit: [see below for narrative].
26.04.04	Clinical Team Meeting	Review: agreed to visit GB following day.
27.04.04	Con Psychiatrist (F) CPN (C)	Domiciliary visit for CPA assessment see below for narrative.
30/04/04	CPN (C)	Risk assessment drawn up [see below].

DATE	CONTACT	EVENTS
10.05.04	Clinical Team Meeting	*"seen at weekend"*
15.05.04	CPN (B)	Visit to deliver medication. GB said he did not need any because he had some the previous week "I have got the medication, I don't need it, but will take it from you"; CPN (B) note: *"seen today - there appeared to be an edge to Earle today. He asked why I was visiting and when told that I was delivering him some meds he said that he had had some delivered earlier in the week. When asked who by he couldn't say. I explained that I was visiting because it was in the team's diary to visit him. He appeared to reluctantly accept this however he did not invite us into his flat at all."*
17.05.04	CPN (C) Hove Support Worker (A)	Last visit and contact by team before incident [see below for narrative].
21.05.04		GB threatens council carpenter with knife.
		Possession notice delivered to GB address; no reply.
		Homicide.

2. Care Plans and Risk Assessments

The care plan under which Mr. Butler was being managed during this period was formulated by CPN (C) on 5 December 2003:

2.1 The main objective of the care plan was described as being:

for Earle to remain mentally stable in the community

2.2 His needs were stated to be:

Ongoing support as required, Monitoring of Earle's mental health

2.3 The care services to be provided were as follows[9]:

Care services to be provided	By whom	Frequency
Monitoring of mental health	AOR/Team.	2 weekly. as agreed with Earle
Maintaining and delivery of medication Olanzapine Velotab 10mgs nocte	Pharmacy/ AOR Team/ Earle.	2 weekly
Social/occupational activities	AOR Team.	On going
Receive regular medial review	Con Psychiatrist (F), AOR Team.	3 monthly
Outcome of plan (how to be measured)	For Earle to remain mentally well. Engaging with the AOR team, functioning to his optimum living in the community.	

2.4 The relapse and risk management plan of the same date contained the following:

2.4.1 The steps to be taken if Mr. Butler failed to attend or meet other commitments were indicated by proforma boxes being ticked. These were that he should be sent another appointment, his GP should be contacted, the *"nominated carer"* should be contacted, the case should be discussed with the RMO and his home should be visited.

2.4.2 The signs, symptoms, behaviour suggestive of possible risk or relapse and circumstances which might trigger risk behaviour or relapse were listed as:

- Disengagement from AOR team.
- Cessation of prescribed medication.
- Verbal aggression to AOR team and neighbours.

[9] *The table which follows is a transcription of the care plan.*

2.5 Action to be taken in the event of relapse/risk was:

- Increase frequency of visits.
- Review by RMD.
- Consider referral to Home Treatment Team.
- Consider Mental Health Act assessment.

2.6 The form was not signed by Mr. Butler but it was recorded that he had verbally agreed to the plan.

2.7 No form detailing the current warning signs or history of risk behaviour and risk related behaviour/circumstances appears to have been completed at the time of this review, although one does exist that appears to have been filled in on 30 April 2004. So far as we can tell the only current documentation of the risk, if any, presented by Mr. Butler remained the note of the CPA review that had taken place on 26 July 2003 at which Consultant Psychiatrist (F) had noted that there was a nil risk of self harm, harm to others or of self neglect. We understand from CPN (C)'s evidence that in circumstances where there had been no change in the risk assessment there would be no change in the records. When CPN (C) came to fill in the risk assessment form on 30 April 2004 she ticked none of the boxes that would have indicated any current risk related behaviours or circumstances but did tick the following boxes outlining risk related behaviours or circumstances which had previously:

2.7.1 Extreme verbal abusiveness/threats of violence.

2.7.2 Non-compliance with medication.

2.7.3 Unplanned disengagement from services.

2.7.4 Command hallucinations, paranoid delusions.

2.7.5 Arrest/conviction for other criminal offences.

2.8 As is apparent from the table above and the narrative below, none of these matters were perceived by the team to have recurred in the

period leading up to 30 April and therefore must relate to Mr. Butler's previous history. Therefore for the whole of the period between January and May 2004 the team dealt with Mr. Butler as someone who posed no risk to himself or others.

2.9 CPN (C) pointed out that risk assessments were snapshots of how the client presented on the day of the assessment and that they were aware that there could be changes:

"There was obviously an ongoing risk with all of the clients of Assertive Outreach, but at that point in time [23rd July 2003], the way he presented to Consultant Psychiatrist (F) at that review was such that he felt there was no risk and I certainly felt the same. If there had been I would have said so and we would have taken it to the next stage."

"… we know that anybody can relapse at any point. You are constantly observing your clients for any signs. Yes, it would make the team feel better that at that time he had had been assessed as having no illness, confirming what we were saying and the fact that we felt he was not deteriorating, but it did not mean that we would drop our guard. We were constantly looking at every single client for any signs."

"We were well aware that because of the limits of engagement it was important to do a thorough assessment when we did get access. At all review meetings that was constantly in our minds."

3. CPN (C) and the rest of her team felt that they faced considerable challenges in effectively monitoring Mr. Butler:

"We were depending on his good will to actually see us. The fact was he had not disappeared, he had stayed behind, the flat was clean and tidy and we had not had anything from Housing to say there were any problems. He was going out and doing things whereas in the past he had isolated himself when he became unwell. When unwell he would open the door half way and, in fact, when well he would open the door and invite us in. We had to go on these subtle things to look for illness recurring."

The Team Manager (A) agreed:

"We knew that we did not know a lot of information about much of his life and did not have access to it. We knew that, although he had been well for slightly longer than the last time he was well, we knew that he could keep it from us and that there was a strong possibility that he could relapse again. So I suppose our priority was to keep the engagement and being able to try to see when that was possibly happening. We probably had two approaches, one was to try to increase the engagement we had with him and, secondly, to monitor if the possibility of a relapse was about to occur. So if we felt he was showing signs, we would have to choose our moment. We had very few options with him but the ultimate one would be the Mental Health Act assessment, which we have used in the past and would anticipate using again."

4. Attempts were made to encourage Mr. Butler to engage with the team by inviting him to come on social outings organised by the team. Even

though he might initially express interest in joining in, in the end he would invariably decline. CPN (C) said:

"He was a very isolative man. We had observed him even when he was well on the ward. He did not interact with the other clients on the ward or the staff and only on a very superficial level with the team for him to be able to get things done he wanted. Probably he felt that by seeing us he was fulfilling his part of the care plan and that was what he needed to do to stay away from us or keep us at arm's length…"

"…Over time you could try [to assess his mental state]. That is what we were doing by spending time with him and trying to observe what was going on. We knew from previous admissions that his symptoms were quite open when he was unwell. He became very hostile. He was hostile to neighbours and to staff who were trying to visit him. He did not want to see us. He would only open the door a small amount. In Assertive Outreach we generally go by what has happened in the past to build up a profile of a person's relapse signature. That is how he had relapsed previously and we were looking for changes in how he presented when he came to the door. For instance, was there a time lapse for him to come down the stairs? All these were subtleties. My colleagues used to look what hat he was wearing when he was out on the street… how he presented. Was there any sign that he was looking paranoid when he was out and not aware that we were watching him?"

The Team Manager (A), said:

"We always tried to keep him abreast of what our social activities were, in the hope I suppose that one of the activities he might have agreed to go to. He always politely said he would think about it or he declined. It was an opportunity to draw out conversation with him and assess him. We knew that our link with him was fairly tenuous, so we didn't push the issue of needing to see him in his house. We left that to the review periods."

CPN (C) agreed that the team probably never really challenged Mr. Butler:

We may not have challenged him as much as we should have, but it is easier to see that in hindsight. We would usually challenge a client more if he showed signs of deterioration.

5. She agreed there were a number of things that could have been done to check on whether he was taking his medication but thought that none of them would have revealed that he was not, but she agreed that therapeutically he was in control of what happened not the team.

"We thought he was complying because he had bought into the care plan, if you see what I mean. This was the way he wanted it to happen … He was saying when he was on the ward that he felt the benefit from the medication, even though he did not believe he had an illness."

6. He would not have detailed conversations with members of the team about his activities, and often declined assistance with regard to them. CPN (C) said that she was sure they had offered him a place on a

martial arts group when the team started one.[10] Attempts were made to discuss his illness with him but he always denied he was or had been ill. He said that he took his medication because he was depressed.

7. Team Manager (A) told us that it was felt that to "push" Mr. Butler, for instance by inviting themselves into his flat, would have been counter-productive. It had always been a "s*truggle*" to increase their access to Mr. Butler or their knowledge about him. They were clearly reluctant to be assertive. Team Manager (A) said:

"…we could have been more assertive about imposing our time in expecting to see him, but I do think we regularly discussed it, and the risk of losing engagement or any contact with him was very real. Most of the times we tried to extend conversation were around positive things and not to give him a grilling about his health, so that we could do it more often without losing him. It was far from ideal but it was a regular focus within what can we do to improve our engagement without losing him."

8. No addition or variation appears to have been made to the care plan before 30 April 2004. The panel asked CPN (C) about CPA documentation. She told us that the notes of patients generally were kept in a very muddled fashion, in part because of failings in administrative support. Notes for clients were not kept in one place and this left gaps in information which was available. She admitted that it would have been difficult for a newcomer to the team to obtain a quick résumé of Mr. Butler's case from reviewing the notes. She told us that the team relied on verbal explanations and reference to the details kept on the board in the team office. So far as the available CPA forms were concerned the team only used some of them. The position has changed now in that CPA documentation is entered and stored on the team computer and is therefore much more readily accessible.

9. Analysis of Contacts in 2004

9.1 In 2004 there were a number of occasions when Mr. Butler was not in or did not answer the door when team members called. The precise

[10] *The panel had some doubt whether such an offer had been made for two reasons: firstly there was no record of any such conversation, and secondly the only record we could find of any mention of martial arts was in relation to the visit to his flat on 27 April.*

dates are difficult to decipher from the copies of the record supplied to us but it is clear that Mr. Butler became increasingly difficult to see.

9.2 After the visit on 17 February, when it was observed that there was "little interaction," Mr. Butler did not answer the door, or was out, on the next three recorded attempts at a visit on 1, 2nd and 3rd March. CPN (C) succeeded in seeing Mr. Butler on 4 March on which occasion he was given two weeks' medication. The note of this visit does not suggest that much time was spent assessing his mental state.

9.3 The next visit occurred on 1 April, but there was no reply. No further attempted visit is recorded in the team's multi-disciplinary notes until 21 April, but the records of the clinical team meeting held on 19 April refers to there having been a visit the previous week. The note recorded that there had been no "*warmth or social contact*" and that Mr. Butler might be "*relapsing slowly*" This suggests that there was a visit between one and two weeks after 1 April, but that no note was made, or alternatively not properly filed, in spite of there being concern about Mr. Butler's presentation at it.

9.4 Attempts were then made to see Mr. Butler on 21 and 22 April, but either he was out or he did not answer the door. He also failed to appear at an outpatient appointment with Consultant Psychiatrist (F) on 23 April. Finally he was seen at his flat on 24 or 25 April by the Team Manager (A), NM and Support Worker (A), at least 11 days after the previous visit. Again there is no record of this visit, although we are satisfied it took place.

9.5 Mr. Butler was seen on 27 April at his flat by Consultant Psychiatrist (F) and CPN (C) and this visit is considered in detail below. The next recorded suggestion of a visit is in the minutes of the clinical team meeting which occurred on 10 May where it was said he had been seen the previous weekend. The note gives no clue of what observations were made at this visit and there is no record of it in the

multi-disciplinary notes. It appears that weekly visits were being attempted at this stage.

9.6 The next visit was on 15 May, and finally he was seen on 17 May.

9.7 From the records it appears that 19 attempts were made by the team to visit Mr. Butler between 1 January and 21 May 2004 before the incident, He was seen on 11 of those occasions, albeit briefly. While this averages a visit every 13 days there were several occasions as outlined above when Mr. Butler was not seen for well over 2 weeks. We are unable to establish from the records what was done in relation to such periods to ensure that Mr. Butler had an adequate supply of medication.

10. Evidence of Deterioration in 2004 and the Team's Approach to Monitoring Change

In retrospect it seems clear that Mr. Butler's mental state was deteriorating during 2004:

10.1 On 17 February CPN (C) recorded that there was little interaction apart from Mr. Butler saying he had no problems and was well. This was probably not true: Mr. Butler was often absent from home in March and at some point in that month a neighbour saw gas officials break into Mr. Butler's flat to take the gas meter away.[11] This would suggest a disconnection, perhaps because of non-payment of monies owing for gas supplies.

10.2 In April, after one failed visit, sufficient concern was expressed about Mr. Butler's lack of warmth to cause Consultant Psychiatrist (F) and CPN (C) to make a domiciliary visit. They failed to make contact with Mr. Butler, and he also missed an outpatient's appointment. The manager of the team, visited him over a weekend with colleagues. According to the statement he made to the police the Team Manager (A) had a brief conversation on the doorstep. Although he thought

[11] *The panel was unable to interview the neighbour and did not seek information from the gas supplier as it was felt this was potentially straying beyond our remit.*

there had been nothing to cause immediate concern Mr. Butler had walked away from them without any departing acknowledgement, which was thought to be unusual. He told us:

"…instead of standing on the doorstep, he came out of the house and was dressed for going out. He was sociable and there was no hint of any sort of tension. I suppose I was a little surprised he didn't drop the medication into his house, because he took the medication with him but I had no baseline to think that that was different. He wasn't rushed but he certainly had a momentum that he was going out, so it was a fairly brief discussion with him. I think we discussed that afterwards on the Monday. Again, we were extremely sensitive to any fluctuation in his presentation."

"… he certainly had a momentum. Most of the time I had seen him, and I did not have a particularly good rapport and nor had I spent a lot of time with him, he seemed possibly a little more polite than not saying goodbye but he did seem to have a momentum that he was going somewhere."

11. Support worker (A) accompanied by the Team Manager (A). She recollected that Mr. Butler had opened the door and had seemed quite friendly without any signs of relapse of deterioration. They were with Mr. Butler for five or ten minutes.

12. Support worker (C) who had just joined the team, also accompanied Team Manager (A) on this visit.[12] He had a slightly different perception of the significance of what occurred. He told us that Mr. Butler had answered the door and said he had to go out. Support worker (C) thought this was an excuse to get rid of them and that he did not want to engage with them. There was a brief chat and then Mr. Butler sought to get past them:

"He opened the front door and said 'I am going out now. I am leaving you' as a way to end the conversation, 'I need to go now'. But I just remember I looked in the mirror as we were driving off and to see that he seemed to be dawdling a bit as it he didn't seem to be in any rush to go anywhere which perhaps confirmed that he didn't really want to engage with us. And didn't want to particularly talk to us. So again it was just an excuse to get out of the house and so that we couldn't stand on the doorstep and talk to him… He didn't seem aggressive; he didn't seem paranoid in any way, it was just 'I don't want to talk'. That's not what he said, but it was just his mannerisms and not making a lot of eye contact, and as if 'Just leave me alone.'

13. Although Team Manager (A) discussed what had occurred at the next team meeting he had not been overly concerned. He agreed that was

[12] *Neither Support Worker (C) nor Support Worker (A) could recollect the other accompanying Team Manager (A) on a visit to Mr. Butler, but we are satisfied that they both went on the same visit rather than separate ones. The degree of similarity in their accounts of what happened [although not of their interpretation of the event] would be remarkable if they were describing different occasions, and in any event Team Manager (A) recollects them both being there.*

an indication of how little they knew about Mr. Butler:

"We were grasping at very little."

14. As observed above, there is no note of the visit on 25 April. Team Manager (A) accepted this was an error on his part. In fact we could find no record of any visit made by Team Manager (A) although he recalled participating in them on a frequent basis. He thought this may have been due to his having accompanied support workers who had omitted to record his presence. However the responsibility for recording the 25 April visit would have been his.

15. On Monday 26 April 2004 Mr. Butler's case was discussed at the clinical team meeting. The record of this meeting does not include any reference to Mr. Butler,[13] but Consultant Psychiatrist (F) and Team Manager (A) both told the police that such a discussion took place in which it was decided that he and CPN (C) should visit him the following day, instead of waiting for Mr. Butler to attend a review fixed for the following Friday. Team Manager (A) recalled mentioning to the meeting that when he saw Mr. Butler:

"…although Earle had been polite, he had walked off from us without saying goodbye, which is unusual. I do not know if any minutes of the meeting were taken, there is no set format of recording our meeting and there never has been. By Earle not saying goodbye it caused us to mention it at the meeting. I am aware that this is a tiny alteration in his behaviour, but there is no other way of assessing him as we are not invited into his house and I thought this was worth bringing to the attention of the team, he was still polite and there was nothing else obvious about his behaviour that gave me cause for concern."

16. Consultant Psychiatrist (F) recalls that they decided to visit Mr. Butler, not because of any concerns, but because he had previously told him that they would visit him, and, as he had not turned up at the Friday appointment, thought it would be a matter of courtesy to visit him.

17. CPN (C) told us that the reason it was decided to visit Mr. Butler on 27 April was because he had not appeared for his outpatient appointment the previous Friday and that this was of concern. The

[13] *We were supplied with records of clinical team meetings which took place in 2004. Although these meetings took place weekly and each patient was meant to be discussed, the only records of discussions about Mr. Butler are to be found in the records for the meetings on 19 April, 10 and 24 May, and 7 June.*

visit would be without warning.

18. As can be seen there were slightly different perceptions related to us about whether or not there was any concern at the time. We find it difficult to accept that busy practitioners would make a domiciliary visit if there was no cause for concern, as opposed to fixing an outpatient's appointment. In retrospect, it seems to us that Mr. Butler's behaviour was consistent with deterioration in his condition and an increase in his reluctance to engage with the team. While the team reacted to this appropriately by arranging a prompt visit by the consultant it is of concern that even now they seek to downplay the significance to be attributed to the signs of possible deterioration that were exhibiting themselves. Such signs were very small and equivocal, but this is all they had to go on. Because they knew so little about Mr. Butler, because he would not let them know, the very smallest of signs needed to be taken seriously in his own interests. It appears that the contact made by Team Manager (A) and the support workers over the weekend, although thought by him to have been slightly unusual, was not taken by others to be important. Consultant Psychiatrist (F) cannot recollect it and nothing about it is even recorded. There is no evidence that the slightly different and more concerned interpretation of support worker (C) was even discussed. We should emphasise, however, that there was no reason at this stage for them to fear that Mr. Butler presented a risk of serious harm to the public.

19. On Tuesday 27 April Consultant Psychiatrist (F) and CPN (C) visited Mr. Butler at his flat. CPN (C)'s note reads as follows:

"Consultant Psychiatrist (F) and myself visited Earle at home as he had missed his review. He answered the door after the first knock, and he invited us inside. He said he had just returned from town. His lunch was on a tray and he continued with this. He did not appear suspicious and chatted about what he had been occupying himself with. He had a large drawing board on the sofa and spoke of doing some technical drawings to keep his mind occupied. There were several marks/holes on the back of his lounge door. I asked Earle about this. He said that he had been practising his martial arts and had had an accident. There was a large kitchen knife down the edge of the sofa. He did not make reference to his. It appeared to have a home made sheath on it. He continued the conversation, talking about not having a specific holiday plan for this year. The house appeared tidy and clean as did Earle. He said that he is taking his medication and denied any side effect. He said he had enough medication until the weekend."

In his statement to the police Consultant Psychiatrist (F) described this meeting as follows:

"We asked him if we could come in and he let us in without any resistance. I saw on a small table in the lounge that he had prepared himself a plate of food and he asked us if we minded if he continued eating them. We simply told him to carry on which he did though we were still able to speak to him at the same time. I was there to conduct a review on him and I began to conduct it. I spoke to him about his present mental state, asking him if he had any strange experiences and any paranoid thoughts. He was telling me that he had had no strange experiences and any paranoid thoughts. I know when Glaister is relapsing because he has paranoid thoughts about his neighbours, and he is also very guarded in what he says. In order to directly assess if he is relapsing I specifically ask him about his neighbours and if he is having no problems with them then he is not relapsing. In this meeting he was very cooperative and communicated well, his mood and speech were OK, he said he was happy with his accommodation, was not taking any non-prescribed drugs… I asked him what he wished to do in the future and he said he wished to go back to Jamaica. He said he was taking his medication and I believed that to be the case…"

"I recall CPN (C) commented on a drawing board in his lounge, she also noticed some dents in the door and we asked him what had caused the dents; he told us he had been practising his martial arts. As far as I am aware this is the first I knew of him doing martial arts, I know he is 'into' sports and exercises so it didn't some as a surprise to me. CPN (C) told me he had a knife in the lounge, she asked him why he had the knife, to which he said he had it for practising his martial arts. Afterwards she said she felt he had it for sharpening the pencils that were close to where the knife was. When my review of him was over, he saw us to the door and we left. He had given us no undue concerns about his physical and mental health and I thought the care plan for him could continue as it was. I was of the opinion that Glaister was correctly taking his medication as prescribed [10mg Olanzapine daily] and that he should continue to take it as was prescribed to him. He showed no symptoms to suggest his mental state to be relapsing"

20. In evidence at Mr. Butler's trial Consultant Psychiatrist (F) told the court that he had not been able to find any concerning symptoms or signs. He confirmed that he had asked Mr. Butler whether he was taking his medication, which he said he was. He asked him whether he had had any trouble with his neighbour or was experiencing any strange feelings; he denied that he was. With reference to the knife and the marks on the door, Consultant Psychiatrist (F) said the marks were like punch marks rather than knife marks. In subsequent discussions they and the team had decided that what they had seen.

"was usual and it wasn't unusual for him"

21. Consultant Psychiatrist (F) admitted that he had not been aware that Mr. Butler had previously been found in possession of a knife until shortly before the trial.

22. In his evidence to us about this visit Consultant Psychiatrist (F) emphasised that the reason they went to see Mr. Butler for this review rather than inviting him to the clinic was because at the previous review he had promised Mr. Butler that he would visit him, rather then because of any increased level of concern. He had not been concerned at Mr. Butler's non-attendance for the outpatient's appointment the previous Friday, and had assumed he had not come because of the promise made at the previous review.

23. Consultant Psychiatrist (F)'s description of the knife was somewhat different from what had been said previously:

"Then we went into his financial situation and there was no problem, and then he showed me the knife there. There was a knife next to the sofa on the floor. It was not on the sofa it was on the floor as I remember it, and I could only see the outer part, the handle part of the knife, and it was in a kind of cardboard sheath about I should say six inches in size. He let me ask about that, he noticed before me that there was a knife, and there was a drawing board as well used for drafting. I had seen that in his previous flat as well, sometimes he is doing his drafting work and computer graphics, and there were also pencils. I asked 'What is that?' and he said he was using it for sharpening pencils."

"I noticed that there were some dents in the door; I have seen some photographs which had been shown to me in the court but certainly they were not the ones that were there the day we saw them. There were some dents, and he was saying that he was practising martial arts, then he said he was practising martial arts with knives as well. He was telling us that he was practising martial arts with knives, and then he said that when he practised there was an accident and that was the reason for the couple of dents in the door. The answers he was giving, he was very relaxed when he was talking, and it was a reasonable answer at that time."

24. Consultant Psychiatrist (F) accepted that the information about sharpening pencils may have come from CPN (C) rather than directly from Mr. Butler. He had not asked more about the martial arts because he knew that Mr. Butler engaged in sport and thought he was just unaware that this included martial arts. He later received the impression that CPN (C) had been aware previously that Mr. Butler engaged in martial arts.

25. He accepted that he had not made a clinical note in respect of this visit even though this was a review. He relied on CPN (C) to fill out any required CPA documentation. He would have made a note of any review which took place, as was usually the case, in the outpatients' clinic.

26. CPN (C) gave a similar account to the police in her statement dated 18 June 2004. She described the knife as having approximately a 5 inch handle, but she could not see the blade. She also said that Mr. Butler's explanation was that he was using it for martial arts, although she thought it could also have been intended for use sharpening writing materials. At the trial she described the knife as being large, but not as large as her own carving knife or bread knife. She told the court that Mr. Butler had previously told them he did martial arts, and that she assumed he had been practising further in what he had been doing previously. She had visited him on previous occasions when he had been in a track suit and been sweating, and had mentioned this before. On this occasion Mr. Butler had pointed towards where the knife was as if he had made the marks on the door with the knife but he had not seemed worried; he was "*very open*". They did not see any signs of relapse that day.

27. In her evidence to us CPN (C) explained that she had only called the knife "large" because she herself had very small paring knives. It was not a bread or carving knife. Indeed she said she could not really see it as it was in "*cardboard as if he had just bought it and only the handle was showing*." She had not asked what type of martial arts Mr. Butler was doing. She had not asked more about the knife because his explanation seemed logical, he had given it with no hesitation, and he had not tried to hide it. She had been aware that there had been a history of an "*instrument*" being found in his possession in the past, but she had not been sure of the details which she only came across after the incident. With regard to Mr. Butler's claim that he had been doing martial arts she did not know what level he had reached and this was not a sport about which she or, at the time, any member of the team knew anything.

28. While there was a note in multi-disciplinary records of this visit there was no clinical record made by Consultant Psychiatrist (F). CPN (C) told us that normally she would expect such a note to be written up on

his return from the visit.

29. On 30 April CPN (C) apparently wrote a CPA document as briefly mentioned above. We say "apparently" because the document contains an entry for May, recording part of the incident which we know occurred on 21 May. However, CPN (C) assured us, and we accept, that everything other than this entry was written on 30 April. The document is part of Northern and South Birmingham MHT's then extant CPA documentation. At Part C, in the space on the form for "Risk History –Descriptive Account", CPN (C) has made the following entries:

> History:
>
> 1994 Unprovoked attack on neighbour. Verbally abusive to neighbours at this time.
>
> 1999 Broke neighbour's window – assessed. Put on sec[tion] 3.
>
> 2001 Angry and verbally abusive towards neighbours. Disengaging from team. Section 135 executed but ran away and the police couldn't find him.
>
> March 2001 Fire at Earle's flat. Earle seen leaving with bags. Arrested 5 April 2001 – assessed at police station. Admitted under sec[tion] 3.
>
> Currently. Earle does not allow services to engage. He sees team fortnightly for delivery of his medication. He was reviewed at home by Consultant Psychiatrist (F) on 30 April 2004 [sic]. No concerns at this time as welcoming us into his flat. No paranoia present.
>
> /5/04. Informed by police that Earle had threatened a council worker with a knife. [signed by CPN (C)] [14]

30. CPN (C) ticked a box indicating that discussion of the case with RMO and team members was recommended.

31. In addition to Part C, CPN (C) also ticked various boxes in Part B of the form, which refers to the history of risk behaviour and risk related behaviour/circumstances. The boxes ticked by her were:

31.1 Harm to others – extreme verbal abusiveness/threats of violence.

31.2 Other risk behaviour – severe damage to/destruction of property.

[14] *CPN (C) explained that she was advised by a manager to sign this entry by her manager at that point, because there was no point in re-writing the whole of the risk assessment.*

31.3 Other risk related factors:-

31.3.1 treatment non-compliance: non compliance with medication.

31.3.2 unplanned disengagement from services.

31.3.3 secure unit in-patient admission.

31.3.4 supervised discharge.

31.3.5 Clinical symptoms – command hallucinations, paranoid delusions

31.3.6 Involvement in police/courts – arrest/convictions for other[15] criminal offences.

32. Among the boxes *not* ticked on this form were:

32.1 Non-deliberate self harm: severe neglect of diet/physical health/self care.

32.2 Other risk related factors: non-compliance with other[16] therapy.

32.3 Social vulnerability – social isolation.

32.4 Social vulnerability – "Rootlessness."

33. No ticks were entered in Part A of the form, which was designed to indicate *current* risk related behaviour. The categories available here included:

33.1 Violent ideation, extreme anger, hostility, violent threats, violent acts.

33.2 Risk symptoms [e.g. command hallucinations, persecutory delusions, delusions of passivity, morbid jealousy].

[15] *i.e not violent or sexual offences*
[16] *therapy other than medication*

33.3 Recent discontinuation of medication.

33.4 Preparatory acts (e.g. making will, buying weapons etc).

33.5 Recent severe stress (e.g. loss events or threats of loss).

33.6 Concern expressed by relatives, carers, significant others

34. No other CPA documentation appears to have been completed on this date. We therefore conclude that, with the addition of the above forms, the plan formulated in December 2003 was to continue.

35. We asked CPN (C) why she had written up this form on 30 April. She thought it was because it was the first time she had the chance to do so: she would be looking to update risk assessments when she could. She thought her reference to a review on 30 April must have been an error brought about because she was writing the document on that day. She denied that she wrote this because there had been some anxiety arising out of the visit on 27 April, as opposed to the general need to keep assessments up to date. She was asked why there was no mention of the knife which had been seen. She said that this was:

"Because I was waiting for further evidence that he was either carrying a knife or that there were problems that he had a knife in his possession that he may use."

36. We asked why the box in Part A of the form for "preparatory acts" had not been completed. She answered:

"Because we had seen knives in other clients' houses, he had a reason for it, so at that point I did not see it as a weapon as such. I saw it as being a knife in his house… I was hoping we were going to get further evidence as to whether the knife was there again and question him further about it before putting it in. The week following the incident we went to a number of clients' houses and they had machetes, knives – kitchen knives – in their house and when we reported them to the police they said "Are they shaking them outside? Are they making an effort to threaten anybody with them? Is he person unwell"? There was none of that. At that time he had just been reviewed and we could not find evidence of illness."

37. She accepted that with hindsight, as the appearance of the knife was a new development which there was a need to keep under review, until that had taken place it should have been described as a risk. She refused to accept that it should have been described as a risk without

the benefit of hindsight because:

"… he was not threatening anybody with it He was not doing anything with it. As far as we were aware he was using it in his house. He was not taking it out. There were a number of knives in his house that the police found apparently… Unless we had evidence that he had been using it outside or that there was a risk to somebody else, it would not be put in. Otherwise it would be assumed that he had been threatening somebody with it or had intended to."

"… if we had seen the knife on a couple of occasions and had got no explanation for it, or if he had hesitated before giving an explanation, that would have rung alarm bells and it would have definitely been put in. At that point I thought it was prudent to make the rest of the team aware of it, which is why it was written in the notes and discussed in the Monday morning meeting."

38. There was a clinical team meeting on 29 April. While it is recorded in the diary in which notes of these meetings were kept, and certain matters that were discussed, such as a forthcoming holiday trip, there is no record of any discussion about Mr. Butler or what had been observed during the visit on 27 April. It may be that there was no such discussion. We were told that the Thursday meeting was generally devoted to a discussion about acutely unwell patients or those presenting particular problems. If Mr. Butler was not perceived to be particularly unwell or to be presenting particular problems it seems he might not have been discussed at this meeting. The next Monday, 3 May, was a Bank Holiday, and, as a result, there may have been no clinical team meeting that day: there is no record of one. The following week, on 10 May there was a team meeting: the entry for Mr. Butler merely states that he was *"seen at the weekend"*.

39. According to the Team Manager (A) he was present at some discussion about the knife, but he cannot remember when this was. Overall he thought that what was said was "*reassuring*".

"I know he did drawing and that you need to keep your pencil sharp. I know that he explained it once as that and I know that he also practised martial arts as a hobby. I know that he seemed to Consultant Psychiatrist (F) and to CPN (C) to explain it in a calm and rational way. In context, it did not particularly heighten our concern about him."

"…It had to be considered but his overall presentation was not of increased concern. It is always quite a difficult political issue about knives because a lot of people have knives in their flat. It is not that we are desensitised to it but we had to consider it."

40. CPN (B), recollected a discussion about the visit of 27 April. He told us that a student nurse had been present on the visit and that she had raised with Mr. Butler the knife. Mr. Butler was reported to have said he was using it for his martial arts training. CPN (B) told us there was no mention of the size of the knife, but he personally was aware that in some martial arts training small short handled knives are used. He has not thought this incident was significant:

"It was in the context he was using it for his martial arts training and CPN (C) said he was quite spontaneous about it. He didn't hide it, he said 'Oh I've been using it for my martial arts training.' It is not as if he was sitting back and thinking of an answer that would be suitable."

41. CPN (B) could remember martial arts having been mentioned before as something Mr. Butler was doing. He recalled that Mr. Butler had a martial arts t-shirt, but he had never seen him demonstrate any of his skills.

42. It is, of course, important to resist applying hindsight to an analysis of the reaction of Consultant Psychiatrist (F), CPN (C), and, to the extent to which they were involved, the rest of the team, to the appearance of a knife on Mr. Butler's sofa, marks on the back of his door, and the claim that he was practising martial arts. We have rigorously resisted that temptation, but are nonetheless obliged to record our serious concern at what transpired. It is not our intention in this report to single out individuals for *"blame"*. Not only are we discouraged by our terms of reference from doing so, it is inappropriate in this case. In so far as there were failings demonstrated by what occurred at the end of April and the beginning of May 2004, these arose out of a team practice ethos in which signs of deterioration were likely to be missed, and more weight given to reassuring possible explanations for observations than to the alternatives pointing to an increase in risk. The particular points of concern that it is necessary to highlight are as follows:

43. The record keeping was defective in a number of respects:

43.1 There was no record of Team Manager (A)'s visit to Mr. Butler on 24 or 25 April or of the observations made by him and his colleagues. This

resulted in uncertainty as to who took part in that visit, what was observed, and what significance those present, attached to what they had seen.

43.2 There was no record of any discussion following Team Manager (A)'s visit, or in relation to Mr. Butler's failure to attend his outpatient's appointment on 23 April. This has resulted in it being unclear what view was taken by the team of these events, and what was the reason for the visit on 27 April.

43.3 There is no record of any discussion by the team of the observations of Consultant Psychiatrist (F) and CPN (C) made on 27 April. This makes it impossible to confirm whether the satisfied that the appearance of the knife and the account of martial arts practice was not cause for concern.

43.4 There is no clinical note of Consultant Psychiatrist (F)'s mental state assessment, if he conducted one, on 27 April, and no evidence of any clinical risk assessment which took into account the observations made on that day or of any plan to follow-up these observations.

43.5 The risk assessment CPA documentation prepared apparently on 30 April makes no reference to the history of Mr. Butler having been found in possession of a knife when unwell, or the observation of a knife on 27 April, or that Mr. Butler was apparently practising martial arts, or that there was any need to follow these matters up to confirm whether or not they were cause for concern. Although CPN (C) thought that such steps were necessary no change was made in the care plan, which had not been changed since December 2003, to reflect that need. As a result, team members reading the records might have concluded that there was no need for follow up in relation to the knife or Mr. Butler's claimed interest in martial arts. Indeed there was no recorded attempt to visit Mr. Butler again until 15 May, some three weeks later. In other words, even the usual fortnightly visiting regime was not being followed.

43.6 There was a variation in the recollection of team members. We asked whether Mr. Butler was known to have been interested in martial arts before 27 April. It was suggested this was known, although others, including Consultant Psychiatrist (F) had no prior knowledge of this, and the RMN said he could not recall any conversation in which martial arts were mentioned. This was not surprising because, in spite of an extensive search through the records, we could find no reference to such an interest. Either there had, in fact, been no previous expression of such an interest, or, if there had been, there was a failure to record it. If the interest was a new one this development was not perceived and due significance was not attached to it.

43.7 The approach to the observation of a knife on 27 April betrays an attitude of collective complacency.

43.8 While kitchen knives of varying sizes are naturally commonplace in virtually all homes, they are not commonly seen in living rooms or associated with martial arts practice at home, let alone such practice involving contact with a door, whether or not accidental.

43.9 This knife has been described in various ways, but the accounts of Consultant Psychiatrist (F) and CPN (C) given very soon after the incident suggest it was a large knife with a 5 inch handle. CPN (C) now thinks that it was much smaller than that. Without in anyway wishing to question her good faith in her evidence to us, we prefer the earlier account. This was a large knife, albeit one which could have a legitimate domestic purpose.

43.10 Both Consultant Psychiatrist (F) and CPN (C) seemed to have discounted the explanation, which both of them agree, Mr. Butler gave for the knife's presence in the living room - martial arts practice - preferring instead to believe that it might have been used for sharpening pencils. While there is some suggestion that Mr. Butler actually said this, it seems he also said he used it for martial arts practice. It would have been distinctly odd for a large knife to have

been used for sharpening pencils, but this point was not followed up.

43.11 As noted above there is no recorded evidence that Mr. Butler had ever previously expressed an interest in martial arts. In the context of a service user with a history of albeit minor assaults on neighbours, had this been known of before we would have expected it to be recorded. A general interest in fitness training does not have the same significance in terms of risk assessment as an interest in martial arts involving the use of knives. This should have been treated as increasing Mr. Butler's risk until the full facts about his use of the knife and martial arts have been brought to light.

43.12 Neither Consultant Psychiatrist (F) nor CPN (C) professed to know anything about martial arts, and, apparently, neither did any other member of the team. Yet even the most remote knowledge of this area includes awareness that there are many forms of martial arts. Many are defensive and require no weapons; some may involve weapons and are more aggressive. Almost all are sophisticated disciplines requiring training. Yet Mr. Butler was not asked whether he was undertaking any training, and, if not, why and how he was using a knife.

43.13 There is no recorded plan that this should be followed up either with him or that any advice should be taken from a martial arts trainer. Even if Mr. Butler's interest in this was entirely harmless, the fact that he had expressed an interest in it presented the team with a very unusual opportunity to take an interest in his activities and perhaps engage with him more closely. There is no evidence that any attempt at this took place or was planned, or at least no such step or plan was recorded.

43.14 Even without the benefit of hindsight Mr. Butler was known to harbour paranoid beliefs, particularly when he was unwell. The appearance of a potential weapon close at hand, and evidence of an interest in defensive physical skills, could suggest that Mr. Butler was feeling a need to defend himself. Yet, whatever Consultant Psychiatrist (F) may

have asked of Mr. Butler in this regard is not recorded. This suggests that little importance was placed on what had been observed and that this was the impression which would have been conveyed to the rest of the team.

44. Overall there was an undue willingness to accept explanations that would not involve an increase in the level of risk, as opposed to those indicating the opposite. We consider this was in large part due to a perhaps subconscious reluctance to challenge Mr. Butler through fear that he would disengage. Yet one of the relapse indicators was sudden disengagement. If indeed there was a danger that he would disengage then this should have been taken as a sign of deterioration. The team never resolved this inherent difficulty in their habit of preferring explanations which allowed them not to challenge Mr. Butler. It seems to us that this is the very opposite of what an Assertive Outreach Team should be doing. In short, with this service user at least, we are driven to conclude that the team had lost its way.

45. The team's approach as demonstrated by this case can be contrasted with what Consultant Psychiatrist (B) told us he would have done in these circumstances:

"I think, firstly, I would have got all the relevant information and found out about what his view was about the knife. What were the observations of the staff when they visited the home? Were there any signs of him being unwell at any time? Next, I would have considered whether anything else needed to be done. As a team, we would have discussed that…"

"I do not know whether having a knife in his own house, if he gives a believable explanation, would have resulted in anything being done significantly differently. Someone carrying a knife outside with them would obviously have been of greater concern. I would have taken into account what he said and what the staff's views were who saw him and observed him at the time, and then made a multidisciplinary decision about what was the best way forward regarding that."

46. What was conspicuously lacking from the team's approach was a collective decision on how to follow up this issue, to document this in a plan, and act on it. The effect of these omissions was to be demonstrated in what followed.

47. There was a clinical team meeting on Monday 10 May. The note of

the meeting records that Mr. Butler was "*seen at the weekend*". There is no other record of any such visit. Therefore the panel do not know who made it or what occurred, and, more importantly, no member of the team would have been able to glean such information from the records.[17] If such a visit took place it would have been important for whoever went to have followed up the issues of the knife and martial arts training. Without a record it is impossible to know whether this was done and, if so, with what result. Further, if there was such a meeting, as events on 15 May would show, far from all of the team knew about it.

48. The next recorded visit to Mr. Butler was made on Saturday 15 May, when CPN (B), called at his flat. CPN (B)'s note of his visit was as follows:

"Seen today. There appeared to be an edge to Earle today. He asked why I was visiting and when told that I was delivering him some meds he said that he had some delivered earlier in the week. When asked who by he couldn't say. I explained that I was visiting because it was in the team's diary to visit him. He appeared to reluctantly accept this, however he did not invite me into his flat at all."

49. In his statement to the police, dated 21 June 2004 CPN (B) said that initially Mr. Butler had been irritable as if he had just been woken up. He had told CPN (B) that somebody had already brought his medication earlier in the week. He said this was not a problem and would take the medication CPN (B) had brought anyway. There was a 10 to 15 minute chat on the doorstep and the irritation appeared to evaporate.

50. CPN (B) gave essentially the same account at Mr. Butler's trial but added that there had been nothing unusual about his not being invited into Mr. Butler's flat and that this was not his purpose in any event. He went to give him his prescribed medication. Nothing had been said which gave CPN (B) any cause for significant concern about Mr. Butler's well-being or mental health.

[17] *In fairness we must record that this record came to light after we had interviewed the relevant members of staff; as a result they were not asked about it. As no personal criticisms are made we have not thought it necessary to re-interview them and, in any event, we doubt that in the absence of more detailed records they could now add any helpful information.*

51. In his evidence to us CPN (B) added some detail about this visit:

> *I remember knocking on the door two or three times, and I was about to get back in the car and the door opened and Mr. Butler was standing in black tracksuit bottoms or something. I thought he was sweating… but it was actually the shower, I could hear the shower in the background. He had obviously just come out of the shower to see who was banging on the door and he got irritable. 'Yes, what do you want, sort of thing. I said 'Hi… I've just come to deliver your meds as normal, they're due today. How are you doing?' General social chit-chat about the fact that he was standing on the doorstep with the shower on in the background. He said 'I had them delivered last week' and I said 'OK who delivered them last week, can you check it out.' I said 'If you've had them that's fine, I'll take them back to base.' He said No, no. that's fine, I'll take them off you then.' It turned out to be 15-20 minutes with Mr. Butler getting colder and colder on his doorstep by the minute. He was 'Yes, what do you want' at the start which was the irritable bit, and by the end of the conversation, it was 'No, I'm fine, everything's OK'*
>
> *"I must admit I could have understood why he was irritable because I would probably be exactly the same in the situation early on a Saturday morning with somebody you may not necessarily want to see. That was always there 'Mr. Butler had disengagement with the services, may not want to see us' but we turn up. By the end of the conversation it was as though I had a conversation with him about a month or six weeks earlier when he'd open the door and he was fine, he was smiling and he was appropriate.. That was probably at about 12 o'clock. He'd come round, he was awake, and probably had a chance to look out the window and see who it was on the doorstep."*

52. CPN (B) told us that he had reported back to the team Mr. Butler's assertion about having received medication the previous week. No-one could remember there having been such a visit and, because of this, it was agreed that Mr. Butler should be visited again.[18] CPN (C) told us that she was unaware that anyone had delivered medication to Mr. Butler the previous week. If there was uncertainty of this nature it was in her view more important to ensure that the client had medication and therefore it was appropriate for a supply to have been left in spite of Mr. Butler's assertion. However, her next visit appears to have been triggered by what CPN (B) reported. Although CPN (B)'s observation might have heralded a change in Mr. Butler's condition from that observed by Consultant Psychiatrist (F) at the domiciliary review on 26 April, there is considerable doubt whether he was informed of this. Consultant Psychiatrist (F) told us he could not remember and pointed out that there was not much a of gap for him to have been informed before CPN (C)'s visit on 17 May. He surmised that following that visit, as CPN (C) could find no cause for concern,

[18] *Consultant Psychiatrist (F) told us that he had heard the delivery of medication had been duplicated but it does not appear this was something of which he had first hand knowledge one way or the other.*

the team may have concluded that there was no point in raising it with him. Mr. Butler's name remained in the group of patients who were considered to be stable and of no concern.

53. The agreed visit took place on 17 May. CPN (C) was accompanied by Support Worker (A) and a student. Mr. Butler had answered the floor and stepped outside to talk to them. CPN (C) told him about a social trip the team was arranging, but he indicated he did not want to go on it. She introduced her colleagues and informed him that Support Worker (A) was replacing the RMN on the team. Mr. Butler asked after the RMN, and the course he was going on, and asked CPN (C) to pass on his good wishes. The meeting ended after about 5 minutes with CPN (C) being left with no undue concerns for Mr. Butler's health. CPN (C) told the police:

"I was pleased at how he had reacted to my taking strangers to his home. I had put his meeting with Paul down to him (Earle) having a bad day."

54. Support Worker (A) told the police that she thought Mr. Butler seemed *"quite friendly"* on this occasion. Likewise, a student on a placement scheme, noticed nothing to concern her during this visit.

55. CPN (C)'s note of the visit is less detailed and perhaps slightly more guarded in tone than the above recollections would suggest:

"… Earle answered the door after a couple of knocks. He had his hat on, but did not appear sweaty or overly suspicious. I reintroduced Support Worker (A) and introduced the student to him. He took this in his stride asking about the previous support worker."

56. CPN (C) was asked at Mr. Butler's trial why she had not raised the issue of the delivery of medication with Mr. Butler. She said;

"Because our engagement had been so tenuous with him that I did not want to make him more worried about the reason we had called."

She confirmed this to us:

"That sums it up. It was such a tenuous link to keep engagement with him. There were times when we perhaps should have pressed him further, but we were wary of doing that because of losing engagement with him."

57. She told us that, while she respected CPN (B)'s view that the irritability

he had noticed was due to the early hour of the call, she wanted to check that out. However, she did not raise that as a subject either:

"I did not ask him about his irritability, but visiting him and seeing the difference when I went round with the student, in some way allayed my fears because he was so open and welcoming."

She did not follow up the issue of the knife:

"… because we were on the doorstep on that visit… I did not ask to go in. I knew we had various visits to do following that. I think what I was expecting was that he was going to be either quite hostile or very cagey towards the new people, which would then have started alarm bells ringing. In fact I briefed the student on the way round there, saying that he was disengaging, that CPN (B) had the impression that he was irritable and that in the past the irritability had progressed to him not opening the door or only opening it a certain amount and that he would be quite sharp and uncommunicative. I even asked the student to watch the curtains as we approached, to see if they twitched and he was up there having a look to see who it was at the door. There was no sign of that. He came down straight away and, as I said, he came out onto the garden path. I mentioned earlier that his conversation was very relaxed, initiating conversation with both the student and Support Worker (A)."

58. She did not think that his coming out of his flat was a technique to dissuade them from going in: in the past he had come out and actually told them they could not come in and shut the door.

59. The visit on 17 May was the last occasion on which members of the team saw Mr. Butler before the incident on 21 May. In the previous month issues had been raised, to the knowledge of the team, about:

59.1 His non-attendance at an outpatients CPA review.

59.2 The appearance of a large knife on his sofa.

59.3 His use of the knife.

59.4 Damage to his door.

59.5 A new or renewed claimed interest in martial arts.

59.6 Concern about irritability.

59.7 An unresolved issue about the supply of medication.

60. In addition a glance at Table 2 above indicates that in retrospect Mr. Butler was becoming less willing to engage.

60.1 There were an increasing number of occasions on which team members were unable to make any contact with Mr. Butler.

60.2 On many of the occasions when he was seen there was no access to his flat.

60.3 On the occasions when he was seen there was often minimal engagement or interaction.

61. According to CPN (C)'s notes she left a letter with Mr. Butler on 21 April informing him of his out-patient's appointment on Friday 23 April. It remains unclear whether he had received any prior notice of what was intended to be a CPA review, and whether he failed to attend of his own volition or because he had received no reminder of it until 21 April. As disengagement would have been a potential sign of relapse it is of concern that this was not followed up. It does not appear that appointments letters are kept as a matter of routine in the client's records, and there is no record that Mr. Butler was ever asked why he had not attended this appointment.

62. While CPN (C) and Consultant Psychiatrist (F) were satisfied with the explanation given by Mr. Butler on 27 April for the presence of a knife on the sofa, they could not be, and in CPN (C)'s case, were not absolutely sure that this episode was not cause for concern. As observed above there should have been an expectation that the matter would be followed up. There is no evidence of any plan to do so or of any attempt to do so. There is no record of any discussion with the team about it. Therefore it is not surprising that CPN (B) did not even pose a question about martial arts or the knife at his visit on 15 May. An opportunity was lost to consider whether the irritability he observed was in any way connected with these earlier observations and whether the acceptance of the earlier explanations should be reviewed.

63. It is more surprising that CPN (C) did not follow up these issues when she visited on 17 May. It is disappointing that there was no concerted attempt to obtain an invitation to go into the flat to check on its

condition, and, in particular the state of the door. It appears from CPN (C)'s evidence at Mr. Butler's trial, when she was asked to look at police photographs of the door, that more damage was inflicted to it after her visit on 26 April. Awareness of this at the time might have suggested to her that Mr. Butler's explanation that there had been an accident was a dubious one.

64. There was no investigation of Mr. Butler's claim, made on 15 May, that he had already received his fortnightly batch of medication. The records we have seen are so incomplete that the possibility that he was telling the truth about this cannot be ruled out. There is a brief suggestion in the clinical team meeting records that there was a weekend visit for which there is no corresponding multi-disciplinary team note in Mr. Butler's records. We have seen no complete prescription and administration records. Indeed the only record of delivery seems to be that entered in the multi-disciplinary team records by the visiting team member. The importance of verifying or refuting Mr. Butler's claim should have been apparent to the team. Some team members seem to have been inclined to disbelieve the claim. However some, in particular Community Psychiatric Nurse (A), believed that his claim was checked and found to be accurate. We have no means of ascertaining whether her belief is correct. If Mr. Butler's claim had been found to be false, then he was seeking to deceive the team about medication issues; which in turn might have led to a suspicion of non-compliance. Not only was no attempt made to track down the true facts, the issue was not discussed with Mr. Butler. This can only have added to the impression that could have been fostered by the persistent delivery of medication through his letterbox that the team treated medication as a formality rather than as a matter of importance.

65. In the Chapters which follow we pick up and consider various themes that emerge from our consideration of the care provided to Mr. Butler.

CHAPTER 7

OVERVIEW OF CARE

1. The Views of Team Members

With hindsight some members of the team accepted that subtle signs of deterioration were missed, although they defended their performance in the circumstances facing them. CPN (C) said:

"…perhaps looking back we can see that he was not engaging as much as he had been and was missing a bit more, but that was not an unusual pattern. At that point, looking back to how he presented at his review and when we were visiting, it was not a large enough change or was not backed up by any other changes to unduly flag up any concerns."

CPN (B) said:

"… we had some good signs in that he hadn't run away like he had done when he came to Servol for 18 months or two years, we had kept an engagement going with him for five years. It may not have been the best quality engagement but at least it was an engagement. It may have offered him an opportunity further on to be more forthcoming… I don't know, but things might have changed."

The Team Manager (A) told us:

"… we could have been more assertive about imposing our time in expecting to see him, but I do think we regularly discussed it, and the risk of losing engagement or any contact with him was very real. Most of the times we tried to extend conversation more around positive things and not to give him a grilling about his health, so that we could do it more often without losing him. It was far from ideal but it was a regular focus within what can we do to improve our engagement without losing him."

2. When asked what lessons she and the team drew from this tragedy, Community Psychiatric Nurse (A) started with the need, as she saw it, for improvements in staff support following the incident in a time of trauma. So far as the incident itself she thought the lessons to be learnt were in relation to liaison with the police, and in relation to efforts to contact service users' families.

3. Team Manager (B) – Rehabilitation and Recovery, when asked what the team had learned, suggested it was the need to be wary of desensitisation in the case of service users who were at the less challenging end of the spectrum:

"You are handling so much risk on an ongoing basis that you are kind of numb sometimes. "

4. He thought it was helpful to have access to psychologists which they had now, but did not have at the time.

5. Service Manager (B), who had had limited personal involvement with Mr. Butler thought the lessons the team ought to learn were in connection with working with other agencies and including family members. When asked whether she thought the team had learned those lessons, she told us that she brought them up as she felt strongly about it, but she could not say whether the team had learned those lessons.

6. Consultant Psychiatrist (F), the Consultant, was more critical:

6.1 He felt there had not been sufficient time to discuss individual patients. The team had divided the names of patients into three columns on a whiteboard, starting with those causing most concern. They were discussed in order of concern. Although they had tried reversing the order, this had not worked very well:

> *"I now see that is not a good idea either because people assume that they are in the stable column so they are not being discussed properly, only just their name, 'There are no concerns' and that is it. We do not give them time. That is the practice we had and that is the practise we still have I think."*

6.2 He thought there was a conflict between his notional and legal responsibility as consultant responsible for the care of Mr. Butler and the position of the care coordinator in the team: the coordinator, not the consultant possessed all the information relevant to the assessment of the service user's state. Where no concerns were expressed he would only see a service user once every three or six months.

6.3 He was frustrated that there was no psycho-social resource available to the team. He himself was trained in cognitive behavioural therapy but did have the time to offer this, and there had been no psychologist available. Because of his split responsibilities, he was functionally more of a visitor to the team than a full team member. He had raised this issue on his appointment but nothing had been done about it by

the time of the incident, although it has been remedied now.

6.4 He observed that on occasion patients who should have been seen fortnightly were not seen for a month, and he felt this was too long. Consultant Psychiatrist (F) was "*shocked*" when he heard that Mr. Butler had not been taking his medication, but remained concerned as to how consumption of oral medication in the community could be corroborated. He was clear, however, that if he had known of Mr. Butler's non-compliance

"… then I would give serious consideration to saying 'Unfortunately I can't keep you in the community if you are not going to take your medication, and we will have to go through the same routine that we did in the past. If you don't want to come to hospital and you don't want to take the medication then I will go for a Mental Health Act assessment and have you brought into the hospital anyway."

6.5 Consultant Psychiatrist (F) was asked what lessons had been learned and in a very full reply suggested the following:

6.5.1 He needed to record his consultations and clinical recommendations personally rather than relying on others.

6.5.2 As a team they needed to monitor more closely how often they had seen clients, what information they had about them and to ensure that risk histories and so on were kept up to date.

6.5.3 They had believed they knew about Mr. Butler because they had known him for seven years, but after the incident they realised they had not. This pointed to a need for co-ordination and communication.

6.5.4 Team management by job-sharing managers was unsatisfactory and this played its part in the lack of supervision of documentation.

6.5.5 There was a need for one to one meetings between the consultant and the manager on a regular and frequent basis, whereas previously there had been few, if any.

6.5.6 There was a need to have input from a psychologist on a team like this and it could not be properly called multi-disciplinary without this.

6.5.7 If the consultant was to be responsible for patients then he had to see them and the caseload and other commitments had to be such as to allow this to occur. It was not right that the consultant had to rely on the judgement of the care co-ordinators.

7. The Views of Senior Management

7.1 Dr. Neil Deuchar, the Medical Director, who undertook the internal review, echoed many of these concerns, but he was more specific about the care provided to Mr. Butler: He thought that the practice of posting medication through the letterbox was questionable.

7.2 He felt that the monitoring of compliance with medication needed to include a focus on subtle changes: and the need to put all the information together:

"There are indicators as to whether someone is taking medication or not… but sometimes those indicators are quite subtle, sometimes they are not present – nothing is conclusive. I believe that just Mr. Butler's presentation alone would have demonstrated a lack of side-effects. [He] did not appear to put on weight, he didn't appear to be sedated, he didn't have any stiffness or tremor, all of which can happen to a greater or lesser degree when you treat someone with anti-psychotic drugs and they take them. So none of that would be conclusive but, if you put that together with some of the other things that were going on at that time such as hearing of voices, the eviction notice, it would have created a picture of a man who was undergoing a relapse of a similar signature to the ones he had had before. He doesn't seem to be having any side-effects of his medication, he is not putting on any weight – is he really taking it? Then, of course, the knife – the jigsaw puzzle wasn't put together, that was the crucial issue."

"What I know about this is that on 21 May 2004, the Small Heath Assertive Outreach Team could have known that, at the time of a previous relapse, he armed himself with a knife, there were no signs that he was taking medication, he had been a bit iffy about seeing the team, the neighbour had made complaints about him shouting in the night, he was faced with eviction and he had a knife in a homemade sheath in his living room. If I were a consultant psychiatrist in any team and I see that suite of information, I would be worried. The issue is that they did not put the pieces together and they did not have access to some of them. That should be mendable."

7.3 Dr. Deuchar felt that there had been a need to see the discovery of the knife in Mr. Butler's flat as a significant matter:

"Again, it is always easier in retrospect but, as someone in charge of risk assessment and risk management in a multi-disciplinary team, I would take the view that, if it was in the container that he had bought it in, it might indicate that he had bought it relatively recently, so what is the significance of that? If he bought it recently, maybe he hadn't but maybe he had, and there were punch marks in his door, and he says he is using it for martial arts: I don't know many people who undertake those sorts of martial arts in this country. I just think that you have to contextualise components of information and try to build a picture of what is happening, that is your job."

7.4 He believed that the team would probably have wanted to consider an assessment, possibly under the Mental Health Act if they had put together the following information:

7.4.1 The knife seen at Mr. Butler's flat.

7.4.2 The previous history of possessing a knife.

7.4.3 Problems with neighbours.

7.4.4 Problems with the Housing Department.

7.4.5 Lack of signs of taking medication.

7.5 He thought there was a need to ensure that persons "*who were not high on the team's radar*" and seemed to be stable were subject to an assessment of their suitability to remain under the Assertive Outreach Team. This might lead to discharge to the Community Mental Health Team, which would, in retrospect, not have been appropriate in this case, but this requirement would mean *"tighter case load management and exit risk assessment*"

7.6 In this case the care plan had been reduced to fortnightly visits and monitoring of mental health. In his view:

"What are you expecting someone to do when you monitor someone's mental health? Delivery of medication, which we knew was an impotent activity, and regular medical reviews, all of which are laudable, standardised approaches to albeit a somewhat reductionist style of mental health care…they did not hit the spot, they were not managing their interactions with the person in a constructive, imaginative or innovative way. They were not thinking about what they were doing…If someone misses an appointment or there is a failed contact, in Assertive Outreach you have to deal with that quite proactively, which is why we have developed the protocol for what you do"

7.7 He pointed out that the degree to which a service user's private life is

invaded has to be greater under the Assertive Outreach Team than under the Community Mental Health Team.

"…because that is what it is, it is assertive. Assertive Outreach Teams are designed, are predicated on skills, techniques and ways of interfacing with people who do not particularly want to be interfaced with. My perception of this case was that this was not happening to the degree to which it should be happening because the team thought they did not need to do it. Therefore, my view is that, if the team did not feel they needed to do it, they should have been considering transferring him back to the CMHT. After all, he had been on Assertive Outreach for about eight years and, while the debate still reigns as to the optimum amount of time for someone to be on Assertive Outreach, it is not eight years."

7.8 He thought that there needed to be encouragement to Assertive Outreach Teams to gather sufficient information to be able to assess the risks. There was now a protocol of steps to be taken if contact was lost, including contact with the Housing Department, and other local contacts, involving the breaking of confidentiality where necessary. Assertive outreach necessarily involved potentially acute issue of public safety and that requires what ever needs to be done to protect public safety to be done.

7.9 The Chief Executive of the Trust, Sue Turner, expressed the view that the team still lacked insight into the events we are considering. She attributed this to the traumatic experience they had in connection with Mr. Butler's trial. She felt that they still had not achieved closure and that until they had done so, they would not as a group be able to reflect and learn.

8. The View of Mr. Butler's RMO

8.1 The panel was greatly assisted by meeting Consultant Forensic Psychiatrist (B), Mr. Butler's current RMO at Ashworth Hospital. He enjoys the advantage not only of great experience in serious forensic cases, but also an independent view based on a rigorous examination of Mr. Butler's history. His view was that:

"… beforehand it would have been very difficult to predict that an incident of this severity would have happened. What the team might have done, had they been better informed of his background, was be aware of the likelihood of relapse and not the likelihood that an incident of this severity would happen. I do not think that anyone could have predicted this kind of incident – just in case there was any confusion about that. I do not think that there were any errors in risk assessment, that would have been very difficult to get right, but perhaps they might have been more aware of the risk of relapse."

8.2 In other words with better collection of information the team could have been aware of the risk of relapse, but would still have been unable to predict a homicide.

8.3 He also considered that awareness that Mr. Butler had a knife, and that he had damaged his door might have led to a more active reconsideration of compulsory admission, if they had also been aware of his:

"…not wanting to be ill, not wanting to admit to symptoms, covering up *symptoms."*

"The first objective sign of risk to others was when they saw the marks on the door suggesting he had used the knife even if only on the door, and the knife in the sofa so that it was readily available. It is like he is starting to think I don't want it in the kitchen, I want it here in case it is happening now. I believe they should have asked him about that and there is no record that they asked him what the knife was doing there. They note that the knife is there and perhaps they did ask him and he came up with something or other as to why it slipped down the sofa. It is almost as if it were hidden where only he would know and he could whip it out at a moment's notice."

8.4 We observe that these matters were known to the team as being part of Mr. Butler's history, even if they were unaware of the degree to which they were present in 2004. While it appears that Mr. Butler was asked about the knife and the marks on the door, it does not appear to us that there was any structured and collective team thought about the significance of these observations, which, we agree with Consultant Forensic Psychiatrist (B), showed objectives signs of a real increase in risk.

8.5 Consultant Forensic Psychiatrist (B) also observed that the team had seen the core issue to have been the delivery of medication, whereas the issue actually included the taking of medication, not just its delivery:

"They were not sensitive to the issue, which you saw all the way through his history, that he tried to avoid that at all possible opportunities. So the handing of it to him was not the end of the matter. You then had to look to see that he was taking it and perhaps monitor the side-effects. He is on medication with us and he has clear side-effects. He has permanent lip movements as a result of tardive dyskinesia from taking the medication, so we know he is taking it because we can see it. Right from his very first admission, there is evidence that he was very sensitive to the side-effects of medication and, had they read those notes from Stafford where he was first admitted, they might have been aware of how sensitive he was. Therefore, seeing no side-effects, so to speak, they might have been alerted to greater anxiety about his compliance."

8.6 Consultant Forensic Psychiatrist (B) had increased the dose of Olanzapine in hospital from 10mg a day to 15mg and Mr. Butler was exhibiting some side effects. In his view he would have been likely to have shown such effects on 10mgs as well, had he been taking this. He also pointed out that when a team describes a client as "*reasonably OK*" this has to be seen in the context of someone who has "*an incredibly empty shell of a life*" who is totally isolated, and has nothing in his life. Notes are primarily written to record change in condition:

"What they are saying is we probably cannot do much better than this in the community and we are certainly not going to admit him at this stage, because there are no overt signs. Therefore, while the records suggest that he is doing alright, he is doing alright at that quite impaired level and that is the starting point. Then on top of that you have the problem with the chronic delusions actively present but he is just not talking about them, because he knows that if he talks about them, that is what will get him admitted or his medication increased or he will be put on a depot instead of oral medication."

8.7 Consultant Forensic Psychiatrist (B) thought that while it might have appeared there was a large and sudden deterioration in Mr. Butler's health in May 2004 he had already been very ill:

"I believe that he is really quite ill throughout this period, and that is why he is living this barren existence. He is not engaging with anyone because he is paranoid that the neighbours are in the plot, they are all part of MI5 historically, he is probably popping in and out of shops very quickly because he does not like being around all these strange people and he is just not talking to anyone. He has lost contact with the family, he thinks his brother is dead, there is nobody in his life at all. I think he is really quite ill but he is quite a determined and competent fellow. He knows what he can and cannot do, that there are limits and he has learned what behaviour gets him admitted, so he is not doing that. Then it all blows apart when 20 police are in front of the door, he thinks this is when they are going to do it, they are going to take all my goods, take whatever is in my bank account and I shall disappear. I believe that he is really quite ill and what he sees is the worst possible thing for him: a whole load of policemen on his doorstep."

"Therefore, while it seems like a very big deterioration in a period of a month, he is really quite ill and at the end of the month, he is surrounded by prison officers and being interviewed by police and people he thinks are going to kill him any second – that is a very bad month. Therefore, he is more ill but I think he is pretty ill anyhow."

8.8 He suspected that Mr. Butler had continued to harbour delusions about authorities such as the police and MI5, and that this had not come to light because he was not being asked about them in specific terms, rather than that he had learned not to talk about such things. He should have been tested several times a year to see how he responded, to see whether he had become more sensitive or abrupt

than before.

9. The View of the Panel

9.1 We agree with Consultant Forensic Psychiatrist (B) that it is likely that Mr. Butler was in fact unwell and suffering paranoid delusions about figures of authority throughout 2004. He was afraid of being returned forcibly to hospital, of having his home and money taken away, and, at least on occasions, afraid for his life. He lacked any insight into his illness and did not consider it necessary to take any medication, except, perhaps, occasionally to help him sleep, calm him down, or present an acceptable face to the team.

9.2 Mr. Butler was and remains a man with impressive and positive intellect and talents. Throughout his time in the community he struggled to occupy himself with projects which would satisfy him intellectually. However, he sought and received no support in this, or, indeed, in any other aspect of his life. He lost meaningful contact with his family and, as Consultant Forensic Psychiatrist (B) points out, was "*living the bare bones of existence*" in an "*empty shell of a life*".

9.3 The routine of support and monitoring provided by the team failed to detect the depth of the illness, the non-compliance with medication, or to appreciate the significance of the increasingly overt signs of disturbance, such as the appearance of the knife and the damage to the door or to provide meaningful social support in terms of contact or occupational assistance.

9.4 The team was not uncaring people who could not be bothered to do their job and they did not intend to engage with Mr. Butler on an inadequate basis. Rather they were oversensitive to the perceived danger of disengagement while at the same time becoming desensisitised to Mr. Butler's desperate state. Their fear of disengagement resulted in their allowing Mr. Butler to dictate the rules of engagement. Thus they did not insist on being invited into his flat, they desisted from challenging questions, and they took at face value

his claims to be complying with medication. They became the slaves of routine and perfunctory contact and lost the ability to deploy energy, imagination and initiative.

9.5 The team's care of Mr. Butler was heavily influenced by their understandable perception that he did not present a high risk to himself or the public. However, this did not lead them to question the purpose of his remaining a client of their team. Had they undertaken a rigorous analysis of this, if only at one of the CPA reviews, they might have not only realised how little they actually knew about Mr. Butler but done something to remedy that deficiency.

9.6 The team's task in caring for and supporting Mr. Butler was made immeasurably more difficult by the serious failure of the team and its administration to keep his records in a useable order. This led to important information being unavailable or to it slipping below the horizon and to it not being taken into account constantly as it should have been. Tools designed to ensure this did not happen, in particular the CPA system of reviews and documentation were not used thoroughly. Clinical notes were not made by the RMO of some important assessments. Clinical team meeting discussions were not recorded or transferred to Mr. Butler's records. Delivery of medication was not systematically recorded. This meant that anyone wishing to obtain an overview of Mr. Butler's condition and progress faced a Herculean and impractical task of analysis.

9.7 A constant refrain of team members we met was that they did not have the benefit of hindsight. This is of course true, it would have been difficult if not impossible to have predicted that, even if he relapsed, Mr. Butler would commit an act of homicidal violence. However, the duty of the team was to care for and support in the community a man known to suffer from a serious mental illness which made life extremely difficult for him. He was allocated to the team because of his correctly perceived need for assertive care, in other words he had to be supplied with active and imaginative support and care even

though he was very reluctant to accept it. If an Assertive Outreach Team cannot deliver that service it brings into question why such a team exists.

9.8 The inability of this or probably many other teams to have predicted that Mr. Butler would have unleashed homicidal violence on a police officer does not justify inadequate scrutiny of Mr. Butler's past history or a failure to develop their management of his case into an effective care plan. In particular:

9.8.1 The history did include the fact that he was found in possession of a knife when he was unwell.

9.8.2 He was known to cause trouble to neighbours when unwell.

9.8.3 Disengagement was known to be a sign of relapse.

9.8.4 Financial self-neglect was another such sign.

9.8.5 Apart from a specific regime of medication, the care plan was non-specific and formulaic.

9.8.6 There was no constant review of the support, or consideration of trying other measures.

9.8.7 No consideration was given to routinely gathering information from other sources.

9.8.8 They allowed themselves to get into a position in which Mr. Butler himself was their only source of information.

9.8.9 They saw the risk of disengagement as justifying an unassertive and passive approach to the case rather than as a feature to use to test Mr. Butler's condition.

9.8.10 They did not consider use of more assertive measures such as invoking supervision under section 25 of the Mental Health Act or even to follow the frequency of visits required by the discharge plan.

9.9 Like the Chief Executive, we are not satisfied that at least some members of the team have developed the necessary insight into the lessons to be learned from this tragedy. In fairness, we accept that they have all been traumatised by these events and their aftermath. They must have been shocked to discover only in the course of the trial and the accompanying glare of publicity that Mr. Butler had concealed so successfully his non-compliance with medication. They were fearful of the disciplinary consequences and for their jobs, and probably still are. A defensive reaction, even if this is subconscious, is understandable. Therefore it is at least possible that they have more insight and are more self-critical than they have made apparent to us.

9.10 In summary, Mr. Butler was failed by the team who gave him inadequate care and support. This was caused not by individual incompetence or uncaring attitudes, but by a collective acceptance of difficulties as being insuperable, the loss of the will to be assertive and a failure to persist in a systematic, co-ordinated and thoroughly documented programme of care and support. If these things had been done, we consider it likely that the team would have been more aware of the risk of relapse, as suggested by Dr. Deuchar, but it would be wrong to conclude that they could have predicted a homicide.

9.11 The concerns we have identified in this chapter confirm the need to examine themes we identified in our analysis of the incident. We do so in the chapters which follow.

10. Recommendations

10.1 As part of the discharge planning for any patient intended to be referred to the Assertive Outreach Team, the requirements of engagement must be considered and, where possible agreed with the patient. Where agreement is not possible, it should be made clear that non co-operation with the requirements of engagement may lead to re-admission. The use of statutory powers for a supervised discharge should be considered in all cases considered suitable for care in the community by an Assertive Outreach Team.

10.2 Care planning in assertive outreach cases should include a strategy for moving users on, including, where appropriate, defined aims which if achieved will lead to discharge from the care of the team.

10.3 The requirements of engagement should generally include a requirement that the user permits team members to enter his residential accommodation for the purpose of meeting him when they deem it appropriate. The care plan should include a contingency plan preferably agreed with the service user, for use if such access is consistently refused.

10.4 Where compliance with medication is a concern, the requirements of engagement should include the measures required for appropriate monitoring of compliance. In appropriate cases physical investigations, such as blood tests, should be considered.

10.5 Discharge and care planning in assertive outreach cases should include a programme of social support, including occupational activities and resources individually tailored to the user and appropriate to his/her age, ethnicity, intellectual abilities and other relevant characteristics, as opposed to restricting such support to commonly used resources.

10.6 Discharge and care planning in assertive outreach cases must include identification of social and statutory contacts with whom it is in the interests of the user and the public that information about him/her may be exchanged or obtained. It should be made clear to the user that confidential information may be disclosed or obtained without his/her consent where it is considered to be in his/her interests or those of the public to do so, and that such communication may take place for the purpose of detecting or addressing any risk to the user or the public or deterioration in the user's mental state or condition. Such contacts should, where appropriate, include the user's neighbours, and landlords.

10.7 Delivery of medication to a service user in the community should be

made directly to the user, and except in the most exceptional circumstances should never be by leaving medication with a third party or at the user's address or otherwise indirectly. Where such methods of delivery are used the reasons for this must be documented.

10.8 All contacts with the user by team members must be recorded in accessible form in the user's records. Such records should contain an account of the interaction, whether any action previously required has been performed, an assessment of the user's condition, any changes from previous assessments observed, and any action required as a result of the visit.

10.9 Arrangements must be made to ensure that all clients of the team are discussed by the team on a regular basis with sufficient time for the case to be presented and consensus reached as to what changes if any have occurred in condition and risk, and what changes if any are required in the care plan. Such discussions must be documented and included in the user's records.

10.10 A risk assessment should be prepared when a user is accepted into the care of the team. This should be reviewed on an agreed regular basis and otherwise when required by a change in condition or circumstances, the up-to-date risk assessment document must be readily accessible not only to the team but any other mental health care worker or representative of other statutory agencies where this is appropriate.

10.11 Care Programme Approach methods and documentation must be used in all cases managed by assertive outreach.

10.12 Generally users deemed suitable for support through assertive outreach should be seen at least once a week by a team member for assessment, interaction and support. If a less frequent routine is adopted the reason for this should be documented.

10.13 In the event of attempted contact failing, the reason for this must be

investigated and documented.

10.14 The resources for providing social and other support available to the team should be regularly reviewed with regard to the needs of the service users.

10.15 The work of the team should be reviewed on a regular basis with a view to establishing outcome measures, monitoring of standards of documentation, compliance with applicable policies, and ability to identity and address exceptionally challenging cases.

10.16 Finally, we recognise that this Inquiry and its findings are likely to add to the stress suffered by this team and its members. We feel that it would be beneficial to them to have the opportunity of discussing our findings with us in a private seminar.

CHAPTER 8

MEDICATION HISTORY AND MONITORING

1. Medication History

1.1 The precise detail of what was prescribed, dispensed and administered is not easy to extract from the voluminous records presented to the Inquiry. The table at Appendix 4 shows such details of doses and prescriptions as we have been able to ascertain, set out in chronological order.

1.2 When Mr. Butler was initially admitted in 1994 to a hospital in Stafford, the initial impression was that he was suffering from an acute psychosis with paranoid delusions. He was prescribed Chlorpromazine and Procyclidine. From the records he was first given Chlorpromazine following a period when he was agitated and had to be restrained a few days after admission. Soon afterwards he was put on depot medication in the form of Depixol as he was unwilling to take oral medication.

1.3 There was an improvement in his presentation, though it appears not complete recovery from psychotic experiences. He was a difficult patient to engage and a difficult patient to assess. Consideration was given to prescribing Clozaril early on his admission but he was unwilling to comply with any blood monitoring. He was given a trial of Risperidone and at the time of discharge from the first admission he was on oral Risperidone and depot Depixol. Later, the Risperidone was changed to Stelazine and after that Sulpiride and then back again to Stelazine. In April 1996 he refused his depot medication. However, he appears to have reverted to it in July of the same year. After he refused the depot medication, he was started on Clopixol tablets which he took for a 3 month period.

1.4 In October 1996 he was started again on Risperidone. In January 1997, he was given Lithium Carbonate but it is unclear from the notes

for how long. In April 1997, he was given an anti-depressant Venlafaxine and this appears to have continued up to January 2000. In 1999, it is recorded that he was on Amisulpride and Clopixol depot. A test dose of Piportil depot was given but it appears that he was not started on this. In April 2001, it is recorded that he was refusing medication. Following a period when he was disturbed, he was given intramuscular Lorazepam, Haloperidol and Acuphase in April 2001 as rapid tranquilisation. There continued to be problems with him refusing medication. The depot medication appears to have continued up to June 2001. He was started on Olanzapine Velotab tablets in July 2001 and was subsequently on Olanzapine until the time of the incident which is subject to this Inquiry.

1.5 From reviewing his medical records, it is difficult to assess the times when various medications were started and stopped and the reasons why there were changes. However, it is clear that there was an improvement in his mental state following the giving of antipsychotic medication. The extent of that improvement is unclear. However, it appears he was more cooperative, less irritable and easy to manage when he was on medication. When he was finally discharged into the community it is not clear from the records whether there were any psychotic symptoms present, or whether he could be described as somebody with a chronic psychosis or somebody who had fully recovered. Recording of symptoms and the monitoring of mental health appears to have focussed on factors such as suspiciousness, hostility, sensitivity, irritability, co-operation, and self-care. It is difficult to assess whether there were any underlying abnormal beliefs, e.g. persecutory delusions, as there is no specific recording indicating whether these symptoms were sought.

1.6 Mr. Butler was prescribed Olanzapine 10mg daily (an atypical antipsychotic drug) prior to leaving hospital in 2001 and remained on this drug and dose up to the time of the incident. It was felt this was the best medication given his history of poor compliance and sensitivity

to side-effects, particularly on the older anti-psychotics (typical antipsychotic medications or phenothiazines). The Olanzapine dose that he was given was within the recommended dose range in the British National Formulary. The recommended daily dose is between 5mgs and 20mgs daily.

2. Monitoring and Non-Compliance with Medication

2.1 It was a basic assumption of those agreeing to the discharge of Mr. Butler into the community that his illness was capable of being controlled by the prescribed dose of Olanzapine. We have seen that while Mr. Butler had been in hospital he had shown extreme reluctance to submit to medication, only doing so towards the end of his admission, perhaps once he realised that acceptance was the only route available to him to gain his discharge notably after his unsuccessful appearance at the Mental Health Review Tribunal. Even then there was no evidence of any insight or acceptance of mental illness.

2.2 While we do not wish to suggest that it was inappropriate to prescribe Olanzapine to Mr. Butler, we are concerned at the degree to which reliance was placed on its efficacy, to the effective exclusion of other forms of therapy and support. We have seen that the regular visits were largely focused on the need to deliver medication rather than on any in-depth monitoring of Mr. Butler's mental state. The team shied away from any action which might provoke Mr. Butler into disengaging further from the team, and the delivery of medication on a fortnightly basis to Mr. Butler became a more important issue than gaining access to see him. Thus they accepted a routine of fortnightly visits, although the usual frequency for their service users was a weekly visit. Even though many of these contacts were brief encounters on the doorstep they did not force the issue when not invited in, but were content with doorstep conversations.

2.3 The team found themselves relying almost exclusively on the efficacy of medication without giving themselves even the most basic regular

means of monitoring this. They relied on the fact that Mr. Butler's presentation to them in the brief encounters that he permitted gave no cause for concern. This was effectively a self-fulfilling prophesy unintentionally designed to minimise the chances of noticing the minor changes in behaviour that might have indicated the beginning of a deterioration. We heard much evidence from team members about the difficulties in monitoring compliance with medication. These can be summarised as follows:

2.3.1 Unlike depot medication, which is injected periodically by a health care professional, the team has to rely on the service user to consume oral medication. Direct observation of this would have required a daily visit. Even then users can be adept at simulating consumption. Indeed it was thought that Mr. Butler may have deceived staff that he was taking medication even while he was in hospital.

2.3.2 No blood test was undertaken to monitor drug levels in this case. Either such testing was unavailable at the time or would have been very expensive and time consuming or was not seen as an informative test.

2.3.3 If a service user is living alone it is difficult to ensure any visual monitoring of compliance.

2.3.4 The pharmacy was reluctant to dispense a single drug in mediboxes.

2.3.5 There was little alternative to asking Mr. Butler whether he had taken his medication and accepting his answers.

2.4 Although CPN (C) outlined non-compliance with medication as a risk factor to relapse, there is no evidence the team had a strategy to investigate his level of compliance or to demonstrate action to take in the event of non-compliance. Managing compliance with medication in

the community can present difficulties and there is a fine line between being intrusive and knowing the progress service users are making. Care co-ordinators have a key role to play in overseeing compliance with treatment and need to question service users regularly and have the right to do so.

2.5 Mr. Butler had a history of lack of insight and non-compliance, yet the only monitoring of medication compliance was through asking Mr. Butler whether he had taken it. While we fully accept that the problems mentioned above were very real and presented challenges to effective monitoring, their existence should have led to an even more energetic search for solutions in individual cases as opposed to passive acceptance of the status quo. We see little evidence of any sustained discussion of this issue in Mr. Butler's case. The panel heard from several team members of their concern about challenging Mr. Butler about taking medication, fearing upsetting him to the extent that he would drop out of contact.

2.6 While it is difficult to be sure on the evidence, we are satisfied that some doubt was raised within the team before the incident about Mr. Butler's compliance. Such doubts must have been expressed in order for Psychiatrist (Training Grade) to have been informed on 21 May 2004 that there had been such doubts, and for the police officer, Sergeant H, to recollect that similar information had been given to her. To the extent that they were raised, however, the doubts had been dismissed. There were no grounds on which the team could properly have dismissed such doubts: their only source of information suggesting medication had been taken was from Mr. Butler himself, and yet he was known to lack insight and had a history of non-compliance.

2.7 It is doubtful that any team anywhere else would have acted differently with a patient of this low level of perceived risk, if there were no grounds for doubting compliance. However, a more graduated approach to the relaxation of monitoring should be planned in cases

such as this. Thus in general a change straight from in-patient visual monitoring of consumption to open trust of the service user should only be adopted in cases where there are grounds for such confidence. The options for this should include: temporary placement in supervised accommodation, direct visual supervision of consumption of medication, audit of medication containers, blood analysis for drug levels, monitoring for signs of known side effects. The assistance available with section 25 discharge under supervision should be considered.

2.8 Consideration needs to be given to laboratory testing of blood levels of medication. This is not the answer in all cases, but if it were discussed routinely in the case of all service users with a history of non-compliance being discharged from formal in-patient care, a baseline of compliance could be achieved from which confidence and trust could be built up. It would be important to deploy this as far as possible in partnership with the service user, as indicated below.

2.9 Monitoring medication carefully is also important in avoiding stocks of medication building up and being used at a later stage in a suicide attempt for example. Although Mr. Butler was not assessed as being suicidal and had no such history, nevertheless the fact that 432 tablets (more than 14 months supply of medication) were found in his flat at the time of the incident was a serious concern as indeed was the fact that the team had no knowledge of this until they learned of it in court.

2.10 Looking for side effects of medication is another means of monitoring compliance. CPN (C) stated:

"in the past initially it made him quite sleepy and he was putting on weight which was why he was doing more working out, we knew that he went out running a lot and that he was running or biking on the canal paths."

2.11 From a review of the clinical notes however there is no documentation or evidence of weight gain or of this type of life style.

2.12 CPN (C) also described the plan to monitor his compliance as:

"...monitor him for any deterioration, looking for relapse signatures from previous relapses… in the past his self care had gone down, he was not eating or washing and his house was in a terrible state. We would watch to see if he was hallucinating or if there was any increase in aggression towards the team… everybody was coming back saying they could not see deterioration, so we had no evidence that this man was not taking his medication."

2.13 It is of note that CPN (C)'s emphasis was on observation rather than communication, and there is little or no indication in the records that even this level of monitoring was maintained.

2.14 Consultant Psychiatrist (F) outlined his assessment procedure for monitoring compliance on review of Mr. Butler:

'*Whenever I review patients I ask them about their medication, whether they are happy about the medication, and I always ask about their side effects and whether they are experiencing any side effects of the medication, whether they understand the medication and whether they would like to continue with it or whether they have any concerns. This gives me the impression about whether they have any problems or will continue to take medication'.*

2.15 It appears that this intensity of inquiry about medication did not permeate across other members of the team. As a response to their concern about challenging Mr. Butler about his compliance, the team could have discussed Mr. Butler's compliance and sought methods which could be engaged to ensure discreet monitoring without being intrusive. A key player in this would have been the RMN whilst he was with the team. As a support worker he had a good rapport with Mr. Butler and was the key member of the team consistently invited into his home. An opportunity may have been missed in not directing the RMN to ask to see his bottle of medication, to suggest removing his empty bottles, to ask how he was getting on with taking his medication, if it was causing him any side effects or concerns or indeed if he recognised the value of it. Team discussions about Mr. Butler's care and one to one supervision meetings with the RMN would have provided the opportunities to ensure good compliance monitoring. If such a pattern had been established it would have been easier for it to be continued by other team members.

2.16 The opportunity was not taken on any visit to Mr. Butler's home to ask him to produce the medication boxes nor was he asked where he kept

medication in an attempt to review his supply. This was thought to be too intrusive and to risk inciting Mr. Butler to disengage. In such cases consideration should be given at the time of discharge to monitoring of this nature with a full explanation to the service user of the reasons for it. It would then be more likely to be accepted. It is unclear whether Mr. Butler was taking medication only when it suited him or if he had stopped taking it altogether. This calls into question the direction of the team in taking a "softly, softly" approach with regard to monitoring as opposed to directly questioning or challenging about his claims of compliance, particularly bearing in mind they were aware of his non-compliance in the past and the information from CPN (D) who was fully aware of his non compliance when he was last an in-patient.

2.17 No measure will stop the really determined service user from concealing his non-compliance for a time, but an openly energetic and positive policy of monitoring in discussion with the user will persuade some of the need to comply, particularly if they are aware that non-compliance is likely to lead to re-admission to hospital. Where no effective monitoring is possible, even equivocal indications of relapse might suggest re-admission if the risks are of sufficient concern. As always ideal practice looks for a partnership between the team and the user.

2.18 We have seen as an example of a positive and genuinely assertive model for monitoring compliance a draft policy for a London Assertive Outreach Team.[19] This suggests four stages of self medication which, in summary are:

2.18.1 *Stage 1*: medications are kept in a locked box at the service user's house; staff retain the key and the service user dispenses medication only under the direct supervision of staff. Users progress from this stage when reliably remembering medication times and are self-administering safely.

[19] *Assertive Outreach & Recovery Team Operational Policy June 2008*

2.18.2 *Stage 2*: much the same except that the user has the responsibility to request assistance or attendance by staff for the purpose of supervising medication.

2.18.3 *Stage 3*. The user is given the key to the medication box; initially only one or two days medication is provided and the user takes responsibility for self administration subject to staff monitoring.

2.18.4 *Stage 4*: the user is given a full week's supply and expected to self-administer without prompting. Spot checks continue.

2.19 Such a scheme may be over-elaborate in many cases, but it does have the advantage if impressing on the service user and members of the team the importance attached to compliance and the need to decrease the intensity of supervision and monitoring on a planned and understood basis.

3. Delivering Medication through the Letterbox

3.1 On a number of occasions when the team visited Mr. Butler they received no reply at the door and in such instances thought it acceptable to deliver medication through the letterbox rather than insist on doing so personally, a practice which first started as early as November 2001, a month following Mr. Butler's discharge from hospital. CPN (C) told the panel:

"the policy of putting medication through the door was discussed with the team. I understand at the time it was not the policy to do that, but it was the practice across all Assertive Outreach Teams... We felt that it was important that people got their medication rather than not... as far as I am aware it had been taken to the Assertive Outreach Forum to be discussed as an issue."

3.2 The Team Manager (A) also confirmed that this practice was:

"accepted non ideal practice… it was a practice that was used with other patients as well although not very often and certainly not if there were risks of anyone else picking up the medication… it was a policy that caused concern and it was discussed at the Assertive Outreach Forum".

3.3 Minutes of the Assertive Outreach Forum dated 11 April, 2006 recorded:

'it was noted that medication can still be delivered through the letterbox which, in theory, means staff could go a month without seeing the client'

3.4 CPN (D) the F grade nurse in the team (the most junior of the qualified nurses) told the panel that although she was aware this practice was taking place she herself had never done it.

"I really do not know why other people did it and I did not… I know I said I felt uncomfortable doing that."

3.5 If CPN (D) had, (as she indicates) expressed her concern about this practice to the team, it appears that no formal action took place. Although the panel heard the issue was taken up at the Assertive Outreach Forum there was no amendment to the policy to indicate this practice could take place or that the Trust supported this practice. Presumably, this itself may be a reason why she felt uncomfortable. The panel was also left with the impression that although CPN (D) had expressed her concern to the team, it may seem that as a more junior member of staff (although a qualified nurse) her views were either not listened to or not taken into consideration. This may offer some insight into the team culture at the time. CPN (C) told us:

"There are still arguments about whether if someone is disengaging it is better that they have medication there (through the letterbox)".

3.6 We suspect that this practice would not have been allowed if the Trust's Medicines Code, approved in April 2004 but put into operation on 1 May 2005, had been in force at the time. That Code provides:

Medication for self-administration must be directly handed to the client for whom, they have been prescribed, or to a responsible adult nominated to receive the medicines by the client. Under most circumstances medication should not be delivered through a letterbox. This should only be done in exceptional circumstances, as an agreed contingent, and as part of a care plan that has been previously discussed with the service user. In all cases there should be a clear risk assessment that enables the team, and individual member of staff who will be accountable, to demonstrate that the benefits of such action far outweigh any risks, which should be considered minor. Medication should never be delivered in this way if it is known, or suspected, that children live on the premises, or into communal letterboxes.

4. Signing Medication Cards

4.1 A further area of concern was that no medication cards recording community dispensing were to be found in the records produced to us and CPN (C) told the panel that the team did not sign the medicine card when medication was delivered/dropped off. CPN (B) confirmed that this was not always done which raises issues about the legality of the practice, and on a practical level, it had the potential to cause confusion (within a model whereby different members of the team was tasked with the delivery of medication). This confusion was played out during CPN (B)'s visit on Saturday 15 May 2004, in his attempt to deliver medication to Mr. Butler who told him that he had already received it the previous week. He did however agree to accept the medication being offered. CPN (B) returned to the team base; he told us:

"I took it back to the team meeting on the Monday and nobody could remember visiting him the previous week..."

4.2 The signing of a medication card would have been a quick and accurate record to indicate whether medication was delivered and would avoid having to rely on individual memory. It would also have reduced any confusion amongst team members. It is concerning that medication cards left unsigned were not picked up at patient review, by the care co-ordinator, medical staff, or during dispensing by pharmacy staff or during audit.

5. Recommendations

5.1 In all cases requiring monitoring of compliance the team should actively consider what techniques can and should be used other than asking the service user routine questions.

5.2 In cases with a history of non-compliance with medication regimes the care plan should specify the steps that will be taken to monitor future compliance and the agreement of the service user sought for these steps. The steps that should be considered should include, but not be limited to:

5.2.1 Regular questioning of the service user.

5.2.2 Inspection of medication containers and medication in his possession.

5.2.3 Initial direct visual observation of consumption.

5.2.4 Requirements as to the place where medication is delivered and consumed.

5.2.5 Laboratory testing of blood drug levels.

5.2.6 Monitoring of side effects.

5.2.7 Regular recording of signs and matters relevant to the monitoring of side effects, such as weight and tremors.

5.2.8 Medication cards must be signed when medication is delivered and regular audits of this practice should take place.

5.3 In all such cases a structured programme of monitoring should be considered allowing for changes in intensity in accordance with any changes in the level of concern about compliance.

5.4 The Trust should investigate whether tests of Olanzapine levels are available and if so consider defining the class of case in which such tests should normally be conducted.

5.5 The Trust should ensure that medication is never delivered otherwise than personally to the service user as a matter of routine and in any event never so delivered without a good and documented reason.

5.6 The Trust should review its recording policies and practice with regard to the dispensing and delivery of medication by Assertive Outreach Teams to service users to ensure that delivery can be proved and audited.

CHAPTER 9

LIAISON WITH OTHERS

1. In retrospect there were a number of problems facing Mr. Butler of which the team was unaware. If the team had been aware of them they would inevitably have had a greater level of concern about his well-being than they did. These problems included the following:

1.1 There was a housing benefit review for which Mr. Butler provided no evidence of income and subsequently incurred rent arrears culminating in his receipt of a notice of intention to repossess his flat;

1.2 His neighbour had observed officials breaking into his flat and taking away the gas meter.

1.3 The same neighbour has stated that Mr. Butler had been behaving in an anti-social manner for some time before the incident.

We will deal with these themes individually

2. Benefit and Rent Arrears

2.1 Mr. Butler, as was his entitlement, was in receipt of housing benefit from the time he acquired the tenancy of the flat in Long Acre. His housing benefit would have paid for his rent directly and he would have been liable for no additional rent so long as the benefit continued. In January 2004 he did not complete or return a form applying for his benefit to be renewed. As a result, in April 2004, the benefit was stopped and he became personally liable to pay the rent due on the flat. He paid none and as a result a notice of intention to seek possession of the flat was served on him on the day of the homicide. It is clear that whatever correspondence he received from the Council in respect of this matter, he took no steps to rectify it or to tell anyone from the AOT of the problem. Had he done so, or had the team become aware of it by some other means they would undoubtedly have taken steps to sort out the difficulties and the issue of the eviction

notice would have been avoided. It is also highly probable that such developments would have alerted the team to the strong possibility that Mr. Butler's mental health was deteriorating. It seems highly likely that Mr. Butler simply ignored his developing financial problems.

2.2 Such information as we were able to obtain about this issue was kindly provided by two housing officers, Local Housing Manager, present housing manager for Nechells and Review Manager, housing manager for vulnerable persons. The management and allocation of housing and the administration of housing benefit are dealt with by different departments. The department administering housing benefits also has to deal with a number of other forms of benefit such as council tax benefit. The department manages about 8,000 council tenancies in the Nechells area; of those 70% are in receipt of benefit. The department labours under a huge problem with rent arrears. The Local Housing Manager told us in Birmingham as a whole the arrears amount to something like £14 million, and in Ladywood East, the district which includes Nechells the arrears total about £3 million.

2.3 The Local Housing Manager and the Review Manager had extremely limited documentary records available to them. For example they had nothing to help them on what, if any, contacts there had been with mental health services at the time Mr. Butler was allocated his flat in Long Acre. They suggested that the file may have been moved around the organisation and that the police had taken it. However we are satisfied that we have seen such documents as had been obtained by the police and they contain no reference to this issue.

2.4 The Local Housing Manager told us that he had spoken to all the housing officers who had covered the area at the time and they had no recollection or knowledge of Mr. Butler's illness. What is clear is that there was no reference to his vulnerability on any file now in the possession of the Housing Department at the time. The Local Housing Manager told us:

"There were numerous people managing, there were numerous housing officers in the area. If indeed it was on the file it must have slipped through the net. In the

normal course of events, we would have taken a slightly different action on the arrears action than we did."

2.5 The Local Housing Manager surmised that the tenancy file had gone missing.

2.6 The Review Manager explained that if a referral had been made by mental health services to the Housing Department, as is clear from the RMN's recorded actions occurred in this case, there would have been a housing needs assessment and a council property would have been selected on that basis. Normally information about that, including details of the relevant contacts in mental health services would have been kept on file and he would have expected the department to have been fully aware of the previous history and any relevant behaviour in any previous tenancy.

2.7 We were told that housing benefit is reviewed annually and that the claimant has to fill out an application form each year. If this is not returned benefit is stopped. If the department is aware that the recipient of benefit has mental health needs the local housing officer might offer assistance in filling out the form but, because the administration of benefits is dealt with by a separate department, this does not always happen. They tended to find in such cases that when the benefit was cancelled and a notice of intention to seek possession is served this prompts someone to come and talk to the Housing Department and the benefit can then be reinstated.

2.8 The Local Housing suggested that things were dealt with better now than they have been and that officers dealing with different functions do talk to each other. However, problems are not always communicated.

2.9 So far as could be ascertained from the limited records available Mr. Butler's housing benefit was due for review in January 2004. A form would have been sent out to him, but this was not returned. This would have triggered a reminder letter which would have warned

Mr. Butler that his benefit was liable to be stopped and he would then become liable for the full rent on his flat. The Local Housing manager accepted that some people see a letter like that and ignore it.

2.10 Mr. Butler's benefit was stopped on 5 April 2004 and thereafter he became liable to pay the full rent on his flat. This accumulated at the rate of £38.04 a week. By 26 April the total arrears were £152.20. Arrears of £150 or more automatically trigger the sending of a letter. After two months arrears have accumulated a notice of intention to seek possession is printed automatically. This is reviewed by an officer who decides whether it should be served: he has discretion whether to do so. For example, if he is aware of a benefit problem, family or health problems the notice will not be served and the tenant will be visited. The notice to Mr. Butler was delivered on 21 May, and referred to the rent arrears due to 17 May.

2.11 Considering the position that had arisen in this case, the Review Manager told us:

> *"I think just listening to what we have been saying there, a lot of it is down to the individual as well, but if he has a key worker and we are aware of it then yes obviously we would expect that someone would contact that person at some stage during that arrears process. Similarly Mr. Butler would be receiving notices and rent arrears letters; also, if [he] has been in contact regularly with his keyworker, he should be making him aware of those, for him to contact the department as well."*

2.12 It is not within our terms of reference to investigate the running of the Housing Department or its provision of service to Mr. Butler, but it clear that there existed in 2004 an alarming lack of liaison between it and mental health services. We are quite satisfied on the evidence we have seen that mental health service workers, and in particular the RMN must have made housing officers aware of Mr. Butler's mental health needs when he was allocated his flat in Long Acre. He could reasonably have presumed that the Housing Department would retain on its records information that Mr. Butler had mental health needs and was a user of mental health services.

2.13 We are satisfied on the information that we have been able to obtain

from the Housing Department that no such information was in fact recorded or retained by it, or alternatively that it was not made available in any useful form to those managing Mr. Butler's tenancy. As described to us the system relied far too heavily on individual initiative and recollection and as a result it could only have been a matter of good fortune if those dealing with benefits claims and arrears became aware that the person concerned was vulnerable and probably required assistance. Bearing in mind that Mr. Butler would have been allocated a flat on the basis of his special needs and vulnerability it is nothing short of shocking that something as important as this should have been left to chance. While we were told that there are now new systems and protocols in place we have not had an opportunity to examine these in practice, but from what we were told we are far from satisfied that there is any system of liaison between mental health services and the housing and benefits departments which would prevent what occurred here happening again.

2.14 There is no evidence that any member of the Assertive Outreach Team made contact with housing officials since Mr. Butler had been allocated his flat in Nechells in October 2001. This is in contrast to the period leading up to the last hospital admission when there had been considerable contact when concerns had been raised. The difference was that then there were concerns known to the team, whereas in 2004 they were unaware of any. This suggests the need for regular contact with agencies such as housing, even if it appears that all is going well. The clinical or CPA reviews would be an appropriate time for such routine contact.

2.15 It is clear that if mental health services had been told about Mr. Butler's failure to submit his benefits renewal form or his rent arrears or other information suggesting that he was getting into financial difficulties and was not seeking help that they would have taken action. It is likely that such matters would have been taken as signs that he was relapsing or in danger of doing so. We asked Consultant Psychiatrist (B) what he

would have predicted the effect to be on Mr. Butler of receiving an eviction notice.

He said:

"We know in that people with mental illness, when faced with stressful life events, that can cause a flare-up of their illness, and precipitate relapses as well. I would have been wary about such a significant life event happening if he was being evicted, and the impact it would have on him. I would have been particularly concerned if he had reacted in a hostile and aggressive manner, or had shown signs of being unwell in any way."

2.16 With regard to what might have happened if the team had been made aware of this he said:

"If we had known that he was in arrears, we would try to find out from him what was happening and why he had got into arrears… We have times when people have got into arrears and we have not been fully informed about that. As I have said, each individual patient is different. With him, I would probably have been a bit more worried about the circumstances than with someone else, with a different kind of illness or history."

2.17 Consultant Psychiatrist (F) thought that evidence of financial difficulties could suggest self neglect.

2.18 CPN (C)'s understanding was that the Housing Department had flagged up Mr. Butler's file so that if there were any issues the team would be contacted. She thought that receipt of an eviction notice would have been very upsetting to anyone. She would have anticipated that Mr. Butler, on receiving such a notice.

… would have been very angry because he had put a lot of work into the flat. It was a lovely looking flat and he had been decorating it all and buying things for it. To have that pulled away from him would have made him extremely angry. Anybody would have been. The workman who happened to be there at that time probably got the brunt of the anger that was within him... Whether he was unwell or well I think that would have happened. In the past he had been in advance with his rent and actually got £600 reimbursed because he had paid a top-up of his rent. From that point of view I think he would have been angry.

3. Our conclusions on this theme are as follows:

3.1 There was no liaison between the Housing Department and the mental health service in connection with Mr. Butler's increasing difficulties with housing benefit and rent. This was not the direct responsibility of the health services because they were not made aware of the problems either by Mr. Butler or the Housing Department.

3.2 It is of concern that the Housing Department did not communicate the existence of such problems to the health services when officers within the department knew or ought to have known that Mr. Butler was in receipt of mental health services: it was they who had facilitated the acquisition of the tenancy at Long Acre for him. However, there is no evidence that those officers who were or should have been aware of Mr. Butler's circumstances were aware of the action it was proposed to take in relation to his benefits or rent arrears.

3.3 The Housing Department was able to produce no records other than the rent account and correspondence in connection with rent arrears. There was nothing on their files as produced to us that showed that their tenant had mental health problems.

3.4 The benefits department likewise seems to have had no record that Mr. Butler received mental health services.

3.5 Had proper records been kept by the housing and benefits departments, and had there been a policy of liaising with mental health services about problems experienced with tenants, the rent arrears and issue of a possession notice may well have been avoided.

3.6 There appears to have been no contact of a routine nature by mental health services with housing officials since Mr. Butler's discharge from hospital in October 2002. The co-ordination of Mr. Butler's care should have ensured a liaison was maintained and as a minimum, contact made with the Housing Department in preparation of the annual review of housing benefit.

3.7 The service of a notice of possession was probably a contributory factor in the deterioration of Mr. Butler's mental state on the day of the incident.

4. The Removal of the Gas Meter

Mr. Butler's neighbour recalled that in March 2004 gas company officials broke into Mr. Butler's flat to remove the gas meter. If this is

correct this is added evidence that Mr. Butler was neglecting his financial affairs and was in difficulty. Although we have not specifically investigated the incident or looked for who had knowledge of it, it seems likely that it was known to a housing officer as well as the gas company. Again the mental health service team was unaware of this. The incident is another example of something one would have expected the team to have become informed of through proactive contacts. We do not go so far as to suggest that there should be routine contact with utility companies, but in cases where self neglect and financial problems have been part of the service user's history some routine review of his financial welfare would not seem out of place.

5. Anti-Social Behaviour

An elderly, retired couple[20] who were Mr. Butler's neighbours had tried to engage their neighbour in conversation several times, but he had always rebuffed them by putting his head down and ignoring them. From shortly after he moved in they noticed that he would be constantly "*banging about*" in his flat above and they would hear him talking loudly to himself, saying things like "*F***ing leave me alone*". They also noticed that he never answered his door to anyone; on occasions people would knock on their door and ask them whether Mr. Butler was in. They could tell that he was because they could hear him. Mr. Butler would slam his door on leaving his flat loudly; on one occasion he did so with such force that their clock fell off the wall. They had not reported their concerns to the Housing Department as they did not believe they would do anything about it.

5.1 There is no indication in any evidence we have received that any member of the Assertive Outreach Team spoke to these or any other neighbours or even approached them. Therefore they were not aware of the information about Mr. Butler's behaviour which they possessed.

[20] *The inquiry panel invited this couple to contribute our inquiry, but very understandably they declined. As they witnessed some of the events of 21 May, they have been subjected to a great deal of stress. The inquiry has, however taken into account the statements made by them to the police, as well as the evidence at the trial.*

The recollection of the neighbours is now, of course, coloured, if not overwhelmed, by the tragedy that occurred on 21 May which must have left them feeling exposed and vulnerable. The information now obtainable from them is a general indication that Mr. Butler's behaviour was never truly settled after he moved into his flat. Had inquiries been made of them over a period of time a picture might have been built up of whether it was improving or deteriorating. A suggestion that Mr. Butler was shouting to himself about wanting to be left alone might have added to doubts about his mental state and his compliance with his medication regime, and led to a closer consideration of how this should be monitored.

5.2 Doubtless, even if an approach to these or other neighbours had been considered the team would have felt constrained by the duty of confidentiality owed to Mr. Butler. This almost certainly would have made them reluctant to make any approach. While many teams elsewhere might adopt a similar attitude, we think that the effect of the duty of confidentiality needs to be rethought. Mr. Butler was a service user part of whose relapse signature was his behaviour towards his neighbours, and his attitude towards others as evidenced by his willingness to let visitors into his flat. The people most likely to have useful information about that would have been his neighbours. Unfortunately Mr. Butler was not in regular contact with other members of his family and therefore there were no family members who could provide useful information, and he had no known friends. Unhappily he was almost totally socially isolated. Sad though this is, it is the experience of the mental health professionals on this panel that this is not unusual among service users in the community. Further, given his history of arguments or assaults on neighbours they were the most likely ones to be at risk from his behaviour, although it must be emphasised once again that it would have been difficult to predict that he would present a homicidal risk even if everything we now know about Mr. Butler had been known by the team at the time. In a case such as this it would have been in the best interests of Mr. Butler

himself and the community in which he lived if information had been sought from neighbours.

5.3 It is not necessary to disclose confidential information about a service user to make and exploit opportunities to obtain information from neighbours about him. These neighbours were obviously used to calls from frustrated would-be official visitors of Mr. Butler. It should not be thought objectionable or a breach of confidence to seek information. Of course not all neighbours will be willing to divulge information, but in a case where they are being disturbed it might be thought that they would be unlikely to withhold it.

5.4 There is, of course, something potentially disturbing about state officials, even if well intentioned ones employed by the National Health Service, effectively encouraging neighbours to report matters of concern about another neighbour, particularly where this is without the consent or knowledge of the subject of the Inquiry. There is also the anxiety that in seeking information, the team member may be implicitly, if not explicitly, disclosing that the subject of the inquiry is a service user and, hence, someone with a mental health history. The unfortunate stigma attached to such a status, however unjustified should not be ignored. In a case such as Mr. Butler's the need, in his and the public's interests, for the outreach team to be able to seek information from neighbours and other contacts in the community should be considered as part of the discharge planning. The service user's understanding of the need for information and consent for approaches to be made should be sought as part of the planning process. Should the need for such approaches be apparent to the team, but not recognised by the service user, that should be taken into account in deciding whether it is appropriate to discharge the patient at all, and, if it is, where the balance of the personal right to privacy and the public interest in protection from risk and safeguarding of mental health lies. If the balance is in favour of the team being free to seek information and, if necessary for that purpose to share information, then they should document their reasons, and thereafter be free to

seek information. Should such action be included in a care plan without the service user's informed consent, he should be told what is to happen, and of his rights in respect of the decision.

5.5 This difficult area is considered further in the chapter on confidentiality.

6. Recommendations

6.1 Mental health services should initiate urgent discussions with the Housing Department and the benefits department to provide a system of mutual exchange of information in the interests of their mutual clients, such exchange to have due regard to the rights of users to confidentiality, but also to their and the public's interests in safety, health and welfare. This should be routinely embedded as part of CPA procedures and practices.

6.2 Mental health services should request the Housing Department to review its policies and procedure to ensure that, where a tenant is known to have a mental health history or to be in receipt of mental health services, no steps should be taken to enforce the collection of rent arrears or to seek possession in such a case without consideration of whether the assistance of mental health services should be sought.

6.3 Mental health services should explore with the Housing Department and other social landlords how they can assist in compliance with the Pre-action Protocol for Possession Claims based on Rent Arrears.[21] The provisions which appear to be relevant are reproduced in Appendix 6.

6.4 Consideration should be given to ensuring routine contact with the housing and benefits departments as part of the regular review of each service user in receipt of public housing and/or housing benefit.

6.5 The Trust should review its policy with regard to seeking and sharing information about service users taking into account the observations

[21] *See http://www.justice.gov.uk/civil/procrules_fin/contents/protocols/prot_rent.htm*

we have made above.

CHAPTER 10

MANAGEMENT OF THE ASSERTIVE OUTREACH TEAM

1. Introduction

When the Assertive Outreach Team was initially set up, it was the first such service in Birmingham, no other similar models existed to learn from or to visit at the time. Being the first of its kind elevated the team to an elite status and with a reputation for good practice standards and services to patients, the team regularly received visitors who came to hear about their work and model of care. The Assertive Outreach Model developed in Birmingham was adopted by mental health services throughout the country.

1.1 The assertive outreach model created in Birmingham was thought to be so successful it has become an essential part of mental health policy, which has mandated the provision of Assertive Outreach Teams in an adjunct to services provided by Community Mental Health teams: Johnson et al (2001)[22], NHS Plan (2000)[23], MHPIG (2001)[24]

1.2 The panel had difficulty in understanding exactly when the team was formed but from documentation it is estimated to be between 1996 – 1997.

1.3 CPN (B) outlined that :

'historically the Assertive Outreach Service was the original Aston Home Treatment Service based at All Saints Hospital. When the patches changed in 1996 Aston became part of the Small Health Team. Small Health already had an existing Home Treatment Team, so the Aston Home Treatment Team changed it's name to the Small Heath Assertive Outreach Team'.

1.4 At the outset of the service, the Trust had very charismatic leaders in Dr. Sashidharan, Consultant Psychiatrist, and Mr. John O'Mahony Chief Executive, and attracted international interest from figures such as Dr. Hickling, a Jamaican Consultant Psychiatrist, all of whom were

[22] *Mental Health Service Provision in England. Acta Psychiatricial Scandavica 104 (suppl. 410) 47 - 55*
[23] *NHS Plan: a Plan for Investment, a Plan for Reform (2000) DoH*
[24] *Mental Health Policy Implementation Guide (2001) DoH*

instrumental in setting up the team and were very committed to the model. The team linked with various key services around the world and became a model of national and international significance. Team members were encouraged to be involved in shaping and designing the service and in bringing together the operational policy, and there appeared to be a dedicated team cohesiveness and an eagerness to make the model a success.

1.5 At the point of formation, the team consisted of four nursing posts and a consultant psychiatrist; there was no social work, psychology or OT input. Community Psychiatric Nurse (B), Community Psychiatric Nurse (A) and the Team Manager (B) – Rehabilitation and Recovery were all original team members and were still in post at the time of the incident.

1.6 Community Psychiatric Nurse (A) who was a qualified nurse in the team at the outset, described that the model of care adopted by the team:

"...came from America and was based very much around social interventions and social engagement which definitely was the biggest emphasis in terms of what we would be looking at…"

1.7 At the time of formation, Team Manager (B) – Rehabilitation and Recovery outlined that the team had regular debate and discussion about ethical issues around the levels of coercion or oppressive practices that the team might or should employ: for example by the nature of their clientele they would be knocking on doors of people who did not want to see them; similarly they would be offering medication to some people who did not wish to be medicated. Such discussions and debate are an essential component of any team's practice to set ground rules and boundaries; it is regrettable these discussions did not continue as a matter of routine rather than on an ad hoc basis. This may have led to missed opportunities for discussion on key issues related to Mr. Butler's care because of, for example, team members not gaining access to or being invited into his home, and a lack of sharing of information and knowledge of techniques which could be employed.

1.8 The on-going learning and development of a team is crucial to ensure the focus is retained on specific issues of care and in setting strategies for those patients who are more difficult to engage. All of this is important in the development of members of the team but especially junior and unqualified support staff and staff rotating into the team such as students.

2. Leadership of the Team

2.1 The Assertive Outreach Team at the time of the incident consisted of a Service Director, Mr. Ken Jackson and a Clinical Director, Dr. Peter Lewis, who together had overall management and leadership of the service as well as the full range of mental health services provided in the area. In addition Consultant Psychiatrist (D) was the programme lead for assertive outreach for the Trust. Service Manager (A), joined the service on 12 April 2004 and reported to Ken Jackson. Prior to his arrival, the duties of this post had been covered by service managers for some time before the substantive appointment was made. The team manager (B) (Rehabilitation and Recovery) was part time with the Assertive Outreach Team and part time with the Rehab and Recovery team; he reported to Service Manager (A). The clinical lead was the Team Manager (A); this was a full time post reporting to Service Manager (A). The Team Manager (A) outlined both their roles as:

"I was taking a lead in checking the overall running of the assertive outreach team specifically in it's clinical interactions with the clients."

2.2 He described Team Manager (B) – Rehabilitation and Recovery's role as:

'the interface with the management structure of the locality. He did a lot of the meetings and the processes there, whereas I ensured that the care plans were appropriate, that we were critically appraising our progress with clients and overall where the service should be'.

2.3 The Team Manager (A) was in an acting position for 3 years before his post was made substantive.

2.4 Over time the team went through many changes of consultant

psychiatrist. Community Psychiatric Nurse (A) told the panel:

'Initially, when we started it (the consultant) was Dr.B but he left and after that we had a succession of consultants – I think the record for one year was about 22. They could not recruit a permanent person to the post so it was just a succession of locums…...until Consultant Psychiatrist (F) came to join our team…'

2.5 Consultant Psychiatrist (F) gives a slightly different account but nonetheless expressed the same concern:

"…there were 16 consultants in a one year period, so more than one consultant a month…'

He further asserted:

"The team adapted to run on their own and the consultant worked with their plans. That was the way the team worked, and there were several consultants in the team but no consistency. In that sense the consultants input is there but it is not integrated into the team."

While the rate of change decreased in the period of 2000-2004 such constant change of senior personnel was bound to have an unsettling effect.

2.6 In addition a number of mergers took place, the last two of these involving the merger between North and South Birmingham mental health services in April 2003 and the subsequent merger with Birmingham Social Services in October 2003. This merger added further confusion and complication for the team as there was little or no clarity or leadership to identify which policies were to be implemented, those from North Birmingham services or from South Birmingham services. Ken Jackson asserted:

'I think the morale was affected because we seemed to be going through a constant period of change. We had moved from two Trusts into this very huge organisation and with it came all sorts of issues about communication, direction, where we were all going, how things were working… think our communication structures were not robust…'

2.7 With this merger and the formation of the Trust as it is today, the management structures were changed and clinical directorates were developed, Heart of Birmingham became one of five adult directorates and Small Heath Assertive Outreach Service became part of the Heart of Birmingham directorate.

2.8 It would appear that as time passed, team members became complacent in their day to day roles and took much for granted. They did not seem to question practice or to have a clear sense of purpose of the role they were undertaking. This can be evidenced by some of the practices around medication and clinical notes which the team employed as highlighted in this report. This lack of questioning of practice may have been a result of disjointed management structures, following the merger, and perhaps a view by Trust senior management that the team was highly experienced and so 'an eye was taken off the ball'. The team was very much left to its own devices. Ken Jackson asserted:

"A lot of people in that team had been there from the start of the concept of assertive outreach and there is something about moving on, there is something about changing and bringing new people in who can take a fresh look at what is being done. I think there may have been an attitude that has grown up in the team that says 'Well we know what we're doing, we've been doing it for a long time and nothing serious has happened, so we're doing it right', and that is the danger. The danger is allowing a well-established team to continue to operate without reviewing them properly and taking a hard, independent look that says, 'Let's have another look at what you're doing, how you're doing it and what the outcomes are…We did not review effectively what was going on."

2.9 With the arrival of Service Manager (A), a new service manager, his main focus initially was with the in-patient services. Arriving as he did very soon before the incident under review, he had little opportunity to form more than a first impression of the team and its workings before it occurred. He met regularly with the Assertive Outreach Team (every morning for coffee) and his retrospective impression was that the managerial leadership could have been a lot stronger. He told us:

"there were people there who were saying 'No I'm not going to do it that way. I'm going to do it this way'. And there was no-one there to challenge that. So a lack of management, hands on visible management and leadership; probably someone with a good knowledge of Assertive Outreach, because there was always the charge you were open to: 'You don't understand it, so you can't really comment."

2.10 He described the team as being '*very experienced*' but thought that there were no formal opportunities for the team to have discussions about policies or procedures, and although in principle there was supposed to be a weekly business meeting in practice it did not happen. This was mainly because of time over-running in the

discussion about patients.

2.11 The lack of psychological input to the team further reduced the options of treatment and care. Together with minimal Occupational Therapy input this may have hindered the developed of the range and quality of services provided to patients. It is essential when establishing team resources that all professional and multi-disciplinary skills are employed to meet the variety of demands for care.

2.12 The absence of such posts led to an overemphasis on the medical model and on medication as the main method of treatment. This itself can, and we consider did, have a negative effect on the staff group who are inhibited in developing skills in psychodynamic, psychosocial interventions or a model focused on recovery.

2.13 Consultant Psychiatrist (F) took up post of consultant psychiatrist for the team in 2003, prior to which he was the acting consultant psychiatrist for the team. He had also worked with in the area as a Senior House Officer, Specialist Registrar, and associate specialist (now called a Senior Community Medical Officer) and so knew the team and service well. He had been a Consultant Psychiatrist in India before coming to England when he again starting training for MRCPsych. By the time we interviewed him he had left the team, but he described his role as having been:

"consisting of responsibilities for different teams. One is the Assertive Outreach Team to which I am supposed to give half of my time, and also I have responsibility for the Primary Care Liaison Team with a population of 25,000 in inner city Aston, plus the Home Treatment Team in Small Health. My job also includes in-patients care for assertive outreach patients and primary care patients and we have day services. In summary my responsibilities are for the assertive outreach population in Small Health and the primary care liaison population in inner-city Aston, which was at that time 25,000."

2.14 This was an extensive workload for one consultant psychiatrist and because of his role he described his interface with the Assertive Outreach Team as being:

'more or less a visitor to the team'

2.15 When he applied for the post of Consultant Psychiatrist, Consultant

Psychiatrist (F) felt the extent of the role was unsatisfactory and raised this at his interview when he told the interview panel:

'I can only accept this job provided that the job is reorganised; the Royal College guidelines say that in an inner city a primary care population of 25,000 is one job'

2.16 Dr. Peter Lewis, Clinical Director, told the panel that:

'In terms of Consultant Psychiatrist (F) he was previously managing a patch of 25,000 adjusted population of a PCL team in Small Heath, in addition to doing 0.5 in assertive outreach. According to the [Royal] College guidelines, 25,000 adjusted population is a full job for a consultant psychiatrist so long as they do home treatment as well as inpatients. But he was also doing assertive outreach. In effect he was doing 0.25 more than he should have been, according to Royal College guidelines '

He further explained:

'the intention of the service redesign was to precisely describe the populations and their morbidity in order to match the available resources more appropriately'.

2.17 As the service redesign did not take place the consequence was that there was a lack of involvement by Consultant Psychiatrist (F) in Mr. Butler's care and because of this, he was bound to be much more accepting of others' work as he was not physically present within the team frequently enough to be able to oversee or supervise practice. In addition team members were not reliant on him day to day and some considered him a relatively junior consultant psychiatrist, (presumably as they had known him as an SHO and SpR within the team).

2.18 Prior to Consultant Psychiatrist (F), the consultant psychiatrist for the team was Consultant Psychiatrist (B), he originally joined the team towards the end of 2000 initially as a locum consultant. This post became permanent in February 2001 and he remained in post until November 2002. He described one of the reasons he left was:

"…because it was very busy and difficult. Half the job was in managing this group of assertive outreach patients, and the other part was managing in-patients, outpatients, home treatment teams, the day hospital, training supervision. It was impossible to fit everything in. I was beginning to burn out, even after a year. It was impossible to check what each and every worker did, and whether he or she was documenting everything 100 per cent accurately, or what was being discussed."

2.19 There also appeared little in the way of performance management of the service either by the Trust Board or PCT commissioner to justify value for money. Ken Jackson told the panel:

'There were no discussions around outcomes, it was often and even now to a large extent around numbers. How many people are actually seen? How many people are on enhanced CPA? In terms of recording what we had, it was more on a yearly basis during the autumn assessment that the issue of our performance came up….'Have you got a team in place and is it working to approved measures'.

2.20 It is interesting that the measures referred to relate to the numbers of patients under the care of the team and if it matched the ratio which the team was aiming for in line with Mental Health Policy Implementation Guidance[25] of 1:10.

2.21 However, it is important to recognise that the lack of scrutiny concerning activity either within or outside the Trust is no different to other assertive outreach teams across the country.

3. Model of Care

3.1 Within any population there is a small number of people with serious mental health problems with complex needs who have difficulty engaging with services and often require repeat admissions. Community mental health teams are able to support people with serious mental illnesses as effectively as assertive community treatment teams, but assertive community treatment may be better at engaging clients and may lead to greater satisfaction with services[26].

3.2 Community Psychiatric Nurse (A) describes that at the point of inception:

"we were able to trawl through the CMHT's existing clients and say this person looks like he or she would benefit from this type of service."

3.3 As Mr. Butler was thought to be too difficult for the CMHT to form a rapport with or to engage in services, he was an appropriate candidate for this new developing service. With much smaller caseloads than the CMHT, the Assertive Outreach Service had more opportunity to input time and effort to their clients. Community Psychiatric Nurse (A) told us:

[25] *Department of Health (2000) The Mental Health Policy Implementation Guide, London: Dept of Health*

[26] *Killaspy, H.; Bebbington, P.; Blizard, R.; Johnston, S.; Nolan, F.; Pilling, S. & King, M. (2006) The REACT study: randomised evaluation of assertive outreach community treatment in north London, BMJ, 332 (7545).pp 815 -818A. Medical Journal. 8.4.06*

"we have much smaller caseloads, which in turn means that we are able to spend longer periods of time with people and be more flexible and creative in the way we work. You are dealing with somebody who is at the point of starting to look at their life and what they want to do, whether they want to move on to education, or a job."

3.4 At the time of the incident the team had a caseload of 65 patients, a ratio of 1:8 staff/patients, which is in line with Mental Health Policy Implementation Guide [27].

3.5 Mr. Butler quite rightly was regarded as suitable for assertive outreach model of care. CPN (B) asserted:

"our philosophy was that we are not going down the medical model route, but we are going down the engagement route first to see why they have difficulty in engaging."

3.6 Similarly, the Team Manager (A) recognised that:

"not wanting to engage was a fairly frequent feature, although for people who did not want to engage we tended to have more success than we did with Mr. Butler."

3.7 Mr. Butler's difficulty with engagement was well recognised by the team. Community Psychiatric Nurse (A) stated that:

"With someone like Mr. Butler you are always treading a very fine line between him engaging and just completely blanking us out. Sensitivity was probably at the forefront of everybody's intervention with Mr. Butler and you had to try to get it right in order not to frighten him off."

3.8 However, the frequency and intensity of contacts as outlined by Community Psychiatric Nurse (A) did not seem to apply to Mr. Butler's care as his visits were reduced to fortnightly and seemed to be based primarily around delivering medication. This decision to visit him fortnightly was inconsistent with the model in which more frequent contacts, i.e. 2-3 times a week or weekly visits, are the norm. Indeed at the formal review and section 117 discharge meeting which took place on 4 October 2001 it had been agreed that there would be regular input from the AOT which would be once a week at least.

3.9 Fortnightly visits by an Assertive Outreach Service goes against set guidance and begs the question as to how assertive an assertive outreach team should be in directing the levels of care provided, and

[27] *Mental Health Policy Implementation Guide. London: Dept of Health, (2000)*

what level of say the team have in deciding the frequency of visits. If this decision is left solely in the hands of the service user who is already difficult to engage, they will opt for minimal contact. Despite the team's concerns about maintaining contact, there is a great need to negotiate frequency within the remit of the model guidance.

3.10 The Team Manager (A) told the panel:

"in the past we had discussions where we insisted we wanted to see him more often than we did, but he said he did not want to be visited any more than every two weeks and we had to put that in the care plan. We knew that he tolerated, quite often reluctantly, our intrusion into his life and that, if we were too assertive, we would lose contact."

3.11 Also in support of this CPN (C) asserted:

"underlying our thoughts was that we wanted to maintain contact with him and that it was better to see him even if it was only to deliver medication fortnightly than for him to take off and for us not to be able to monitor him."

3.12 The discussion about frequency of visits took place in the main between Mr. Butler and the RMN, support worker. There is no documented indication that the RMN was directed by either the care co-ordinator or any other qualified members of the team to have a discussion on frequency.

3.13 This raises a further concern about the role of the care co-ordinator, and the team approach; in principle they ought to have been setting the standard and level of care delivery and ensuring the documentation of all such decisions.

3.14 If Mr. Butler was seen fortnightly and had relatively little input from the team and there was limited access inside his home whilst assessed as being at low risk, the question should have arisen (at some point during their 7 years working with him) as to whether he continued to be suitable for the model of care the team provided or if he should be transferred to a generic CMHT. If he had been transferred, presumably he would have continued to be followed up, remained under CPA, had a care co-ordinator and attended out-patient appointments. As there is no evidence to suggest that such a

discussion took place we infer there was a failure by the team to identify the appropriate level of services which would best meet his needs.

3.15 The team philosophy and model is called into question and is in direct contrast with what team members have outlined above, for example:

- CPN (B)'s assertion about engagement rather than the use of the medical model.
- CPN (C)'s view that delivering medication fortnightly as the only means to maintain contact would be sufficient.
- Community Psychiatric Nurse (A)'s outline of the value of having more time to spend with patients to work towards moving on with their life.

3.16 In circumstances where patients are hard to engage despite every effort, there has to come a time when the team needs to decide a firm course for action, laying out options available for care and bringing together firm proposals for future provision. Such discussion will include a range of issues such as the appropriateness of the approaches used by the team, whether the model of care suitable to the needs of the individual and what other care facilities might be more suitable etc, yet it is concerning that the Team Manager (A) told the panel:

"engagement was a main theme with Mr. Butler, engagement was a constant discussion within the team as engagement itself is so much a part and parcel (of the model)….. it was regularly discussed in our Monday short-term issues meetings, it was regularly discussed in our handovers in the morning…"

3.17 Even if there had been this level of discussion there is no evidence of the team taking action or adopting different techniques or practices to ensure better engagement with Mr. Butler. Certainly no such discussions have been documented either in Mr. Butler's notes or his care plan or in the team meeting notes.

3.18 It seems the team itself encountered difficulties with the care pathway

of patients under their care. Community Psychiatric Nurse (A) asserted:

we have many problems with throughput in assertive outreach about whether people ever leave assertive outreach and how appropriate that is, or whether it is the very fact that they are under assertive outreach that maintains their mental wellbeing. The pathway out of assertive outreach was always quite grey plus there was an issue with other teams' capacity to take on clients from the Assertive Outreach Team. So it was not unusual for someone to be on it (the AOT) for that length of time, and that would be mainly due to the fact that we would have struggled to refer on to somewhere else."

3.19 However, CPN (B) felt differently about Mr. Butler being referred out of the Assertive Outreach Team. He stated:

I don't think there was any talk about it (his transfer out) at that particular moment, because we were only really starting to get to know him in effect. It had been five years and we thought we were making some progress with him'.

3.20 Matching the care and service provided to patients is essential to the patient's recovery and to achieve the best use of resources. Teams need to be constantly and consistently reviewing their caseloads so that:

3.20.1 clients do not stagnate within the service.

3.20.2 there is a throughput and pathway between services.

3.20.3 the services offered is tailored to meet the needs of the individual.

4. Team Working

4.1 Mr. Butler was last discharged from hospital in October 2001 following an admission in April 2001 under Section 3 MHA 1983. It appears from review of notes that there was involvement by the Assertive Outreach Team in his care during this admission and specifically in the planning of his discharge. Planning for the discharge of hospital inpatients and devising care plans to support the service user when they are back in a community setting, is an important part of the CPA. This transition from hospital to community care is a period during which there is most potential for service users to slip out of contact with services.

4.2 CPN (C) and Consultant Psychiatrist (F) (SpR at that time) attended the ward round on 6 June 2001 in which Mr. Butler was discussed and CPN (B) visited Mr. Butler on the ward in July.

4.3 In preparation for his discharge, the RMN worked with both Mr. Butler and the Housing Department to secure accommodation, and accompanied him to view a property when it became available. Community Psychiatric Nurse (C) met with both of them during this viewing. The RMN also supported Mr. Butler when signing the tenancy agreement.

4.4 Community Psychiatric Nurse (A) prepared a relapse and risk management plan which also listed signs and symptoms suggestive of possible risk or relapse. Community Psychiatrist (B), his RMO at that time and the consultant psychiatrist for the Assertive Outreach Team, prepared a good outline of his risk history, his paranoid beliefs and his non willingness to comply with treatment.

4.5 Taken together this amounts to good team work to ensure the team kept in touch with his care and treatment whilst an in-patient and to formulate a comprehensive plan of care to ensure continuity following discharge.

4.6 The team met formally each Monday and Thursday to review all patients under their care. A white board categorised patients as high (acutely unwell), medium (have concerns about) or low risk (stable) and discussions about each individual's current progress took place.

4.7 Consultant Psychiatrist (F) highlighted that the team:

> *"…struggled to discuss all the patients every time because we have around 60 patients. We start around 9.30 and we need to finish by 12.00 because we have various other commitments. We would start from No.1 and keep going until we reached No. 60 but as we went on the latter part would be neglected. Then we thought we would start from the bottom and move up, but that did not work very well either, so now I can see how much the team was struggling on the issue."*

4.8 As might be expected patients at high risk were given more attention, which limited the time allocated for discussion of patients at low risk –

the category into which Mr. Butler fell. The weakness in this model meant that there was never an opportunity for the team to have in-depth discussions and to share information about their involvement or encounters with Mr. Butler. Consultant Psychiatrist (F) asserted:

'…this was not a good idea because people in the stable column are not being discussed properly, only just their name, 'there are no concerns' and that is it. We do not give them time. That is the practice we had and that is the practice we still have I think."

4.9 Had they devoted more time to discussing Mr. Butler's care, they most likely would have reflected on the fact that very rarely did anyone gain access to his home, (particularly since the departure of the RMN from the team, who had most contact in his home). Furthermore, it would have presented an opportunity to discuss his compliance with medication, the practice and frequency of putting medication through his letterbox and the overall social context of his life. The combination of these factors may have together presented a very different picture to the team and may have caused them to raise his level of risk from low to medium or indeed to high risk.

4.10 Although it is appropriate to give attention and focus to high risk patients nevertheless the team has a duty of care to all patients and the use of regular case presentation to focus on key issues related to those not at high risk would have been beneficial. Service Manager (A) said in interview:

"you would have thought that where there were issues of engagement, or lack of engagement, perhaps it should have been flagged up much, much higher."

4.11 It appears Mr. Butler care was allowed to drift from week to week, month to month without a comprehensive discussion and sharing of information between team members and indeed other agencies. Such discussions could have given the team a greater understanding of the difficulties they were faced with in managing Mr. Butler's care.

4.12 On review of contacts recorded in clinical notes, the panel estimated that between April 2003 to April 2004 the team had approximately 8 hours of contact with Mr. Butler: a large number of contacts took place

on his doorstep or there was no reply at all. This short time spent in face to face contact, should have acted as a trigger for the team to re-evaluate his level of risk as he proved difficult to engage and appeared to be withdrawing from the service.

4.13 CPN (C) told the panel that Mr. Butler was in the lowest 10% of concern for patients within the team although they did have concerns that he had no insight into his illness. Taking into account that Mr. Butler was placed on Supervised Discharge following his admission in 1999 and was subject to Enhanced CPA/Section 117, together with his history of risk as indicated by the fire in his flat, abuse of his neighbours, his non-compliance with medication whilst in hospital and the limited contact he maintained with the team (which was further reduced following the departure of the RMN) the panel was concerned that all the facts relating to his previous history were not taken into account in making a full assessment of his risk and his need for care. Had this occurred the panel felt the level of concern which the team attributed to Mr. Butler might have been higher and more assertive action would have been taken to improve the quality and effectiveness of the contact with him. Gaining access to his flat should have been given a higher priority. Even if he was correctly placed in the lowest 10% of the case load he should have received more attention.

4.14 The management of Mr. Butler's medication has been dealt with separately, but, it is important when reviewing how the team worked together to highlight the apparent lack of review of Mr. Butler's compliance with medication, particularly given his history which was known to the team. It was a serious error on the part of the team and the team management that questions about Mr. Butler's compliance did not feature prominently in any of their discussions. This does not appear to have taken place although general the issue was brought to the Assertive Outreach Forum for discussion.

4.15 Similarly the decision to deliver medication through the letterbox

almost as a matter of routine should have alerted team managers to question the rationale of this practice especially as it became a regular routine. Such practice should have been discussed in team meetings and in one to one supervision sessions.

4.16 Every service user, regardless of their level of concern, must have a full and thorough case presentation in order to understand all elements of their presentation and care both current and in the past. This is especially important in an assertive outreach model where there is a team approach to care, and where it is necessary to draw together all information about progress and identify concerns from all members of the team.

5. Patient Clinical Records

5.1 At Harry Watton House the Assertive Outreach Team is based on the first floor and the medical records department is based downstairs. One would therefore expect that all records to have been kept in the medical records department but that was not the case. Service Manager (A) describes the notes as:

"a bit shambolic… if you went downstairs to the medical records department to get notes, some were not down there".

5.2 Many sets of notes were not returned after use, some were left in filing cabinets, others in desk drawers. Following contacts with patients, notes were not always returned to medical records and tracer cards were not used effectively. Some notes were signed out by doctors who had since left the service and therefore access proved difficult resulting in regular searches of desks and filing cabinets to locate them. There was also an issue with the numbers of volumes of notes which in some cases was unclear as to how many volumes existed.

5.3 CPN (C) outlined some of the problems with notes as she viewed them:

'Notes are extremely muddled. When I first joined the team there were two sets of notes, there were social services notes and nursing and medical notes. As a team we trialled the joint note system, but when somebody was an inpatient we continued to see them, so sometimes we were writing in the notes, but sometimes we were

keeping our own action records as a base to what we had been doing with them….. getting files put together on discharge was a nightmare… there were even blood results that were years out of date."

"A separate folder had all the patient's notes for the day and they were filed into the individual person's notes but the quality of the admin staff, temps and everything else meant that sometimes you would find things in the wrong places. Things such as letters and so on would not be there because they would be in a different file. When people started a new file the relevant information was not always brought forward."

"When I joined the team I wanted to get hold of all the notes for the clients I was care co-ordinating. At that point they were in various different places throughout the Trust, this was not just in Mr. Butler's case. I set up a system where we audited at the weekends to see that we had the notes there, that the previous notes were all there and if not which ones were missing. On Monday morning we would give the admin worker a list of what she needed to chase up. Unfortunately they did not get chased up. I still do not know what happened to the audit we did. It was kept in a file in Harry Watton House and seems to have disappeared… it left gaps in the information because it was not available."

5.4 The panel too experienced great difficulty in accessing information about Mr. Butler and his care due to the state of his clinical notes, the order and presentation of which was lamentable. The notes required hours of examination to piece together a history and chronology of events and from a professional stance they did not serve their purpose.

5.5 Indeed such was the case when Police Sergeant H telephoned on the day of the incident seeking information about Mr. Butler's psychiatric history; she spoke to a member of staff who had no previous knowledge of Mr. Butler and was reliant solely on information gleaned from the records.

5.6 Consultant Psychiatrist (F) also experienced difficulties in ascertaining patient information prior to patient reviews, he told the panel:

"We can't get a snapshot. There is not even a kind of summary statement about the patient… because all our patients have more than a 10 year history, and at least have five or six folders, so it is not easy to go through all these files. There is no summary statement anywhere."

5.7 Following the incident under investigation, Ken Jackson set out to provide an initial document to give a brief description of Mr. Butler and his history. He described sitting through a weekend trying to pull information out of *'very untidy notes'* which were *'all over the place'*.

5.8 The panel heard that all members of the team received regular supervision and there was a cascading supervision structure in operation. However, it is unclear whether supervisors discussed record keeping or reviewed care co-ordinators standards of documentation. If this had taken place it might have initiated discussion about documentation of visits and contacts as well as Mr. Butler's overall plan of care.

5.9 The overall management and the responsibility for the maintenance of records were a concern for the panel who queried whether audits of records were taking place or if audits of case notes had been built into the annual audit plan. Indeed if audits are in place, it is important for the service to review how lessons arising are put in place to address shortfalls. Ken Jackson told the panel:

"the Trust had guidance around the quality of notes and note-keeping and how they should be done."

5.10 Administrative support to the team was minimal with a half time secretary allocated to work for the team and also to cover the consultant's out-patient clinics. This fell well below expected standards and hindered managing clinical notes, taking of accurate minutes of patient reviews and team meetings as well as the support of team members in performing their roles. Having adequate and dedicated administration to support the team, could have produced better outcomes for the upkeep and retrieval of notes and therefore the flow of information required by the team.

6. Care Programme Approach (CPA)

6.1 CPA[28] was introduced in 1990 as the framework for care for people with mental health needs. The key elements are the systematic assessment of individuals' health and social care needs, the formulation of a care plan to address those needs, the appointment of

[28] *Department of Health (1990) Caring for people. The Care Programme Approach for people with a mental illness referred to specialist mental health services. Joint Health/Social Services circular. C(90)23/LASSL(90)11*

a care co-ordinator to monitor the delivery of care and the regular review and, when necessary, amendment of the care plan in line with the service user's changing needs. The importance of close working between health and social services is stressed. The Mental Health Act *Code of Practice* (Dept of Health & Welsh Office, 1993)[29] makes it clear that the CPA applies to all those receiving specialist mental health care, including detained and informal hospital inpatients.

6.2 A two tier system of CPA has been established nationally. People on *Enhanced* CPA are likely to have multiple care needs which require inter-agency co-ordination, to require more frequent and intensive interventions, to be at risk of harming themselves or others, and to be more likely to disengage with services. Mr. Butler was subject to an Enhanced level of care under the CPA.

6.3 The assessment of risk and the development of strategies to manage it are essential elements of the CPA process. These processes should be fully integrated with the CPA and included as part of the care plan. CPA documentation should include a comprehensive assessment of needs, including an assessment of risk, and a clear plan of actions and interventions to be provided, along with other necessary factual information; these should be contained within a concise format. Care plans also need to be accessible to the service user, their carer and all agencies involved.

6.4 A considerable amount has been written in government and local guidance, and in other homicide inquiries and analyses of inquiries in relation to management of risk. One such analysis of all homicide inquiries from 1988 – 1997 concludes that in many cases the actual violence itself was not predictable but that the relapse could have been and with a reasonable standard of care, the patient may not have been

[29] *Department of Health & Welsh Office (1993) Mental Health Act 1999. Code of Practice. London: The Stationery Office.*

in the community.[30] A clear risk management plan to offer adequate care or to at least notice any relapse is therefore crucial. Another article addresses the issue, amongst others, of the repetitiveness of advice from inquiries about the need for good risk management and assessment by drawing out practical lessons for services. Two recommendations are:

6.4.1 Mental health teams need to develop a common way of formulating, describing and communicating violence risk.

6.4.2 All mental health teams should have access to a structured clinical assessment of violence risk and should incorporate its findings into the care management of patients with a history of violence.[31]

6.5 Whilst the quality of a risk assessment is essential, it also needs to be translated into a care plan that is both supportive to the patient but also manages the risk. Other recommendations include the need to act promptly when deterioration is observed.

6.6 It is useful to note the guidance mental health services had about risk management in the relevant years. An essential national document, *Modernising the Care Programme Approach*[32] confirms:

'Risk assessment is an essential and on-going part of the CPA process, and care plans for all those requiring enhanced CPA should include a " what to do in a crisis" and a contingency plan.'

6.7 Birmingham is cited as an example of providing levels of care based on risk assessment, so it's importance was locally established and the 'robustness of the care package to offer support and safe management in the community are determining factors.'

6.8 The document is also notable for its rounded view on risk.

[30] *Munro, E and Rumgay, J(2000) The Role of Risk Assessment in reducing homicides by people with mental illness-LSE.*
[31] *Review of Homicides by patients with Severe Mental Illness Imperial College London March 2006*
[32] *Effective Care Co-ordination in Mental Health Services – Modernising the Care Programme Approach 1999*

'Risk assessment is not, however, a simple mechanical process of completing a pro-forma and risk cannot simple be considered an assessment of the danger an individual service user poses to himself or others. Consideration also needs to be given to the user's social, family and welfare circumstances as well as the need for positive risk taking'.

6.9 Positive risk taking is not about taking dangerous risks. At its simplest, it can be described as working with the patient through good care planning to build up the stability, meaning and social contact in their life which together with medication compliance makes deterioration and its potential links to violence a lower hazard. These are often called "protective factors." A patient who remains isolated or socially excluded may be more vulnerable to relapse. This model of risk management fits well with the Assertive Outreach Team, with members stating that they worked in a model of social engagement.

6.10 The Assertive Outreach Operational Policy in 2003 indicates that a history of risk is one of the criteria for entry to the service and that the care co-ordinator should make:

a comprehensive multi-agency/disciplinary account of risk including the impact any substance misuse has on risk.

6.11 One of the policy standards asserted:

All risk assessments should be reviewed at any change of circumstances and at least every 6 months.

6.12 However, although the policy included risk assessment it offered no over-arching guidance on the management of risk once assessed and how to review risk in the overall context of the service user's life. It may be the team did not have enough guidance or training on the importance of this.

6.13 Given this policy expectation, we can trace how risk was managed in relation to Mr. Butler.

6.14 At the start of Mr. Butler's admission in April 2001, there was a clear risk history written on the pro forma on the 6 April 2001 including the incident in 1999 when he threw a brick at a neighbour's window and was found in possession of a knife. It also described the fire in his flat

and the circumstances of that admission. Another note later on the same document mentioned head butting a nurse in the early part of the admission. In the current warning signs section, the general box for violent ideation, extreme anger, hostility, violent threats, violent acts was ticked. In the history section, destruction of property, non compliance and unplanned disengagement were all ticked. In a report for the Mental Health Review Tribunal on 5 July 2001, Consultant Psychiatrist (B) noted a *"significant"* risk history. So, at the very least, the ward had a reasonably thorough risk history on the 'Summary of Warning Signs and Risk History' but this was not reviewed in documents until April 2004. In her evidence, the care co-ordinator, CPN (C), stated that she did not know that Mr. Butler had previously carried a knife.

6.15 At the discharge planning CPA review on 29 August 2001, there is no evidence of a detailed review of risk although relapse indicators are covered and there is a care plan.

Relapse signs were noted as:

- Disengagement with the team
- Cessation of prescribed medication
- Verbal aggression

6.16 Action to be taken in the event of a relapse:

- Increase frequency of visits.
- Review by RMO.
- Consider home treatment input.

6.17 Given what is known of Mr. Butler, this does seem limited in relation to three further well known relapse factors:

- Self neglect.
- Isolation.
- Difficulties with neighbours.

6.18 There was no detail of the level and type of aggression.

6.19 It is impossible to know whether a fuller account of relapse factors would have led to a more detailed relapse plan. The actions to be taken seem very general and do not seem to relate to Mr. Butler's individual needs. There is no identified plan about how to identify such relapses: presumably the care plan for *"continued, regular input from Assertive Outreach"* was supposed to cover it all.

6.20 In the note of the section 117 planning meeting on 4th October 2001, there is no evidence of a risk review nor is there any analysis of risk in the discharge letter to the GP dated 29 October 2001. It should have been essential to have informed the GP of any relapse indicators and plans but these are not present in the letter. Discharge from a ward to the community is one of the most important points not simply to review risk assessment but to develop a risk management plan.

6.21 In the Care Programme review documents for April 2002 and July 2003 there is still no evidence of any review or analysis of risk and the Relapse and Risk Management Plan was not up-dated. The Relapse and Risk management plan at the December 2003 review is virtually a copy of the pre-discharge review in August 2001 with the added action of *"consider mental health act assessment"* in the event of relapse. Whilst, it is recognised that some relapse signs may not change greatly, the August 2001 review did not demonstrate an in-depth risk assessment or a full account of relapse; thus an inadequate bench mark was established. Interestingly, in the December 2003 documentation for the first time the box was ticked indicating that the carer was to be contacted if the patient failed to attend. Given that there had been no contact with Mr. Butler's family, nor was there any planned, this was probably impractical.

6.22 The assessment of Mr. Butler's risk was not comprehensively documented in his notes and it appeared that the risk assessment information up to the time of the homicide in May 2004, was formulated in August 2001 which was not in keeping with policy guidance. It is concerning that the assessment of risk was not reviewed fully

particularly in light of the relapse indicators described above that had been identified in 2001.

6.23 The team's management of risk in relation to Mr. Butler certainly falls into the category of mechanistic risk filling in a pro-forma as described in the Modernising the Care Programme Approach quote above. There is little attempt to consider risk within the context of his life. Risk management was narrow as it relied totally on team observation. There is no recorded attempt to consider liaison with relevant agencies or his family, however limited the contact, after the 2001 discharge. Nor is there an attempt, for instance, to engage with Mr. Butler about the issue of risk. His views would undoubtedly have been different to the team's, probably more about the risks of medication, the actions of the police and indeed of the mental health team itself. It may however have opened up a different communication, but there was no attempt to engage with him in more varied ways on any level. Limited communication became the norm. The consequence was that one of their main relapse signs and chief concerns happened without their noticing it – disengagement.

6.24 As the care co-ordinator for Mr. Butler, CPN (C) described her role as:

> *"representing Mr. Butler's interests, to co-ordinate the care and to make sure that the care plan that we planned with him has been carried out and that he is being offered all the opportunities that anybody else has in the team – employment, housing support or whatever."*

6.25 Standard 4 of the *National Service Framework*[33] set out the requirement for service users to have a written copy of their CPA care plan. The care plan should include the action to be taken in a crisis by service users themselves, their carers and their care co-ordinators.

6.26 It is not clear whether Mr. Butler had a copy of his care plan and whether the care plan fulfilled his needs as he saw them. Neither is it clear from records the extent to which Mr. Butler was involved in developing his care plan. The panel was of the impression from

[33] *National Service Framework for Mental Health (1999) DoH*

examination of documentation that this was unlikely. Service users whose relationship with mental health services has broken down can become more engaged if they feel listened to and have a genuine say in decisions about their care. It is essential for service users to feel part of the decision making about their care and for care to be patient centred.

6.27 The current model of assertive outreach with small case loads enables care co-ordinators to give time and commitment, which is appreciated by the service user[34]. Mr. Butler's desire to study and return to work were never highlighted in his care plans, which indicates the plan was based on the view of the professionals involved and did not take into account his own needs for self improvement. Staff defined problems receive more attention than those defined by the service user themselves, is a theme which Perkins & Fisher (1996)[35] identified in their audit of CPA.

6.28 The team, in providing care to Mr. Butler did not demonstrate the level or standard of care review as set out in CPA guidance or the Trust's policy. Reviews usually involved both the care co-ordinator and Consultant Psychiatrist (F) but did not involve others who were concerned with his care. In setting up review meetings the team did not consider inviting other professionals or agencies and so liaison and communication opportunities were lost. Prior to the incident a care review took place at Mr. Butler's home on 27 April 2004 with only Consultant Psychiatrist (F) and Community Psychiatric Nurse (C) present, this is clearly inadequate and goes against the principles of CPA.

6.29 Equally important is the lack of information passed to other professionals and agencies involved in his care and welfare following a

[34] *Sainsbury Centre for Mental Health (1998) 'Keys to engagement: Review of care for people with severe mental illness who are hard to engage'. London: Sainsbury Centre for Mental Health.*

[35] *Perkins, R. & Fisher, N. (1996) Beyond Mere Existence: The auditing of care plans. Journal of Mental Health, 5, (3) 275 – 286.*

review, for example there is little evidence in the team files of information communicated to Mr. Butler's GP. CPA policy directs that in the event that those involved in care are unable to attend a CPA review, it is good practice that a full report is sent to them outlining activity over the previous six months together with a copy of the reviewed care plan agreed for the coming months. This ensures that all involved in care are up-to-date and familiar with the direction of care.

6.30 Of concern was the team's lack of contact with the Housing Department. Mr. Butler's accommodation was secured for him prior to his last discharge from hospital at the end of 2001 with the intervention of the RMN. The Review Manager for Vulnerable People told the Panel that on referral to the Housing Department a housing needs assessment would have taken place and a council property would have been selected on that basis. The Housing Department at that time would (in light of their discussion with the RMN and CPN (C)) have been aware that Mr. Butler used local mental health services and had a care co-ordinator.

6.31 In his previous accommodation in February 2001 the Housing Officer (A), reported to the mental health team that a neighbour had complained about him being noisy in his flat, playing loud music and being abusive to her partner. In March 2001 the key worker received a phone call from the Housing Officer saying that Mr. Butler had set fire to his flat at 2.30am and it was badly damaged. Taking these events into account, the housing officer played a key role in alerting the team to events taking place and these instigated action by the mental health team to carry out a mental health assessment at that time. It is regrettable that the mental health team and the Housing Department failed to maintain this level of contact.

6.32 From the initial contact by the RMN at the end of 2001 to secure accommodation for Mr. Butler, his Housing Department file would have been expected to hold information about contact with mental health

services, names of those involved in his care together with contact details. However, when the file was reviewed following the incident only limited documentary records were available and contained no reference to Mr. Butler's contact with mental health services. The housing officers who covered the area at the time had no recollection or knowledge of Mr. Butler's illness.

6.33 Communication must be two way and as a minimum the Assertive Outreach Team should have communicated with the housing team at least in completing the annual review of Mr. Butler's housing benefit. Had contact been maintained, it would have ensured that despite changes of personnel over time dealing with his housing issues, a record of contact with mental health services would have been documented in his housing records. Crucially it would have ensured that contact was made when Mr. Butler failed to pay his rent, which would have averted the eviction notice and presumably acted as an indicator for a comprehensive assessment of his mental health. Unfortunately, such opportunities were lost in the lack of joint working.

7. Team Learning from the Incident

7.1 As with any serious untoward incident the analysis of practice in the wake of an incident is essential to identify lessons and to ensure changes to practice are swiftly implemented to avoid or minimise further incidents. It is regrettable that this did not occur in this case. Due to the nature of the incident, i.e. homicide of a policeman, the initial investigation was taken out of the hands of the local team managers and placed with the Service Director who collected information related to the incident to report directly to the Chief Executive.

7.2 Team members were not encouraged to discuss the incident in any detail or to understand care and practices for fear of contaminating evidence which would later be sought through judicial proceedings, and both internal and independent inquiries. Although the team was offered emotional support, there was a missed opportunity to review

care to examine and understand where care processes might have led to the incident. The Trust was unaware that Mr. Butler was not taking his medication until this information was revealed in court, a year following the incident. Had this information been known sooner, presumably the Trust would have instigated an immediate review of the assertive outreach model and practice.

7.3 Ken Jackson outlined that there was:

"a lot of high anxiety and upset about what had gone on, there was lots of worry in the team."

7.4 It is unfortunate that team members had the impression that 'heads will roll' adding further to their anxiety and suggesting a culture of blame.

7.5 On the Monday following the homicide, Ken Jackson was asked to complete a report of the events and told the panel:

"I was advised that I needed to start pulling together information around what had happened."

7.6 He also told the panel that statements were taken from CPN (C) and the Team Manager (A) but could not recall anyone else having made a statement. He was unable to produce these statements and the panel never had sight of them. Ken Jackson further added that he produced an initial document that gave a very brief description.

'This (report) underwent a number of rewrites, because I initially did a report which I sent to my boss and what came back was 'This isn't good enough. It needs to be redone'. So I went away and wrote another draft and submitted it to her and I was told it did not have enough details, you need to do it again and I think that was what I came up with'.

7.7 However, it was unclear to the panel and to Mr. Jackson which version of the report submitted was the final report due to the number of draft reports. This clearly would have caused confusion for the team and would have staggered learning and the team's critical review of its practices and procedures.

7.8 Also concerning was that the Internal Inquiry Report did not seem to be shared with either the team, team managers, the Trust Risk Manager or Service Director. The Risk Manager eventually asked for

the report to be given to him; this arrived without an action plan. Ken Jackson told the panel:

"….I was interviewed and was expecting a report to be completed and then shared. The report as I understand it never appeared. I never saw it anyway. I know there was a report being completed and in fact I had discussions with one or two people who said that the recommendations were being written up and it would be shared in due course. I am afraid for me they never materialised and I was increasingly concerned that as the Service Director of the area that this incident had occurred in, I had not seen the report. I was not even aware that there was an action plan that had been written."

We have been told that subsequently Mr Jackson and others were involved with effecting changes but these seem to have been after the sessions referred to below

7.9 It must be noted also that Dr. Peter Lewis had received the report only after insisting he received a copy, which he shared with Ken Jackson.

7.10 We have been told that there were 3 sessions in 2005 and 2007 at which copies of the internal report were handed out to staff and then taken back at the end of the session. The last two of these sessions took place well after our own inquiry had started. We understand that there were concerns about disseminating the Internal Inquiry Report because of the perceived risks of leaks. We consider that the priority ought to be to ensure that all staff are in a position to know what changes in practice need to be made. If this involves the public knowing what is being done then should result in reassurance. We do not consider that external inquiries such as ours would be prejudiced by any resulting publicity.

7.11 Opportunities were obviously lost to ensure lessons learned were shared with the team and across the Trust in a timely fashion and to ensure issues addressed in the action plan were put in place as a matter of priority.

7.12 Following the incident the Staff Counselling/Support Service met with the team to offer support and to debrief the team. Sadly however, the team did not find the approach of the counsellor helpful and there is no

evidence that they received a proper debrief at this crucial time.

7.13 Undoubtedly the days and weeks following the homicide were difficult for the team and for Trust senior management. There was a recognition that the team was shocked and traumatised and a sense of blame for what had happened may have prevailed. The Director of Operations asked Service Manager (B), an experienced nurse to provide peer group support and supervision to the team in an effort to:

"...check that we were providing a safe service to service users."

7.14 However, the team felt this had been imposed upon them and viewed it with suspicion. Service Manager (B) felt a great sense of hostility from the team as she described:

"I don't think they were looking for someone to suggest things to them, they wanted someone to just say 'it's ok', go along with it, so they became quite hostile, quite resentful toward me, but I think it (the hostility) was generally to the organisation at the time."

7.15 Despite the Director of Operations visiting the team on several occasions to explain Service Manager (B)'s role and emphasising that this was not to blame anyone, nevertheless the team felt there was a blame culture and they felt isolated. The panel was sympathetic to the position of the team and recognised the sense of trauma which some members continued to experience when the panel met with them.

8. Conclusion

8.1 The panel felt there were a number of failures in the leadership and working practices of the team. Firstly the team was allowed to operate with a part time team manager whose role caused some confusion and lacked the consistency and continuity essential to a successful service. In addition the acting clinical leadership role for 3 years was not a tenable position and should not have continued over such a lengthy period of time. Also, the burden of a heavy workload placed on the Consultant Psychiatrist for the team depleted the clinical leadership and expertise essential to its function. Furthermore the absence of any psychological input and minimal occupational therapy resulted in a

limited range of services being provided by the team and ultimately, an over-reliance upon the medical model.

8.2 It is regrettable that the team appeared to drift and not question their practice; it was perhaps inevitable that poor decision-making and judgements began to penetrate and eventually became everyday practice. Significant areas such as risk assessment, risk management and record keeping were not given the level of intensity expected in an assertive outreach team, whilst the model of assertive outreach itself over time, was not evaluated. Furthermore, it appears the Assertive Outreach Forum did little to impact on the function of the team. All of this was compounded by the fact that some of the staff in the team had remained in post since the outset. With no performance monitoring the team began to stagnate, lost their sense of purpose and direction and even their expertise in providing care to Mr. Butler. The team dynamics changed once the charismatic leaders, who were at the forefront of developing the assertive outreach model, left the team. It appears that they inadvertently took the energised, enthusiasm with them, leaving the team to drift without the skilled leadership and without any formal review of the model of care and indeed the practices employed by the team.

8.3 Trust senior management should have recognised that following the merger of North and South Birmingham clarity of practices needed to be affirmed in order to support the on-going and safe working practice of the team. It was also, however, the responsibility of the team leaders to raise such issues with senior management but they failed to do so for some considerable time: this allowed the team to drift.

8.4 Following the homicide, the team should have been able to discuss and debrief together without fear of repercussion from senior management. In addition senior management should have ensured that the Internal Inquiry produced a timely report and an action plan shared with directors, managers, team leaders and staff as soon as it was completed. It was a serious error that this did not happen,

compounded by the fact that the Service Director was kept out of the loop of involvement and progress, limiting the valuable learning which should have been swiftly put in place. As a minimum this would have ensured an urgent review of the assertive outreach model across the Trust, led by the Assertive Outreach Forum. Stringent measures should have put in place to ensure that the action plan was fully addressed, within a given time frame and assurance provided to the Trust Board that this was carried out.

9. Recommendation:

9.1 Acting managerial roles should be short term, preferably up to six months with permanent appointments taking place thereafter.

9.2 The skill mix of Assertive Outreach must include psychological and occupational therapy services to ensure there are a range of therapeutic approaches and interventions from all members of the multidisciplinary team. This will extend the range of services provided.

9.3 A critical review must be put in place to ensure all patients (particularly those at low risk) should be subject to a full team discussion. Every patient must benefit from this every six months.

9.4 All team members must have regular seminars to discuss issues of practice which can cause concern or to develop a team approach to care.

9.5 Team learning is important to ensure there is time for reflection on team practices, and to take views of new members into the team. This will underpin practices and ensure that team members are in agreement and aware of actions to take in certain circumstance to promote care. This is especially important for new members joining the team and for junior staff to develop their skills in working in Assertive Outreach.

9.6 Action plans developed following Serious Untoward Incidents involving patients of the team must be discussed with the team and a time frame

for implementation the actions set and audited.

9.7 It is essential that staff follow Trust Policies in order to ensure the safety of patients and members of the public and that nursing staff are held to account for their practices.

9.8 The care co-ordinator must clearly set boundaries, organise liaison and set structures of activity for the team and other agencies involved.

9.9 Meaningful audits of records must take place at least on an annual basis with lessons learned addressed within the service.

9.10 There needs to be a clear mechanism to ensure that information is shared between agencies such as the police, housing etc.

9.11 The Trust needs to ensure performance indicators are embedded within services to provide assurance related to activity and standards of practice to senior management and the Trust Board.

9.12 All team members must ensure they have opportunities to visit other Assertive Outreach Teams and Community Mental Health Team to learn from others and to review their practices and care processes.

9.13 The value of the Assertive Outreach Forum must be recognised as a means to develop common practices across all Trust AOT services. The forum should be more widely used and available to all members of the team. Regular feedback about the forum must be provided to the team.

CHAPTER 11

SOCIAL CARE

1. Background Points

1.1 The social model of intervention in mental health services should complement and ideally interweave with the medical model. It encompasses some of the following elements to support people to live their lives as they would choose:

1.1.1 Ensuring basic needs such as food, warmth and decent accommodation are met.

1.1.2 The provision of social care services including day care, home support, residential care, etc as required.

1.1.3 Social interventions based on the strengths of the service user: this involves working alongside the service user to meet their goals for the life they want to lead – giving their life meaning. This is less about direct provision of services as supporting people build up their own social, occupational and personal networks in the community. This should ensure the prominence of the service user in their care.

1.1.4 In 2004, this perhaps became more generally identified as social inclusion with more established links to the importance of the recovery model and the service user having control of their life.[36] All the concepts were well known since the late 1990's even if the language is different. Certainly the Journey to Recovery in 2001 stated that health and social needs must be met - that they are crucial to recovery including the "opportunities to engage in ordinary social activities – which can play their part as can stronger, supported, networks for service users."[37]

[36] *Mental Health and Social Exclusion Office of the Deputy Prime Minister June 2004*
[37] *The Journey to Recovery – the Government's vision for mental health care. November 2001. Department of Health.*

1.1.5 An awareness of carer needs and the legislation in the Carers (Recognition and Services) Act 1995.

1.1.6 All this should be underpinned by an understanding, valuing and working with individual needs and qualities including beliefs, culture, views and race along with awareness of the misunderstanding, stigma and disadvantage that mental health service users face. A vital element is to work in partnership with the service user.

2. Four components of the Assertive Outreach approach in the national Policy Implementation Guide relate broadly to social interventions – these were:

- The basics of daily living
- Family/carers and significant others support and intervention
- Social systems interventions
- Help in accessing local services and educational, training and employment opportunities.[38]

3. Birmingham's Assertive Outreach Operational Policy in 2003 stated under "Social/Practical Support" states:

> "The provision of a wide range of practical supports in assisting service users in dealing with issues that are usually paramount to them. This is likely to include assistance with benefits and financial issues, the need to assist service users in acquiring appropriate accommodation, as well as assisting their ability in coping with day-to-day living tasks to ensure a reasonable quality of life. This support includes the need to assist service users in developing social networks within the community and in accessing ordinary community resources. A knowledge and familiarity with the local community and resources are vital."[39]

3.1 It also picks up in separate sections on support to families and carers, vocational training/occupational/activity/employment and psycho-social interventions – so the policy element for social interventions was certainly in place.

3.2 A criticism could be that the policy is somewhat lacking in fundamental social care principles of partnership with the service user, the wider

[38] *The Mental Health Policy Implementation Guide – Department of Health.*
[39] *North Birmingham Mental Health NHS Trust and Birmingham Social Services Department – Final Draft – 10-01-03*

goals in social inclusion model (well known in 2003 but not necessarily called social inclusion) and recovery – respecting diversity, identifying needs and strengths.

4. The Team's Social Care Interventions – Based on Care Plan Evidence, Notes and Interviews

4.1 Before focussing on the team's provision of social interventions from 2001-2004, it is helpful to highlight the main points of two other periods of care by the Assertive Outreach Team responsible for Mr. Butler. These are October 1995 – December 1997 and August 1999 - April 2001. It should be remembered that all care was provided both within the Care Programme Approach and the legislative structure of section 117 of the Mental Health Act 1983. The main concerns from Mr. Butler's history at initial point of contact were his past self-neglect (including having no utilities), isolation and aggression to neighbours.

5. October 1995 – December 1997

5.1 Two staff members from the Assertive Outreach team provided support initially, a CPN and a support worker. Mr. Butler was at Servol Trust so there was considerable liaison between the two teams. Mr. Butler's mental health and functioning fluctuated greatly over this time. The Assertive Outreach team tried varied and many ways to support engagement with intermittent success including trips, visits to the Job Centre, contacts and work programmes to help structure time including daily living skills training. Dr. Ah wrote in March 1996 that Mr. Butler's key workers:

> *"have made persistent and vigorous attempts to involve him in a more structured rehabilitation programme which I believe he certainly needs, but regretfully we have had little joy in persuading him to go anywhere."*

5.2 The assertive team approach was continued and a care summary and plan on 11 April 1996 stated that the aim *"is to offer practical help and support, to maximise Earle's strengths, to improve his quality of life and to monitor his mental state."* This included trips to the pub, to play snooker, the theatre, and review of computer training which proved difficult for Mr. Butler to concentrate on.

5.3 The Assertive Outreach team continued to visit, quite often with Dr. Ak, and work as well as they could with Mr. Butler, although by November 1996, it was being reported by Servol hostel staff that there was little improvement. He remained subdued and uncommunicative; he continued to present as hostile and aggressive if prompted to attend to his personal hygiene. Throughout this period into 1997, the team attempted ways to support and engage Mr. Butler.

5.4 By May 1997, Mr. Butler was beginning to show more active hostility to interference by both Servol and the Assertive Outreach team. At a review on 1 May 1997 Mr. Butler had become irate and shouted at Servol staff for inviting his brother without informing him. He apparently was not amenable to reasoning, and the review was postponed. He said he was not happy taking medication as he has no need for it and *"he has never been ill, the police kicked his door down without reason to do so."* He was also going to press charges against the police force. Mr. Butler apologised later.

5.5 From that point on, Mr. Butler was out from Servol most of the time – he was at libraries or looking for courses and was not available for Assertive Outreach team visits. This change was seen in the context of him now managing his day to day activities such as personal hygiene and food preparation more independently. Mr. Butler began to question his care and instructed a solicitor to this effect; the solicitor wrote asking about his care plan and if there were any legal reasons why he remained at Servol. Mr. Butler also requested more independence at a review in August 1997 and he was put in touch with a social worker to work on this. Notes from the review describe him as *"much better now."*

5.6 The progress towards independence was probably too slow for Mr. Butler, and in November, he left to stay with friends, according to the records, and here the Assertive Outreach team contact ended for nearly two years. Given the high level of in-put for over two years and the original presentation in Stafford, it is perhaps surprising that there

were no attempts to locate Mr. Butler other than informing his brother and his GP. However, the team thought he was well and perhaps decided he had the right to make his own choices at that point. The concern is that there is no evidence of any debate or planning about this.

5.7 The team had put in considerable energy and effort over this time in relation to social engagement and interventions. It is evidence of what Consultant Psychiatrist (G) described as investment in long term relationships. However, there is no evidence of supervision or team discussion over the years. This is not to say none occurred. If they had, what would a supervisor or colleagues working in a social model framework of engagement have asked?

- What was Mr. Butler's contribution to the care plan? There was little evidence of what he hoped for until August 1997 or any sense of his *"voice."*
- Although he was reluctant to talk about his illness, what had the impact of his illness meant for him? It had curtailed his life in many respects but there is no record of this type of discussion.
- What were his goals and how could he be helped to achieve them? Independent living was not mentioned until he himself raised it after two years. The care plans seemed to be quite general.
- What other support/contact could be offered to his family and how to work with them within the parameters of his reluctance for them to be contacted? His family may have found his illness worrying, frightening or mysterious – there is no record of trying to address this.
- If interventions were not succeeding, what other approaches could be tried, there could have been more focus on what Mr. Butler himself wanted.

All these questions may have been asked but there is no record of this.

6. August 1999 - April 2001

6.1 After being located again, Mr. Butler was admitted under a section 3 of the Mental Health Act 1983 on 12 August 1999: home leave was tried early from mid September with the Assertive Outreach team visiting again. At this time there are more mentions of contacts with his brother. Some of the same members of the team continued to visit, especially the RMN and the new key worker Community Psychiatric Nurse (A). The focus was inevitably on settling back home and matters such as benefits although he mentioned his wish to study more and go back to work. He refused to believe that a neighbour may have complained about him. After a proposal was made to place him on a section 25 (aftercare under supervision), Mr. Butler stopped replying to calls and finally, following liaison with the Housing Department about more neighbours' complaints, he was brought back to hospital under section 135 of the Mental Health Act 1983.

6.2 Mr. Butler was finally discharged under Section 25 in February 2000.[40] The discharge was undertaken with thoughtful and considered planning. A care plan, based on a CPA meeting, stated that his needs were *"To live in his own home with as much independence as possible and with the support of appropriate services to maintain mental health and live a good quality of life. To be less isolated, maximise social activity/outlets."* In the care plan this was translated as – *"medication as prescribed, meet with AO on a weekly basis, encourage social activity, general monitoring of mental health and out patient clinic."*

6.3 Dr. H also wrote a clear, helpful letter outlining the agreements for section 25 and 117 and stated *"Support will be offered to you in dealing with benefits and anxieties associated with interpersonal relationships."* Community Psychiatric Nurse (A) in her evidence mentioned that Dr. H thought that there should be some attempt at more intellectual engagement to meet Mr. Butler's individual needs but

[40] *A detailed description of the care provided from this date to the date of the incident appears in the chapter on the care of Mr. Butler 2000-2004 and is only referred to here to make clear the context of the observations we make on social care.*

there is no record of this being followed up.

6.4 A pattern of visits by the same worker developed with Mr. Butler reporting attempts to get jobs or go on courses. He was admitted to one course, for instance, but then decided he could not be bothered. There is no evidence that he was offered any support with his ambitions. He questioned the weekly visits in May; it appears they were changed to fortnightly without being discussed at a review, even though weekly visits were part of the Section 25 care plan. However, two subsequent medical reviews indicated he was well. It was often noted in the records that he is not doing much with himself.

6.5 A pattern of being often out for team visits developed by December and the same worker noted in January 2001 that he looked as though he might be becoming unwell. Mr. Butler left a note to say he had gone abroad but, by February, neighbours complained about his behaviour again. He was finally admitted on 5 April 2001 after an incident with a fire at his flat in March.

6.6 Therefore, from his discharge in February 2000 to April 2001, Mr. Butler was visited regularly by an unqualified worker with whom he evidently got on well and who, because of his close relationship, noticed a deterioration.

6.7 A supervisor over this time may well have asked similar questions as above, particularly about Mr. Butler's involvement in the care plans but also:

6.7.1 Was it right simply to change weekly visits to fortnightly without any (documented) team discussion? This was a particular concern given Mr. Butler's need for aftercare under supervision.

6.7.2 In so far as it was being actively followed, what parts of the care plan had the aim of reducing isolation? The notes suggest mere observation rather than much by way of active or assertive intervention.

6.7.3 Was anything done to support Mr. Butler in his many attempts to seek employment and training places? It is clear to us that he trusted his support worker the RMN but it is open to question whether there were missed opportunities to offer support that he wanted.

6.7.4 Was the right balance achieved between privacy and self-determination, and the need to more assertively support someone in their life choices?

6.7.5 This is a difficult balance, no doubt, but there is no evidence of the considerations that should have influenced these decisions. It therefore appears that Mr. Butler's wish for privacy was acquiesced in without a care plan review. His wish for privacy was, in fact, evidence of his further self-isolation, and this was not picked up.

6.7.6 Mr. Butler's brother was mentioned with some regularity during this time in the records. Could a carer's assessment have been appropriate? In relation to the Carer's Act 1995 criteria, he may not have offered a "substantial amount of care" but he may have had the "intention" of offering more had this been possible or accepted by Mr. Butler. At any rate, his needs were not acknowledged and it is probable he would have found more information and support helpful. The point is that this was not explored.

6.7.7 This may have been an appropriate time to consider discussion of advocacy as Mr. Butler may have opened up more to someone outside the mental health services, possibly gaining more support and understanding of his illness. Of course, further attempts at interventions may have been unsuccessful but again, there is no evidence they were considered.

7. October 2001 - April 2004

7.1 Considerable work was put in by the RMN to arrange accommodation for Mr. Butler for his discharge in October as he could not return to the same accommodation, and he had trial section 17 leave at temporary hostel accommodation. A section 117/CPA discharge meeting on 4 October 2001 included in the care plan *"regular AO input at least weekly, regular outpatients appointments, and the AOT to help him with social and other day to day needs."* Mr. Butler made it clear he was not keen on this immediately as he was going to decorate his newly allocated flat. This does not appear to have been seen as a warning signal that other methods of intervention might have to be considered. Medication was dropped though his door one month later and again two weeks after this. This is covered more fully in another chapter of the Inquiry report but in the social care context, it indicates the beginning of a focus mainly if not exclusively on medication.

7.2 A different pattern of AO involvement developed over this two and a half year period. A wider range of people visited, including the new key worker Community Psychiatric Nurse (C) initially covering for maternity leave. Occasionally Mr. Butler let people in, but often they stayed at the door. Occasionally medication was put through the door and quite often there was no reply. Mr. Butler's world, and his life, were not really discussed or at least not referred to in the notes. Once in a while, he was asked on a trip and usually refused, but sometimes he spoke of going on a course or trying for a job. There is certainly no record of any attempts to ask about his aims, hopes, or of any way of helping with these. Mention of his family faded away, and there were no records of trying to contact them. We only learn later that his mother died in Jamaica during 2002 – there was no mention of this at the time, Mr. Butler may have decided he did not want to share – or perhaps he was never asked about his family. We learn from Consultant Psychiatrist (A)'s evidence that Mr. Butler's not attending his mother's funeral may have affected his relationship with his other brother, but again, this was not been picked up.

7.3 There were medical reviews during this period, and CPA review

records are evident from 26 June 2002. There is no record of anyone else being invited or asked to contribute other than the key worker and the team doctor. On this occasion it was stated that Mr Butler was to continue engaging with the Assertive Outreach team who could look at educational opportunities for him. There is no evidence in subsequent records that this happened. In April 2003, the plan in relation to social interventions changed to *"encouraging Earle to participate in social activities".* A client holiday to Weymouth appears to have been the only social activity offered. In July 2003, the plan now referred to *"Mr. Butler continuing to occupy himself with his studies"* – but there is no mention of what these were or any questions about these, and by the December 2003 review this had changed to *"social/occupational"* activities. There is no evidence that Mr. Butler either signed or participated in these plans to any meaningful level. The major elements of the care plan focussed on medication, although there is very little account of even this being discussed in detail at any point. Certainly the voice of Mr. Butler is not apparent in the records.

7.4 The contrast between the Assertive Outreach interventions for this last two and a half years in the community and the other two periods above is marked. Even though there had been a tendency to back off Mr. Butler from 1999-2001, perhaps missing opportunities to engage, there was more of a sense of knowing him – and evidence of more meaningful discussion - than in these notes and certainly more mention of family contact, other aspects of his life and also contact with other agencies such as Housing. In fact, at a generous calculation of visits in the year April 2003 – April 2004, Mr. Butler probably had face to face contact with the team for little more than eight hours. If this was not really noticed, it is maybe partly because the amount of face to face contact was not much more for the year before. On this basis it is not possible to offer either meaningful relationship building or to really know how a person is living their life.

7.5 A supervisor would have asked all the questions above but also:

7.5.1 What was Mr. Butler's social framework? What was the contact with his family, friends and neighbours about? What was he actually doing? These issues could have been addressed without being intrusive but there is no evidence that these issues were even approached.

7.5.2 Were the Housing Department involved as before? Staff from there had been very involved both before and after the last admission, making direct contact with the team. Evidence from Community Psychiatric Nurse (C) suggested they thought the Housing Department would let them know of any concerns but nothing was arranged, and there does not appear to have been any plan for routine contact.

7.5.3 Why was the quality (and quantity) of contact diminishing each year? Was it because a particular key worker had left? Was this about race, gender or a particular style of engagement? What could be learned form past engagement? There is no evidence of these crucial questions being considered.

7.5.4 Where was Mr. Butler's voice? Even more than in the past, his voice was not present: it was not sought or heard.

8. It was asserted by at least two members of the team, in evidence to the panel, that social engagement was the main ethos of the team and their social activities, but there is no evidence that over the last two and a half years the team did anything other than focus on medication, dropping it off, superficially monitoring limited symptoms, and occasionally offering their routine social activities which Mr. Butler clearly never wanted or was understandably unlikely to be interested in.

9. It is clear that Mr. Butler was difficult to engage, and this led the team to allow their fear of him disappearing again to outweigh his need for persistent engagement. Yet continued attempts at social engagement

that were meaningful to Mr. Butler may have led to some thread of a reciprocal relationship. The team had legal obligations to Mr. Butler under Section 117, and not only was this rarely referred to in care plans, the weight of it was not recognised in the level of care provided.

10. Reciprocity has been referred to in this way: *"If society is to impose a duty to comply with treatment and care on those who suffer from mental disorder it must impose a parallel duty on health and social care authorities to provide an appropriate standard of treatment and care."*[41] This quotation refers to compulsion in hospital but the principle is the same: when an unwilling person is encouraged, particularly under section 117, to take medication and accept visits and involvement, then this resistance has to be responded to with an appropriate level of care.

11. Research about the advantages of Assertive Outreach over other interventions for some patients states in its conclusions that:

- A comprehensive care model with social and practical support, an avoidance of an exclusive focus on medication, and committed staff with sufficient time, help to engage 'difficult to engage' patients.
- Relationship issues are central to disengagement and engagement, with patients preferring a partnership model and an involvement in clinical decision-making.
- African–Caribbean patients do not have qualitatively distinct processes of disengagement and engagement.[42]

11.1 Although this research was published in 2005 the first two points have been part of the Assertive Outreach approach for some years. What this team actually provided, illustrated from the level of care offered from 2001, fell short both in terms of essential Assertive Outreach and social care principles, and their own Operational Policy.

11.2 *"They're so lonely. – with all their expertise, they are still being put in a flat and left – door shut. What do you think they do on the other side of that door? They are lonely. They need occupying. Just imagine someone sat in this room on their own, 24 hours, with nothing – nothing at all – to do."*

These words of relatives of the victim to this Inquiry sum up the same

[41] *Report of the Expert Committee – Review of the Mental Health Act –November 1999 3.2*
[42] *Priebe S, Watts J, Chase M, Matanov A – Processes of engagement and disengagement in AO Patients: Qualitative Study BJP 187 2005 438-443*

points more succinctly and more movingly. Regrettably the Assertive Outreach team failed in this case to bring to bear the appropriate energy, commitment, or initiative to care effectively for Mr. Butler's social needs. This was obviously not the team's intention, but the consequence was that a man in desperate need of effective support was left isolated and alone.

12. None of the 27 recommendations in the Internal Inquiry, helpful though some of them are, specifically touched upon the social framework for interventions.

12.1 Recommendation 1 noted that *"the team did not have sufficient information to execute its care plan comprehensively. They did not know enough about the patient ----".* The Inquiry may have drawn a conclusion from this that social interventions had been marginalised but does not analyse the point further. There is no comment on the lack of evident partnership with Mr. Butler, an essential element of the recovery/social interventions approach to which Assertive Outreach teams should aim to adhere. It does not refer either to the minimal work latterly on supporting his clear aim to lead a normal life with studies and /or employment.

12.2 Recommendation 4 stated that *"every attempt should be made to identify a significant other and/or carer and /or relative specified and trusted by the patient who should be accessed regularly with a view to assisting workers and other team members to engage the patient more meaningfully."* This fails to acknowledge that carers need support, information and guidance too in order to help maintain their involvement and their engagement is not merely to assist teams.

13. At the time of the index offence the relationship between social care and health agencies was in a state of transition. Birmingham City Social Services and the Trust had been integrated through section 31 of the Health Act 1999 in 2003. As in most areas of the country the effects of integration were still developing in 2004 and, for instance, there were still separate social and healthcare procedures. The social

worker, if an Approved Social Worker, could be pulled out of the team to go on general rotas. Social workers had two supervisors and their role was not always clear. Nationally, this transitional stage was not unusual. Social workers, however, were not allocated cases that may have had specific social care needs and, in fact, had generic roles. Certainly, the monitoring of medication was seen as the main aspect to one support worker who went on to do a social work course. It does not seem that social workers had much influence on the philosophy and approaches in the team, and some now still comment that the medical model dominates rather than the merging of models mentioned in paragraph one. There are now more social workers in the team and the Trust is evidently taking social care very seriously as shown in the evidence of Sue Turner. We were told that the Trust has recently - in 2007 - created the post of Director of Social Care. Around the country, local authorities and Trusts have to decide how far partnership can carry forward the requirements of both organisations and evidently here, there is the hope that more planning in integration can achieve this. What is certain is that the importance of fostering social interventions alongside medical approaches should be recognised in any partnership arrangements. This is, of course, being reflected in government policy guidance.

14. Recommendations

14.1 The Trust should review its policies in relation to social engagement and interventions with its Local Authority partner to ensure that the importance is recognised and the effectiveness of these policies should be closely monitored, challenged and re-designed if necessary.

14.2 The service user should be actively encouraged to be involved with care planning linked to his/her hopes and ambitions. The social care element of the plan should be detailed and relate to the individual's circumstances. It should be pro-active rather than limited to monitoring. If a person refuses to be involved, this should be noted at every review. The offer of an advocate should be considered.

14.3 The importance and relevance of being on section 117 aftercare should be acknowledged in the CPA and care planning.

14.4 Relatives, friends and carers should be supported in their role and if they meet the criteria for a carer's assessment, this should be done. At any rate, they should be given appropriate information and support. This should be offered whether or not they are in contact with the service user.

14.5 If agencies have engaged with service users and team in the past, their relevant, continued involvement should be maintained and support and necessary information coordinated and exchanged.

CHAPTER 12

CULTURE, RACE AND THE SERVICE USER

1. Our terms of reference require us to examine "*any issue raised by cultural diversity which appear to be relevant in order to obtain a better understanding…*" In this chapter the relevance of Mr. Butler's ethnic and cultural identity is examined and the extent to which these were taken into account in the care provided to him. We also look at the culture of the team. The Inquiry lacked direct evidence from Mr. Butler or his family to help the panel arrive at an informed view about his cultural background and therefore this chapter is restricted to those matters which have emerged from the evidence we have been able to collect, together with our impressions of the organisational culture of the Trust, both before and after the incident on 21 May 2004, and the impact this had on Mr. Butler's care.

2. In Birmingham the Trust has sought to move forward the agenda for delivering race equality through the appointment of Ms. Lakhvir Rellon as Director of Diversity and the continuing implementation of a Race Equality Scheme published in 2006. As is clear from the reports we consider below, any problems in delivering appropriate mental health care to members of a minority ethnic group in Birmingham are not unique to that city but are symptomatic of a nation-wide issue, and it should not be thought that any criticisms made in this chapter in the context of race and culture are intended to be more than constructive assistance to the Trust and the public towards the improvement of services in the future.

3. In order to assess what happened in Mr. Butler's case from the perspective of the racial and cultural influences at work, it is necessary to take into account the background of theory and policy against which this case must be examined. Superficially it might be thought that a university educated man able in the past to obtain skilled employment, receiving mental health services from a team well used to the diverse

ethnic and cultural requirements of central Birmingham would not have a great need to be considered from the viewpoint of his membership of an ethnic minority. However, this is clearly not the case.

4. The General Problem

Consultant Psychiatrist (A) graphically put the general relevance of a combination of adverse life experiences due to ethnicity and mental illness to us:

"In the sample that I have in which I did not set out to make any link between disorder and being bullied because of being black, it certainly seemed that those who said they were being bullied had a much higher set of problems. Whether the problems were due to them being sensitive before or the bullying, I don't know, it is difficult to say. However, this thing of being Caribbean and having the name, say, Burke, and knowing full well that when I go to Ireland or Scotland or here in England – Birmingham – it will not give me an entry into the Consultant Psychiatrist (A) scenario… I think, therefore, that the Caribbean people bring with us a different frame into the mix and feel the rejection that much more than the Asian or African people, and that is half of the problem. The structural difficulty in Britain excludes the Caribbean person by race and he or she wants to be included by tradition and culture and cannot, it is impossible. Therefore, we shall have more and more of what we have had until the state decides that we shouldn't. I do not know how we would go about it, I really don't know."

5. Consultant Psychiatrist (A) acknowledged that there were inherent difficulties in arranging services which are capable of addressing these issues:

"… it raises a substantial issue of the colour code of presenting the services. There are very few of us black psychiatrists, and I do not believe that it is useful to say that a white psychiatrist is less able than a black one for a black patient, or an Asian psychiatrist is more capable with an Asian patient."

"The colour code of presenting the services of police, psychiatry, education and law means that the population that feels most harassed and displaced becomes subject to a passive position in the system far more than we realise. One wonders how you get around it. I don't know if the nurses were black or white but do we need a way of communicating with this man where the unconscious signals are registered accurately and not partially. I do not mean to say that an African from East Africa will be good with me from Jamaica, I do not think that that is useful. I think it is total nonsense in fact. It must have something to do with my acceptability of him and him of me, and the extent to which we can rap or communicate with each other. There is no [reason] to believe that a white person or a Chinese man or woman cannot communicate across the board, but are there circumstances where communication is prevented or limited by virtue of ethnic, cultural, racial and language factors? Those are useful questions."

6. Different Treatment for Ethnic Minorities

6.1 Historically a disproportionate number of members of the Black community generally come into contact with mental health services,

are admitted under the Mental Health Act and, once admitted, are subjected to more restriction and coercive measures. This echoes the experience of such groups with law enforcement agencies.[43] In this context there is a need to understand the perception of oppression harboured by many individuals from such backgrounds. Such negative messages may lead to black and minority ethnic communities having a low image of themselves. Trivedi[44] writes about internalised oppression as a response to oppression by an individual who has experienced it. This response, Ferns[45] argues:

"….is shaped by strong negative messages from the external environment, which may lead to the individual engaging in self blame, developing low self esteem and making them vulnerable to collusion with oppression".

6.2 For example, according to Ferns, many Black and minority ethnic [BME] service users feel that they are the problem as opposed to the lack of appropriate services for their needs. As one service user put it to an official review:[46]

Coming to mental health services was like the last straw… you come to services disempowered already, they strip you of your dignity, you become the dregs of society.

6.3 In contrast some Black people may not necessarily identify with the inferior 'other' suggested by institutional racism. Keating[47] argues that race and it's subcomponents of culture, ethnicity as well as racism within it, is a socially constructed concept which carries:

…the edifice of negative social meanings…[48]

6.4 According to Keating, the negative interactions between mental health services and Black people, particularly African Caribbean men, in their diagnostic and treatment processes are often influenced by the perceptions of both service users and mental health service staff, and a strong belief on the part of the former that if a need ever arose to use

[43] *See Pathways to Care for Africans & Caribbean People in the UK, McGovern & Cope, Fernando S et al 2006*
[44] *2001*
[45] *Ferns P (2006) Letting Through Light – A Training pack for staff working with BME Communities,[Handout for training session]*
[46] *Breaking the Circles of Fear [see below]*
[47] *African and Caribbean Mean and Mental Health, Keating, Race Equality Foundation 2007 page 3*
[48] *quoting Knowles, C. (1999) 'Race, identities and lives', The Sociological Review, 47, 1, pp. 110–35.)*

them, these services will discriminate against them. Keating describes the effect as the "*spiral of oppression*" (Appendix 7). Whatever it may be said this spiral should be called, its resonance in the case of Mr. Butler prompts us to include it in this report in diagrammatic form[49].

6.5 Fernando[50] argues that while attempts were made in previous institutional settings to engage the service users in a therapeutic approach:

> "..emphasis was still on medical, rather than sociological explanations for the problems…. In fact 'social psychiatry' merely emphasised social factors contributing to illness rather than causing the illness, very different to seeing illness as being socially constructed."

6.6 This view is echoed by Keating[51] who equates social inequalities with those conditions that are created within societies that result in less favourable treatment of some groups. This includes the restricted access to resources such as services and goods that promote their psychological as well as material wellbeing, often being detrimental emotional well being and potentially leading to a breakdown in mental health.

7. The Problem Identified in the NHS

7.1 It is now well recognised that there is a problem with regard to mental health services provided to the black and ethnic minorities In introducing *Delivering Race Equality in Mental Health Care,*[52] Professor Kamlesh Patel said:

> *"There is discrimination, both direct and indirect, in mental health care. Just about everyone accepts that, and that the situation must change – quickly and permanently. What has been lacking is a comprehensive, credible programme of action for eliminating discrimination."*

7.2 This was a conclusion reached through a series of reports and recently highlighted in *Breaking the Circles of Fear*[53], which based its study in part on Birmingham. This described the disproportionately adverse experience members of the Black community had of mental health

[49] *Appendix 7*
[50] *Cultural Diversity, Mental Health and Psychiatry: The struggle against Racism. 2003 page 97*
[51] *Keating 2007 [above] page 3*
[52] *Department of Health 2005 gateway reference 4393*
[53] *Keating et al, Sainsbury Centre for Mental Health 2002*

services:

> There is a profound paradox at the centre of Black people's experience of mental health services in England. Young Black men, in particular, are heavily over-represented in the most restrictive parts of the service, including secure services. And Black people generally have an overwhelmingly negative experience of mental health services. Yet these same communities are not accessing primary care, mental health promotion and specialist community services which might prevent or lessen their mental health problems. They are getting the mental health services they don't want but not the ones they do or might want.
>
> We have reached a point in the relationship between the Black communities and mental health services when there are truly *Circles of Fear*. Black people mistrust and often fear services, and staff are often wary of the Black community, fearing criticism, and not knowing how to respond, and fearful of young Black men. The cycle is fuelled by prejudice, misunderstanding, misconceptions and sometimes racism.

7.3 The research considered by the review indicated that members of the Black community were more likely to be subject to compulsory admission, re-admission, over-diagnosis of schizophrenia, police involvement in hospital admission, the use of section 136/137 of the Mental Health Act, over-use of psychotropic medication. The review identified the "*circle of fear*" as being created by a combination of fear of mental illness, fear of Black people and fear [on the part of Black people whose fear is grounded in negative experiences of other "coercive" agencies such as the police], and similar fear on the part of mental health service staff.

7.4 Of ten key findings the following find echoes in the present case:

- There are circles of fear that stop Black people engaging with services [as described above]
- Mainstream services are experienced as inhumane, unhelpful and inappropriate
- Black service users are not treated with respect and their voices are not heard. Services are not accessible, welcoming, relevant or well integrated with the community.
- The care pathways of Black people are problematic and influence the nature and outcome of treatment and the willingness of these communities to engage with mainstream services.
- Black people come to services too late when they are already in crisis, reinforcing the circles of fear.

- Acute care is perceived negatively and does not aid recovery.
- There is a divergence in professional and lay discourse on mental illness/distress.
- Different models and descriptions of 'mental illness' are used and other people's philosophies or worldviews are not understood or even acknowledged.
- Service user, family and carer involvement is lacking.
- Conflict between professionals and service users is not always addressed in the most beneficial way.
- The concept of 'culture' has been used to attempt to address some of these issues but can divert professionals away from looking at individual histories, characteristics and needs.
- Stigma and social inclusion are important dimensions in the lives of service users.

7.5 The review described some of the perceived impediments to Black people obtaining appropriate mental health services as including the following:

> Black people see using mental health services as degrading and an alienating experience: the last resort. They perceive that the way services respond to them mirror some of the controlling and oppressive dimensions of other institutions in their lives, e.g. exclusion from schools, contact with police and the criminal justice system. There is a perception that mental health services replicate the experiences of racism and discrimination of Black people in wider society, particularly instances where individuals have experienced the more controlling and restricting aspects of treatment

7.6 The review also identified on the one hand a lack of knowledge about the services on offer and on the other hand a lack of knowledge and understanding on the part of staff about cultural traditions and the impact of racism on the lives of service users.

7.7 Among the aims of the strategy recommended by the review were:

- Ensure that Black services users are treated with respect and that their voices are heard.
- Deliver early intervention and early access to services to prevent escalation of crises.
- Ensure that services are accessible, welcoming, relevant and well integrated into the community.

- Increase understanding and effective communication on both sides.

7.8 While the review proposed that these aims needed to be delivered by development of gateway organisations by the Black community, they are clearly aims which should permeate the work of any mental health service providing support for a Black service user, or, indeed a service user from any community.

8. *Inside/Outside*[54] reiterated the continuing barriers to access to proper mental health care faced by members of black and other ethnic minority groups:

> For decades the disparities and inequalities between black and minority ethnic groups and the majority white population in the rates of mental ill health, service experience and service outcome have been the focus of concern, debate and much research. However, there is little evidence that such concerns have led to significant progress, either in terms of improvement in health status or a more benign service experience and positive outcome for black and minority ethnic groups. If anything, the problems experienced by minority ethnic groups within our mental health services may be getting worse.
>
> … We must begin by acknowledging the problems of mental health care as it is experienced by black and minority ethnic groups:
>
> - that there is an over-emphasis on institutional and coercive models of care;
> - that professional and organizational requirements are given priority over individual needs and rights;
> - that institutional racism exists within mental health care.
>
> There does not appear to be a single area of mental health care in this country in which black and minority ethnic groups fare as well as, or better than, the majority white community. Both in terms of service experience and the outcome of service interventions, they fare much worse than people from the ethnic majority do. In addition, disease burden associated with mental disorder appears to fall disproportionately on minority ethnic populations

9. On the other hand it was felt that new models of treatment, presumably including assertive outreach, received a more positive response from minority ethnic groups:

> New service models, introduced in the wake of the MHNSF and the NHS Plan, are likely to be more acceptable to people from minority ethnic groups in comparison to more traditional mental health services. For example, minority ethnic groups report greater levels of satisfaction in relation to Home Treatment/Crisis Resolution services[47]. Given the significance attached to treatment delay in accounting for the adverse experience of African Caribbean people in psychiatric care[48], early intervention services have the potential to prevent aversive care pathways for

[54] *NIMHE 2003: the principal author was Professor Sashidharan who was good enough to meet us, and the working group included Lakhvir Rellon who gave evidence, and a member of the panel, Dr. Ndegwa.*

> minority groups. However, intensive case management has shown little differential effect in black patients

10. The paper called for enhanced organisational capability to enable cultural issues to be dealt with adequately, identifying these as part of mental health care to be provided for minority ethnic groups but, more importantly to improve the overall quality of assessment, care, support and treatment provided to such groups. Methods to achieve this advocated included developing a culturally competent workforce by measures including improved training, collaborative work with the voluntary sector and enhancement of the flexibility of working practices to meet the needs of culturally diverse groups of people.

11. *Delivering Race Equality in Mental Health Care*[55] brought forward proposals to tackle the challenges identified in this work and in response to the report into the death of "Rocky" Bennett, in which the Inquiry described as a "disgrace" the fact that the BME communities did not get the mental health services to which they were entitled.[56]

12. **Defining Culture in the Context of Care and Treatment**

Ferns[57], a trainer in mental health,[58] provides a model for defining culture which can help us in looking at the case of Mr. Butler. Ferns' model is particularly relevant as it forms the basis of some of the training in mental health currently on offer as part of workforce development in the West Midlands region[59]. This includes training available for the Assertive Outreach Team in charge of the care and treatment of Mr. Butler, albeit three years on after the incident. The trainer writes [emphasis supplied]:

> People's cultural values, or what they think is most important to protect in a situation presented, influence what they would do in that situation leading to actions and outcomes. These are clues about the nature of culture and how it can be seen as series of layers that interact with each other. You have, no doubt, also noticed how

[55] *DoH 2006 gateway reference 4393,*
[56] *Independent Inquiry into the Death of David Bennett – Blofeld et al, December 2003 page 58: http://www.nscsha.nhs.uk/resources/pdf/review_inquiry/david_bennett_inquiry/david_bennett_inquiry_report_2003.pdf*
[57] *Ferns P (2006) Letting Through Light – A Training Pack for Working with BME communities , Pavilion Publishers, London, UK*
[58] *http://www.fernsassociates.co.uk/site/*
[59] *http://www.fernsassociates.co.uk/site/files/1RaceEqualityAndCulturalCapability.doc*

varied people's cultures and values can be. If you look deeper, you find that their values are based on certain beliefs and assumptions that give meaning to why something is important – in other words they give rise to values.

13. Mr. Butler's own Ethnic and Cultural Background

13.1 Although relevant details can be found elsewhere in this report, it will be helpful to recall some of them here. Mr. Butler is of African Caribbean ethnicity. He was born in Jamaica and came to England shortly after his birth with his mother. He has an older half brother, who now lives in this country and with whom Mr. Butler has had some contact in adult life, and a younger full brother with whom contact has been lost. Mr. Butler spent much of the first nine years of his life in Jamaica with his mother and his siblings. His mother then brought her family back to this country where they lived with Mr. Butler's father until his parents divorced in the early 1970s. He continued to live with his mother until he left home to go to university. His mother re-married, but her husband died, and she returned to Jamaica where she remained until her death in 2002. Mr. Butler had always maintained close links with her. He is recorded as having graduated from Aston University with a BSc in mechanical engineering. He was employed for 3 years by Rolls Royce in Stoke-on-Trent as a design draughtsman, and was the only Black graduate trainee. He was made redundant, and he has sustained a belief that he was made redundant because of his ethnicity. He then obtained work in Watford for a short time and subsequently for a further year with a company in Hertfordshire as part of an engineering design team. It has been suggested that he left this job because of racist harassment. He does not appear to have had employment since 1985.[60] This background was known to the Assertive Outreach Team when they assumed the role of supporting Mr. Butler.

13.2 Mr. Butler first came to Birmingham in part to benefit from the services known at the time to be on offer at Servol, a specialist housing service. He was transferred from Stoke-on-Trent after experiencing what he

[60] *This account is largely taken from the forensic psychiatric report of Consultant Forensic Psychiatrist (B) dated 14 April 2005 [6.926]*

perceived to be racially motivated harassment. Mr. Butler's background was informed and influenced by his experiences as an African Caribbean living in a hostile environment.

Consultant Psychiatrist (E) acknowledged as long ago as 1995 that:

"as you know the Potteries are not known for their racial tolerance and I have little doubt that this young man has experienced racial hostility, possibly of a quite severe kind."

She confirmed this in her evidence to us:

'…the home of the National Front, isn't it? They are not known for their racial tolerance.'

13.3 On the other hand, some pertinent abnormalities were apparent in Mr. Butler's core beliefs, which were probably attributable to elements of his mental disorder as well as actual experiences concerning his racial and cultural identity. Consultant Psychiatrist (E) stated:

"maybe he would be less able to say, 'This is all to do with persecution of me on the basis of my race', if he was being examined by black psychiatrists and black psychologists who could say, 'Yes, that may be true, but the MI5 is a step too far'. "

13.4 This combination resulted in a range of complex needs and assessed risks that were apparent from his first admission, for example the:

'…risk (of) acting on his denial (that he was unwell at the time of his admission), just simply vanishing from services, getting back into this picture of gross social isolation, living without electricity, not eating, self-neglect'

13.5 Mr. Butler had a background of achievement as evidenced by his academic qualifications and employment at Rolls Royce. Evident important core values for him must have included the worth of a good education and of working hard. CPN (B) recalled in his oral evidence how the Assertive Outreach Team:

"… also knew that he said he didn't want to engage with us with all our training stuff because he was going off to the library and doing research. He was doing a dissertation on something I think it was computer studies or something like that. He had shown it to… (who) seemed to verify the information that Mr. Butler had documented was genuine."

"It wasn't rubbish and he had shown it to the consultant at that time... Mr. Butler knew what he was doing because he was doing a Masters in computer studies or something. The stuff that he produced made sense. It was the way it was described."

13.6 What was missing, most noticeably after the departure from the team of the RMN, were any effective steps to address Mr. Butler's social isolation with any form of engagement appropriate him. This emergent picture was in stark contrast to the initially recorded purpose of the referral to Servol.

14. Conflict, Culture and Beliefs

14.1 In addition to his core belief that he did not have a mental health problem, Mr. Butler's persistent beliefs that the police and other organs of the state intended to ruin or destroy him must also be taken into account when analysing his race and cultural needs. Such a presentation is not uncommon in mental health services for Black men. Whatever the cause of his problems, as early as 1995 before he was transferred to Servol, Mr. Butler was dismissive of the value of clinical intervention. Consultant Psychiatrist (E) told us:

"I remember Mr. Butler saying, 'The Section 3 is a bit pointless anyway, because what's going to be any different? You or some other doctor is going to turn up, somebody else is going to do something else, what difference is it making?', and I thought that was a perfectly reasonable argument".

14.2 While in isolation such beliefs and persecutory beliefs about the police can be viewed as abnormal, they must be considered in a socio-political context in which, as we have seen, Black men are historically more likely to be stopped, searched on the suspicion of having committed an offence, arrested and detained in custody by Police (with an increased likelihood of detention and/or transfer under sections of the Mental Health Act 1983). The attitude of such service users is likely to be informed by the justifiable perception that Africans and Caribbean people have a greater chance of coming into contact with mental health services than others.[61]

14.3 On the other hand the team may have been inhibited in their dealings with Mr. Butler through the effect of a rather different image of him from that which he had of himself. Mr. Butler belongs to an ethnic minority group historically known to present challenges, when it comes

[61] *See Fernando S et al above*

to contact with services.[62] Given that background, there is no evidence that the Assertive Outreach Team approached his care in a manner that optimised the quality of the contact. Indeed the opposite may have been the case. We have identified examples of the team under - or over-reacting to what they observed. Some of Mr. Butler's behaviours and characteristics would have been cause for alarm and concern even taking into account the different cultural context in which he lived his life. A more proactive response to the team's observation of the knife on the couch coupled with marks on the door might have been expected. We wonder whether the apparent under-reaction was due to a hesitancy to be seen as acting on a cultural stereotype.

15. Trans-cultural working relationships and responsiveness

15.1 A principal purpose of the transfer from Stafford to Birmingham was to take a different approach to addressing these needs with particular reference to his ethnic and cultural background and experience. CPN (B) stated that:

"...he was referred into what was deemed to be a culturally sensitive service for his needs which was the Servol Organisation, which is an African-Caribbean community association that houses people with enduring mental health issues, engages them in trying to issue housing and whatever else."

15.2 This Inquiry did not focus on the Servol Organisation, as Mr. Butler no longer had contact with them at the time of the incident. However, Consultant Psychiatrist (E)'s referral to Servol and the psychologist (A) working there, resulted in one of the few attempts made in Birmingham to engage meaningfully with Mr. Butler in a way which took into account his ethnicity and culture.

15.3 In looking to evaluate the facts of the case in the care and treatment of Mr. Butler, a key fact is that his last discharge from hospital prior to the 2004 incident which led to his arrest was in October 2001. Whether or not he did so completely satisfactorily, he was able to survive in the community for a period of two and a half years. The mental health team made the justifiable judgement at the time, that given appropriate

[62] *See the references above*

support, Mr. Butler would be able to look after himself within the community. At the time of his discharge the care plan included regular medication, weekly visits for monitoring and support, and regular reviews. What is an issue is the quality of the support delivered under that rather general plan.

15.4 There is a correlation between race and culture when working with people from Black and Minority Ethnic (BME) Groups. The quality of trans-cultural working relationships has a bearing on the outcome of the service intervention. Team practices may disproportionately disadvantage patients from different cultural groups, particularly if they are known to potentially (and historically do) disengage with services. An example was the team's acceptance of brief meetings at Mr. Butler's front door, and their reluctance to seek to persuade him to let them in on a regular basis. There was no member of the team who succeeded in engaging with Mr. Butler's specific and personal needs except for the RMN, who was partially successful in obtaining meaningful engagement. The RMN:

'… knew how far to go, and …knew when to back off, and if (he) thought (he) was at any risk, then (he) would not hesitate to leave (Mr. Butler) alone and go back and seek support..',

15.5 It is not without significance that at this point the RMN was the one team member who shared ethnicity and certain aspects of culture with Mr. Butler. His approach demonstrably succeeded in sorting out Mr. Butler's housing needs, by way of example. On the other hand the team did not appear to offer leadership to the RMN or build on his relationship to deliver a meaningful care plan. The team's difficulties in trans-cultural working relationships are encapsulated in something we were told as an illustration by Approved Social Worker (B), an approved social worker in the team from 2002 and for a short time manager of it after the incident:

"In a few of these instances you can see a light go on. It is like 'Ah! Why didn't I think of that?' It is that sort of response and then things are able to move. I am not throwing stones or anything like that but these are the things that have happened. We had a problem with a chap… I suggested to the worker that we should go and see his nearest relative… We went and visited her…. She said 'And of course my

dad had a problem with my mum because I'm white and he is half-caste.' And I said 'Yes I know' and it was only when we got back to the office that the white worker said 'I didn't know that this guy was black.' We were trying to get him out of hospital into an area that was predominantly black and they were saying 'We don't think he is going to fit in' and there was me from my point of view who could see that he was black. He was light skinned but I could see and I was trying to direct him to an area where I felt he would settle. It was at that point almost like QED time, 'I didn't realise, now I see approved social worker (B) that this is why you were going down that road. … It is a way in which things are done and this might possibly come from the point of view that the team was all white. The only black input would be from students or social work assistants who would not have much of a voice as I would…"

15.6 Further, they did not, in spite of their collective knowledge of Mr. Butler's impressive intellectual capacity and interests, initiate or offer appropriately stimulating activities or other opportunities for engagement and personal and social development. The benign but ill-informed approach of the team was demonstrated by one senior member who told us:

I treat every client with the respect I would want myself. It does not matter about their background. Having been a Scot who has come to England I have had racist comments about Scotch this and Scotch that, so I do understand some of it, but I try to treat everybody the same…

15.7 We suggest that, although this witness, who denied having been offered any training in diversity or cultural competence, was undoubtedly well meaning, an African Caribbean with direct experience of losing his employment through perceived direct racial discrimination is unlikely to take kindly to having this compared to the problems of a Scot coming South of the border.

15.8 It is the Inquiry's view the team's approach was formulaic routine and unimaginative, focusing on medication and monitoring, with little evidence of reference being made of Mr. Butler's cultural needs after his move from Servol. For example, it is very likely that education and intellectual stimulation were important components of Mr. Butler's cultural values. In the past his educational achievements had resulted in him obtaining skilled employment and through that material independence and a valued place in society despite facing racism and other hardships in his life. He was clearly trying to exploit these talents even in the face of his debilitating illness through his visits to the library, occasional if ineffective consideration of undertaking further

education and in his drawing at home.

15.9 Undoubtedly this was not a profile for a service user under the care of this team to which they would have been accustomed. However the negative effect of the type of adverse life experiences and stimuli recorded throughout Mr. Butler's history and decline in mental health among Black men is generally well recognised.[63] It has long been acknowledged that in mental health black and minority ethnic communities experience notable inequalities.[64] There were no effective measures put in place to address the needs arising from it.

15.10 When asked whether the team was able to engage with him intellectually or in relation to his interest in design one senior member of the team gave an answer which in our opinion unwittingly demonstrated the limited and stereotypical outlook adopted by the team:

"I think all the team did because we were all aware of that, but he was such a quiet and closed man he did not want to discuss anything to do with his personal life. It was good when he started talking about his holidays. That was something else that at least we could find common ground to talk about. I talked to him about his recipes when he was cooking and tried to encourage him to come and cook for our drop-in, which several of our service users used to do and taught some of us different recipes. We had multi-cultural meals on a drop-in day because different service users will cook and teach other backgrounds. We might have ackee and salt fish one day, a lovely chickpea curry the next and then perhaps I would do bangers and mash or whatever, depending on who was attending."

15.11 Essentially the team gave up trying to find an approach based on Mr. Butler's individual background and culture:

"I offered him the Frantz Fanon service, thinking he might find that better culturally, if that was what he wanted. But having looked though the notes when he was in Servol, which is specifically an African Caribbean hostel he did not seem to build any stronger relationships there, so it was just a matter of exposing him to the whole team and trying to find anybody in the team who could build a relationship with him."

15.12 Service Manager (B), a manager brought in to supervise the team following the incident, was critical of the support offered to Mr. Butler:

"They did not really know Mr. Butler, that he was quite an educated gentleman. They

[63] *D McGovern, RC Cope Social Psychiatry 22:33, 139-149, Springer, 1987 Fernando, S. (2003)*
[64] *DH Earwicker, R (2005) Tackling Inequalities: Status Report on the Programme for Action, DoH Publications, London, UK*

didn't engage with him, ask what his interests and hobbies were, what he'd like to do. He was interested in writing a thesis on the computer. You might think it's total madness, but if you'd engaged with him he might have gained some sort of confidence or support from him. He was quite a bright guy, but he was also capable of disengaging from services…"

"You have to remember that you're working in an inner-city area, lots of high-rise flats, various crime, a very transitional area, you have to take that into consideration when you're looking after people, and he's an Afro-Caribbean male who may not want to go down to cook on a Sunday in the Social, he may not want to go bowling, very few of his type do, he's an intelligent man, why would you want to go bowling? He was quite happy to go to the library and write a thesis, so you have to take in his ability and his cultural background. You have to keep scratching, keep digging…"

15.13 She agreed that there had been difficulty in engaging with people who had come from a well-educated background:

"I think it's true. The thing that he was black as well as all these other things didn't really help him, that's why your team needs a good skill mix of people from diverse backgrounds culturally that you can engage. It is difficult. You have to remember, some people cook very well, you go to their house, it's immaculate. I've worked in inner-city areas with people who have a Masters Degree, who are lawyers, if they are well they would be brilliant, they have the latest book, they can tell you all the theses, they're very academic, very able, more than I am, but you have to try and engage with them at their level. … I think you have to recognise that people come from all different walks of life, and people arrive at where they are for different reasons, so yes, it is difficult to engage with them."

15.14 She was concerned about the absence of a cultural element from the team:

"I think the cultural element was not there. One of the support workers was an Afro-Caribbean guy, but his support in experience or expectation of what you wanted to know was limited, of what the team required from him. He was not working in the team at the time of the incident."

"… you don't need a black person, you need someone who is culturally aware of what's out there and how you can engage with people… There's no point in having someone the right colour because you're ticking the right boxes, you might get someone who is totally unaware of their own cultural background. When you write a care plan you have to make sure you're addressing that individual's needs and making sure you're aware of the things that might come up. That's what you do through case-busting and multi-professional services, and through being creative."

15.15 We were unable to find evidence that Mr. Butler's needs were addressed with his own ethnic and cultural background in mind. For example his beliefs relating to persecution by the police were likely to be informed in part by his real-life experiences of contact with them at the time of compulsory assessment and admission. His beliefs about financial difficulties would have been reinforced by the impact of racism on his employment. We saw no evidence of these matters

being discussed or addressed in the latter years of contact with him.

15.16 As a result of the consequent lack of communication and interaction with the team on his own level, it would not be surprising if this had not reinforced a negative self-image for Mr. Butler based as it would have been on his oppressive experiences of society and authority, particularly during the hard times in the Potteries.

16. Mr. Butler's case indicates at various stages a bias on the part of the team in giving inadequate weight to the effect of Mr. Butler's past experiences on his mental state. Such a bias runs the risk of compounding the severity of the illness, provoking a relapse or even triggering illness. He had a genuine history of adverse experiences of the society in which he lived and rejection of his view of that would not have encouraged him to engage beneficially with the team.

16.1 Mr. Butler faced hostility in Stoke on Trent, and there is indisputable evidence some members of his community (at the time) did not welcome his presence. As well as losing his job, this would have had a significant bearing on his sense of security in that community and possibly his sense of security living in the UK overall.

16.2 The main concerns from Mr. Butler's history at initial point of contact were his past self-neglect (including having no utilities), isolation and aggression to neighbours. His described living circumstances in Stoke-on-Trent at the time would have had an impact on the development and severity of a mental illness and possibly other needs.

16.3 Mr. Butler's history suggests that as far back as 1999 the contacts he had with the police (including the last occasion prior to the incident) were when they "…*came to use the Mental Health Act again*," or to arrest him for violent incidents which ranged from brick throwing to assault and possession of a knife. There may be a link between Mr. Butler's sense of insecurity, his experience of racism, and his possession of a knife.

17. Mr. Butler was not readily compliant with the care and treatment packages put in place at different stages of service intervention. This attitude might well have resulted from his past experiences, but there is no evidence of the team looking at his case from that perspective. Apart from the visits by the RMN, limited evidence was seen by this Inquiry of a model which exhibited understanding of this or which reinforced Mr. Butler's ability to self manage, and even less evidence supporting resilience building approaches. In short the team overall showed a lack of awareness of the racial and cultural issues raised in Mr. Butler's case, failed to respond to the needs arising out of these issues and, in particular failed to find out sufficient information about Mr. Butler's personal culture.

18. **Working with Mr. Butler's Family and Significant Others**

The evidence suggests Mr. Butler had minimal contact with his family at the time of the incident. Where family have minimal involvement with a service user, as was the case with him, there is an increased need for more robust and meaningful support. Attention needs to be paid to the issue at CPA reviews, and in discussions with the service user. There is no reason why the family cannot be contacted unless the service user specifically prohibits it. Consideration needs to be given in reviews, with the service user, and, where appropriate, with family members, to the possible reasons for contact being limited or non-existent.

19. As the family did not take up the Inquiry panel's offer of an oral hearing, little new evidence can be presented on the reason for the minimal contact with family members or on the effect of the transfer had any local social connections Mr. Butler may have had. However, without suggesting that this factor was part of Mr. Butler's case it is well known that mental illness may lead to particular stigmatisation:-

20. In terms of mental illness and fear of mental health Corrigan et al proposed that fear of mental illness leads those perceived as mentally ill being avoided. Such avoidance creates a social distance between

people with mental health problems and the rest of society and leads to them being socially excluded. (Sayce 2000; Link et al, 1999). Phelan & Link (1998) suggest that fear of mental illness and people with mental health problems can stop individuals from engaging with services.[65]

21. It may be argued that this phenomenon is even more isolating amongst those who have felt prejudice through racism. Even the possibility of this should have led to more energetic efforts to engage with members of Mr. Butler's family and to find out more about them.

22. Effectiveness of Individual Practitioners from a Cultural Perspective

Some team members did not get past Mr. Butler's doorstep. The RMN took what could now be described as a Community Engagement approach. He did not hesitate to engage Mr. Butler in the non-traditional setting of a barber shop when opportunity presented itself, and generally seems to have spent more time talking to him and trying to establish what he thought his needs were. Significantly a forensic report recorded that Mr. Butler himself had spoken highly of the RMN. When he left the team Mr. Butler asked after him. This positive reaction is likely to reflect the more personalised approach taken by the RMN as being what Mr. Butler preferred. Many service users find this personalised way of working quite empowering.

23. In contrast approaches adopted by other members of the team, may have been perceived as depersonalised. We do not suggest that it would have been easy for all members of the team to engage with Mr. Butler on the same basis as the RMN, particularly given their lack of understanding of the reasons for his reluctance to engage.

[65] *Breaking the Circles of Fear (above) page 19; Corrigan et al, Familiarity with and social distance from people who have serious mental illness, Psychiatric Services, 52 (7) 953-958 (2001); Sayce L, From Psychiatric Patient to Citizen: Overcoming Discrimination and Social Exclusion, London, Macmillan Press (2000); Link et al Public conceptions of mental illness; labels, causes, dangerousness, and social distance, American Journal of Public Health, 89 (9) 1328-33 (1999); Phelan JC & Lin k BC, The growing belief that people with mental illness are violent; the role off the dangerousness criterion for civil commitment, Social Psychiatry and Psychiatric Epidemiology. 33 Suppl 1:57-12 (1998)*

24. The RMN himself denied that he had any distinctive effect in his engagement with Mr. Butler, but the reality is that he treated him as a "brother". Any service user treated in this way would have appreciated such an approach. Whether he was aware of it or not, his approach was beneficial. While the difficulties for different individuals to emulate the approach of another should not be under-estimated, the RMN's particular if partial success does not seem to have been recognised as a pointer to what was required for successful engagement. The RMN was junior, unqualified and perhaps was given less importance as a result. In the context of the care of Mr. Butler what he was able to achieve should have been thought of as very important, both while he was with the team and even more so after he had left. The question of how to replace him effectively and build on what he had done should have been a matter of constant review as part of the planning process. Cultural awareness, properly understood and acted upon, would have kept this issue at the forefront of the team's thinking.

25. In many respects, it would appear that the RMN and Mr. Butler had less in common than they had differences, even though Mr. Butler valued the relationship they had. However, through the very common lived experience of being a Black man living in inner city UK, the RMN presented a significant inroad for the Assertive Outreach Team in terms of access into some of Mr. Butler's core beliefs and assumptions in the context of that lived experience. Common areas of interest were restricted to the professional relationship between the two different individuals. There were also differences, in particular in relation to employability, as well as resilience and coping strategies of day to day living in inner city Birmingham. Despite these differences, the RMN's approach would have been perceived and received by Mr. Butler as different and the preferred option over other approaches. This would have been in part because of their shared experience, but significantly, in part because the RMN demonstrated respect for what was different in Mr. Butler's life.

26. Team Culture

26.1 It is possible that Trust wide organisational factors may have had implications for the cultural group to which Mr. Butler belonged, in for example, risk management around the time of incident. When examining an organisation, its allocated resources are an overarching contributory factor in the organisation's culture of working. The Birmingham & Solihull Mental Health Trust's flexible way of working had its merits as well as restrictions. The existence of an apparent 'blame' culture within the organisation was captured during the Inquiry panel's interview with Lakhvir Rellon, the Director of Diversity for the Birmingham and Solihull Mental Health Trust, who said that:

"… resources (for dealing with diversity across the Trust) did not materialise. Along the way, the service lost its direction. There were huge difficulties, from my perception, in the way it was set up because… Staff working in the mainstream services almost felt that they were being blamed for not having done things right."

26.2 It is possible that the Assertive Outreach Team had a working culture that would have had the potential to disfavour disproportionately certain groups with specific cultural needs. One example would be the team's behaviour being driven by routine as opposed to a thought out process, when working with African Caribbean patients who did not readily engage with the service, like Mr. Butler. Another example is that it does not seem to have occurred to the team that offers to Mr. Butler to join pre-arranged activities at the day centre, and holidays, might not have been appropriate given his interests and background. The evidence cited above suggests that at least some members of the team imposed their own culture in this way as opposed to responding to Mr. Butler's.

26.3 Whether aware of it or not, the Assertive Outreach Team had its own culture which drove the way it managed Mr. Butler's case. As one of the first outreach teams in the country it may have perceived itself as delivering a high standard of care and of being at the forefront of the field. They clearly believed that they did practise in an inclusive,

appropriate manner. The reality was different: the support they offered was not reflective of the individual with whom they were trying to engage. This was bound to increase rather than diminish the distance between mental health services as represented by the team and Mr. Butler.

26.4 Furthermore, as can be seen from the preceding chapters the Assertive Outreach Team had, particularly in the latter part of the period under review, a culture in which the medical as opposed to a social care model was adopted in their interactions with Mr. Butler. They fell into a routine of perfunctory monitoring from which a focus on his needs as an individual with a particular and personal background informed by his own culture and ethnicity was absent. As noted in the Social Care chapter research indicates that a reduction in emphasis on medication and an increase in user involvement and social and practical support helps to engage *"difficult to engage"* patients.

26.5 Unrealised by them, the team may not have been very well equipped for this task. They do not appear to have exploited effectively the relative success in engagement enjoyed by one of their number, who shared ethnicity with Mr. Butler, or sought alternative means of effective engagement once that colleague had left. It was unclear to us how many members of the team had received training relevant to meeting such challenges, even though such training was, in theory available to them.

26.6 A contributory factor too, may have been the half-time managerial arrangements. This has been changed since the incident. The resources for supervision and leadership in the areas of racial and cultural awareness and diversity may have been lacking as a result.

26.7 It is inevitable that teams will develop a collective culture and that this is likely to differ from that of the service users they support. What is needed, and was lacking here, was an appreciation of the difference in cultures, and a commitment to responding to the user's culture rather

than imposing their own.

27. Training in Race Equality in Mental Health Services

27.1 In evaluating training needs of the team to the extent relevant in Mr. Butler's case, we are satisfied that the Trust has an adequate organisational commitment to provide for race equality training for all those who need it. However, Lakhvir Rellon encapsulated the organisational challenge despite the availability of Race Equality training, when she highlighted the general trend that those:

"…who turn up……you can bet your bottom dollar that when you put on race equality training, it is usually Black workers who come.

27.2 Ms. Rellon has introduced training based on the Letting Through Light Audit, but this has not been without problems:

'…getting the consultant body to sit down and look at the 'Count Me In' census is extremely difficult, because you cannot get past the point of their rubbishing the methodology. So, consistently, you have to revisit and say put the methodology to one side, there are some clear indicators of things that are not right. Many issues within Count Me In are to do with clinical practice'.

27.3 We are not, however, satisfied that the team has taken adequate advantage of or adequately absorbed the training that was available. While members of the team may have received training, we saw no evidence of this being applied in any conscious attempt to identify or address Mr. Butler's needs from an ethnic or cultural perspective. It is possible that this reflects the same phenomenon identified by Ms. Rellon, namely that those least personally affected by such issues are also the least likely to accept that they exist. The evidence we received from at least one member of the team, quoted above, seems to support this perception.

27.4 This Inquiry recognises the challenges as well as constraints within health and social services, of which mental health services are a part, in differentiating real, and lived experiences from episodes attributable to delusions and psychosis where one becomes ill. Training in race and cultural issues and the application of that training are essential if there is to be an effective understanding of points of reference for each

service user in the context of diagnosis, treatment and support. As suggested in *Breaking the Circles of Fear* the training needs to address, among other topics, language assessment, carer and community involvement, non-medical models of mental health problems and conflict resolution.[66]

28. Summary

28.1 Mr. Butler was transferred from Staffordshire with good intentions in part to address key aspects of his cultural needs through the Servol Organisation. Once it was judged that he did not fit in with the Servol Organisation's regime, ideas for engaging with him by reference to his ethnic and cultural background faded away. There was a team assumption that this approach had been tried so would not be successful, at any level or in any other way.

28.2 The approach adopted by the team lent itself to a *"one size fits all"* approach which would be a deterrent for someone with as complex needs as Mr. Butler. There is little evidence that the team made adequate attempts to reinforce his cultural heritage or address his needs from an ethnically or culturally reactive perspective.

28.3 What is more evident, particularly in the period leading up to the tragic incident, is a culture within the team, which was one of the first in the country, which could be viewed as organisational cultural arrogance, driven by the core belief, albeit one not based on any evidence, that the way the AOT functioned was inclusive, appropriate and probably the best possible. Consultant Psychiatrist (D)'s summarised assessment captures, in essence:

> *"… 'They didn't know that they didn't know'. That, to me, is one of the big learning things about this. It would have been very hard to have done more I think because he was such an isolated man it seems to me."*

29. Returning then to the "*spiral of oppression"* regrettably we see all the elements of it present in the case of Mr. Butler:

[66] *Breaking the Circles of Fear (above) page 81 Recommendation 10*

29.1 *Negative perceptions*: Mr. Butler came to the team with negative perceptions of society, authority, and mental health services. The team approached him with the negative perception based on his reluctance to engage and his inability to comply with their routine model of care.

29.2 *Reluctance to seek help*: Mr. Butler's persistent failure to seek help when he needed it was driven in part by his negative perceptions, fuelled by his mental illness.

29.3 *Services not sure how to engage*: we have seen that the team in effect gave up seeking to achieve more than perfunctory monitoring based on a medical model and did not take a cue from the one partially successful approach.

29.4 *Increased risk of worsening distress*: the withdrawal of the team from provision of effective support undoubtedly increased this risk as Mr. Butler fell into increasing social and other difficulties.

29.5 *Increased likelihood of coercive interventions*: The longer Mr. Butler's unnoticed deterioration escalated, the more at risk he must have perceived himself to be of compulsory re-admission to hospital.

29.6 *Reinforcement of negative perceptions*: The resulting reinforcement in negative perception on the team's part led to a further hesitancy in their approach to the case.

29.7 *Continued reluctance to engage*: at the end it might be thought that there was a "stand-off" between the team and Mr. Butler. Both were in reality reluctant to engage with the other. In the meantime Mr. Butler's condition deteriorated out of control ending in the tragedy of DC Swindells' death and the ultimate coercive intervention for Mr. Butler of criminal conviction and detention in a high security hospital.

30. Recommendations

30.1 The Trust should review methods of care assessment to ensure they

include all information relevant to the service user's racial and cultural background: knowledge of such information should not be assumed and must be sought and recorded in every case.

30.2 The Trust should ensure that teams continue dialogue with all service users with a principal purpose of ascertaining and recording their views, their needs and their ambitions.

30.3 The Trust should ensure that a cultural profile of each service user is maintained and updated which should include details of his ethnic and family background, his relevant experiences, and his cultural needs.

30.4 The Trust should ensure that regular opportunities are provided within teams for open discussion of racial and cultural issues arising out of individual cases and the case load in general.

30.5 The Trust should consider incorporating the elements of the cultural formulation proposed in DSM-IV[67] into local practice and other means of fostering culturally responsive support for service users.

30.6 The Trust should provide the resources for and develop the relevant policies to ensure the integration of racial and culturally relevant training into team routine and practice through active management and supervision.

30.7 The Trust should ensure that all Assertive Outreach Team staff receives relevant racial and culturally relevant training through appraisal, and personal development planning.

[67] *See Appendix 8 extracted from Fernandez and Diaz, The Cultural Formulation: A Method of Assessing the Cultural Factors Affecting the Clinical Encounter, (2002) 73 Psychiatric Quarterly 271 page 5*

CHAPTER 13

CONFIDENTIALITY & SHARING INFORMATION

1. A duty of confidence arises when one person discloses information to another e.g. patient to clinician, in circumstances where it is reasonable to expect that the information will be held in confidence.

2. Patients have a human right to privacy under Article 8 and confidentiality is an essential ingredient of the 'therapeutic alliance' between the patient and the professional, helping the patient to trust the professional and so aiding their treatment, care and recovery.

3. The key principle of the duty of confidence is that information confided should not be used or disclosed further in an identifiable form, except as originally expressly or impliedly agreed to by the confider, or with his or her subsequent permission. Issues around confidentiality however should not be used as a reason for not liaising with other agencies such as housing, social services etc. Agencies cannot treat patients safely, or provide continuity of care, without having relevant information about a patient's condition and medical history.

4. Patients must be consulted about when and what information may be helpful to share with services and professionals should be clear about how the sharing of such information could benefit the patient or help to prevent harm to others and whether there are any potential negative consequences. Such liaisons are essential in order that appropriate support to the individual can be maintained. Advocates and advice services can support patients in helping them decide what information should be shared.

5. Under common law, disclosure of personal information is permitted if it is necessary to prevent abuse or serious harm to others. Under Article 8 disclosure may be permitted where it is judged, on a case by case basis, that the public good to be achieved by the disclosure outweighs both the obligation of confidentiality to the individual patient concerned and the

broader public interest in the provision of a confidential service. Wherever possible the issue of disclosure should be discussed with the individual concerned and consent sought. Where this is not forthcoming, the individual should be told of any decision to disclose against his/her wishes.

6. The Mental Health Act 1983, Code of Practice[68] advises that: occasionally it may be necessary to disclose confidential information in the public interest. The draft revised Code would make it clear that public interest in disclosing information may vary according to the type of information.[69]

7. The public interest in disclosing information may vary according to the type of information. Even in cases where there may not be an overriding public interest in disclosing detailed clinical information about a patient's state of health, there may be such an interest in sharing more basic information about the patient's current and past status under the Act where that is vital for properly informed risk management by the relevant authorities. It will usually be possible to distinguish such basic information from personal information about an individual's mental health and treatment plan.

8. The current Department of Health guidance on patient confidentiality emphasises that communication between agencies is often necessary for the benefit of the healthcare of the patient and all efforts should be made to obtain the patient's consent for such disclosure. The difficulties that might arise if they refuse their consent should be explained to them.[70]

9. Whoever authorises disclosure must make a record of any such circumstances, so that there is clear evidence of the reasoning used and the circumstances prevailing. Disclosure in the public interest should also be proportionate and be limited to relevant details. It may be necessary to justify such disclosure to the courts or to regulatory bodies

[68] *Mental Health Act 1983 – Code of Practice (revised) DoH 1999 paragaph 1.8.*
[69] *Consultation on the draft revised Mental Health Act 1983 Code of Practice DoH para.17*
[70] *Confidentiality – NHS Code of Practice 2003. Relevant extracts are contained in Appendix 9.*

and a clear record of the decision making process and the advice sought is in the interest of both staff and the organisation.

10. With respect to Mr. Butler's care, there is no indication or evidence in case notes that the disclosure or sharing of information was discussed with him, that consent to do so was sought or that consideration was given to the necessity for such action. Furthermore, there was no evidence of discussions within the team of the need to share information with any other agencies.

11. It is a fundamental role of care co-ordinators to initiate and maintain contact and partnership working with other agencies providing care or services to patients. Had regular contact been maintained with the Housing Department for example, the care co-ordinator is likely to have been aware that Mr. Butler was not paying his rent and the Housing Department would have known that he was under the care of mental health services. Such a liaison and sharing of information would have raised an alarm that his tenancy would be compromised, indeed serving an eviction notice would not have taken place as a first option to non payment of rent.

12. In some cases however, it may not be possible to disclose information without compromising care. This may have been the team's reasoning in the case of Mr. Butler. Staff of the Assertive Outreach Team may have been concerned that disclosing information related to his mental health might cause him to reject their interventions and ultimately lose the little contact they had with him. Nevertheless, there is no evidence that such discussions about sharing information took place with him prior to his discharge from hospital. Such arrangements should have been made part of the conditions of discharge and be clearly documented in his care plan. However, there is a need for the team to weigh up the consequences of such action against the risks that Mr. Butler might have presented to the public if he failed to cooperate. As a minimum, a team discussion should have taken place in order to decide what action was appropriate to put a plan in place.

13. Working in the community can bring rare opportunities that are not predominantly available in other spheres of care delivery in mental health services, i.e. contact with the general public. Such contacts cannot be under-estimated for the value they can contribute to the understanding of circumstances and can give a clear picture of the person cared for. Community care workers meet and greet neighbours with regularity, while maintaining confidentiality as to the nature of their identity and business. Nevertheless, these encounters can be critical to gleaning information which may be of benefit in the overall understanding of current circumstances. In Mr. Butler's case his neighbours were concerned about his activity at night as he could be heard walking around his flat and playing music into the early hours. In addition his previous history of aggression towards his neighbours should have given rise to anxiety and concern for their welfare. The Assertive Outreach Team did not engage with Mr. Butler's neighbours and so were not aware of their experiences of him as a neighbour. This was a missed opportunity for a more detailed understanding of his day to day living circumstances as well an opportunity to assess his mental health and to detect signs of deterioration/relapse. CPN (C) told the panel:

…..if Mr. Butler had seen me talking to neighbours it would have increased his paranoia and probably have diminished the slight relationship that we had with him.

14. In view of these circumstances there is a need for staff to re-visit the area of confidentiality and sharing information as set out in the draft Mental Health Act, Code of Practice to ensure that confidentiality is not used as a means which prohibits gaining knowledge therefore impacting on providing a comprehensive assessment and care package.

15. Recommendations

15.1 The Trust should take steps to ensure that Outreach Teams liaise and share with other agencies involved in care to enable them to obtain an in-depth understanding and knowledge of all aspects relevant to the

individual's care and to be in an informed position to plan care appropriately.

15.2 The Trust should take steps to ensure that outreach teams can demonstrate that discussions took place around whether or not to share information with other agencies or Mr. Butler and that the rationale for reaching their decisions is documented.

15.3 Outreach teams should have regard to the need to utilise the engagement of neighbours/members of the public (where appropriate) recognising their valuable contribution.

CHAPTER 14

RECOMMENDATIONS

1. CHAPTER 1 – INTRODUCTION

1.1 We consider it is essential that the Trust now reviews the records of Mr. Butler and ensures that a properly ordered and as complete as possible a set is collated for future use. Further, given the complexity of his case, an accurate summary should be drawn up of the salient points of the history for use in the future, should Mr. Butler ever require outpatient mental health service in future. Accordingly we recommend that the Trust undertake such a review.

1.2 This report should be published in its entirety, but that before doing so an opportunity is given to Mr. Butler to make representations on the subject so that these may be taken into account in the SHA's decision-making process.

1.3 The Trust and the Strategic Health Authority should consider whether the issues in this report require a review of policy and practice in community mental health services generally in their respective areas and, to the extent that they consider that a a review is necessary, ensure that it is carried out and publish the results.

1.4 The Trust and the Strategic Health Authority should produce and publish a statement indicating the extent to which they accept the findings and recommendations in this report and the action taken to implement those recommendations which they accept.

2. CHAPTER 3 – THE INCIDENT

2.1 Mental health services in Birmingham should review with West Midlands Police the advice, support and training available to the police for dealing with the mentally ill, in particular in relation to techniques of engagement, detention and reduction of risk.

2.2 Mental health services should seek to open a dialogue with West Midlands Police to explore methods of improving engagement with

persons with differing mental health needs and cultural backgrounds consistent with the protection of the public.

2.3 The Trust and the Strategic Health Authority should review with the police procedures and resources whereby advice could be made available to the police in relation to incidents involving known mental health service users.

2.4 The Trust should review record keeping policies to ensure that a document is constantly available in an easily accessible form to enable important information relevant to a service user's mental state, needs, and risk to be available to professionals who do not have a personal knowledge of the case. This could take the form of the new computerised CPA documentation that has been brought in, but the Trust should review the type of information kept in this form in the light of the history in this case.

3. CHAPTER 7 – OVERVIEW OF CARE

3.1 As part of the discharge planning for any patient intended to be referred to the Assertive Outreach Team, the requirements of engagement must be considered and, where possible agreed with the patient. Where agreement is not possible, it should be made clear that non-co-operation with the requirements of engagement may lead to re-admission. The use of statutory powers for a supervised discharge should be considered in all cases considered suitable for care in the community by an Assertive Outreach Team.

3.2 Care planning in assertive outreach cases should include a strategy for moving users on, including, where appropriate, defined aims which if achieved will lead to discharge from the care of the team.

3.3 The requirements of engagement should generally include a requirement that the user permits team members to enter his residential accommodation for the purpose of meeting him when they deem it appropriate. The care plan should include a contingency plan

preferably agreed with the service user, for use if such access if consistently refused.

3.4 Where compliance with medication is a concern, the requirements of engagement should include the measures required for appropriate monitoring of compliance. In appropriate cases physical investigations, such as blood tests, should be considered.

3.5 Discharge and care planning in assertive outreach cases should include a programme of social support, including occupational activities and resources individually tailored to the user and appropriate to his/her age, ethnicity, intellectual abilities and other relevant characteristics, as opposed to restricting such support to commonly used resources.

3.6 Discharge and care planning in assertive outreach cases must include identification of social and statutory contacts with whom it is in the interests of the user and the public that information about him/her may be exchanged or obtained. It should be made clear to the user that confidential information may be disclosed or obtained without his/her consent where it is considered to be in his/her interests or those of the public to do so, and that such communication may take place for the purpose of detecting or addressing any risk to the user or the public or deterioration in the user's mental state or condition. Such contacts should, where appropriate, include the user's neighbours, and landlords.

3.7 Delivery of medication to a service user in the community should be made directly to the user, and except in the most exceptional circumstances should never be by leaving medication with a third party or at the user's address or otherwise indirectly. Where such methods of delivery are used the reasons for this must be documented.

3.8 All contacts with the user by team members must be recorded in accessible form in the user's records. Such records should contain an account of the interaction, whether any action previously required has

been performed, an assessment of the user's condition, any changes from previous assessments observed, and any action required as a result of the visit.

3.9 Arrangements must be made to ensure that all clients of the team are discussed by the team on a regular basis with sufficient time for the case to be presented and consensus reached as to what changes if any have occurred in condition and risk, and what changes if any are required in the care plan. Such discussions must be documented and included in the user's records.

3.10 A risk assessment should be prepared when a user is accepted into the care of the team. This should be reviewed on an agreed regular basis and otherwise when required by a change in condition or circumstances. The up to date risk assessment document must be readily accessible not only to the team but any other mental health care worker or representative of other statutory agencies where this is appropriate.

3.11 Care Programme Approach methods and documentation must be used in all cases managed by assertive outreach.

3.12 Generally users deemed suitable for support through assertive outreach should be seen at least once a week by a team member for assessment, interaction and support. If a less frequent routine is adopted the reason for this should be documented.

3.13 In the event of attempted contact failing, the reason for this must be investigated and documented.

3.14 The resources for providing social and other support available to the team should be regularly reviewed with regard to the needs of the service users.

3.15 The work of the team should be reviewed on a regular basis with a view to establishing outcome measures, monitoring of standards of documentation, compliance with applicable policies, and ability to

identity and address exceptionally challenging cases.

3.16 We recognise that this Inquiry and its findings are likely to add to the stress suffered by this team and its members. We feel that it would be beneficial to them to have the opportunity of discussing our findings with us in a private seminar.

4. CHAPTER 8 – MONITORING OF MEDICATION

4.1 In all cases requiring monitoring of compliance the team should actively consider what techniques can and should be used other than the service user being asked routine questions.

4.2 In cases with a history of non-compliance with medication regimes, the care plan should specify the steps that will be taken to monitor future compliance and the agreement of the service user sought for these steps. The steps that should be considered should include, but not be limited to:

4.2.1 Regular questioning of the service user

4.2.2 Inspection of medication containers and medication in his possession.

4.2.3 Initial direct visual observation of consumption.

4.2.4 Requirements as to the place where medication is delivered and consumed.

4.2.5 Blood drug levels.

4.2.6 Monitoring of side effects.

4.2.7 Regular recording of signs and matters relevant to the monitoring of side effects, such as weight and tremors.

4.3 In all such cases a structured programme of monitoring should be considered allowing for changes in intensity in accordance any changes in the level of concern about compliance.

4.4 The Trust should investigate whether tests of Olanzapine levels are

available and if so consider defining the class of case in which such tests should normally be conducted.

4.5 The Trust should ensure that medication is never delivered otherwise than personally to the service user as a matter of routine and in any event never so delivered without a good and documented reason.

4.6 The Trust should review its recording policies and practice with regard to the dispensing and delivery of medication by Assertive Outreach Teams to service users to ensure that delivery can be proved and audited.

5. CHAPTER 9 – LIAISON WITH OTHERS

5.1 Mental health services should initiate urgent discussions with the Housing Department and the benefits department to provide a system of mutual exchange of information in the interests of their mutual clients, such exchange to have due regard to the rights of users to confidentiality, but also to their and the public's interests in safety, health and welfare. This should be routinely embedded as part of CPA procedures and practices.

5.2 Mental health services should request the Housing Department to review its policies and procedure to ensure that, where a tenant is known to have a mental health history or to be in receipt of mental health services, no steps should be taken to enforce the collection of rent arrears or to seek possession in such a case without consideration of whether the assistance of mental health services should be sought.

5.3 Mental Health Services should explore with the Housing Department and other social landlords how they can assist in compliance with the Pre-action Protocol for Possession Claims based on Rent Arrears.[71] The provisions which appear to be relevant are reproduced in Appendix *6*.

[71] *See http://www.justice.gov.uk/civil/procrules_fin/contents/protocols/prot_rent.htm*

5.4 Consideration should be given to ensuring routine contact with the housing and benefits department as part of the regular review of each service user in receipt of public housing and/or housing benefit.

5.5 The Trust should review its policy with regard to seeking and sharing information about service users taking into account the observations we have made above.

6. CHAPTER 10 - THE FUNCTION, MANAGEMENT AND WORKING OF THE AOT

6.1 Acting managerial roles should be short term, preferably up to 6 months with permanent appointments taking place thereafter.

6.2 The skill mix of Assertive Outreach must include psychological and occupational therapy services to ensure there are a range of therapeutic approaches and interventions from all members of the multi-disciplinary team. This will extend the range of services provided.

6.3 A critical review must be put in place to ensure all patients (particularly those at low risk) should be subject to a full team discussion. Every patient must benefit from this every six months.

6.4 All team members must have regular seminars to discuss issues of practice which can cause concern or to develop a team approach to care.

6.5 Team learning is important to ensure there is time for reflection on team practices, and to take views of new members into the team. This will underpin practices and ensure that team members are in agreement and aware of actions to take in certain circumstance to promote care. This is especially important for new members joining the team and for junior staff to develop their skills in working in Assertive Outreach.

6.6 Action plans developed following Serious Untoward Incidents involving patients of the team must be discussed with the team and a time frame for implementation the actions set and audited.

6.7 It is essential that staff follow Trust Policies in order to ensure the safety of patients and members of the public and that nursing staff are held to account for their practices.

6.8 Medication cards must be signed when medication is delivered and regular audits of this practice should take place.

6.9 The care co-ordinator must clearly set boundaries, organise liaison and set structures for activity for the team and other agencies involved.

6.10 Meaningful audits of records must take place at least on an annual basis with lessons learned addressed within the service.

6.11 There needs to be a clear mechanism to ensure that information is shared between agencies such as the police, housing etc.

6.12 The Trust needs to ensure performance indicators are embedded within services to provide assurance related to activity and standards of practice to senior management and the Trust Board.

6.13 All team members must ensure they have opportunities to visit other Assertive Outreach teams and community mental health team to learn from others and to review their practices and care processes.

6.14 The value of the Assertive Outreach Forum must be recognised as a means to develop common practices across all Trust AOT services. The forum should be more widely used and available to all members of the team. Regular feedback about the forum must be provided to the team.

7. CHAPTER 11 – SOCIAL CARE

7.1 The Trust should review its policies in relation to social engagement and interventions with its Local Authority partner to ensure that the importance is recognised and the effectiveness of these policies should be closely monitored, challenged and re-designed if necessary.

7.2 The service user should be actively encouraged to be involved with care planning linked to his/her hopes and ambitions. The social care

element of the plan should be detailed and relate to the individual's circumstances. It should be pro-active rather than limited to monitoring. If a person refuses to be involved, this should be noted at every review. The offer of an advocate should be considered.

7.3 The importance and relevance of being on section 117 aftercare should be acknowledged in the CPA and care planning.

7.4 Relatives, friends and carers should be supported in their role and if they meet the criteria for a carers assessment, this should be done. At any rate, they should be given appropriate information and support. This should be offered whether or not they are in contact with the service user.

7.5 If agencies have engaged with service users and team in the past, their relevant, continued involvement should be maintained and support and necessary information co-ordinated and exchanged.

8. CHAPTER 12 - CULTURE, RACE AND THE SERVICE USER

8.1 The Trust should review methods of care assessment to ensure they include all information relevant to the service user's racial and cultural background. Knowledge of such information should not be assumed and must be sought and recorded in every case.

8.2 The Trust should ensure that teams continue dialogue with all service users with a principal purpose of ascertaining and recording their views, their needs and their ambitions.

8.3 The Trust should ensure that a cultural profile of each service user is maintained and updated which should include details of his ethnic and family background, his relevant experiences, and his cultural needs.

8.4 The Trust should ensure that regular opportunities are provided within teams for open discussion of racial and cultural issues arising out of individual cases and the case load in general.

8.5 The Trust should consider incorporating the elements of the cultural formulation proposed in DSM-IV into local practice and other means of fostering culturally responsive support for service users.

8.6 The Trust should provide the resources for and develop the relevant policies to ensure the integration of racial and culturally relevant training into team routine and practice through active management and supervision.

8.7 The Trust should ensure that all Assertive Outreach Team staff receives relevant racial and culturally relevant training through appraisal, and personal development planning.

9. CHAPTER 13 - SHARING INFORMATION

9.1 The Trust should take steps to ensure that outreach teams liaise and share with other agencies involved in care to enable them to obtain an in-depth understanding and knowledge of all aspects relevant to the individuals care and to be in an informed position to plan care appropriately.

9.2 The Trust should take steps to ensure that outreach teams can demonstrate that discussions took place around whether or not to share information with other agencies or Mr. Butler and that the rationale for reaching their decisions is documented.

9.3 Outreach teams should have regard to the need to utilise the engagement of neighbours/members of the public (where appropriate) recognising their valuable contribution.

TERMS OF REFERENCE

ENCLOSURE 1

Birmingham and The Black Country NHS
Strategic Health Authority

Independent Investigation into the Care and Treatment of GB

Terms of Reference

1. To examine the circumstances and events relating to the treatment and health care of GB by Birmingham and Solihull Mental Health NHS Trust and its predecessor organisations where relevant, and in particular the treatment and health care in the period leading up to the death of DC Swindells.

2. To examine the mental healthcare received by GB in the context of his life history, taking into account any issue raised by cultural diversity which appear to be relevant, in order to obtain a better understanding of.

3. To assess the extent to which the treatment and health care of GB complied with statutory obligations, relevant guidance from the Department of Health and local operational policies.

4. To identify any constitutional systemic or professional deficiencies in the treatment and health care provided to GB, including any deficiencies in the quality of the assessed risk of potential harm to himself or others by root cause analysis and such other means as appear appropriate, for the purpose of enabling lessons to be learnt rather than the apportionment of blame or liability.

5. To consider the effectiveness of interagency working, including communications between the mental health services, the police and other agencies with particular reference to the sharing of information for the purpose of risk assessment.

6. To review the internal inquiries into the care of GB already undertaken by Birmingham and Solihull Mental Health NHS Trust, any action plans that may be formulated, including the immediate remedial action taken at the time of the incident, or action take as a result of the internal inquiry and assess the effectiveness of their implementation.

7. To inquire into such other matters as may appear necessary for the purpose of investigating and reviewing the treatment and health care of GB.

8. To prepare and produce a report on the above, including any recommendations for future action the panel finds it appropriate to make, for publication by the Strategic Health Authority.

It is hoped that additional members of the inquiry panel shall be appointed by the Strategic Health Authority in consultation with the Chair, Robert Francis QC, by the end of 2005 and that the panel will deliver their report to the Strategic Health Authority by about June 2006. The panel is requested to inform the Strategic Health Authority of the progress of the investigation at approximately three month intervals, following the appointment of the full panel.

Corinne Taylor
Secretary to the Board/
Head of Corporate Affairs

Date: 24 January 2006

Incorporating the NHS in Birmingham, Dudley, Sandwell, Solihull, Walsall and Wolverhampton

APPENDIX 2

LIST OF MATERIALS

Medical Records	-	Ashworth Hospital
	-	Birmingham & Solihull Mental Health NHS Trust
	-	GP
	-	North Staffordshire Hospital NHS Trust
Police Records	-	West Midlands Police
Court Transcripts	-	Birmingham Crown Court
Press Cuttings	-	Local and National Newspapers
Trust Internal Inquiry Report	-	Birmingham & Solihull Mental Health NHS Trust
Rent Statements / Correspondence	-	Birmingham City Council Housing Department
Policies	-	Birmingham & Solihull Mental Health NHS Trust
	-	Birmingham & Solihull Mental Health Trust Assertive Outreach Team
Clinical Review Meetings	-	Birmingham & Solihull Mental Health Trust Assertive Outreach Team

APPENDIX 3

PUBLICATIONS

A Model of Care of Mental Health Services in the Heart of Birmingham
Heart of Birmingham

An Organisation with Memory
Department of Health, 2000

Assertive Outreach
Kings Fund, December 2004

Assertive Outreach and Recovery Team Operational Policy
Wandsworth Assertive Outreach and Recovery Team

Breaking the Circles of Fear
Sainsbury Centre for Mental Health, July 2000

Briefing note to guide commissioning of Dedicated Teams or Integrated Teams to provide the Assertive Outreach Function.
National Forum for Assertive Outreach (NFAO), October 2006

Building as Safer NHS
Department of Health, April 2001

Building Bridges
NHS Executive, November 2005

Code of Practice Mental Health Act
Department of Health & Welsh Office, March 1999

Could do Better? London Development Centre
Care Services Improvement Partnership (CSIP), October 2006

Delivering Race Equality
Department of Health, October 2003

Effective Care Co-ordination in Mental Health Services
Department of Health, January 1999

Engaging and Changing
National Institute for Mental Health in England (NIHME), October 2003

HSG (94) 27 Guidance on the Discharge of Mentally Disordered People and Their Continuing Care in the Community
Department of Health, May 2004

HSG (27) Amendment Independent Investigation of Adverse Events in Mental Health Services
Department of Health, June 2004

Independent Inquiry into the Death of David Bennett
Norfolk, Suffolk and Cambridge Strategic Health Authority, December 2003

Inside Outside
National Institute for Mental Health in England (NIHME), October 2003

Journey to Recovery
Department of Health, November 2001

Mental Health Commissioning Strategy for Working Age Adults 2005 to 2008
Heart of Birmingham, March 2005

The Mental Health Policy Implementation Guide
Department of Health, March 2001

Mental Health Implementation Policy – Adult Acute In-Patient
Department of Health, April 2002

Mental Health Implementation Policy – Dual Diagnosis
Department of Health, April 2002

With Satefy in Mind : Mental Health Services and Patient Safety – Patient Safety Observatory Report
National Patient Safety Agency, July 2006

NSF for Mental Health
NHS, September 2005

Report of Clinical Governance Review at North Birmingham Mental Health Trust
Commission for Health Improvement, July 2001

Report of the Independent Inquiry into the Care and Treatment of David Johnson
Birmingham Health Authority (now West Midlands Strategic Health Authority), January 2004

Report of the Independent Inquiry into the Care and Treatment of Arshad Mahmood
Birmingham Health Authority (now West Midlands Strategic Health Authority), June 2000

Report of the Committee of Inquiry into the Death in Broadmoor Hospital of Orville Blackwood and a Review of Two Other Afro-Caribbean Patients – "Big, Black and Dangerous?" - Broadmoor

Report of an Independent Review of the Care and Treatment of Mr. Ogilpis Hamilton and Mr. Abdul Rehman
Birmingham Health Authority (now West Midlands Strategic Health Authority), March 2004

Safety First
Department of Health, March 2001

Schiizophrenia – Core Intervention in the Treatment and Management of Schizophrenia in Primary and Seconday Care
National Institute for Clinical Excellence (NICE), December 2001

Standards for Better Health
Department of Health

Still Building Bridges
Department of Health & Social Care Group, March 1999

APPENDIX 4

WITNESS LIST

Team Manager (A)
Nette Carder - Director of Operations
Consultant Psychiatrist (A, B, C, D, E, F, and G)
Consultant Forensic Psychiatrist (A and B)
Registered Mental Nurse (A)
Dr. Neil Deuchar - Medical Director
Service Manager (A and B)
Approved Social Worker (A and B)
General Practitioner
Team Manager (B) – Rehabilitation & Recovery
Review Manager (Birmingham City Council)
Social Worker (A) (HMP Ashworth)
Police Sergeant H
Housing Officer (A)
Ken Jackson - Service Director
Support Worker (A, B and C)
Primary Care Liaison Manager
Peter Lewis - Clinical Director
Staff Support
Community Psychiatric Nurse (A, B, C, D and E)
Accommodation Officer
Psychologist (A)
Lakhvir Rellon - Director of Cultural Diversity
Local Housing Manager (Birmingham City Council)
Community Psychiatric Nurse
Social Worker
Student (A)
Support Worker (A, B and C)
Sue Turner - Chief Executive
Service Manager
Risk Manager

APPENDIX 5

SCHEDULE OF MEDICATION PRESCRIBED

DATE	MEDICATION
17/03/1994	Chlorpromazine 100mg prn Procyclidine
23/03/1994	Chlorpromazine 150mg
13/05/1994	Tests dose of Depixol depot
18/04/1994	Chlorpromazine 100m qds
01/06/1994	Depixol 75mg every 2 weeks
25/07/1994	Depixol 100mg weekly
31/10/1994	Trial Risperidone Risperidone 2mg bd Depot continued
?/08/1995	Trifluoperazine 10mg nocte Depot continued
15/?/1995	Sulpiride Procyclidine 5mg daily Depot continued
18/07/1996	Plan to replace depot with Risperidone
11/04/1996	Stelazine 5mg tds Procyclidine 5mg tds
22/03/1996	Stelazine tmg tds Procyclidine 5mg tds
26/04/1996	Refused depot
11/04/1996	Clopixol tablets 10mgs bd for 3 months
12/07/1996	On Depixol 50mg every 2 weeks
01/10/1996	Risperidone 12mg nocte

DATE	MEDICATION
07/01/1997	Lithium Carbonate started 600mg nocte
09/04/1997	Efexor 150mg bd
?/08/1997	Efexor 75mg bd
23/07/1997	Efexor 37.5mg
?/09/1999	Amilsulpride 200mg bd Clopixol depot 300mg every week Test dose of Piportil palmitate depot given - 25mg? Amilsulpride increased to 400mg bd
?/01/2000	Depixol 20mg Orphenadrine
?/02/2000	Venlafaxine 37.5mg morning Amilsulpride 400mg bd
?/04/2001	Medication free assessment
10/04/2001	Refusing medication
14/04/2001	1m Lorazepam 2mg 1m Haloperidol 5mg 1m Acuphase 100mg
6/06/2001	Depot Clopixol 200mg - weekly Refusing medication
22/06/2001	Zuclopenthixol 200mgs IM Haloperidol 5mg Lorazepam 2mg
29/06/2001	Zuclopenthixol 200mg repeated
?/07/2001	Olanzapine Velotab 10mg given Better compliance
2001/2002/ 2003/2004	On Olanzapine 10mg - daily

Note:

Efexor	is the same as	Venlafaxine
Stelazine	" "	Trifluoperazine
Zuclopenthixol	" "	Clopixol

APPENDIX 6

EXTRACT FROM PRE-ACTION PROTOCOL FOR POSSESSION CLAIMS BASED ON RENT ARREARS

4. (a) If the landlord is aware that the tenant has difficulty in reading or understanding information given, the landlord should take reasonable steps to ensure that the tenant understands any information given. The landlord should be able to demonstrate that reasonable steps have been taken to ensure that the information has been appropriately communicated in ways that the tenant can understand.

(b) If the landlord is aware that the tenant is under 18 or is particularly vulnerable, the landlord should consider at an early stage –

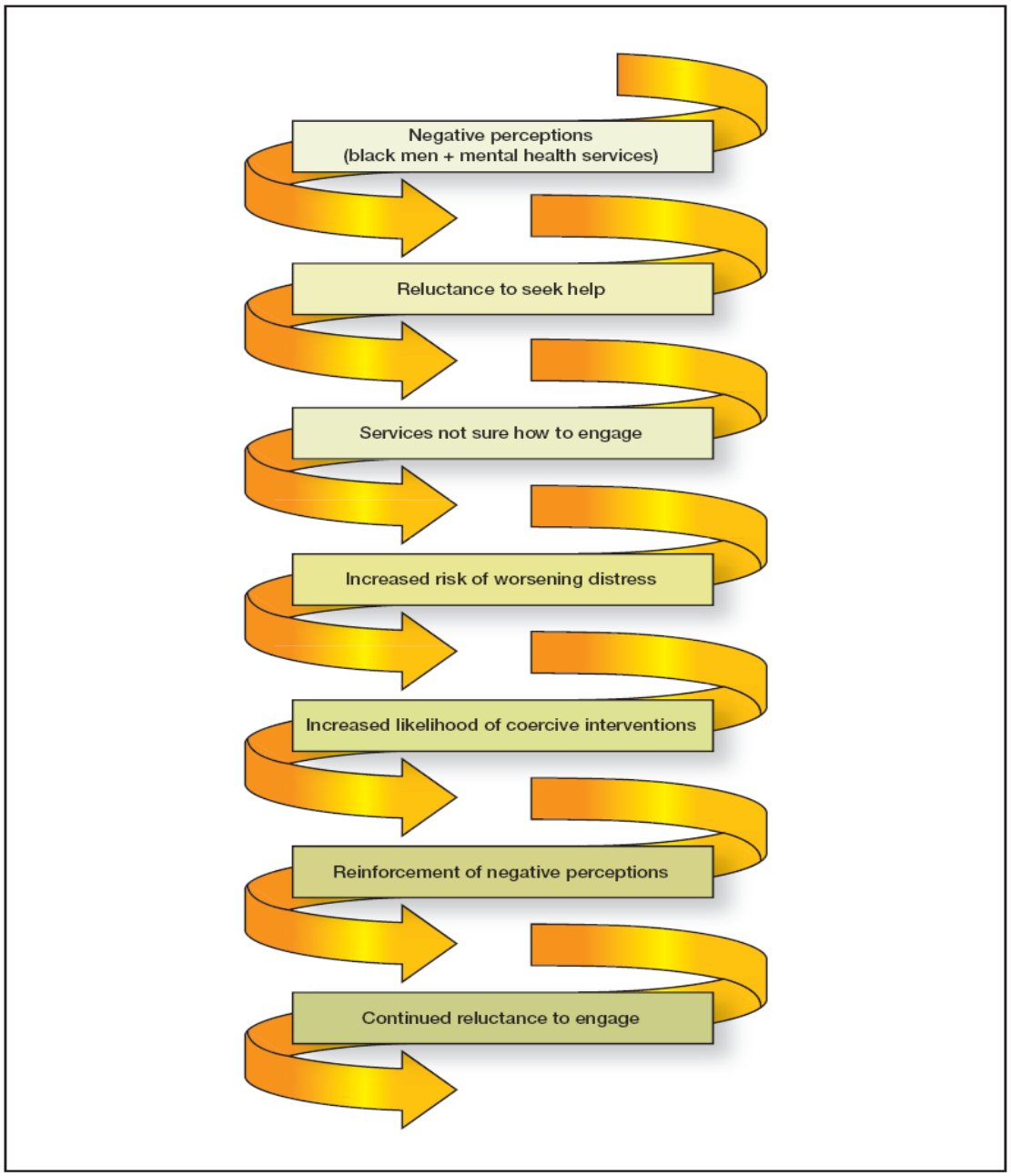
(i) whether or not the tenant has the mental capacity to defend possession proceedings and, if not, make an application for the appointment of a litigation friend in accordance with CPR 21;

(ii) whether or not any issues arise under Disability Discrimination Act 1995; and

(iii) in the case of a local authority landlord, whether or not there is a need for a community care assessment in accordance with National Health Service and Community Care Act 1990.

APPENDIX 7

THE "SPIRAL OF OPPRESSION"[72]



[72] *From African and Caribbean Mean and Mental Health, Keating, Race Equality Foundation 2007 page 7*

TABLE 1
Components of the Cultural Formulation

Cultural formulation section	*Subheading*
Cultural identity of the individual	• Individual's ethnic or cultural reference group(s) • Degree of involvement with both the culture of origin and the host culture (for immigrants and ethnic minorities) • Language abilities, use, and preference (including multilingualism)
Cultural explanations of the individual's illness	• Predominant idioms of distress through which symptoms or the need for social support are communicated • Meaning and perceived severity of the individual's symptoms in relation to norms of the cultural reference group(s) • Local illness categories used by the individual's family and community to identify the condition • Perceived causes and explanatory models that the individual and the reference group(s) use to explain the illness • Current preferences for and past experiences with professional and popular sources of care
Cultural factors related to psychosocial environment and levels of functioning	• Culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability • Stresses in the local social environment • Role of religion and kin networks in providing emotional, instrumental, and informational support
Cultural elements of the relationship between the individual and the clinician	• Individual differences in culture and social status between the individual and the clinician • Problems that these differences may cause in diagnosis and treatment (e.g. difficulties in eliciting symptoms and understanding their cultural significance, in determining whether a behavior is normal or pathological, etc.)
Overall cultural assessment for diagnosis and care	• Discussion of how cultural considerations specifically influence comprehensive diagnosis and care

Note. Summarized from DSM-IV, pp. 843–844.

Extracted from Fernandez and Diaz, *The Cultural Formulation: A Method of Assessing the Cultural Factors Affecting the Clinical Encounter*, (2002) 73 Psychiatric Quarterly 271 page 5.

APPENDIX 9

EXTRACTS FROM *CONFIDENTIALITY – NHS CODE OF PRACTICE [DoH 2003]*

10. Patients entrust us with, or allow us to gather, sensitive information relating to their health and other matters as part of their seeking treatment. They do so in confidence and they have the legitimate expectation that staff will respect their privacy and act appropriately. In some circumstances patients may lack the competence to extend this trust, or may be unconscious, but this does not diminish the duty of confidence. It is essential, if the legal requirements are to be met and the trust of patients is to be retained, that the NHS provides, and is seen to provide, a confidential service. What this entails is described in more detail in subsequent sections of this document, but a key guiding principle is that a patient's health records are made by the health service to support that patient's healthcare.

11. One consequence of this is that information that can identify individual patients, must not be used or disclosed for purposes other than healthcare without the individual's explicit consent, some other legal basis, or where there is a robust public interest or legal justification to do so. In contrast, anonymised information is not confidential and may be used with relatively few constraints.

12. t is extremely important that patients are made aware of information disclosures that must take place in order to provide them with high quality care. In particular, clinical governance and clinical audits, which are wholly proper components of healthcare provision, might not be obvious to patients and should be drawn to their attention. Similarly, whilst patients may understand that information needs to be shared between members of care teams and between different organisations involved in healthcare provision, this may not be the case and the efforts made to inform them should reflect the breadth of the required disclosure. This is particularly important where disclosure extends to non-NHS bodies.

38 … Patients understand that some information about them must be shared in order to provide them with care and treatment, and clinical audit, conducted locally within organisations is also essential if the quality of care is to be sustained and improved. Efforts must be made to provide information, check understanding, reconcile concerns and honour objections. Where this is done there is no need to seek explicit patient consent each time information is shared

Annex A para 5

d. Share the minimum necessary to provide safe care or satisfy other purposes.

This must clearly be balanced against the need to provide safe care where missing information could be dangerous. It is important to consider how much information is needed before disclosing it. Simply providing the whole medical file is generally needless and inefficient (for both parties), and is likely to constitute a breach of confidence. The Caldicott principles[7] should be followed–

Figure 6 – The Caldicott Principles

i. Justify the purpose.

ii. Don't use patient identifiable information unless it is absolutely necessary.

iii. Use the minimum necessary patient identifiable information.

iv. Access to patient identifiable information should be on a strict need to know basis.

v. Everyone should be aware of their responsibilities.

vi. Understand and comply with the law.

Annex B - Disclosure in the public interest

30. Under common law, staff are permitted to disclose personal information in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others where they judge, on a case by case basis, that the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual patient concerned and the broader public interest in the provision of a confidential service.

31. Whoever authorises disclosure must make a record of any such circumstances, so that there is clear evidence of the reasoning used and the circumstances prevailing. Disclosures in the public interest should also be proportionate and be limited to relevant details. It may be necessary to justify such disclosures to the courts or to regulatory bodies and a clear record of the decision making process and the advice sought is in the interest of both staff and the organisations they work within.

32. Wherever possible the issue of disclosure should be discussed with the individual concerned and consent sought. Where this is not forthcoming, the individual should be told of any decision to disclose against his/her wishes. This will not be possible in certain circumstances, e.g. where the likelihood of a violent response is significant or where informing a potential suspect in a criminal investigation might allow them to evade custody, destroy evidence or disrupt an investigation.

33. Each case must be considered on its merits. Decisions will sometimes be finely balanced and staff may find it difficult to make a judgement. It may be necessary to seek legal or other specialist advice (e.g. from professional, regulatory or indemnifying bodies) or to await or seek a court order. Staff need to know who and where to turn to for advice in such circumstances.

Figure 7
Risk of Harm

Disclosures to prevent serious harm or abuse also warrant breach of confidence. The risk of child abuse or neglect, assault, a traffic accident or the spread of an infectious disease are perhaps the most common that staff may face. However, consideration of harm should also inform decisions about disclosure in relation to crime. Serious fraud or theft involving NHS resources would be likely to harm individuals waiting for treatment. A comparatively minor prescription fraud may actually be linked to serious harm if prescriptions for controlled drugs are being forged. It is also important to consider the impact of harm or neglect from the point of view of the victim(s) and to take account of psychological as well as physical damage. For example, the psychological impact of child abuse or neglect may harm siblings who know of it in addition to the child concerned.

17.2 People who give information have the right to expect that the recipient will not share it if it is clear from the circumstances that it was meant to be kept confidential. Certain situations, such as discussions with a doctor or social worker, are generally presumed to be confidential.

17.3 However, there are circumstances in which it is both justifiable and important to share otherwise confidential information about patients who are, or have been subject to the Act, to minimise the risk of harm.

17.4 Before considering disclosure of confidential information the individual's consent should always be sought. For consent to be valid, the person must be capable of understanding what is being asked, appreciating the consequences for them and weighing up the options in order to reach a decision.

17.5 If a patient is unconscious or unable, due to a mental or physical condition, to give consent or to communicate a decision, the health professionals concerned must take decisions about the use of information. This needs to take into account the patient's best interests and any wishes previously expressed by the patient, and be informed by the views of relatives or carers as to the likely wishes of the patient. If a patient has made his or her preferences about information disclosures known in advance, they should normally be respected.

17.6 Otherwise, in the absence of consent, a breach of confidence can only can only lawfully be justified if: there is a legal requirement or authority to do so – for example a court order or a requirement under the Act requiring disclosure, or a relevant provision of data protection legislation; or there is an overriding public interest in disclosing the information where the professional must exercise judgement.

17.7 The "public interest" is not the same as what might be of interest to the public. Where personal health information is involved public interest justifications for overriding confidentiality could include (but are not limited to) protecting others from serious harm and preventing serious crime.

17.8 The public interest in disclosing information may vary according to the type of information. Even in cases where there may not be an overriding public interest in disclosing detailed clinical information about a patient's state of health, there may be such an interest in sharing more basic information about the patient's current and past status under the Act where that is vital for properly informed risk management by the relevant authorities. It will usually be possible to distinguish such basic information from personal information about an individual's mental health and treatment plan.

17.9 The judgement to be made needs to balance the public interest in disclosure, including the need to manage any risk and prevent harm to others, with both the rights of the individual(s) concerned and the public interest in maintaining trust in a confidential service. Solid justification is required to breach clinical confidentiality and specialist or legal advice should be sought before information is disclosed. Any decision to disclose should be fully documented.

17.10 The common law does not normally permit disclosure of someone's personal information purely in their own interests, if they have capacity to consent to the disclosure, but refuse to do so. However, where the Act authorises treatment without consent, information which could not otherwise be shared, may be shared in so far is it necessary for the provision of the treatment in question.