Birmingham and The Black Country NHS
Strategic Health Authority

# The Report of the Independent Inquiry into the Care and Treatment of KM

**Commissioned by**
**The Birmingham and Black Country Strategic Health Authority – 2005**

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## INQUIRY PANEL MEMBERSHIP

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## ACKNOWLEDGEMENTS

We would like to take this opportunity to convey our condolences to the family of Mrs H. who tragically died as a result of the incident which prompted this report. We also hope that Mr. M, who was injured, has fully recovered from his ordeal.

We would like to thank everyone who gave up time to give evidence to the Inquiry Team. All of the witnesses who gave evidence to the Inquiry Team are listed in Appendix 3.

Any Inquiry like this requires good management and organisation and in this respect we are indebted to Ms. Pearl Green who carried out these duties with a great deal of professionalism.

In addition to taking verbal evidence we read a great deal of written material. In all we read some 5570 pages of documentation, a full list of which can be found at Appendix 4.

Lastly our task was made easier by the efficient manner that the Fiona Shipley Transcription Service promptly provided us with the transcriptions of all our interviews.

## PREFACE

The responsibility for setting up independent inquiries remains with the Strategic Health Authorities. The Birmingham and Black Country Strategic Health Authority commissioned the Inquiry team to carry out this investigation 'as soon as possible'.

We are aware that by the time our report is published three years and more will have elapsed since the incident. All the families involved will also have had to relive their previous distressing experiences for which we can only apologise. Some staff will have moved on to other employment and some will have all their anxieties rekindled.

We hope that the process we adopted helped alleviate any anxieties that the people we interviewed may have had. We were encouraged by, and grateful for their frank and open discussion.

## TERMS OF REFERENCE

The Inquiry team were given the following terms of reference to review KM's care as drafted by the Strategic Health Authority, the PCT and the Mental Health Trust. These are:-

1. Examine the circumstances and events surrounding the treatment and health care of KM by Birmingham and Solihull Mental Health NHS Trust (BSMHT) and its predecessor organisations where relevant.

2. To examine the 'life history' of KM in the context of mental healthcare received, taking into account cultural diversity in order to gain a better understanding of the individual.

3. Assess the extent to which the care of KM complied with statutory obligations, relevant guidance from the Department of Health and local operational policies.

   - ❑ To establish a root cause analysis to identify constitutional or systemic failings, if any, rather than apportion blame to any particular team or individual which should take into account the quality of the assessed risk of potential harm to himself or others.

   - ❑ To consider the effectiveness of inter-agency working with particular reference to the sharing of information for the purpose of risk assessment.

4. To review the internal inquiries into the care of KM already undertaken by Birmingham and Solihull Mental Health NHS Trust, any action plans that may have been formulated, including the immediate remedial action taken at the time of the incident, or action taken as a result of the internal inquiry and assess the effectiveness of their implementation.

5. The agreed time scales for independent review were:

   - ❑ Approximately six months.

   - ❑ A progress report to the Strategic Health Authority, the Primary Care Trust and BSMHT within three months.

   - ❑ A draft/interim report to be submitted after five months to the Strategic Health Authority, the Primary Care Trust and BSMHT.

   - ❑ Final report to be signed off by the Strategic Health Authority.

## PROCEDURE ADOPTED BY THE INQUIRY

a) Witnesses received a letter in advance of appearing to give evidence. This letter asked them to provide a written statement, as the basis of their evidence, to the Inquiry and informed them of the terms of reference and the procedure adopted by the Inquiry. It also covered the areas and matters that were to be discussed with them, and they were assured that they could raise any matter they wish which they felt might be relevant to the Inquiry.

b) Witnesses were invited to bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wished to accompany them, with the exception of another Inquiry witness. It was explained to the witnesses that although there was an expectation that the questioning would be directed towards them, there might be occasions when the person accompanying him/her could be asked to clarify a particular point.

c) Witnesses were not asked to affirm their evidence, but the seriousness of the proceedings was pointed out to them and we were assured that all the witnesses we saw would answer our questions in their own truthful manner.

d) Evidence was recorded and a written transcription sent to witnesses afterwards for them to sign.

e) Any points of potential criticism were put to witnesses of fact, either verbally when they first give evidence, or in writing at a later time, and they were given a full opportunity to respond.

f) All sittings of the Inquiry were held in private. The draft report was made available to the Health Authority, for any comments as to points of fact.

g) The findings of the Inquiry and any recommendations are usually made public.

h) The evidence which was submitted to the Inquiry either orally or in writing will not be made public by the Inquiry, except insofar as it is disclosed within the body of the Inquiry's report.

i) Findings of fact were made on the basis of the evidence received by the Inquiry.

j) Comments, which appear within the narrative of the report and any recommendations, were based on those findings of fact.

## SUMMARY OF EVENTS

KM attended his General Practitioner in November 2001 complaining of feeling depressed and anxious as well as having difficulty in sleeping. His symptoms did not improve and he was referred to Consultant Psychiatrist A, Northern Birmingham Mental Health NHS Trust.

On 28 May 2002, KM was assessed by a CPN, accompanied by a student nurse, who recorded in the CPA Assessment Summary 'history of significant and unstable risk in relation to significant violence/harm to others'.

On 21 June 2002, the Senior House Officer, (SHO) assessed KM and following a discussion with the Associate Specialist, another appointment was made for 16 August 2002 when he saw the Associate Specialist. His mother accompanied him as suggested by the SHO. An appointment was also made for KM to attend the Early Detection and Intervention Team (ED:IT) on 12 August which he failed to keep.

KM's mother told the Associate Specialist about the arguments which had taken place between KM and some of the local shop keepers. She was not unduly concerned about her son's mental state and so he was discharged from the mental health services back to the care of his General Practitioner.

Some few weeks before the tragic incident KM and the victim's husband, Mr. H, were involved in a collision. Mr. H agreed to pay for the damage to KM's bicycle but, according to KM, the money was not forthcoming.

On 9 September 2002, KM attended the Job Centre. Whilst waiting, he felt he was being 'looked at' which he did not like, resulting in him hitting another man who was also 'signing on'. He was charged with assault and given bail.

On 16 September 2002, KM went to one of his local shops with a machete and fatally injured the shop owner, Mrs H. She was taken to a local hospital and then later transferred to the Queen Elizabeth Hospital where she died the following morning.

After he left that shop KM went to another shop, nearer his home, where he attacked and seriously injured another man, Mr. M. Later that day KM attended a local police station, and was arrested. He was charged with murder and *'wounding with intent to do grievous bodily harm'.* Consultant Psychiatrist B assessed KM, and found him *'fit to be interviewed'.*

He was transferred to HMP Birmingham and then to HMP Woodhill. Having been further assessed by Consultant Psychiatrist B and the Consultant Forensic Psychiatrist, he was admitted on 17 April 2003 to the Raeside Clinic under section 48/49 MHA 1983. The following day he appeared in Court pleading guilty to manslaughter and grievous bodily harm.

When sentencing KM on 25 April 2003, the Judge, QC said, *'treatment at a secure unit was in the public interest'* and he has been detained since under Section 37/41 of the Mental Health Act 1983.

## BACKGROUND TO THE INQUIRY

KM was a patient of the Northern Birmingham Mental Health NHS Trust between May 2002 and August 2002. For some years before this date there were discussions about the appropriate configuration of mental health services for people living in Birmingham.

Following a long and public consultation process the South Birmingham and Solihull Mental Health Services came together to form the South Birmingham and Solihull Mental Health NHS Trust leaving the Northern Birmingham Mental Health NHS Trust to care for people in that geographical area.

In 2001 there were visits to both Trusts from the Health Service Commission for Health Improvement. The team, which visited the Northern Birmingham Mental Health NHS Trust, identified deficiencies in the robustness of its 'governance' systems and made several recommendations.

Sometime in 2001, the Chief Executive left the Northern Birmingham Mental Health NHS Trust leaving the financial director to 'act' into the post of Chief Executive. At the same time the Director of Nursing, who had already been away from the Trust for some time left, resulting in the deputy Director to 'act up' into that position.

The Northern Birmingham Mental Health NHS Trust has been regarded as very proactive in developing approaches to mental health delivery, in particular changing to smaller functional teams to deliver care, many new services were initiated. Senior managers perceived that there was inadequate long-term funding. As a result the Trust became highly dependent upon non-recurrent finances for recurrent activities, whereas other organisations, also encouraged to introduce these models of care, were able to manage their finances in a more robust way.

The Trust was faced with a difficult financial future with possibly having to make some very difficult decisions about changes in services in order to manage their financial position. We were told by witnesses that, with hindsight, the Board was not provided with robust and accurate information about the financial position of the Trust.

As a result, the Board had to balance new initiatives or pilot schemes and deciding what its 'core business' was. As there was a lack of financial clarity it is probably fair to say that the focus of the Board was split between the merger with the South Birmingham and Solihull Mental Health NHS Trust and their financial position.

During 2002 the decision was taken to merge the existing Trusts in Birmingham and Solihull creating a new organisation, one of the largest in the country. The new Trust came into being in April 2003.

In the meantime the merger as well as the financial position dominated Board discussions whilst the new organisation was in 'shadow' form. It was a period of great change with lots of uncertainty.

The homicide was discussed in the confidential part of the October 2002 Board meeting. The minutes stated:

> *"The Chief Executive reported that an inquiry was taking place with regard to a serious machete incident. The former Medical Director, advised that this incident would follow the homicide inquiry policy and involve Non-Executive Directors adding that when the person involved was assessed and after the assault took place they were found to be acutely mentally ill, there was a possibility that this was not found upon the initial presentation to the service.*
>
> *Following the former Medical Director's investigation of the person's casenotes contact has been made with the person's GP and improvements to the service are being investigated."*

We were unable to locate any other papers relating to the homicide and could only conclude that the incident definitely slipped down and then off the 'agenda' until after the new chief executive received a letter from one of the local Members of Parliament. The letter came in response to one of the victims' families writing to her seeking information about what was happening and what action if any was being taken.

It should be remembered that KM was sentenced in April 2003 at the same time the new Trust came into being.

# CHAPTER 1

## KM'S LIFE UNTIL 2002

KM was born on 12 October 1976. He lived with both his parents and his younger sister until he was about four years old when his parents separated and he remained with his mother. KM has stated that there was a lot of arguing and on one occasion his father hit his mother with a rolling pin. When he was seven years old his mother began another relationship with a man who KM referred to as his stepfather. He has two half sisters from this relationship. KM said that although there was no further violence in the home there were many arguments.

KM suffered from asthma and some ENT problems during his childhood. At 12 years old he was diagnosed with heterozygous sickle cell disease but does not appear to have had any adverse health conditions as a result.

At school he was not much of an achiever, not interested in academic matters and describing himself as "the clown, just wanting to mess around". He was popular and had many friends. He admitted to having "a bit of an attitude" with respect to authoritarian figures. He gave no history of being bullied but had been in trouble on a couple of occasions for fighting with fellow pupils. In fact on one occasion he came to the rescue of a female pupil at school with him who was being intimidated by her boyfriend. He kicked this person's car and received a police caution.

In 1992 he left school at 16 years old with no formal qualifications and attended a catering course at college, completing a NVQ. He gained employment through an agency and although some were permanent jobs he was unable to keep any job for very long. He could not always remember why he left some of the jobs but he appeared to have various difficulties with some work colleagues. During one job he had problems with the area manager who KM felt had made a 'big deal' out of a very small mistake and so he left to work in a public house. Although he liked this job he left because of the poor pay. In his next position he had more problems with a male colleague. He called KM a 'faggot' in jest but if KM called him a similar name he did not like it. It ended with the two men fighting and although not considered to be serious, KM was sacked.

He worked in another public house where one of his workmates "stared at him" which led to an argument being broken up by the head of security. On leaving the public house KM was attacked by two men and he "kicked off" which resulted in him being sacked.

At the beginning of 2000 KM had a road traffic accident sustaining minor injuries causing pain in his back and shoulders. On 28 January 2000 he saw his General Practitioner A, who prescribed Ibubrofen, an anti inflammatory drug.

**3 FEBRUARY 2000**

KM went back to see his GP as he was still in pain and was prescribed Diclofenic, another anti inflammatory drug, to ease his discomfort.

Two further appointments were made for 21 and 28 February, neither of which were kept by KM.

**MAY 2000**

KM returned to see his GP complaining of insomnia and broken sleep. He denied having nightmares but was restless and unable to relax. The GP recorded:

> *"Panic attacks occasionally. Happy at work. Single no girlfriend, had relationship for 3 years – broken up…. Family – mv-No psychotic illness. ME (medical examination) anxiety state with sleep disturbance"*

He was prescribed Dothiapin 25mgs, to be taken four times a day.

He returned again 20 October 2000 and this time was prescribed Zolpidem 10 mgs. To be taken at night. The notes recorded

> *" …. not sleeping – no domestic problems or at work. Not stressed at work addition explained treatment Zolpidem 10 mgs. Nocte….."*

**12 JANUARY 2001**

KM was convicted with two accounts of 'Battery'. He assaulted two female customers, a mother and daughter whilst they were queuing at the bank. KM slapped the mother and put chewing gum in the daughter's hair.

**1 FEBRUARY 2001**

KM went back to see General Practitioner B, another GP in the practice, complaining of mild eczema on his upper arms and chest. He was given advice with regard to his sleeping.

**24 APRIL 2001**

KM did not keep an appointment with his GP.

**12 JULY 2001**

KM was found guilty at Birmingham Magistrates Court and had to pay £50 to each victim plus £110.00 costs. In his defence KM said that he had been called a "black bastard" and a "coon".

**8 November 2001**

KM attended his GP as he was still not sleeping. The GP recorded:

> *"single. On examination no relationship problems. Smoke—no. drinks about 4 units per week. Goes to bed at 3-4am, watching TV, playing video games. Advised about sleep hygiene"*

On this occasion KM told his GP he had given up smoking. He was prescribed Citalopram, an anti-depressant.

**20 November 2001**

KM returned to see GP B as he was still having problems with sleeping and was irritable. The computer records states that they had a long chat resulting in GP B recording,

> "anxiety and depression. Try Paroxetine"

| **COMMENT** |
| --- |
| When we interviewed GP B he informed us that KM was reluctant to be referred to the Mental Health services at this time. |

# CHAPTER 2

## KM'S CONTACT WITH MENTAL HEALTH SERVICES IN 2002

### 6 FEBRUARY 2002

The police were called to the National Exhibition Centre by a Security Officer, who told them "a male was going berserk with a knife". A member of staff was working in the kitchen laughing and joking with another staff member when KM grabbed her by the chest and held a knife to her throat for two minutes causing a red scratch to her skin.

### 11 February 2002

KM went back to see GP B as his symptoms were still present. He could not tolerate the Paroxetine and so his treatment was changed to Citalopram (an anti-depressant) 20mgs.

### 28 February 2002

KM returned to his GP. He was doing 'ok' on Citalopram but was now complaining of

> *"abnormal extreme thoughts that he doesn't like and tries to suppress. Willing to attend CMHT –refer"*

### 4 March 2002

GP B wrote a referral letter to Consultant Psychiatrist A, based at HW House.

> *"I would be most grateful if you could see this 25-year-old gentleman who is complaining of symptoms which is suggestive of anxiety / depression.*
>
> *He presented a few months ago requesting sleeping tablets for insomnia, which I declined. Since then he has continued to see me and is currently on Citalopram 30mg daily he seems to think that these are helping. However, he has problems with intrusive thoughts of an aggressive nature, which he recognizes as irrational and anti-social. But is concerned that he is having to battle with this.*
>
> *He has a normal premorbid personality, and no past medical history of note.*
>
> *Thank you very much for seeing him"*

**COMMENT**

This letter was found in the Trust medical notes and had Consultant Psychiatrist A's name written at the top of the page and "Assessment Clinic" written at the bottom of the page.

**14 MARCH 2002**

KM saw his GP. He complained of a cough and cold and an elixir was prescribed.

The Team Secretary, Primary Care Mental Health Team, wrote to KM, copying it to his GP

*" Assessment Clinic*

*I have received a referral from GP B asking for you to be seen by our team.*

*Could you please contact us in the next 14 days on the above number to arrange an appointment.*

*The assessment is usually about 1 hour, you are welcome to bring someone with you to help explain your difficulties if you wish"*

**COMMENT**

The prescription for Citalopram was due to finish on 16 March 2002.

**15 MARCH 2002**

The team secretary, Primary Care Mental Health Team, wrote again to KM, copying it also to his GP

*"further to our conversation regarding the Assessment Clinic appointment. I can confirm an appointment has been arranged for you come to the assessment clinic at the above address on Wednesday 29th May 2002 at 11.00am (map enclosed). You will be seen by a member of staff who will discuss with you your difficulties and ways they may be able to help.*

***Please confirm by telephone that you will be attending or if the appointment is not convenient please contact the above direct line number and an alternative appointment will be arranged."***

**18 MARCH 2002**

GP B wrote a further referral letter to Consultant Psychiatrist A, based at HW House. He said:

> *"I would be most grateful if you could see this 25-year-old man with symptoms of anxiety and depression.*
>
> *He presented with this problem around November of last year, complaining of insomnia. Later it became apparent that he was having intrusive thoughts for which he recognized as abnormal and extreme.*
>
> *These are causing him some distress and I have started him on Citalopram 20mg daily.*
>
> *He has a past medical history of asthma.*
>
> *I would be grateful if you would kindly see him and advise".*

| **COMMENT** |
| --- |
| This letter was found in the GP records and had a hand written comment "file copy". As there was not a copy of this letter in the Trust medical records we could not be sure that it was available to the mental health services. |

Sometime during March 2002 KM went to Mr. M's shop with a machete inviting him to fight. Mr. M reported this to the police.

**23 MARCH 2002**

KM went to Mr. M's shop, brandishing a knife and threatened the staff.

**18 APRIL 2002**

KM failed to surrender to custody – appeared at Solihull Magistrates Court and was fined £20 plus £20 costs. The Court requested a Pre-sentence Report for the next hearing on 21 May 2002.

**8 May 2002**

Following a visit to the Perry Barr Probation Office a Pre-sentence Report was completed for the Court. It contained details of the offence in February 2002 and stated that KM intended to plead guilty.

In the section headed **ASSESSMENT OF RISK OF HARM TO THE PUBLIC AND THE LIKELIHOOD OF REOFFENDING**, the report states:

> *"although it would appear KM does not have much of a criminal history, it is a little concerning that this is the second time he has been convicted of an offence of Common Assault. Although KM considers himself to be a fairly tolerant person, he does admit that when he suffers persistent taunts of unacceptable behaviour or language, this does make him angry and he would like the opportunity of work being undertaken with him to teach him alternatives other than to break the law. Without such work, I do believe there could be a risk of KM re-offending if he is placed in a similar situation again which could also, of course, pose a risk of harm to the public*
>
> *Although KM is currently receiving medication for depression, he is adamant there is no risk of self harm"*

The Probation Officer went on to recommend a 12 month Community Rehabilitation Order with the following areas of work to be undertaken:

- Offending behaviour and consequences
- Victim awareness
- Anger management and alternatives
- Gender issues particularly, as on both occasions, KM has offended it is women that have been targeted
- Relaxation techniques
- To set up an interview with Employment Officer who runs weekly Job Surgery at the Perry Barr Probation Service. He is aware that not to do so would mean him quickly being breached and returned to Court.

**10 MAY 2002**

KM saw his GP complaining of pins and needles in his fingers as a result of his weight training regime. He was prescribed Ibuprofen (an anti-inflammatory drug) and was told to suspend the exercises.

| **COMMENT** |
| --- |
| When we interviewed GP B he told us that his practice would have been to telephone the mental health services prior to writing. The letter from the team clerk predates this referral letter which validates this. GP B also knew that KM responded to the team clerk's letter as he was copied into the letter containing the appointment for 29 May 2002. He also told us that he knew that KM was not taking the anti-depressant but did nothing further because of the forthcoming appointment. |

**21 MAY 2002**

KM appeared at Solihull Magistrates Court and was charged with Common Assault. He had assaulted a co–worker at the NEC on the 6 February 2002. He was found guilty and received a Community Rehabilitation Order for 12 months and ordered to pay compensation £50 plus costs £100.

**22 May 2002**

KM kept his first appointment with the Probation Service and was given 12 further appointments.

**29 May 2002**

KM kept the appointment for a preliminary assessment at HW House. A Community Psychiatric Nurse (CPN) conducted the assessment accompanied by a nursing student, who wrote the notes:

> *"… KM lives together with his mother and has two half brothers and several half sisters with whom he does not keep much contact and about whom he did not talk about. He had undergone training in catering up to NVQ level. However, because of his restless nature he cannot remain in one employment for long and has been changing jobs after short periods, never sticking to one for more than six months. He is presently looking for work. KM believes that he talks loudly in his sleep and because people are aware of this condition he feels that his privacy is being invaded. Also he feels that people are making funny faces at him, conspiring against him or still, he is the subject of their conversation all of which irritate him. People's body language around him make him aware whether they are hostile to him. He denied hearing any voices.*
>
> *KM has had altercations with people on quite a few times and on two occasions these have led him to be booked by the police. The first time it was when he slapped a woman in a bank because she had called him 'a black bastard' and for which he had to pay a fine. On another occasion while he was on duty he got engaged in a fight with a co-worker who was making fun at him. He has been sentenced to one year probation. He further admitted thumping a man while travelling by bus which he considered more serious than the two previous cases. However, this was not reported to the police. He admitted to drinking alcohol and smoking cannabis only on occasions.*
>
> *KM is worried about his insomnia and the intrusive thoughts and would like to have it all sorted. The tablets he has been taking have to cheer him up and is not feeling so irritated. He has also taken up Thai boxing. The three wishes that he would like to come true are*

1) *sort out all his problems*
2) *have some money*
3) *be able to sleep without worries*

*The plan of action which has been made known to KM and to which he is agreeable is that he should undergo a further assessment and in the meantime continue the medication prescribed by his GP. He will also have to keep off the cannabis which usually make the paranoia worse".*

During this appointment the Care Programme Approach (CPA) was completed and recorded as level 1, although undated and unsigned. The risk assessment outcome was scored as 3. The provisional diagnosis was 'possible psychosis, anxiety and intrusive thoughts'. Current warning signs were ticked against 'violent ideation, extreme anger, hostility, violent threats, violent acts and persecutory delusions'.

The RISK HISTORY text stated:

*" he has been involved with the police on two occasions. 1) hitting a lady in the bank because as he said it she called him a black bastard. He was made to pay a fine for the assault. 2) he felt that a group of people at work had overheard him talking in his sleep had read his thoughts and he hit one of them. He was sentenced to one year probation. In view of possible psychotic experiences, the plan is to get a further risk assessment from a psychiatrist".*

**COMMENT**

The Risk Screening Tool used in the Northern Birmingham Mental Health Trust had been described by CHI as inadequate.

The information source for this assessment was the patient's interview and KM made no secret of telling the mental health staff about the times he was involved with the Police and that he subject to a Probation Order. It is unfortunate that contact was not made with the Probation Service.

**COMMENT**

On 28 May 2002 the GP notes record behavioural problems – assaulted work colleague but do not record a further prescription for Citalopram.

21 June 2002 the GP notes record paranoid psychosis NOS and sleep disturbances but no further repeat prescription for Citalopram.

**18 JUNE 2002**

Whilst he was waiting to 'clock off' KM had a verbal altercation with a fellow worker and pushed him over some pallets causing injuries to his head and wrist. KM was not arrested on this occasion as the victim did not press charges.

KM attended the Probation Office and the notes stated:

> *"seems very sure about himself. Intends to stay away from offending behaviour in future. Next appointment 25 June 2002"*

**21 JUNE 2002**

KM kept his appointment with the Senior House Officer (SHO). She recorded that for five years he had had disturbed sleep and attended his GP requesting sleeping tablets for insomnia. He had restless sleep saying he was worried that people could hear him shout in his sleep and so know what he was thinking. In the past he had tried to stop himself falling asleep so people wouldn't be able to hear him shouting.

The notes continue:

> *"….described situations where people have talked about subjects he was thinking of previous night. He doesn't know how people could know what he was thinking but gave one explanation as hearing shouting in his sleep. Says it is now too coincidental and feels that he is right about them talking about his thoughts. However, he does say he has been wrong about this in the past and says that he has misinterpreted things if he was given the correct explanation. Also has had experiences of people pointing and talking about him in streets – even strangers. eg., today when cycling here someone pointed and laughed at him. One example of people hearing thoughts – thinking one evening of taking up karate promotion full time and next day someone he didn't know at work was making fun of that particular job although he hadn't told anyone of what he had been thinking……..*
>
> *...denies hearing voices. Described in past believing TV was referring to him. He had pinched a nerve in his back and was watching TV and a comment was made about pinched nerves. At the time he said he believed that this was directly referring to him but now he believes that this was just a passing comment and not meant for him…..*
> *……at times he suffers from intrusive unwanted thoughts mainly violent in nature. Had thoughts in the past to hit his uncle who he gets on with really well and has no arguments. Is able to get rid of these thoughts….."*
>
> *Mental state examination*
>
> *"well kempt. Pleasant and co-operative. Good eye contact and rapport. Smiling and behaving entirely appropriately. Psychomotor activity normal. Speech spontaneous, normal rate, volume and quantity. Mood fine no depressive/anxious symptoms. Thoughts - concerned about people being*

*able to know what he's thinking. No abnormal perceptions. No DSH/ suicide ideas. Cognition intact, insight – believes mainly right about his ideas but accepts he could possibly be misinterpreting things and accepts that if necessary medication could help him.*

*Impression*

*25 year old man with paranoid ideas – unable to prove if unshakeable and so true delusions and psychotic symptoms. Fully functional at present. Goes to work and gym. Self care fine. Not overly bothered by experiences. On Citalopram - mood. May have obsessional thoughts – unable to elicit.*

*Plan Continue Citalopram. Need further period of assessment. See in 2/12 with his mother".*

The SHO wrote a letter dated 3 July 2002 to GP B, outlining her interview with KM and informing him that KM should continue on the medication Citalopram and that he would be seen in two months with his mother.

| **COMMENT** |
| --- |
| The SHO assumed that KM was receiving medication, presumably from the GP. |

**25 JUNE 2002**

KM reported to the Probation Office. He was still looking for work as the machine operating job he had had was only temporary. The Job Centre arranged some interviews for him.

Sometime in June KM went to Mr. M's shop, reportedly 'spoiling for a fight' which again Mr. M said he reported to the police.

**4 JULY 2002**

KM threw a stone at the front of a stationary car with three women inside. He was arrested but the case was dismissed because no evidence was offered in Court.

**9 JULY 2002**

KM attended the Job Centre and was convinced that two men standing in the queue were talking about him. He attacked one of them, punching him in the face. During the ensuing fight KM was grabbed around the throat and punched. He was arrested, firstly for assault and secondly for resisting arrest. When he came to Court one charge was discontinued and he was found not guilty of the other.

**10 JULY 2002**

The Probation Officer made a home visit. He recorded" All OK".

KM was involved in an incident, having a machete in his possession outside Mr. M's shop.

**COMMENT**

Mr. M reported to the police, that he had been harassed on previous occasions by KM.

Mr. M also told them that he had intervened in a fight between KM and another man. The police note at the time stated *"appears to have mental health problems."*

When the police attended KM's home they were told that he only visited to see his sister.

When we interviewed the Detective Inspector he told us that the police records went back four years and nothing of note had come to their attention at that address. If, for example, somebody had reported a noisy party, there would have been a record of that but not that a visit had been made to 'check out' someone living there.

**16 July 2002**

KM attended the Probation Office but did not stay very long as he had an appointment at the Job Centre. He was advised that if he had not found another job he would be referred to the Employment Officer.

**31 JULY 2002**

The ED:IT Co-ordinator, wrote to KM offering an appointment on 12 August 2002 for a further assessment as part of his continuing care by the SHO, at HW House, which he did not keep.

**13 August 2002**

KM was in the process of completing a 'forklift truck' driving course and attended the Probation Office weekly. After 20 August 2002 it was only necessary to attend every two weeks.

**15 AUGUST 2002**

The ED:IT Co-ordinator again wrote to KM, offering a second appointment on 18 August 2002 for their initial meeting at HW House and copied this letter to the SHO.

**16 AUGUST 2002**

The Associate Specialist saw KM in the outpatient clinic with his mother. He interviewed KM's mother on her own as well as with KM. The notes state:

> *"16/8/02 - Seen in outpatient clinic with mother.*
> *Report: according to mother he is fine apart from he becomes easily angry and irritable. He denies the paranoid thoughts described before. He says sometimes he feels other people talking about him and reckons it is a natural feeling anybody would get. Denies hearing voices. Coping well and sleep and appetite okay.*
>
> *Mental state examination: he is casually dressed, pleasant and relaxed. Speech and mood are normal and no overt symptoms.*
>
> *Plan: discharge from the clinic. No medication."*

The Associate Specialist wrote to GP B. The letter was dictated the same day as the outpatient appointment but dated 21 August 2002, and said,

> *".....As you are aware, at our last assessment we had difficulty to draw a conclusion as to whether he was suffering from mental illness or not. When I enquired of his mother she believed he is keeping fine apart from him loosing his temper quite easily. She hasn't noticed any abnormal behaviours or gestures in him. According to his mother he is a inquisitive and cautious person.*
>
> *KM denied the paranoid thoughts which were described in my earlier letter. He says he sometimes feels other people are talking about him and he reckons he gets a normal reaction to this. He denies hearing voices. I understand he is coping well and doing his job without a problem. His sleep and appetite are fine.*
>
> *When I saw him today he was casually dressed, pleasant, quite relaxed and stable in mood. His speech and mood were normal. There were no overt psychopathological symptoms.*
>
> *In today's assessment along with his mother, I couldn't find any clear psychotic symptoms in him. It appears to me that he is a person who has a paranoid personality. I don't think he needs pharmacological intervention at this stage. Therefore, following discussion with his mother, I have discharged him from our clinic but please do not hesitate to contact us again if you think we can help him".*

**COMMENT**

The Associate Specialist could not remember whether he had all of the clinical notes when he interviewed KM and KM's mother. He thought he must have had them at the end of the clinic. He wrote in the notes "he denies the paranoid thoughts described before" which implies that he had seen the notes at some point.

The internal report states:

> *"……The service user's discharge resulted from a unilateral and autonomous decision out of the context of the multi disciplinary team, and apparently without the Associate Specialist having had access to the CPN's letter which may not have been integrated into the clinical records at the material time of the Associate Specialist's consultation with the service user……"*

**15 AUGUST 2002**

The ED:IT co-ordinator wrote to KM offering him yet another appointment on 18 September saying:

> *"if you are unable to make this appointment or if you have any queries you would like to discuss please feel free to call the ED:IT team"*

**18 August 2002**

The ED:IT co-ordinator wrote to Consultant Psychiatrist A informing him that KM had not attended on 12 August 2002 and that he had been offered a further appointment on 18 August 2002.

> *" KM was offered an initial appointment on 12 August 2002 but failed to attend. Since I am going on leave for a few weeks I have offered him another appointment on 18 September 2002.*
>
> *I hope that this is satisfactory to you and in the meantime, if you have any queries or would like to discuss this further please feel free to call the ED:IT team"*

Sometime during August 2002 Mr. H, the victim's husband, whilst driving his car, collided with KM who was riding his bicycle. Mr. H invited KM back to his shop to discuss compensation. There was some disagreement about what amount of money was due to KM and so he went away empty handed. KM returned several times over the next few days demanding his money, which he never received.

**20 August 2002**

KM kept his appointment at the Probation Office and was seen briefly in the corridor

**3 August 2002**

KM kept his appointment with the Probation Officer. KM was no longer employed because of his poor time-keeping.

**9 SEPTEMBER 2002**

KM attended the Job Centre. Whilst he was there he was verbally abusive to another man and assaulted him. Another man went to apprehend KM and was also assaulted by him. The police were called, he was arrested and later charged with 'battery' contrary to Section 39 of the Criminal Justice Act 1988. He was also charged with resisting apprehension and later bailed to attend the Magistrates Court on 11 September 2002.

**16 SEPTEMBER 2002**

KM went back to Mr. H's shop at about 11.52 hours. KM was seen to be holding a machete and swing it hitting Mrs H several times. In all he hit her about six times before she fell to the floor. He then walked out of the shop. At 11.58 hours the shop alarm was activated and a customer dialled 999. The Police arrived about 12.09 hours followed shortly by the paramedical staff. When they arrived Mrs H was still breathing. She was taken to the City Hospital, examined by a doctor who noted she had three head injuries and injuries to her left hand. At 15.30 hours she was transferred to the Queen Elizabeth Hospital and sadly she died the following day at 11.45 hours.

KM was seen still carrying the machete when he entered Mr. M's shop. He was shouting and was heard to say "I hate you." He struck Mr. M on the back of his neck and his left hand for which he required hospital treatment. At the same time two Police Officers were patrolling the area and were flagged down by a passer-by and went to the aid of Mr. M.

At 19.50 hours that evening KM, accompanied by his father and uncle went to a local police station after having been persuaded by his sister and father to give himself up. When KM was arrested and read his rights, the Police Officers asked him if he understood, to which he replied "yes".

**17 SEPTEMBER 2002**

Consultant Psychiatrist B examined KM at Queen's Road police station. He declared him fit enough to be interviewed by the Police Officers. In his notes Consultant Psychiatrist B stated that KM had not been arrested prior to 2001. He told Consultant Psychiatrist B that he felt that people had been bothering him for 5 years. KM recalled the incident in the Job Centre when according to him two people were laughing at him, that he assaulted a woman at a bus stop and the latest incident in the Job Centre the previous week. KM told Consultant Psychiatrist B that someone had created a monster and that his family thought he was paranoid. He also said that he had last worked three weeks ago but was fired for being late. When Consultant Psychiatrist B discussed the index offence with KM he accepted that the police had the 'right person'.

Consultant Psychiatrist B recorded his mental state:

> *" lives with mum. Family think he's paranoid. Would see self as depressed ….problems with thoughts.*
>
> *Pleasant, subdued, doesn't feel he is ill. Appears low, denies suicidal ideation. Denies problems with thoughts.*
>
> *Impression*
>
> *Probable paranoid psychosis. Constant watch – marked affective presentation. Fit for interview. Police informed. D/W Reaside – they will see in custody.*
> *needs detailed mental state assessment over time. He presents with symptoms in June which appear to be indicative of evolving psychosis"*

At 20.31 hours KM was charged with the murder of Mrs H and the Section 18 wounding of Mr M. He made no reply after being cautioned and charged. He was remanded in police detention to appear at the Magistrates Court on 18 September 2002.

**18 SEPTEMBER 2002**

KM was transferred to HMP Woodhill and was seen by the prison doctor who concluded that he was "not suicidal but would need watching".

**19 SEPTEMBER 2002**

Consultant Psychiatrist B saw KM again, who, on this occasion thought he was a suicide risk.

**24 SEPTEMBER 2002**

Two prison doctors assessed KM as having sociopathic personality disorder rather than any marked illness. They recorded there was no evidence of any psychosis or abnormal perceptions and therefore there was no need for any intervention under the Mental Health Act 1983.

**17 DECEMBER 2002**

The Consultant Forensic Psychiatrist examined KM and completed a full psychiatric history. The resultant report stated:

> *..." KM describes the gradual onset of a variety of psychological symptoms over the last seven years. These include the belief that he is shouting out his thoughts during his sleep and that people throughout Birmingham therefore know what he is thinking. [This is a symptom known as thought broadcast]. Evidence of this is provided by his observation of people making comments to him and about relating to these thoughts [sensitive ideas of reference]*
>
> *This pattern of symptoms, with a gradual onset and a prolonged duration, suggests that he is suffering from schizophrenia.*
>
> *The development of KM's mental illness pre-dated his first criminal conviction in July 2001.*
>
> *Similarly it seems that his attack on Mr. M was also related specifically to his persecutory symptoms and auditory hallucinations, these symptoms having led to ongoing altercations between the two men.*
>
> *His attack on Mrs H was not related in such a simple way to his symptoms of mental illness although there seems little doubt that he was suffering with such symptoms on the days of the attack. His belief that people in the shop were laughing at him is likely to have been a symptom of his mental health illness……."*

# CHAPTER 3

## KMS MENTAL HEALTH UNTIL SENTENCING IN APRIL 2003

### 10 JANUARY 2003

Consultant Psychiatrist B saw and examined KM at the request of his defence team. Consultant Psychiatrist B agreed with the Consultant Forensic Psychiatrist's earlier assessment. Consultant Psychiatrist B added:

> *"I would recommend a trial of anti-psychotics given active symptomatology, I suggest an atypical (NICE guidelines)"*

### 17 APRIL 2003

KM was admitted to the Raeside Clinic under section 48/49 MHA 1983. The following day he appeared in Court pleading guilty to manslaughter and grievous bodily harm.

### 25 APRIL 2003

When sentencing KM, the Judge QC said 'treatment at a secure unit was in the public interest'. He has been detained since under Section 37/41 of the Mental Health Act 1983.

# CHAPTER 4

## KM'S MENTAL HEALTH ASSESSMENT

### Referral to Primary Care Mental Health Team by General Practitioner

KM saw his General Practitioner to complain about his sleep problem in May 2000, October 2000, February 2001, November 2001, 11 February 2002, and 28 February 2002. This final contact with the GP resulted in KM being referred to the Primary Care Mental Health Team. GP B telephoned the team secretary to request a referral, and also wrote a referral letter dated 18 March 2002. The contents of the letter have previously been outlined in the body of this report. It is important to note that the main focus of the referral letter appears to be the presence of intrusive thoughts of an aggressive nature, which the patient himself recognised as being irrational and anti-social, and it notes that he was concerned at having to battle with them.

### Response to the Referral by the Primary Care Mental Health Team

Referrals to the Primary Care Mental Health Team (PCMHT) were dealt with through a single point of access meeting, which was multi-disciplinary in nature. The Inquiry Team were told that at times ten or more referrals would be discussed. Team members would discuss the referrals based on the information available, and if necessary would liaise with the referring GP's. Referrals were then prioritised and allocated. Apparently urgent referrals would be dealt with through the duty system, referrals which appeared to require a medical opinion or the input of another identified team member might be allocated directly, for example, to Medical Outpatients, Social Worker, or Occupational Therapist. Any other referrals that appeared to require an initial assessment would be allocated to the weekly Assessment Clinic. This clinic was staffed by three nurses and three social workers on the basis of a rota. Three patients would be booked in for an hour each. Staff had no identified special training for these assessments. If staff members were new to the team they might shadow a colleague in the Assessment Clinic, but an assumption appeared to have been made that staff would be able to perform adequate assessments based on their professional qualifications and their experience.

As a result of the referral of KM he was given an appointment to attend the Assessment Clinic on 29 May 2002. This appointment was made on 15 March 2002. The general waiting time for all referrals at that time seems excessive. However, although some witnesses implied to the Inquiry Team that the referral letter from the GP indicated a degree of urgency, and that the information contained in the letter clearly implied the presence of psychosis, the Inquiry Team did not feel that the content of KM's referral letter did not warrant an urgent appointment. It is worth noting that KM is described in the letter as recognising his aggressive thoughts as being irrational and anti-social and it implies that he is battling against them. This description implies that the thoughts might well be due to obsessive compulsive phenomena, which would have been compatible with the GP's suggested diagnosis of anxiety/depression. Furthermore, members of the PCMHT informed us that the GP's in that particular surgery were known to be very good, and that if they had wanted an urgent referral they would have said so in the letter.

**Initial Assessment by the Community Psychiatric Nurse (CPN)**

The details of the CPN's assessment have been outlined earlier in this report. The CPN told us that it was difficult to gather information from KM. It was difficult to get him to elaborate on any of his problems, and initially it was difficult to get him to talk about the nature of his thoughts. We were also told that KM was very composed at interview, and replied quietly. He did not appear to be upset. KM himself told us that he saw his problems at that stage as being down to difficulties with sleep, and he did not therefore perceive any other experiences or thoughts as indicative of mental health problems.

On the basis of this assessment the CPN identified significant risk. When discussing these with the Inquiry Team he did indicate that he was concerned that KM's past behaviour of offending would predict the possibility of future offending. He was also concerned that KM was still experiencing his intrusive thoughts, and the CPN was concerned that KM might be psychotic. In the past he had ideas about a colleague and had acted on them, but these concerns were balanced by the fact that these events had happened in the past and KM had subsequently changed jobs. The thoughts he was experiencing at the time of this assessment were not focussed on

any one individual, there was no intention to act on them, and KM was not at the time in crisis.

The CPN was sufficiently concerned to want KM to be seen by a doctor on the day in question, but we were told that no doctors were available. We received conflicting opinions about the availability of medical advice in such situations. The former Medical Director told us that no team would be left without a psychiatrist during working hours, and other witnesses told us that doctors would be available although they might need to be contacted by mobile telephone. However, it is clearly the case that no doctors were allocated to be available at the time of the Assessment Clinic although sometimes they might be seeing their own patients in the clinic at the same time. Some witnesses told us that doctors would always be prepared to drop whatever they were doing to provide urgent advice or input. We have some reservations about this arrangement because not all doctors are equally approachable, at times doctors might be very busy with other commitments and not be able to drop everything, and some staff in other disciplines might be apprehensive about approaching very busy doctors to help out. It was also suggested to us that staff could gain access to medical advice through a referral to the Home Treatment Team, but the current Medical Director told us that CMHT's abused the Home Treatment Team by saying "if there is something serious and urgent get the Home Treatment Team to manage it". And this was clearly a strategy that the current Medical Director deplored. Therefore, having made an initial assessment and having identified the possibility of a psychotic mental illness and significant issues of risk to others, the CPN was left in his view without the possibility of gaining further medial advice on that occasion.

This initial assessment was subsequently discussed within the Multi-Disciplinary Team meeting, and it was agreed that KM would be seen at the next available outpatient appointment. It was intended that he would see a Consultant Psychiatrist for clarification of the diagnosis and for an appropriate treatment plan.

**Clinic Assessment by the Senior House Officer**

When we interviewed the SHO, she told us that KM was one of the patients who '*stuck'* in her memory. She found him unusual in that he talked about his unusual ideas, experiences and thoughts but kept talking about them as if he didn't think they

were happening. He felt that he could be wrong, he wasn't sure about them but he just didn't know. He had a very good rapport with her and she described him as "a really pleasant chap", and found nothing of the oddness that one might expect with someone suffering from schizophrenia or an acute psychotic episode. She said,

> *..."I wonder if this is somebody early on in a psychotic illness that we are seeing here?'. That is why I have always remembered him in that way"……*

The SHO also told us that she had the CPN's initial screening notes, the CPA documentation and anything else that was in the file, which she would have read.

She told us that she discussed KM with the Associate Specialist, to seek his advice about a plan of action and KM's next appointment at which she wanted for when the consultant was available. She also discussed the appointment for KM to be seen by Early Detection Intervention Team (ED:IT) with the Associate Specialist in fact she told us that:

> *….."I vividly remember talking to Dr T about KM, and I remember thinking 'We need to see him again with somebody who knows him well, and it would be a very good idea to refer him to the early detection team'. I do remember they were very, very new at that time. I had just heard about them, either that week or the week before because it was fresh in my memory, and I thought 'KM could be somebody who is exactly their type of client'. I remember that quite vividly, and I know I faxed off a referral – I am sure it was very shortly."*

| **COMMENT** |
| --- |
| This fax was not in the clinical notes but there is a handwritten note of what the SHO said in the telephone conversation she made. |

| **COMMENT** |
| --- |
| The SHO told us she was critical of herself for not documenting either the referral to ED:IT and her discussion with the Associate Specialist.. |

The SHO saw KM on 21 June 2002 for approximately one hour in the Outpatient Clinic. At the time the SHO had had four months experience as a trainee in Psychiatry. Her Consultant, Consultant Psychiatrist A was on annual leave at the time, and as a result she was not being supervised. The clinic for Consultant

Psychiatrist A was not cancelled. It will be recalled that the CPN, had wanted KM to have a Consultant opinion.

The SHO thought that KM did not appear to express his beliefs with the absolute conviction that she would have anticipated in somebody who was deluded. It is worth stating at this point that traditional teaching describes delusions as fixed abnormal beliefs held with absolute conviction. A more sophisticated view, now backed up by persuasive academic research, indicates that actually many patients have a degree of uncertainty regarding their delusions. The SHO was not aware of this at the time.

KM told the SHO a significant amount regarding his aggressive and offending behaviour, which in retrospect we might consider to have been prompted by his psychosis. This was not apparent to the SHO. He also described being bullied which was taken at face value.

Following her assessment the SHO asked KM to wait while she discussed his presentation with the Associate Specialist, who was working in clinic at the time. The SHO informed the Associate Specialist that she had seen KM and that she was unsure whether he was in need of anti-psychotic treatment. It was agreed that KM needed a further assessment. The SHO was unable to recall whether they agreed that he would be seen at the next available appointment, or whether he would be seen in two months time. In other words, it is not clear whether an appointment two months from then was the first available or the chosen length of time away.

The SHO told us that she discussed with the Associate Specialist the question of a referral to the ED:IT Team. The SHO recalls this conversation but did not document it in the case notes. She had just recently heard of the ED:IT Team and thought that KM might be a suitable patient for their intervention. She believed that she faxed a referral to them although the fax is not in the case notes. She did speak to a member of ED:IT as they documented her contact.

The SHO asked KM to return with his mother to that subsequent appointment. She cannot recall the conversation in detail but she wanted somebody to come along and corroborate KM's history, and perhaps to shed further light on how he had been and the extent to which he was troubled by his problems. She cannot recall exactly how

they agreed that it would be his mother, but believes this was following a discussion of possible alternatives, and that KM was satisfied with the choice of his mother. KM subsequently told us that he had been happy enough to be accompanied by his mother, although he did feel a little uncomfortable about her attending as he was not sure if he would have wanted to discuss some issues in front of her.

The SHO believed that KM was still taking his medication from his GP. In her history, the SHO noted many of the aspects of the presentation that one would wish to consider in formulating a risk assessment and management plan, but she did not complete a risk assessment form, and did not describe the risk issues under a separate sub heading. We were told by other witnesses that medical members of the team did not use CPA documentation or risk assessment forms, but that typically risk issues were covered in their letters in the text, in other words one would often need to read the entire letter to be able to pick out all the items relevant to risk assessment and risk management. In addition, e SHO did not report this assessment to the subsequent team meeting.

**Assessment by the Associate Specialist**

The Associate Specialist was working in parallel with Consultant Psychiatrist A. The Associate Specialist was not formally supervised by Consultant Psychiatrist A. We received no unambiguous evidence that he had ever had an appraisal, and we received no evidence that he was mentored in his capacity as an Associate Specialist. In fact, we had some difficulty in understanding what precisely were the differences between his role and that of Consultant Psychiatrist A. One could argue that he was effectively fulfilling the role of a Consultant Psychiatrist, but being employed in the capacity of an Associate Specialist.

The Associate Specialist's assessment of KM on 16 August 2002 has been described earlier in this report, as was the issue of the availability of previous letters and clinical notes to him at that time. The Associate Specialist did know that anti-psychotic treatment was under consideration. The Associate Specialist saw KM's mother on her own at first, and then saw KM with his mother. At no time did he see KM on his own. The entire assessment took no more than ten minutes.

When interviewed by the Inquiry Team the Associate Specialist told us that in terms of a differential diagnosis he had considered the question of whether there was a psychotic illness, and whether, if so, it was a schizophrenic illness. Alternatively if there was no evidence of psychosis, he thought that the problems might have arisen from a neurotic condition such as anxiety or depression, or possibly a drug-induced state. The Associate Specialist conceded that he had not made any reference in his notes to the issue of substance misuse, he had not recorded the presence or absence of symptoms associated with neurosis, and that although he had claimed to have considered a number of possibilities, he did not really record the evidence for or against them. He attributed this to the fact that he was busy, and that he had therefore not recorded all the details.

Similar comments pertain to the issue of a mental state examination not being recorded in the notes. There is reference to KM's pleasant and relaxed manner and his casual dress, the fact that his speech and mood were judged to be normal and there were no overt symptoms. Detailed evidence regarding the presence or absence of delusions and the presence or absence of hallucinations is absent.

The Associate Specialist's notes make no reference to issues of risk, there is no evidence of a risk assessment or risk management plan in the subsequent letter to the GP, and no risk assessment form was completed. KM was discharged back to his GP on no treatment, and his presenting complaint of problems with sleep was unresolved. In fact the issue of problems with sleep were not referred to in the Associate Specialist's notes or the letter to the GP.

The Associate Specialist informed us that on the day that he saw KM he also had to see the patients booked into Consultant Psychiatrist A's clinic as this had not been cancelled although Consultant Psychiatrist A was on leave. The Associate Specialist therefore had to see approximately ten or twelve patients.

The Associate Specialist did not consider KM to have any significant mental illness and decided there were no significant risks and discharged him from any follow-up. He told us that KM did not want any further contact but KM told us that his problems were unresolved and he would have done anything required to find a solution to

them. The Associate Specialist told us he did not know about the referral to ED:IT and he did not mention the discharge to the MDT meeting.

**General considerations regarding the assessment of KM**

As we have seen KM had three separate assessment interviews but at the end of that process the mental health services were no closer to a full appreciation of his difficulties. Arguably the initial assessment by the CPN came closest to recognising the extent of his difficulties and the need for early intervention. It is noteworthy that, because he was still undergoing an assessment, he had not been allocated to any one individual person to take responsibility for his interim care, and to plan for and manage any crises that might have arisen. Although his initial referral was discussed in an MDT meeting he was finally discharged without that discharge being discussed again in the MDT. Had there been such a discussion it is possible that the CPN could have raised lingering concerns regarding KM and challenged the Associate Specialist's final assessment.

KM initially presented complaining of poor sleep, and after three months he was discharged from Mental Health Services without any real explanation or resolution of this presenting complaint.

We acknowledge that there were objective difficulties in assessing KM. His mental health problems were longstanding and he had little insight into them. All he was concerned about were his problems with sleep. His personality was intact, for the most part he was working, and his abnormal beliefs and experiences were relatively stable. His offending behaviour was however escalating.

Significant issues of risk were identified at KM's initial assessment, but these issues of risk were effectively lost. No record of risk assessment or any risk management plan was recorded in the final notes or letter prepared by the Associate Specialist.

Because there were difficulties in reaching a conclusion regarding KM's mental health problems the SHO arranged that he would attend clinic with his mother. Seeking the opinion and assistance of an informant is standard practice in mental health services, but this practice has to be handled sensitively. It is advisable to see the service user on their own initially, conduct an appropriate interview with them on

their own, and then ask their permission to interview their informant. The informant is usually then interviewed in the presence of the service user, although on occasion it may be better to interview the informant on their own. Except in extreme circumstances, this is always done with the explicit permission of the service user. The reverse of this practice effectively occurred in this case, with KM's mother being seen prior to the Associate Specialist seeing KM with his mother. KM was not seen on his own by the Associate Specialist.

In our opinion systems failures contributed to the difficulties in effectively managing this case. Clinics were not cancelled in the absence of the Consultant Psychiatrist, and a very junior trainee psychiatrist was left to do a clinic without what we would regard as adequate supervision arrangements. In order to properly supervise trainees in clinic, a senior doctor needs to be available; with sufficient time to conduct an extensive interview with the service user should it be required:

- to clarify any areas that the trainee has been unable to clarify;
- to ensure that the trainee has been able to formulate and implement an appropriate treatment plan;
- to include a plan for the management of any risks that have been identified.

Clearly these arrangements were not in place. The Associate Specialist at the time did not have appropriate arrangements for appraisal and supervision of his practice.

We have already identified the lack of robust arrangements for access to senior medical opinion for staff working in the assessment clinic. KM was not in crisis when seen by the CPN; hence referral to the Home Treatment team would not have been accepted under their then criteria. That route to a more conclusive assessment and hence more appropriate care plan was not open.

A number of witnesses did indicate to us that there was, within the organisation, a general pressure not to diagnose psychotic mental illness in young Afro Caribbean men because of their apparent over-representation in Mental Health services. We considered the possibility that individuals assessing KM had been reluctant to make such a diagnosis for this reason. Nonetheless in the course of our Inquiry we obtained no evidence to support this possibility. Racism, however, is a very real part

of the lives of minority ethnic groups in our society. Sensitive discussion of such issues with KM might have deepened the rapport established with him and enabled those assessing him to gain greater insight into the delusional beliefs underlying his claims of racial abuse and bullying.

**The Early Detection and Intervention Team (ED:IT)**

Based on the fact that KM was suffering from a psychotic mental illness at the time of his first assessment it would have been perfectly appropriate to refer him to an Early Intervention in Psychosis Team. However, the referral to the ED:IT Team was not appropriate as their brief was to intervene with individuals who had pre-psychotic symptoms (as they were described to us). As we have seen the ED:IT never did see KM. They sent an appointment when required and followed up his failure to attend with a further one. They played no further part in the assessments and we find no fault with their actions.

However, in the course of our Inquiry we spoke to several witnesses regarding the ED:IT Team, and also read relevant documents regarding it. On the basis of that information we had several concerns about the service itself. These are as follows:

1. There is a lack of clarity with regard to the role of the Early Detection and Intervention Team. The former Medical Director told us "they don't have the responsibility of managing patients or assessing patients or for starting treatment". We found it difficult to understand what would be left over with respect to the effective care of patients. We were further told they had a facilitatory and advisory role, but did not consider that to be entirely appropriate given the resources available (as discussed below).

2. We were told that ED:IT would take on Care Co-ordinator roles if a non-statutory agency acted as the referrer but otherwise would not do so. Because they had no dedicated medical time themselves they felt somehow that other agencies should hold care co-ordinating functions. We did not find this acceptable.

3. We were told that the ED:IT Team could not undertake risk assessments or risk management unless the referring agency was non-statutory. We shared the view of one of our other witnesses who said "I would assume that they would do their

own risk assessment as well. I would just assume that any professional doing their own assessment would automatically do a risk assessment". This comment can be related as well to the issue of care co-ordination because the same witness went on to say, "our CPA policy has always been risk assessment and CPA, for a long time". This statement is in fact entirely in keeping with Government policy. Professionals cannot appropriately manage individuals who might be developing a psychotic mental illness without being able to properly assess and manage issues of risk.

4. We were told that the ED:IT Team currently has a case load of approximately 45 individuals and that they receive 70 new referrals a year. We were given to understand that there were six whole time equivalent clinical staff members in the team as well as non-clinical staff. This represents a caseload of less than eight patients per member of clinical staff. The team manage one new referral every five days. By contrast Assertive Outreach Teams that manage highly complex individuals with significant risk histories have caseloads of ten to twelve per Care Co-ordinator, and such teams provide the full range of interventions including care co-ordination, risk assessment and risk management.

5. Concerns were expressed to us that the ED:IT Team did not fall within the remit of ordinary management structures in the Trust, and was seen to operate without proper integration.

**We recommend that the Trust consider these comments with a view to reappraising the roles, responsibilities and resourcing of this team, given that no two witnesses gave us the same account regarding the roles and responsibilities of the ED:IT, and as we were left uncertain regarding a number of aspects of the team's role and responsibilities.**

# CHAPTER 5

## INTEGRATED SERVICES

The views that follow are based not only upon the Inquiry team's interpretation of the evidence we have received from several sources, but also our general impressions of the role of culture in mental health practice.

During our scrutiny of the psychiatric services that KM had used, we examined the value of culturally appropriate service were KM referred to such a service.

We heard from various senior managers of the Trust regarding the level of cultural awareness, competence and training. The Director of Nursing told us that cultural competence training initiatives have taken place, but people do not always feel that it helps them to do culturally competent assessments. She also told us that a clinical nurse specialist was developing a cultural competence audit.

Following the merger, the Trust appointed a Director of Diversity who attends Board meetings on regular basis and presents both reviews and policies on diversity.

The non-Executive Director, who chaired the internal inquiry, told us that the Director of Diversity was very proactive in addressing cultural issues and raising ethnic issues higher up the organisation's agenda. To date there has been Board awareness training and staff training on ethnic issues.

We were informed about the Frantz Fanon Centre. This service was set up by the Northern Birmingham Mental Health NHS Trust as a result of an incident in Rackhams Department store in Birmingham. The service was set up exclusively for African Caribbean people, particularly where people could get fairly immediate access and response if they wanted help. According to the current Director of the Frantz Fanon Centre, the Centre offers African Caribbean patients.

> *"a gateway, if you like , or a pathway to care and also, I think, a pathway where the old notion of fear and mystery is not so prominent. Then we can work with professionals and maybe give a different perspective on what is happening on the clinical presentations, because many times it is not as clear cut as a definitive psychosis".*

The Centre offers a range of psycho-social interventions and has enabled clients to return to full-time employment in collaboration with other agencies. They also provide advocacy on behalf of service users and their families and this has at times caused conflict in professional relationships.

We heard from one of our expert witnesses that services such as the Frantz Fanon Centre should be complementary and that their strength lies in their flexibility of approach and the non-stigmatising manner in which they work with clients.

| **COMMENT** |
| --- |
| We believe that the advocacy component of the Frantz Fanon service should be retained and developed as an independent service. People particularly need advocacy when they are disbelieved, discounted, devalued and discriminated against as people from BME communities often are in their interactions with mental health services. |

We were told about the difficulties encountered by small black voluntary organisations having to compete with national voluntary organisation for service provision. This is because of a lack of capacity within such organisations resulting in lack of funds to deliver ongoing support to their clients despite the fact that patients, their families valued the work of the voluntary sector providers as did mainstream service providers.

In their evidence to us, the Commissioners for Mental Health Services, in the Primary Care Trust, told us that they had recognised this problem and have been working with the voluntary and independent sector. They have established a local forum providing a dialogue to raise awareness of appropriate provision in mental health services and creating training opportunities to:

- Explain all aspects of the local procurement processes;
- Describe what elements of the service which need to be included to formalise an ‘expression of interest’ ;
- Demonstrate how clinical governance is taken into account in the proposed service.

Other initiatives to help the voluntary sector included training sessions conducted by the Tavistock Clinic in London.

**COMMENT**

The voluntary black organisations have been identified as the only source of culturally sensitive practice (Gray, P (1966) Voluntary Organisation). Their freedom from institutional legislation and a professional body of esoteric knowledge are their strength; such procedures although essential as a safeguard do bureaucratise any effort to change existing patterns of service provision. The black mental health dedicated voluntary sector has become the guardian of good practice and the convenient solution for the colour and culture blind approach of the statutory sector. Black voluntary organisations nurture cultural and ethnic identity, so that users do not feel disenfranchised and their philosophies of living are understood.

Having established that the voluntary sector providers can deliver quality care, where does this leave the responsibilities of the statutory sector? They are charged by their professional bodies with clinical and ethical responsibilities and by the public (through the law) with civil and potentially criminal responsibilities to provide care and to protect the public and the patient.

The majority of the black severely mentally ill are still cared for by the statutory sector. Can hospitals and consultants divest themselves of responsibilities in all these arenas? Is the voluntary sector prepared to adopt a professional code of ethics and to take legal responsibilities? All these dilemmas arise if one conceptualises the two sectors as separate in ideology, geography and funding. Also until the statutory sector can learn to provide more effective services for all, independent and voluntary groups will continue to provide a service.

Indeed it may transpire that statutory sectors find it financially impossible to realise culturally sensitive models. Such a conclusion has not been reached; if it were reached it would condemn all ethnic minorities to receive separate services; such a proposition is not viable economically (Gluckmam P, 1999, *Mental Health Service Provision for a Multi-cultural Society*, pg 239).

Hence, an integrated service is a realistic option. Another option is for the voluntary and independent providers to form networks of providers, such that they can be more directly funded and supported to provide culturally specific services.

## CONCLUSION

We do not seek to give the impression that nothing has changed in the Trust or that change will not happen. On the contrary changes have taken place, sometimes by default or in response to headline incidents. *Ad hoc* change cannot be managed and gives the impression of damage-limitation. Change is inevitable but it must be championed from the centre in order to let those in the field know that it is in their interest, and that of the population which they serve.

**We recommend that the PCT considers the development and funding of a full time comprehensive independent advocacy service.**

# CHAPTER 6

## CLINICAL GOVERNANCE ARRANGEMENTS

### INTRODUCTION

The purpose of this chapter is two fold: firstly to examine the clinical governance arrangements in mental health services in the Northern Birmingham Mental Health NHS Trust as they related to the care of KM prior to the incidents of 16 September 2002. Secondly, to examine whether the development in clinical governance structures and processes that has occurred since the formation of the new Birmingham wide Trust in 2003 have successfully addressed deficits in the governance arrangements that may have existed in the Northern Birmingham Mental Health NHS Trust and were the subject of recommendations made following the *Commission for Health Improvement* visit in 2001.

In the government white paper 'A First Class Service' (DH 1999) Clinical Governance is described as 'a framework through which NHS organisations are accountable for continuously improving the quality of the service and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.' The concept of clinical governance was underpinned by the clinical governance reviews that the Healthcare Commission undertook, in which the performance of individual Trusts was evaluated against a set of clinical governance standards. These reviews have now been replaced by assessment against the 'Core Standards' in the Annual Health Check. However, the move away from clinical governance reviews towards self assessment against the Core Standards, represents a realignment and recategorisation of clinical governance standards rather than a wholesale replacement of the old frame of reference.

In particular, the three clinical governance concepts that are particularly relevant to the care delivered to KM by the North Birmingham mental health services prior to the incidents of 16 September 2002, are reiterated in the Core Standards:

- *First Domain- Safety C1a) 'Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents.'*

- *Second Domain- Clinical and Cost Effectiveness C5 b) 'Clinical care and treatment are carried out under supervision and leadership.'*
- *Third Domain- Governance C7 c) 'Healthcare organisations undertake systematic risk assessments and risk management.'*

**Clinical Governance structures in Northern Birmingham Mental Health Trust**

In 2001 the Commission for Health Improvement carried out a review of the clinical governance arrangements in Northern Birmingham Mental Health Trust. The review acknowledged that the Trust had received national recognition for its development of 'functionalised' community mental health teams and that service design in the Northern Birmingham NHS Trust had provided the template for the prescriptions in the National Service Framework for Mental Health, published by the Department of Health in 1999. However, the review was critical of the clinical governance arrangements in the Trust; an absence of clinical governance structures at directorate level had left the Executive Team with little means of embedding the principles of clinical governance in local services. The absence of structure was also, according to the review, preventing senior management from receiving information about the quality of care being delivered to service users.

The report stated, among many things:

> "CHI has concerns with the current centralised structure and approach to clinical governance is at odds with the decentralised operational working of the localities. There is no clearly defined structure through which to implement clinical governance within localities or clarity about engaging staff at local level. Having recently restructured the Executive and identified central clinical governance resources, there is now a need to build clinical governance capability at locality and team levels".

This view was shared by the former Medical Director, who told us that there was a lack of attention to processes and details. He added,

> "…. It was a transformation period. Things had to be done; if we waited for the policies to be in place nothing would have happened. Sometimes the preoccupation with policies is because you are anxious about change. Obviously we need to have these things in place. It is self-evident that we need to have these in place, but given the time that is taken up with all the other things, sometimes this is not on top of the agenda. That certainly was the case in North Birmingham and CHI was quite correct. I am not a great believer in this kind of inaccurate clinical governance structures……."

> *"……. What delivers safe and effective services is good quality people rather than formal structures. Structures were an attempt to actually make sure that the deficits in terms of workforce and people skills could somehow be managed. Organisations ought to be responsible for their clinical outcomes anyway, they have to be judged by that. But a governance structure, I have said over the years, has grown completely out of proportion……."*

At that time, the process for dealing with complaints or serious incidents was led by the then Chair of the Trust, who reviewed all complaints. A new sub-committee with a remit for clinical governance was set up and chaired by a non-executive director. The Medical Director and Director of Nursing had joint responsibility for presenting clinical governance issues at Board level. Two new posts, a Clinical Effectiveness Manager and a Risk Manager were developed at corporate and local levels in order to strengthen the Trust's structure. Their role was to provide strategic management of the key elements of clinical governance. Both post holders left and local clinical governance leads were identified to operationalise these elements.

The non-Executive Director told us that at that time, the process for managing and monitoring serious incidents had not been embedded into the clinical governance structures, which were fairly early on in their evolution , saying,

> *"that is the kindest way of describing them." My recollection is that we did not have a robust clinical governance structure at that time, which is probably reflected fairly accurately in the CHI review that came some time afterwards. So one would have expected an internal inquiry to follow on. It was as we were moving from one structure to a merger, there was a period of 12 months before the merger which was a rather amorphous period when people were thinking beyond that.*

Senior managers who took over the new Trust were left with the impression that clinical governance arrangements in north Birmingham mental health services had been devolved to localities, and that, in relation to key clinical governance priorities, there was a comparative absence of overarching direction and control from the Trust's senior management. A senior manager who worked in the Northern Birmingham Mental Health NHS Trust and now works in the merged Birmingham wide Trust, reported that information about clinical governance was passed from the localities to the centre, and then 'got lost.'

In the Northern Birmingham Mental Health NHS Trust, the Medical Director and Director of Nursing shared responsibility for delivering the clinical governance agenda. We were told that at the executive level in the Trust, there were some

reservations about the usefulness of clinical governance structures with an expressed view that complicated monitoring or assurance systems could not guarantee the performance of individual teams or clinicians.

Responding in a systematic and timely manner to serious incidents is a key facet in the repertoire of a Trust's clinical governance functions. The Medical Director and, more latterly, the Director of Nursing, carried out 'Multi Disciplinary Reviews' when serious incidents occurred and reported their findings to the Board. A Senior Manager from the Northern Birmingham Mental Health NHS Trust reported that this direct approach, following the collation and analysis of a number of reports, identified trends, which then informed the Board's decision making.

But despite this high level involvement in post review incident analysis, it would appear that there was an absence of process in the Northern Birmingham Mental Health NHS Trust's response to serious untoward incidents. Managers in the newly merged Trust obtained from the Coroner's Court a list of 30 cases involving North Birmingham mental health services, for which clinical reviews had not been undertaken. The Chief Executive, told us that 30 if not 31 were unresolved and unreviewed. These came to light following some correspondence from CHI asking the Trust to provide a complete list of serious untoward incidents from both Trusts for the previous three years. A team led by the previous Acting Director of Nursing in the Northern Birmingham Trust, scrutinised all the serious incident paperwork to decide which ones required full disciplinary reviews. However, this thorough review did not include the KM incident and was brought to the attention of the Trust by a local MP.

**Risk Management in the Northern Birmingham Mental Health NHS Trust**

The CHI review identified deficits in the North Birmingham's approach to risk management; regular training in clinical risk assessment and risk management was not being provided by the Trust for its clinicians and the Trust had not identified a formal systematic risk assessment tool to enable staff to assess risk in individual patients. CHI's assessment was confirmed by evidence submitted to the Inquiry Team by clinicians and managers who worked in the North Birmingham Trust.

The CPA process provides a framework for clinicians, within which communication about risk related to individual service users can occur. A rudimentary risk screening tool was an integral part of the Northern Birmingham Mental Health NHS Trust's CPA documentation. The CPN identified that KM was at the higher end of the scale in risk to others, using this screening tool in his initial assessment of KM. However, medical staff were not fully integrated into the CPA assessment and management process. A doctor involved in the care of KM in the Small Heath Team told the Inquiry Team that they only became aware of the existence of the CPA system subsequent to leaving the team.

**COMMENT**

Medical disengagement from the CPA process is not just limited to mental health service in Birmingham. It is a national problem.

Decisions taken by medical staff lie at the heart of any mental health team's management of risk. Where it is the case that two parallel risk management systems are in operation within mental health teams (a medical risk management process and a CPA risk management process employed by the rest of the multi-disciplinary team), crucial information about service users can get lost and risk management arrangements go awry.

### Supervision Arrangements in the Northern Birmingham Mental Health NHS Trust

In 2001 CHI judged that the supervision arrangements for Senior House Officers in the Northern Birmingham Trust were fit for purpose. However, the Inquiry Team was not satisfied that the day to day arrangements in the outpatient clinic were as robust as they needed to be to ensure that junior and trainee doctors received adequate support and guidance whilst assessing service users. This has been discussed earlier in the report *(Chapter 10 – KM's Mental Health Assessment).* Evidence given to the panel suggested that there were effective and functioning supervision structures for the nursing staff.

CHI were informed that an appraisal system for Consultant Psychiatrists was being introduced in 2001. The panel learned that this system was still in the process of being introduced in 2002–2003.

During our Inquiry we became concerned with regard to supervision arrangements of junior doctors in the Northern Birmingham Trust related to the management and appraisal of the Senior Clinical Medical Officers (SCMOs). Conflicting evidence was given to the panel; a member of the executive team in the Northern Birmingham Mental Health NHS Trust said that Consultants were 'advised very clearly' that it was their responsibility to supervise and appraise the SCMOs. However, other evidence given suggested that the majority of Consultants did not see it as part of their role to supervise middle grade doctors. Two doctors who had worked as SCMOs in the Northern Birmingham Mental Health NHS Trust confirmed that during their time working as SCMOs, they had received no formal supervision. Consultant Psychiatrist A told us that his supervision of the Associate Specialist was never discussed. He told us:

> *"No that was never discussed with me by anyone from the Trust as to what supervision – I mean, it was such a busy job and I believe I supervised him on a regular basis but it was not in a structured manner as with an SHO where you allocate an hour; but with the Associate Specialist we attended three or four meetings together, and even if I saw a difficult patient I would discuss it in the team with the Associate Specialist , then he might have seen the patient and we will talk about it, and we jointly discuss it for both assertive outreach and the primary care team meetings."*
>
> *"…our offices were next to each other and any time he saw a particularly difficult case or wanted to discuss something with me he could come in, or if he saw someone in the clinic or he saw someone who he felt needed a second opinion he would discuss it, and then I would say 'It's okay, I will see him with you next time', or 'I'll see the patient in my clinic for a second opinion'.*
>
> *"I do remember doing that on a fairly regular basis with him, in the sense that sometimes there will be a particularly difficult patient and he would say 'There seem to be some problems and discrepancies between what was documented earlier and how I see it', so I would say 'I will come and see him with you' and I have done that on several occasions…."*

He went on to say, in answer to a question of his own supervision as an Associate Specialist:

> *"again I didn't have any formal supervision. That wasn't in practice at that time, so we didn't have any formal supervision or any discussions about cases, apart from the MDT. No one-to-one supervision…."*

Neither did Consultant Psychiatrist A have any formal appraisal during the time he was an SCMO, although the former Medical Director did have one session with him when he became a Consultant.

| COMMENT |
| --- |
| Notwithstanding any informal types of supervision KM's inappropriate discharge from specialist mental health care by an SCMO took place in a context characterised by ineffective supervision arrangements for middle grade doctors. |

**Present Clinical Governance Arrangements in Birmingham and Solihull Mental Health NHS Trust**

The new Trust has developed an extensive infrastructure in order to deliver clinical governance priorities. At corporate level there is a Clinical Governance sub-committee which reports to the Board. This sub committee is supported by a further five corporate sub- committees which cover the respective component parts of clinical governance. Each of the Trust's nine directorates has a clinical governance committee. These committees are intended to shape arrangements at local level and also act as conduits of information between front line services and corporate structures. The Clinical Directors and Lead Nurses oversee the implementation of clinical governance at directorate level. They are supported by Clinical Governance Facilitators.

People who had experience of working at senior level in the Northern Birmingham Trust and the new Trust reported to the inquiry that the clinical governance arrangements in the new Trust were an improvement on the quality assurance processes of the old Trust. However, reservations were expressed at all levels of the existing organisation with regard to the unwieldy and bureaucratic nature of the present clinical governance configuration. Suspicions were expressed by Executive Team members that the existing committee structure may, in some cases, be inhibiting, rather than facilitating the development of good practice. These suspicions were confirmed by clinicians working at a more local level, who expressed doubts about the extent to which key messages about clinical governance had penetrated services at directorate level.

At a corporate level it was reported that there was some confusion and ambiguity about whether it is the Board or the Clinical Governance sub-committee which has primary responsibility for tracking action plans developed either as a consequence of serious incidents, or in response to government governance targets.

Senior managers gave the panel assurances that risk management training was being offered and accessed in a systematic manner across all Trust services. The Trust gave an assurance to the panel who conducted the Hamilton/Rehman homicide inquires (2004) that there would be a robust system of audit to monitor the implementation of risk management training. Evidence provided to the panel confirmed that this undertaking had been acted upon. Clinicians presently working in the Trust reported that they themselves had recently received risk management training.

Nurse Managers and the Medical Director suggested that there was still a large measure of medical disengagement from the CPA process.

The Inquiry Team was given an assurance that Consultant Psychiatrists and non Consultant Medical Staff were now aware of their respective responsibilities in relation to ensuring that supervision arrangements were in place for all grades of medical staff. More generally the panel was also assured that uptake of clinical supervision for all staff was monitored through the clinical governance structures.

# CHAPTER 7

## MANAGEMENT RESPONSIBILITY FOR THE INTERNAL INQUIRY

The Department of Health guidance contained in the Health Service Circular 94/27 which sets the framework for reporting all serious incidents in mental health services, does state that in the case of violence there must be an immediate investigation to identify and rectify possible shortcomings in operational procedures. It also goes on to say "in cases of Homicide, it will always be necessary to hold an inquiry which is independent of the providers involved." However, the Department of Health guidance does not contain detailed advice as to how internal inquiries should be undertaken but many NHS Trusts over the past few years, and in particular, since the publication of, *An Organisation with a Memory – Report of an Expert Group on Learning from Adverse Events in the NHS (2000) and Building a Safer NHS for Patients – Implementing an Organisation with a Memory (2001)* have developed policies to deal with and provide guidance for staff in dealing with untoward incidents, including homicides. Clinical Governance is the over arching aspect of Trust business which is dealt with in Chapter 11 of this report.

We were asked to review the internal inquiry into the care of KM already undertaken by Birmingham and Solihull Mental Health NHS Trust, any action plans that may have been formulated, including the immediate remedial action taken at the time of the incident, or action taken as a result of the internal inquiry and assess the effectiveness of their implementation.

When the incident occurred the locality manager wrote a brief report which was sent to the medical director. Following this, the homicide was reported in the confidential part of the Board Meeting in October 2002.

> *" the Chief Executive reported that an inquiry was taking place with regard to a serious machete incident.*
>
> *The former Medical Director advised that this incident would follow the homicide inquiry policy and involve Non Executive Directors adding that when the person involved was assessed after the assault took place they were found to be acutely mentally ill, there was a possibility that this was not found upon the initial presentation to the service. Following the former Medical Director's investigation of the person's casenotes contact*

*has been made with the persons GP and improvements to the service are being investigated"*

In April 2003 the Commission for Health Improvement wrote to the Trust requesting details of all serious and untoward incidents which had occurred in the two former Trusts in the previous three years. A manual search was undertaken and at the same time the Coroner informed the Health Authority that there were a number of 'unclosed' cases. The Coroner gave the Trust details of these cases, but it was not until the MP wrote to the Chief Executive, that the KM incident came to light.

The internal inquiry was commenced in April 2004 when a Non–Executive of the Trust - formerly a Non-Executive Director of Northern Birmingham Mental Health NHS Trust, was asked to chair the process. He was assisted by the current Medical Director, the Clinical Director, Forensic Psychiatry, the Director of Nursing, the Deputy Director of Nursing and the Director of Cultural Diversity.

The panel were asked to consider:

- The care the service user was receiving at the time of the incident;
- The suitability of that care in view of the service user's history and assessed health and social care needs (including the service user's cultural identity);
- The extent to which that care corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies, including the Care Programme Approach;
- The exercise of professional judgement (including the systems in place to support the exercise of professional judgement);
- The adequacy of the care plan and its monitoring by the key worker (now Care Co-ordinator).

The current Medical Director wrote to the non-Executive Director on 20 April 2004, informing him that he had had a series of meetings with some of the doctors involved and outlining the history thus far. Further interviews were held between members of the panel and staff involved with KM and KM's mother.

# CHAPTER 8

## DISCUSSION OF THE INTERNAL INQUIRY

### Undertaking the Investigation

Homicides may occur in any mental health service and at any time and to minimise the distress to staff, Trusts should have implemented policies which spell out what actions should happen. A structured approach enables staff to prepare for any external involvement which could be the police, the Coroner or an independent inquiry.

It is accepted practice that while the police are conducting their inquiry it is not appropriate to commission an external inquiry but it is good practice to investigate what happened, who was involved and what can be done in the short term to make the service 'safe' and to support staff. The Trust now has a comprehensive policy in place and we were assured that lessons had been learnt from this case and that in subsequent serious untoward incidents the policy has worked well.

It was very appropriate to appoint a Non–Executive Director to chair the investigation and also appropriate to appoint several senior managers to assist in the process. However, from then on there could have been a more structured approach to conducting interviews, feedback to those interviewed and writing the draft report. There were notes taken of some of the face-to-face interviews but some interviews were conducted over the telephone and were not recorded. Some staff were attributed as being interviewed and were not.

| COMMENT |
| --- |
| All interviews should, wherever possible, be conducted by all of the appointed panel. The interviews should be recorded and a transcript returned to the interviewee for verification and clarification.<br><br>The panel should agree the draft policy, and in particular the recommendations, for their practicality. |

**Family Involvement**

The Policy in operation at the time of incident stated that:

> "initial contact with families/carers will be made by the RMO and the keyworker. The locality manager may decide to assign a named individual to maintain contact with the family/ carer."

We were disappointed to note that despite being discussed at the Trust Board meeting in October 2002 no contact with KM's family was made until some time later. KM's mother was interviewed as part on the internal investigation in 2004 but even this did not prompt further contact with her to inform her of the outcome of the internal investigation.

Neither Mr. H nor Mr. M were ever contacted by either organisation. When we interviewed Mr. H he felt that there was no point in conducting an external inquiry because nothing would be achieved.

| **COMMENT** |
| --- |
| Homicide is an uncommon event in mental health services and, as such, should be treated with openness and honesty, and should be demonstrated by positive action with families who are often left bewildered and isolated. |

**The Delay in Completing the Report**

We know that the north Birmingham mental health services merged with those of south Birmingham and Solihull at the time KM was sentenced in April 2003. Although we asked all senior members of staff why there was this delay there appeared to be no specific reason. An interim report was prepared in June 2004 and a final version eventually went to the Trust Board in July 2005. The key issues, conclusions and recommendations can be found at Appendix 2.

| **COMMENT** |
| --- |
| The delay in setting up this inquiry was seen as regrettable and unacceptable and we have no<br>alternative but to agree with this point of view. We were equally unable to find any reason for the delay in setting up the external inquiry. |

### Debriefing

Interviewed staff, staff involved in KM's care and family members should all have been given a copy of the report and a series of debriefing sessions organised to discuss the outcome and recommendations. Any action plan should be prepared and where necessary discussed with other agencies to ensure that all actions are practical, appropriate and achievable.

**We recommend that the Trust reviews its recent serious untoward incident policy and ensures that in future families are kept up-to-date with actions taken and that staff are prepared for any external inquiry.**

# CHAPTER 9

## KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

In the course of our Inquiry we concluded that the Northern Birmingham Mental Health Trust was in the process of developing high profile services but had lost sight of the day to day issues of a well managed mental health service. Some of these are good financial management, structural processes which help all staff identify 'at risk' patients, the need to monitor individual workloads of doctors and clinics and provide management and clinical support to front line staff.

We were told that clinics could be 'chaotic' with doctors being expected to see patients booked with other doctors thus lessening the amount of time they spent with individual patients.

We recognise that specific issues have already been addressed by the Birmingham and Solihull Mental Health NHS Trust Board, however, during the course of our Inquiry we concluded that the following findings require further attention in order to improve patient safety.

1. The GP wrote his referral letter to the Consultant Psychiatrist A which is common practice. His usual practice was to telephone in advance and he thought he probably would have done so in this case, and he had an expectation that Consultant Psychiatrist A would see his patient. If a GP wishes the patient to have a medical assessment this should be clearly stated in the referral letter.

2. The CPN wanted a doctor to see KM on the same day as his initial assessment but none was available, and at the time, this was not an infrequent situation, although we were told a doctor was contactable by telephone and bleep.

3. KM did not make any secret of his contact with the police and the previous violent incidents he had been involved in. Despite his honesty there was no contact with the police to check this out. Effective liaison might have provided the Team more information to assist them in their assessment and care plan.

4. The SHO considered that it was important to have corroborative information from either a family member/carer or friend. The Associate Specialist saw KM's mother on her own and then saw KM with his mother. He did not see KM on his own. This was an error of judgment as KM had been very open in the previous interviews but may well have been inhibited by having his mother present.

5. Consultant Psychiatrist A was away on the day of the assessment by the SHO, and although supervision was forthcoming from the Associate Specialist there was a lot of pressure of clinical work on the team as a whole and therefore supervision was not as structured as it should have been for a junior doctor.

6. Although the SHO made decisions with support from the Associate Specialist, it is clear that the Associate Specialist did not have any supervision from Consultant Psychiatrist A, either in this particular case or, any systematic supervision on an on-going basis. The Associate Specialist told us that he met with the former Medical Director as and when he needed to. Consultant Psychiatrist A also confirmed this approach.

7. The SHO criticised her own record keeping in failing to record her discussion with the Associate Specialist and the fact that she had referred KM to the ED:IT team. Had these two issues been recorded in the notes then KM may not have been discharged from the service.

8. The outcome of the first two assessments was to continue with the GP's medication and an assumption made that KM was attending his GP. As his presentation was 'unusual' it might have been more helpful if he had been given information about alternative sources of support, for example, black voluntary sector organisations.

9. It was clear that Mr. M made complaints to the police about KM's behaviour but despite KM's own honesty about his violent behaviour no contact was made to glean more information.

10. No attempts appear to have been made to liaise with any other agencies despite KM being subject to a Community Rehabilitation Order. Liaison with the police would have illustrated his forensic history and perhaps the on-going dispute between KM and Mr. M. This could have led to a further risk assessment of his potential dangerousness and reflected in a care plan.

11. Although the Trust policy has an expectation that all discharges are discussed in the multi-disciplinary team weekly meeting, this does not seem to have happened.

12. KM's history and risk of violence was appropriately assessed but not taken into consideration in deciding to discharge him from mental health services. Neither was this decision taken during a multi-disciplinary team discussion.

13. KM's discharge was a unilateral and autonomous decision and not one made by the multi-disciplinary team. It is possible that the Associate Specialist did not have access to the CPN's letter which may not have been integrated into the clinical records at the time of the Associate Specialist's consultation.

14. The SHO's referral to the ED:IT team resulted in the latter sending KM two appointments, the first of which he did not attend. The second appointment was following the homicide. However, we were not surprised that KM did not attend the first appointment as there is no explanation on the letter as to why he is being asked to see this team. The second letter was copied to the SHO, dated 15 August 2002 but she had already left the mental health services and it would not have been available to the Associate Specialist on the 16 August 2002. The Associate Specialist would have been unaware that the ED:IT team had sent KM an appointment when he discharged KM.

15. The referral to ED:IT was not recorded in the notes. His subsequent non attendance would have been brought to the attention of a key worker and, may have led to a more robust risk management strategy.

16. There was no formal de-briefing offered to team members, including the two members of staff employed within HW House who were separately related to the service user and the victim.

17. No support was offered to families of either the service user or the victim.

18. The delay between the incident and the initiation of an internal review process was unacceptable.

19. There was some confusion and lack of clarity about the role and responsibility of the ED.IT team and how it related to other services.

## CONCLUSION

The final assessment of KM was hurried, not thorough and did not include any discussion with him on his own. We also felt that 'risk assessment processes' were being carried out in parallel as it was considered quite difficult to 'engage' doctors in the CPA process.

## RECOMMENDATIONS

The organisation responsible for the treatment and care of KM no longer exists. It is also three years since the incident. The internal inquiry, conducted by the new organisation was published in the Summer of 2005 (Appendix 2), with certain recommendations.

**We would recommend that the Trust Board reviews the internal inquiry action plan and as a result of our inquiry, develops an up-to-date action plan with target dates and named managers with responsibility to specifically address the following:**

1. **The management of the Assessment process and availability of medical staff;**

2. **The assessment and management of risk takes account of a multi-agency and multi-disciplinary information and informs the CPA process;**

3. **Patients' discharge arrangements should be discussed in the multi-disciplinary team;**

4. **The supervision of junior medical staff;**

5. **The management arrangements for planned Consultant absence to make sure that patients attending the outpatient clinic are sufficient time;**

6. **The management of serious untoward incidents which takes account of the needs of families and staff;**

7. **New patient appointments should contain information about the service that the patient is being asked to attend;**

8. **The roles, responsibilities and resourcing of the ED:IT team;**

9. **The development and funding of a full time comprehensive independent advocacy service.**

10. **The Trust reviews it's recent serious untoward incident policy and ensures that in future families are kept up-to-date with actions taken and that staff are prepared for any external inquiry.**

## APPENDIX 1

## KM'S CONVICTIONS AND INCIDENTS WHICH HAVE BROUGHT HIM TO THE ATTENTION OF THE POLICE

| | |
|---|---|
| **12 July 2001** | KM was charge with two accounts of Battery. He assaulted two female customers, a mother and daughter whilst they were queuing at the bank. KM slapped the mother and put chewing gum in the daughter's hair. He was found guilty at Birmingham Magistrates Court and had to pay £50.00 to each victim plus £110.00 costs. |
| **18 April 2002** | Failing to surrender to custody – appeared at Solihull Magistrates Court and was fined £20.00 plus £20.00 costs. |
| **21 May 2002** | Common Assault. Assaulted a co- worker at the NEC by putting a knife to his throat. Appeared at Solihull Magistrates Court and received a Community Rehabilitation Order for 12 months and ordered to pay compensation £50.00 plus costs £100.00. |
| **10 July 2002** | Incident outside the shop where the murder took place, when KM had a machete in his possession |
| **10 November 2004** | KM assaulted a fellow patient who suffered a three inch cut to his head. |

## APPENDIX 2 – INTERNAL INVESTIGATION

### KEY ISSUES

The inquiry panel has identified the following key issues:

### ASSESSMENT PROCESS & CARE

Despite both the GP and the CPN requesting that a Consultant Psychiatrist review the service user, he was, in fact, never seen by a Consultant Psychiatrist before his discharge from mental health services.

Although the CPN and the SHO both found evidence to suggest that there had been a temporal relationship between the onset of his psychotic symptoms and his violent conduct approximately 5 years previously, this appears to have become overlooked during his episode of assessment.

There does not seem at any point to have been multidisciplinary team discussion about the case, assessments having been made in a serial fashion by different people between whom there appears to have been limited communication. This is exemplified by the Associate Specialist having been unaware that the SHO had made a referral to the EDIT team when he discharged the service user.

Although the Associate Specialist interviewed both the service user and his mother on their own (as well as together) more weight should have been given to the presenting history, and arrangements for the service user's longitudinal assessment in the community should have arisen as a result of a multi-disciplinary team discussion and the establishment of CPA arrangements to underpin that process of assessment.

Despite the apparent comprehensiveness of the SHO's assessment, the overview of the service user was somewhat two dimensional, in that it is clear that little was known about who the service user really was and what he did with his time. Issues of diversity may have impacted on the assessing teams shortcomings in developing a true understanding of the service user as an individual, the finding of a 'paranoid personality' being inadequate to inform a plan of action which took all relevant issues into consideration.

The outcome after each of the two assessments was to continue with the GP's medication. There was no offer of any further interventions or consideration of alternative sources of support, for example, black voluntary sector organisations.

The patients' history and risk of violence was initially appropriately assessed but the decision to discharge him from mental health services, being taken out of the context of multidisciplinary team discussion, was inappropriate. Even if this patient was assessed to have a paranoid personality disorder (which is not suggested from the history which would have been available to the assessing team at the material time) arrangements should have been made to discuss both low dosages of anti-psychotic medication and cognitive behavioural therapy with the patient. Many patients, whilst opposed to medication, are amenable to some form of psychotherapy and such therapy can often be inter-woven with an ongoing assessment process under the provisions of CPA in a multi-disciplinary team setting.

## RISK

It is clear that Mr. M had been making complaints to the police inter-alia and the police would therefore have had records of the ongoing dispute between KM and Mr. M at the material time of his assessment at HW House.

With regard to liaison with the police, had the Associate Specialist been aware that the police had received reports from Mr. M of aggressive behaviour on KM's part, then the risk assessment (and management thereof) would have reflected the reality of the situation to a much greater degree.

No attempts appear to have been made to liaise with external agencies. Liaison with the police would have produced antecedent records which would have illustrated his forensic history in greater detail and further discussions with local police may have elicited the on-going dispute between the service user and Mr. M, possibly leading to a revitalised risk assessment of his potential dangerousness and an invigorated care plan which reflected that assessment.

The patients' history and risk of violence was initially appropriately assessed but the decision to discharge him from mental health services, being taken out of the context of multidisciplinary team discussion, was inappropriate. Even if this patient was assessed to have a paranoid personality disorder (which is not suggested from the history which would have been available to the assessing team at the material time) arrangements should have been made to discuss both low dosages of anti-psychotic medication and cognitive behavioural therapy with the patient. Many patient's, whilst opposed to medication, are amenable to some form of psychotherapy and such therapy can often be inter-woven with an ongoing assessment process under the provisions of CPA in a multi-disciplinary team setting. This would have retained KM under psychiatric supervision and, through a process of exposure of his risk in greater detail, may have led to a more robust risk management strategy (particularly if the above mentioned liaison had taken place contemporaneously).

## SUPERVISION

Although Consultant Psychiatrist A was away on the day of the assessment by the SHO, supervision was forthcoming from the Associate Specialist but with was the pressure of clinical work being brought to bear on the team as a whole at the material time, this supervision was not structured.

Although there may have been Consultant Psychiatrist cover for Consultant Psychiatrist A during that day, a majority of Consultants would not see it as part of that duty to supervise middle or junior grade doctors' activities in out-patients.

Although the SHO made decisions with support from the Associate Specialist, it is clear that the Associate Specialist did not have any supervision from Consultant Psychiatrist A either in this particular case or, in terms of systematic supervision, on an on-going basis.

## TEAMS

The CPN wanted the service user to be seen by a doctor on the same day as his initial assessment but none was available, so he offered him the next available appointment, in one month's time, & the duty contact telephone number. At the time, this was not an infrequent situation.

The SHO's referral to the EDIT team resulted in the latter sending KM two appointments, the first of which he did not attend. The second appointment was following the homicide. It is not surprising that KM did not attend the first appointment because there is no explanation on the letter of invitation as to why he is being asked to see this team. Although the second letter of invitation was copied to the SHO, this was dated 15th August 2002 and would not have been available to the Associate Specialist on the 16th August 2002 (the date of his assessment of the patient), thus implying that the Associate Specialist would have been unaware that the EDIT team had sent KM an appointment when he discharged KM.

The service user's discharge resulted from a unilateral and autonomous decision out of the context of the multi disciplinary team, and apparently without the Associate Specialist having had assess to the CPN's letter which may not have been integrated into the clinical records at the material time of the Associate Specialist's consultation with the service user.

The service user's address was consistently mis-spelt from May 2002 onwards. This may have meant that he did not receive the letters from ED:IT. Additionally, there were delays between the dictating and typing of letters.

The likelihood of discharge without further risk assessment would have been reduced further by appropriate liaison with the criminal justice system, notwithstanding the Caldicott implications of such liaison.

## POST INCIDENT ARRANGEMENTS

No formal de-briefing was offered to team members, including the two members of staff employed within HW House were separately related to the service user and the victim.

No support was offered to families of either the service user or the victim.

The delay between the incident and the initiation of an internal review process was unacceptable.

## INTERIM CONCLUSION

In interim conclusion, the assessment of KM was undertaken by three clinicians in series, communication between them being inadequate and unsupervised with a resultant tendency to lose the focus on the relationship between Mr McDonald's psychotic symptoms and his already existent assultative history as the process of assessment proceeded.

At no time was the case discussed in a multidisciplinary team setting and at no time was the management of the case made subject to CPA provisions.

Liaison with the police was absent.

This accumulation of issues resulted in an individual decision being made by a sole practitioner to discharge KM from psychiatric services when the evidence should have strongly suggested that this would not have been an appropriate course of action, given what would have been known about KM at the material time of his presentation

## KEY RECOMMENDATIONS

### ASSESSMENT PROCESS AND CARE

Once a referral is screened by a qualified team member, if that team member lodges a request that the patient is seen by a Consultant Psychiatrist, the patient should be seen by a Consultant Psychiatrist.

Findings at each stage of assessment should contribute towards the building of an overall picture in the context of a longitudinal or serial assessment process. Any association between symptoms of mental illness and aggressive or assaultative behaviour should be flagged in integrated clinical records so as not to be overlooked in subsequent assessments.

Consultants and team leaders must ensure that the whole process of assessment, diagnosis, treatment and care (including discharge) is systematic by way of multidisciplinary team discussion following initial assessment, commitment to CPA, and further interdisciplinary discussion (to include the GP and any other relevant agency) and an “exit risk assessment” at the point of discharge from psychiatric services.

Assessing clinicians undertake holistic, culturally responsive assessments which must include the views of carers who are involved in the patient’s care and other key agencies and which lead to initial conclusions which not only involve the establishment of an accurate diagnosis but which also take heed of the person’s psychological, social and spiritual requirements in a person centered fashion.

Alternative sources of support (particularly in respect of NGO’s) must always be considered.

Delay between dictating and transcription of letters should be reduced by medical staff dictating entries which can be directly transcribed by their medical secretaries onto the patient’s ePEX CPA, thus being instantly available to other healthcare professionals who require access to the doctor’s findings and initial care plan.

## RISK

If there is a history of involvement with the police for assaultative offences which might have had a causal relationship to psychotic symptomatology, liaison must occur between the Trust and the police to ensure that each organisation's assessment and management strategy is informed by any information the other may have about the patient.

A policy relating to information exchange between BSMHT and the police is currently being developed and consultation and introduction arrangements will ensure that all clinicians are fully aware of circumstances in which information sharing should occur and the process for achieving this.

A decision to discharge someone from mental health services should not be taken out of the context of appropriate multidisciplinary consultation and relevant external liaison.

## SUPERVISION

Clinical Directors should ensure that all non-consultant medical staff (including medical students) are making decisions within an appropriately supported and supervised system.

Although staff or associate specialist doctors can make decisions on a day to day basis without recourse to advice from a consultant, there should be a refreshed initiative to encourage consultants to properly and uniformly supervise staff and associate specialist grade doctors and performance manage middle grade staff through a process of annual appraisal.

SHO's should not be left unsupported and unsupervised in outpatient settings.

## TEAMS

There should always be a medical doctor available for urgent opinions and leadership of management strategies in each community mental health team during working hours.

Medical doctors must actively participate as part of a multidisciplinary team and avoid making unilateral decisions, particularly in relation to discharging patients from psychiatric care.

CMHT and other functionalized teams' operational policies require redrafting to ensure that teams inter-digitate with each other effectively and that interface issues, such as referral acceptance and discharge arrangements, are anticipated and resolved by way of coherence between operational policies.

Data quality improvements are required to reduce the likelihood of misinformation in terms of demographic information.

## POST-INCIDENT ARRANGEMENTS

Debriefing should be offered to staff who have been involved with a service user who has committed homicide. This should comprise imparting information about the process that the Trust will follow and their role in this process and, if necessary and appropriate, counseling.

Meaningful liaison should be undertaken between the Trust and the perpetrator, the family of the perpetrator and the family of the victim, following an unlawful killing.

Following an unlawful killing, effective internal and external liaison should lead to the initiation of an interim Medical Director's report, which aims to identify and address service shortcomings at an early stage, whilst criminal proceedings are developing. The Medical Director's report should be concluded once a verdict has been reached and prior to the undertaking of an independent inquiry.

## APPENDIX 3 – WITNESSES

Associate Specialist

Chief Executives (current and former)

Clinical Governance Lead

Community Psychiatric Nurse (CPN)

Consultant Forensic Psychiatrist

2 Consultant Psychiatrists

Co-ordinator – Early Detection Intervention Team

Deputy Director of Nursing

Detective Chief Inspector – Queen's Road Police Station

Director – Afro Caribbean Community Initiative

Director of Diversity

Director of Early Detection Intervention Team

Director of Nursing

Director of Strategy Planning

Frantz Fanon Centre Manager

2 General Practitioners

KM's mother

Locality Manager

Manager – Primary Care Team

Medical Directors (current and former)

Mental Health Nurse

Mr. M (victim)

Mr. H (Mrs H's widower)

Non-Executive Director

Sainsbury Centre for Mental Health

Senior Housing Officer (SHO)

Strategy Planning and Mental Health Manager – Heart of Birmingham PCT

### WRITTEN EVIDENCE

Legal Services Manager – Birmingham and the Black Country Strategic Health Authority

## APPENDIX 4 – INDEX OF DOCUMENTS/REPORTS

### KM'S MEDICAL RECORDS

- General Practitioner
- Northern Birmingham Mental Health NHS Trust
- Raeside Clinic Birmingham & Solihull Mental Health Services NHS Trust

### WEST MIDLANDS PROBATION BOARD

- KM's Records
- KM"s Pre-sentence Report
- Internal Investigation

### BIRMINGHAM & SOLIHULL MENTAL HEALTH NHS TRUST RECORDS

- Memorandum – MDT Discharge Planning
- MDT Recording Protocol
- Memorandum – MDT Format Discussions on 12/6/01
- Clinical Supervision Policy
- Clinical Risk Assessment and Management Training for Medical Staff
- Clinical Risk Management Training Data
- Policy for Clinical Supervision of Nurses
- Clinical Supervision Register (updated May2005)
- Joint Policy on the Provision of Mental Health Care for the Delivery of the Care Programme Approach and Care Management
- CPS Audit Report – Heart of Birmingham Directorate April 2005
- eCPA on ePEX version II January 2005
- Report of Internal Inquiry
- Organisation Chart
- Promoting Diversity in Mental Health Services – Birmingham & Solihull Mental Health Trust Diversity Strategy: 2004 to 2006

- The Management of Serious Untoward Incidents including SUI Flow Chart March 2004
- Serious Untoward Incidents March 1995
- Policy for Action to be taken in the event of a Suicide or Possible Suicide or Homicide Draft February 2002
- Policy for Handling Complaints April 1996
- Frantz Fanon Centre for Mental Health Training Pack
- Early Intervention Clinical Guidelines & Service Frameworks
- Early Intervention Service – Operational Policy
- Early Intervention in Psychosis – Toolkit
- Mental Health Commissioning Strategy for Working Age Adults – 2005 to 2008

## MEDIA

- Man in Court over Machete Attack – 18 September 2002
- Sentence Adjourned in Machete Killing – 28 March 2003
- Police 'Warned' Before Machete Attack – 23 April 2003
- Candelit Vigil for Shopkeeper – 16 September 2003

## POLICE RECORDS

- Case Summary
- West Midlands Police Report on KM
- Witness Statements
- Custody Records
- Joint Review Policing and Mental Health Metropolitan Police Authority 2005

## APPENDIX 5 – LIST OF PUBLICATIONS

**Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community** – HSG(94)27 Dept of Health

**Guidance – "Independent Investigation of Adverse Events in Mental Health Services**" – An amendment to paragraphs 33-36 (pages 10-11) of HSG(94)27

**An Organisation with a Memory** – Report of an Expert Group on Learning from Adverse Events in the NHS – 2000

**Building a Safer NHS for Patients** – Implementing an Organisation with a Memory -2001

**Code of Practice** Mental Health Act 1983

**A National Service Framework for Mental Health** – Dept of Health1999

**Effective Care Co-ordination in Mental Health Services** – A Policy Booklet

**The Journey to Recovery** – The Government's Vision for Mental Health Care – 2002

**Building Bridges** – A Guide to Arrangements for Inter-Agency working for the Care and Protection of Severely Mentally Ill People – 1995

**Still Building Bridges** – The Report of a National Inspection of Arrangements for the Integration of Care Programme Approach into Care Management

**Standards for Better Health Care** – Department of Health, July 2004

**Safety First** - 5-year Report of the National Confidential Inquiry into Homicides and Suicides by people with Mental Illness – 2001

**Mental Health Policy Implementation Guide** – Adult Acute Inpatient Care Provision – 2002

**Mental Health Policy Implementation Guide** – Dual Diagnosis Good Practice Guide – 2002

**Engaging and Changing** – Developing Effective Policy for the Care and Treatment of Black and Minority Ethnic Detained Patients – NIHME 2003

**Delivering Race Equality** – A Framework for Action : Mental Health Service Consultation Document

**Inside Outside** – Improving Mental Health Services for Black and Minority Ethnic Communities in England – NIMHE 2003

**Breaking the Circles of Fear** : A Review of the Relationship between Mental Health Services and African Caribbean Communities – Sainsbury Centre for Mental Health 2002

**David Bennett Inquiry Report**

**Independent Report into the Care and Treatment of David Johnson** – Birmingham Health Authority 1999

**Independent Report into the Care and Treatment of Arshad Mahmood** – Birmingham Health Authority 2000

**Report of an Independent Review of the Care and Treatment of Mr. Ogilpis Hamilton and Mr. Adbul Rehman** - Birmingham and the Black Country Strategic Health Authority 2004

**Big, Black and Dangerous? -** Report of the Committee into the Death in Broadmoor and a Review of the Deaths of Two Other Afro-Caribbean Patients –"