Homicide Investigation Report into the death of a child

Executive Summary

STEIS Reference: 2013/7122

Chair: Dr Alison Reed - September 2014

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Foreword

(This is an extract from the victim impact statement taken with kind permission of Christina's family)

Christina was our youngest child. She was such a sweet caring girl. If we were out in the street and she saw an old person carrying their own shopping, she would say, 'Ah bless them – they should have someone helping them'.

Christina wanted to be a midwife but she didn't like the sight of blood and we used to have a laugh about it. She was determined though, and she would have done it. She loved kids, and because she didn't think she could nurse old people or children, she decided she wanted to be a midwife. When I say that, I mean she couldn't do it because she would be sad if they died.

Every morning we would walk together, she would walk to the bus stop, and I would walk to work. She wouldn't stop talking, and she used to say, 'Mom, I'm not talking anymore because you're not listening'. I had switched off, but I would say, 'I am listening'. We would laugh about it. If only I could have that time back. We would get to the point where we would go our different ways. We would give each other a kiss & say goodbye & she always said 'love you mom'. I can't walk that way anymore; I go a different, longer, way. I just can't walk the way I went with Christina.

Once a month, me and Christina would be at home on our own, we would order Chinese food and watch TV. I can't even watch TV anymore, and I certainly can't watch the programmes we always watched together.

As a family, we went everywhere together. We enjoyed family parties. When the children were young, people used to say how well behaved our children were. We raised them to have manners and be polite.

The school have been wonderful and so have all of Christina's friends, who have also been affected by her death. They wanted us to come to the Prom for Christina, but we couldn't do it, it would have been too difficult.

Christina was cremated in her beautiful prom dress which was a purple/lilac colour. I thought I would see her going off to the prom in it – not in her coffin. At the prom they released purple balloons in Christinas' memory, her favourite colour.

Some months after her death, we had a parcel delivered – it was Christinas' exam results, she had done really well. Also enclosed was the school year book, where Christina was included, and at the back they had done a tribute page to her.

There was a poem and lots of photographs of her and a quote by her headmaster, 'If a school could choose its pupils it would be full of Christinas'.

When I opened up the envelope and saw this it broke my heart. I can't explain the feeling – it is emptiness - like someone has ripped out my heart.

Our family are so devastated I don't know how we will ever get over what has happened. We are a big family and no-one has been left untouched. Christina loved her family and her cousins – they all called her CJ (Christina Joan).

Our lives have been changed beyond all belief by that knock on the door on 7 March 2013. Our lives will never be the same, and I don't know what we will do without our precious daughter Christina.

1. Introduction

In the case of homicides that have been carried out by someone who has recently received mental health services, current national guidance (Department of Health 2007) identifies that following an initial management review; there should be an internal investigation. This investigation should establish a clear chronology of events leading to the incident, determine any underlying causes and identify whether action needs to be taken with respect to policies, procedures, environment or staffing.

The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Board Regulations 2006, made under section 14 (2) of the Children Act 2004. Under these regulations victims of homicide under the age of 18 years have a separate requirement for a child Serious Case Review to be held for every case where abuse or neglect is known or suspected. It also applies when a child dies, or a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

The focus of learning for Serious Case Reviews is fundamentally for those agencies that were already engaged with the subject child and could have, or should have, done more to protect that child and prevent the death or serious injury. Christina was not known to agencies and was thriving in a loving and supportive family environment.

It was agreed by the Birmingham Safeguarding Children Board that this investigation would also serve the requirements under safeguarding legislation in these circumstances, believing it to be the best effective pathway for undertaking the investigation into Christina's death.

The importance of undertaking an investigation into the circumstances surrounding the death of Christina was paramount in enabling lessons to be learned. Christina's family gave evidence to the investigation panel with great dignity and made clear their desire that no other family have to go through what they have suffered.

It was heartening that so many parties involved agreed to take part in the investigation, recognising the gravity of the family's loss and were willing to participate in an open and honest manner.

The investigating panel urge all organisations, but especially those organisations that have not reviewed their part in the life of P, to do so with reference to this investigation report. The report highlights a significant number of issues for consideration with some key themes emerging.

1.1 Incident Description

At around 7.30 am on the morning of 7 March 2013 Christina Edkins, a 16 year old schoolgirl, boarded the number 9 bus to make her usual journey to school. She went on her own to sit on the upper deck of the bus. P was already on the upper deck of the bus, sitting at the back. As the bus proceeded along Broad Street to the Hagley Road in Birmingham, P suddenly stood up, walked forward along the aisle as if to exit and turned toward Christina and stabbed her, in a clearly random unprovoked attack. P then left the bus.

Despite the best efforts of passengers and emergency services Christina died from a single stab wound.

P was arrested later the same day at around 12 noon. A bag containing the knife he used in the attack was found hidden nearby in bushes.

In September 2013 P appeared in Court and in October 2013 he was convicted of manslaughter on the grounds of diminished responsibility. He was sentenced, following medical evidence regarding his mental health, to a hospital order with restrictions without limit of time, Section 37/41 of the Mental Health Act 1983 (Amended 2007). He was detained in a secure psychiatric hospital.

2. Terms of Reference

The Trial Court Judge in the case of P directed that the whole of the sentencing and hearing be transcribed and given to the investigation panel. (This was also given to Christina's family). The terms of reference encompass the following questions from the Judge at Birmingham Crown Court.

1. Why was P not admitted to hospital?
2. Why was he discharged from HMP Birmingham without follow up?
3. Why did the services he was involved with prior to HMP Hewell not deem him to require treatment?

2.1 Table 1 Terms of Reference

1. Whether in the light of information relating to the service users (P) complete treatment history and involvement with other agencies (including primary and specialist care and criminal justice), the incident could have been prevented, or predicted, and what lessons can be learned to reduce or minimise the possibility of such an event reoccurring.
2. Whether P was provided with relevant and appropriate assessment, treatment and care particularly in relation to the following events: a. Care, treatment and involvement of the Black Country Partnership NHS

Foundation Trust (BCPFT).

b. Decisions by services, prior to admission to HMP Hewell in July 2012, not to treat.

c. Care and treatment received in HMP Hewell in relation to his physical and mental health.

d. Care and treatment received in HMP Birmingham in relation to his physical and mental health.

e. Discharge from HMP Hewell in October 2012.

f. Discharge from HMP Birmingham in December 2012.

g. Assessment made for hospital admission to a Psychiatric Intensive Care Unit (PICU) on 20 September 2012.

3. To consider whether appropriate information was shared between agencies in order to provide appropriate assessment and care, and whether systems were sufficiently robust to ensure information was shared.

In particular to review:

a. Information shared between HMP Hewell and HMP Birmingham.

b. Information presented by P's mother to Prison authorities.

c. Information shared at the points highlighted in 2) above.

4. Why assessments, and not psychiatric reports, had been requested by the Court in July 2012.

As a result:

5. To identify any key areas of learning from the event and/or actions preceding or immediately following the event.

6. To provide a report as a record of the homicide review process with recommendations resulting from key findings.

2.2 Meetings with families

The investigation panel met with the families of both Christina and P. The initial meetings with each family allowed an opportunity for them to understand the investigation process and to meet and talk with the investigation panel. This enabled the families to raise any concerns or issues that they felt they would like addressed as part of the investigation. The investigation panel considered that meeting with the families was an essential component of the investigation process. It allowed both families to have a voice in the process and presented a valuable opportunity for the investigation panel to listen directly to what each family had to say.

2.3 Interview with P

The Responsible Clinician for P confirmed, on 25 February 2014, that P did not then have capacity to understand fully what he had done and he was not considered to be fit for interview within the proposed timescale of the investigation.

On 30 April 2014 P's Consultant Forensic Psychiatrist confirmed that it remained the view of the clinical team that P remained unfit to be interviewed.

P remains detained under Section 37/41 of the Mental Health Act 1983 (Amended 2007) in a secure psychiatric hospital.

3. Background

3.1 Christina Edkins

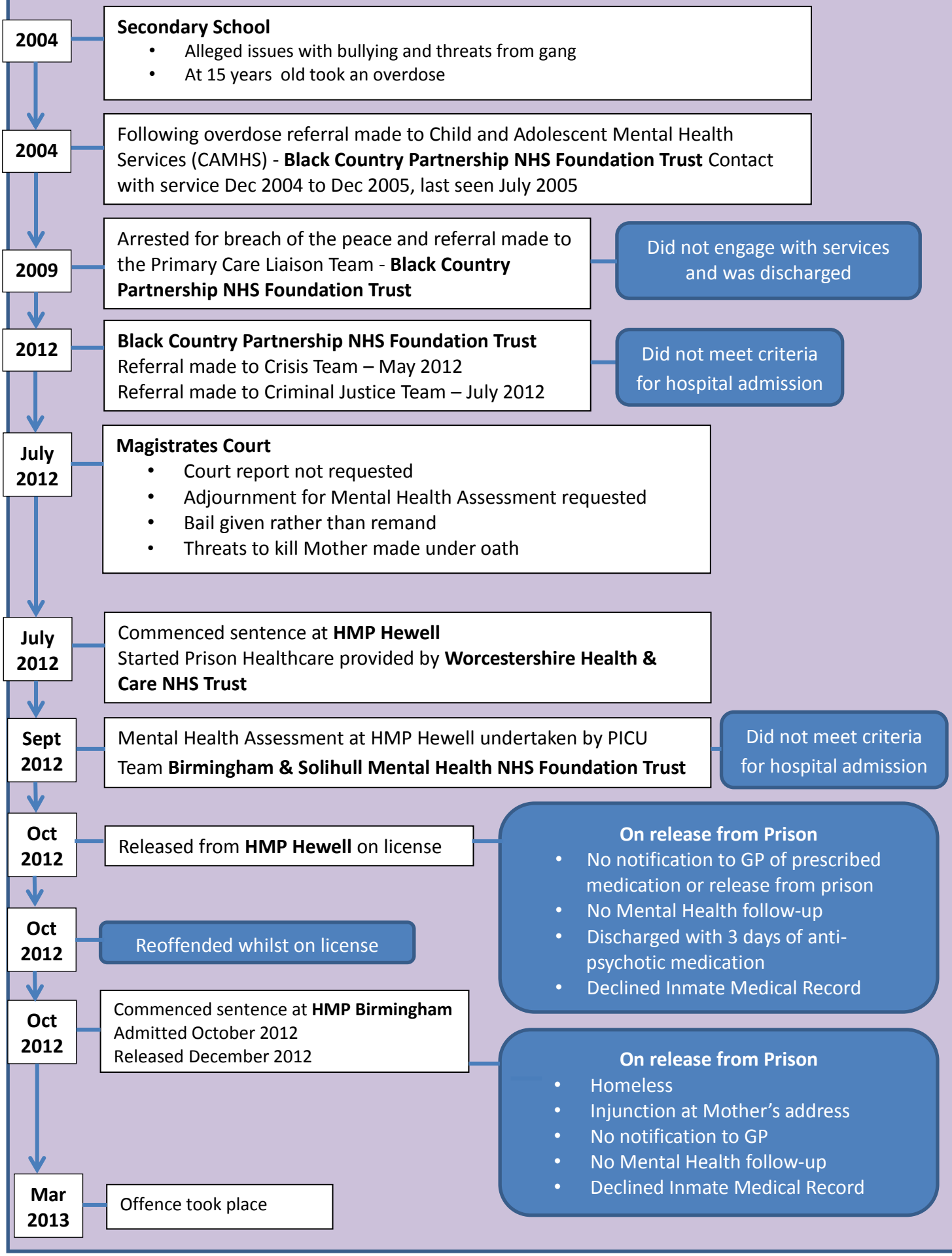
Christina was born in February 1997 and lived in Birmingham with her parents, her brother and sister. She came from a large extended family. She attended St. Edmunds RC School in Spring Hill, Birmingham and Leasowes High School in Halesowen, West Midlands. She was a good dancer, netball player and trampolinist. She was in the school team for netball. She was happiest with her family and friends, going to the cinema and out for meals. She used to love writing and if she had any spare money she would spend it on paper and pens.

She did work experience at a children's nursery when she was in year 10 at school and was chosen to do an internship there. She would go one day a week, going to school first and then to the Nursery and working all day until 5pm. She loved the children and she loved working there.

She was reported to be progressing well with her studies. Her exam results were received by her parents after her death and she had obtained good grades in all of the exams she had taken.

Christina was not the subject of any social care agency engagement, past or current, and there were no issues or concerns within the family. She was a happy, thriving teenager looking forward to adult life.

3.2 Significant Events relating to P Flowchart



3.3 Events immediately preceding the incident

On his release from Prison on 13 December 2012, P told Prison staff that he would be staying with a friend in Birmingham. It is noted that he was not able to return to his mother's address as there was a restraining order in place preventing him from doing so. Subsequently, P's mother reported that he did in fact occasionally attend the house in the early hours of the morning and would tap on the window to get her attention, requesting clothing and food. P's mother stated that she noticed that P was wearing many jackets on top of each other to keep warm. P never entered the house and she did not know where he was staying. She said he appeared unkempt, but he was not violent or threatening towards her.

Between P's release from Prison and the time of Christina's death there is no record to indicate that P was in contact with mental health services, or his GP.

On 7 March 2013, following the fatal stabbing on the number 9 bus, P headed in the direction of the city centre. P was encountered later that morning by the Police on the Hagley Road, Birmingham and was reported to be acting suspiciously. P fitted the description of an outstanding offender for a murder and as a result he was arrested by the Police and taken into custody.

4 Terms of Reference – Key Themes

4.1 Information Sharing

The importance of information sharing cannot be over-emphasised when assessing future risk of an individual. The messages from reports of inquiries and from government departments have all too frequently proved that information indicating an increased risk existed, but had not been communicated and acted upon. All too often the key historical information pointing to risk potential has been omitted, withheld or down-played (Ritchie et al 1994).

4.2 Physical Healthcare in HMP Hewell and HMP Birmingham

It is notable that a number of physical health issues were identified for further investigation while P was in Prison, but these were not all followed up. P's GP was not informed about any of the identified physical health concerns on P's release from either Prison.

4.3 Mental Health Assessments

There were 17 mental health reviews or formal assessments undertaken by 4 different organisations, involving a number of healthcare professionals, between April 2009 and December 2012. None of these assessments resulted in P being detained under the Mental Health Act 1983 (Amended 2007).

A number of assessments were undertaken as stand-alone assessments, but a longitudinal assessment was undertaken over a period of three months, during his stay in HMP Hewell healthcare, between July and October 2012. There was an opportunity for a further longitudinal assessment of his mental health during his time in HMP Birmingham, but he was not seen by a psychiatrist until the day before his release, despite this having been recommended early in his detention.

Three mental health assessments were undertaken by the Black Country Partnership NHS Foundation Trust. All three risk assessments, undertaken in May & July 2012, were undertaken in Sandwell Magistrates Court.

There were six assessments undertaken by a Forensic Physician (FP) whilst P was in Police custody. (Forensic Physicians are self-employed, independent and individually appointed (usually contracted) to provide their services to relevant Police authorities or appointed agencies responsible for the provision of clinical forensic medical services to Police authorities. Many forensic physicians are general practitioners who provide a part-time service in clinical forensic medicine).

Police records indicate that P was regularly uncooperative whilst in Police custody and also on a number of occasions during medical and mental health assessments.

The BSMHFT PICU Team undertook a Prison assessment in September 2012, which did not result in admission. P was also assessed by a Consultant Psychiatrist in HMP Birmingham on 12 December 2012, the day before he was released from Prison.

Two Multi-Agency Risk Assessment Conferences (MARACs) were held by the Police. One on 14 May 2012 and the other on 23 May 2012.

Two further mental health risk assessments were undertaken following the incident on 8 March 2013, both of which were undertaken by teams from BSMHFT. The first of these two assessments was undertaken by 2 higher trainee doctors from the South West Home Treatment Team and Secure Services. They did not identify P as being detainable under the MHA and P, therefore, remained in Police custody. The second assessment, undertaken later the same day, was undertaken by two Consultant Forensic Psychiatrists from BSMHFT Forensic Medium Secure Services, who determined that P was mentally ill and should be detained under the Mental Health Act in a secure hospital.

4.3.1 Table 2 - Details of mental health assessments undertaken

Screening/Assessing Team	Organisation	Date	Outcome
West Midlands Police FP	West Midlands Police	5 March 2009	Released from custody, no further action taken
West Midlands Police FP	West Midlands Police	19 March 2009	Released from custody, no further action taken
BCPFT Primary Care Liaison Team	Black Country Partnership NHS Foundation Trust	1 April 2009	Not seen, discharged when no response from P was received
West Midlands Police FP	West Midlands Police	10 May 2012	Released from custody, no further action taken
West Midlands Police FP	West Midlands Police	11 May 2012	Charged with Criminal Damage
Wolverhampton Magistrates Court	Not confirmed he was assessed	12 May 2012	Sentenced to 6 month conditional discharge
West Midlands Police FP	West Midlands Police	20 May 2012	Released from custody and no further action taken
Crisis Team assessed in Sandwell Magistrates Court	Black Country Partnership NHS Foundation Trust	21 May 2012	Assessment deemed P not detainable and he commenced custodial sentence
HMP Hewell Healthcare	Worcestershire Health & Care NHS Trust	22 May 2012	Concern re mental health symptoms & prescribed anti-psychotic
Criminal Justice Team in Sandwell Magistrates Court	Black Country Partnership NHS Foundation Trust	11 July 2012	Concern re mental state led to reporting to Court and Crisis Team referral
HMP Hewell Healthcare	Worcestershire Health & Care NHS Trust	14 July 2012	Prescribed anti-psychotic medication for paranoid psychosis and admitted to healthcare on ACCT. Low weight
Crisis Team	Black Country Partnership NHS Foundation Trust	17 July 2012	Deemed not detainable or requiring hospital admission. Commenced custodial sentence

Screening/Assessing Team	Organisation	Date	Outcome
HMP Hewell Healthcare	HMP Hewell Healthcare provision by Worcestershire Health & Care NHS Trust	18/19 July 2012	Considered psychotic. Antipsychotic medication and ACCT to continue
BSMHFT PICU Team	Birmingham & Solihull Mental Health NHS Foundation Trust	20 September 2012	Not accepted for a PICU bed – advised Early Intervention Services and psychological intervention
HMP Hewell Healthcare	HMP Hewell Healthcare provision by Worcestershire Health & Care NHS Trust	8 October 2012	Re-referral to PICU team for admission/follow up on release. No assessment or follow-up arranged
West Midlands Police FP	West Midlands Police	20 October 2012	No further action & detained in Prison custody
HMP Birmingham Healthcare	Healthcare provision by Birmingham & Solihull Mental Health NHS Foundation Trust	22/23 October 2012	Concern re mental health presentation and previous prescription of anti-psychotic for psychosis at HMP Hewell. Referral to and accepted by In-Reach mental health team
HMP Birmingham Healthcare	Healthcare provision by Birmingham & Solihull Mental Health NHS Foundation Trust	12 December 2012	Concern re presentation. Plans to study notes & engage Homeless Team, but P was discharged next day without notification. No subsequent liaison.

4.3.2 Risk Chronology

Mental Health patients who die by suicide or commit homicide often have a number of features of high risk, including a previous history of self-harm, violence and substance misuse (Cooper et al 2005).

The chronology of risk table which follows in section 4.3.3 summarises episodes sourced from different agencies, but a comprehensive risk assessment was not available to assessing services/agencies. The fire in 2008 could have resulted in harm to himself and others, but the first recorded incident of an injury to another person was in 2009, the victim being his brother. In May 2012 there was a dramatic increase in the frequency of his reported risk behaviours, including threats, fire setting and assaults, which led to his detention in Prison.

A Sergeant from West Midlands Police stated on interview that there had been 21 telephone calls from 2 or 3 addresses where P's mother was living, which subsequently had Police involvement.

4.3.3 Table 3 – Risk Chronology

Date	Risk history	Source	Outcome
Dec 2004	Fight at school	School/Mother	School Social Worker and police involved
Feb 2006	Encountered on foot in the early hours on foot	Police records	No further action taken
April 2007	In possession of a knife. Believed to be under influence of drugs.	Police records	Reprimanded by the Police. Warning signal placed on PNC
May 2007	Found in enclosed premises.	Police records	Police caution. Warning placed on Police records.
Sept 2007	In area where concerns were raised - person fitting P's description.	Police records	No further action
March 2008	Fire in his room at the family home, P had to be persuaded to leave.	Family	Smoke damage to house.
March 2008	Smashing things in the house	Mother called Police	No further action
August 2008	Threatening mother	Mother called Police	Mother advised to get medical help. A family protection report was made.
March 2009	Pushed young brother into a wall. Possible intoxication noted. Report of bleach and vinegar under his bed.	Mother called Police	Brother assessed at hospital. Police caution.
March 2009	Verbally abusive, smashing ornaments and being hostile towards his mother. Possible intoxication, hitting out at officers.	Mother called Police	Attended Court for breach of peace. GP referral. Plan for 'opt in' letter from the BCPFT Primary Care Liaison Team.
May 2011	Demanding money and stolen mother's purse.	Mother called Police	Police attended and assisted return of the purse.
Feb	Mother reported P more confrontational and	Mother	Moved out of mothers house

Date	Risk history	Source	Outcome
2012	violent.		
May 2012	Made threats that he would stab his mother, as he believed she was withholding his benefits and had not fixed his computer. Brother called Police reporting that P had thrown an electric fire at his mother and it had struck her on the head.	Police records	Police attended and removed P. He was arrested and charged as he had forced entry into the house and had damaged the door lock.
May 2012	Smashed window at mother's house and hid in shed. Trying to set a fire. Police force had to be used to make an arrest, as P had tied himself to a garden bench in the shed and was trying to set fire to items and possibly trying to set fire to himself.	Police records	DASH assessment completed. No physical injury to mother. SIG Warning marker applied by Police to mother's address.
May 2012	Held knife to mother's stomach saying she was trying to kill him when brother present. Mother reports fearing for her life.	Mother called Police	Removed from property. Statement of complaint to Police from mother and victim support requested. Charged with a Common (Section 39) Assault. Later received 26 week sentence of imprisonment and the Court made a restraining order in respect of his mother for a period of two years.
May 2012	Punched female Police officer twice to the face whilst in Police car	Police	Charged with assault on a Police constable.
July 2012	Concern re mental state and spoke about stabbing/killing mother when giving evidence in Court.	Court	CJT assessment. Plan for remand into custody changed to bail. The Court acknowledged that there were no escorting staff available; the panel heard evidence that this was a contributing factor to changing the decision.
Sept 2012	Setting fire to pieces of paper and sliding them under his cell door.	HMP Hewell	Handed over lighter to an officer on request.
Oct 2012	Interfering with vehicles and found crouching down next to a secure parked vehicle in a small side car park next to Walsall Police Station in possession of Class A drugs.	Police	P later pleaded guilty to interfering with a motor vehicle.

4.4 Magistrates Courts

P had previously appeared before other Magistrates Courts in 2009 and 2012. On 11 July 2012 he was at Sandwell Magistrates Court following an incident where Police had been called the previous day to this mother's home, as she stated he was threatening to kill her. It seems that his actions were in response to an apparent delusional belief by P, that his mother was trying to kill him. There were reported concerns by the Magistrate and P's Solicitor regarding P's understanding and ability to give clear instructions. P was subsequently charged with Section 39 Assault.

There was no reference found about his possible unfitness to plead and stand trial or of gaining psychiatric reports. The BCPFT Criminal Justice Team had been asked to see P because there had been concerns about his conduct during the trial and had advised the Court of the assessment difficulties. The case was adjourned to the next day, with the Court specifically requesting the intervention of the BCPFT Mental Health Crisis Team to carry out an assessment the following day.

The investigation panel acknowledges the duty of the Courts to refer to the Bail Act (1976) when making any bail/remand decision. However the panel heard consistent evidence to the effect that other impact factors outside of the remit of the Act influenced the Court's decision making on the day in question.

The panel heard evidence that it had not been possible to remand P overnight as it was then discovered that the Prisoner escort staff had left the Court. The Criminal Justice Team and the Domestic Violence Advisor were concerned about P being given bail as they felt he was a risk to his mother. Apparently P had threatened to kill his mother under oath in Court ('I will stab her'). They were sufficiently concerned for the mother in that they did not support his receiving bail.

On interview, the Independent Domestic Violence Advisor (IDVA) stated that concerns about P receiving bail were raised with the Crown Prosecution Service (CPS) who shared their concern, but the IDVA stated further that there was nothing the CPS could do.

The investigation panel were unable to verify this as the CPS informed us that the records relating to P could not be located.

Further investigation has confirmed that the absence of escort staff in the cells appeared to be a concern to the Magistrates and this was brought to the attention of the Deputy Justices Clerk at that time. This issue was subsequently raised with GEOAmey. The Legal Team Manager from the Black Country Magistrates' Courts confirmed that, on the day in question, strenuous efforts were made by the Legal Adviser to get cell staff back to the Court, including contacting GEOAmeys' control base in Wakefield – to no avail.

An investigation into the matter by the Court revealed that GEOAmey Court staff claimed to have been released early by an Usher, though it has not been explained as to why GEOAmey were not able to provide staff when requested. It was immediately reinforced that the cells required clearance directly from the legal advisers in each of the Courts sitting, before escort staff could leave the building.

The Court under Section 128 (7) Magistrates Courts Act 1980 does have the power to remand to a Police cell, but this would be at the behest of the Police and for the purposes of enquiries into further offences. It is not clear how far this option was explored.

The Bench were concerned that no Prisoner escort staff were available; however, they ultimately took the decision to conditionally bail P and he was bailed to an address in Walsall with an overnight curfew to return to Court the next morning.

When P failed to surrender to custody on 12 July 2012 a warrant without bail for his arrest was issued. The Court specifically requested that the information passed to the Police should include reference to the fact that P had mental health issues and would need assessment.

*The investigation panel provided all stakeholders/parties with a draft copy of the report in order for them to highlight potential requests for amendments or clarification.
The response from Black Country Magistrates Court (HMCTS) was reviewed by the panel. The response alluded to information that was not available to the panel and the requirements of the Bail Act in decision making.

The panel heard from a number of parties who were at the Court and noted that the Magistrates were concerned about P's mental state which could not be fully assessed on the day. There is a difference of view from people present in the Court about events leading up to the bail decision. In the absence of detailed records the panel have noted that the Black Country Magistrates Court holds a contrary view and in particular the requirements governing the application of the Bail Act. Taking into account all the circumstances of this case however the panel remains of the view that the decision to grant bail amounted to a serious near miss.

4.5 Criminal Justice Pathway

One of the themes of this report has been the issue of longitudinal risk assessment and the importance of information being recorded, considered and subsequently re-evaluated at future significant times.

P came to the attention of the Police at a relatively young age and eventually began acting in a way which had the potential for him to be prosecuted. In common with other young offenders his early encounters with the Police resulted in no further formal action being taken. It is evident that front line Police officers were concerned about his behaviour and the concerns raised by his mother, as this resulted in a number of occasions where his fitness to go through the interview and charging process at local Police Stations was assessed. However, these now appear as isolated episodes.

Whilst the Police have powers to decide on low level outcomes, such as no further action or cautions, more serious offences have to be referred to the Crown Prosecution Service (CPS), an independent body that advises on the level of charge based on the available evidence and witness statements. Where it is felt there is sufficient evidence to warrant a prosecution this will then go forward to the Courts.

It will always be essential that where prosecution occurs the CPS is able to provide sufficient information to allow the Court to consider the most suitable sentencing option available to them. The only other prime sources of information will come from witnesses and the Defence Solicitor, only in one of P's three Court appearances, who is dependent upon instruction from P.

The investigation panel have not been able to verify what information has been provided by CPS in this process to the Court. P appeared before Wolverhampton Magistrates on 12 May 2012 and received a six month conditional discharge. This does not appear on the list of previous convictions submitted to the Court and would normally have been taken into consideration in sentencing. Courts can call upon Probation officers to provide additional information to assist with sentencing, but where, as in this case, P was not known to them, the additional information would be obtained through interview with P and CPS papers. His appearance before Sandwell Magistrates Court provided this opportunity, but it was apparent that Probation, the Domestic Violence Advisor and the CPN held a shared view that a full mental health assessment was required to address both health and risk needs. The Courts held a similar view, but as identified in the report, there were delays and problems in organising this. Magistrates have powers to adjourn for more information to assist with sentencing decisions. In this case, although the Court asked for a report from the mental health team, they did not seek additional information from the Probation service.

The investigation panel heard that mental health professionals had personally addressed the Court about their findings, effectively negating the possibility of the Court requesting a full psychiatric report and the Magistrates subsequently concluded that an immediate custodial sentence was appropriate ('so serious that neither a fine alone, nor a community sentence can be justified for the offence' – section 152(2) of the Criminal Justice Act 2003), so did not seek advice from Probation about community order options. A Section 39 assault has a maximum sentence of 6 months and consequently, as an adult, P was not subject to formal supervision on release.

P was subject to three separate periods of imprisonment – on each occasion he entered a busy local Prison with a high turnover of prisoners. Prison records show that, aside from interaction with Prison healthcare staff, his engagement with other Prison activity was minimal and he served his time in a low key way. This is exemplified by the fact that on arrival at HMP Birmingham Prison he gave the Walsall bail address he was given on 30 May 2012 and this was processed as his discharge address, even though in reality it was not available to him. As he was not subject to formal license arrangements, which requires a designated release address and reporting instructions, it would not have been identified as an issue. There is no automatic checking with healthcare for release/discharge arrangements.

4.5.1 Release arrangements in place in December 2012

Adult prisoners sentenced to more than 12 months are released at the halfway stage with formal supervision of a Prison License by Probation. Licenses have a set of standard conditions and others can be added according to the individuals risk and rehabilitation needs.

However, adult prisoners sentenced to less than 12 months are not covered by this provision and consequently, on release, there is no requirement on an individual to maintain regular enforceable contact with a supervisor.

The Criminal Justice Act (2003) followed the recommendations from the Halliday Report – Making Punishments Work (2001) and introduced a new sentence, 'custody plus', to replace all short Prison sentences of under 12 months. It was to be made up of a short period in custody of up to three months (to fulfil the punishment purpose of the sentence) followed by a longer period under supervision in the community (to fulfil the reparation and crime reduction purposes of the sentence) of a minimum of 6 months. This provision was never enacted and the sentence was abolished in the Legal Aid and Sentence Prisoners Act 2012. However, current Ministry of Justice policy is to enact new provision contained in the Offender Rehabilitation Act 2014.

These provisions will mean that an offender sentenced to more than a day, but less than 12 months imprisonment will have a formal period of supervision of 12 months upon release. For example, someone sentenced to a custodial sentence of two months would serve one month in custody, one month on license, and 11 months on post sentence supervision. For those with sentences closer to two years, the supervision period would be short: for example, someone sentenced to an 18 month custodial sentence would serve nine months in custody, nine months on license and three months on supervision. The offender can be subject to requirements throughout the supervision period and so enforcement action for an alleged breach of a requirement can be taken throughout the period. One of the standard conditions is a requirement to live at a specified address.

4.6 Social Services and other agencies involvement

When considering the engagement of statutory agencies with P as a child and young person and his family, the investigation panel gave consideration to the document Working Together to Safeguard Children – a guide to inter-agency working to safeguard and promote the welfare of children, March 2013.

There were a number of occasions when Social Workers from different local authorities and different agency representation were directly or indirectly involved in the care of P, initially as a young person and later as an adult. There were also times when they could have been involved if a referral had been made directly or via Safeguarding processes, but apparently were not. Social Services records in relation to P's siblings have not been examined by the investigation panel as it was outside the remit of the Terms of Reference.

During P's time at school he was being supported by a school based Social Worker and at the same time he was attending BCPFT CAMHS and the Church Centre. The family had been engaged with appointments, including with the school, and the Police had also been involved. There were some efforts at liaison between the parties, but no evident consideration of a multi-agency assessment via a professionals meeting or formal strategy meeting to try to co-ordinate

efforts to meet P's and his family's needs. He had reported bullying to the extent of fearing for his safety and had demonstrated a high level of distress, resulting in him taking an overdose. It is acknowledged that a combination of these factors led to a CAMHS referral and subsequent engagement. However, it is also evident that the situation did not improve significantly and indeed there was subsequent dialogue between the school and CAMHS highlighting further concerns. These further concerns however did not trigger a more holistic view of the situation.

Between 2007 and 2009 when P was still a minor and living with his mother, sister and brother there were a number of incidents, which could have triggered adult and/or child safeguarding referrals. These included P accepting a Police caution for carrying a lock-knife in a public place, setting a fire, smashing objects in the house and writing suicidal messages on his wall. They did not trigger a referral either in isolation or in any attempt to have a holistic overview. The investigation panel were concerned that P was apparently seen merely as an offender by the Police rather than also a vulnerable young person.

In early March 2009 when P was 18 years old the Social Services Emergency Duty Team were engaged following the assault on his brother. This resulted in a Social Worker making a follow-up visit to the home and referral of P and a telephone call, to his GP. The mother reports being told that social services would keep the situation under review, but by her account only received one further telephone call.

There was no further contact with social services, nor a safeguarding referral made, after the incident on 19 March 2009 when P's mother wanted P removed from the family home by the Police because she felt unsafe in his presence and his younger siblings were also present. The next day she went to talk to the GP. P had been hostile, verbally abused his mother and had smashed ornaments in the home. Police officers had reported that P was very uncooperative, appeared intoxicated and became aggressive when questioned.

There were further serious incidents in early 2012, including reported threats to kill his mother, leading to a DASH assessment and subsequent MARAC meeting. The risk level was seen as 'Medium' and there was a referral to the Sandwell Independent Domestic Violence Advisor (IDVA). No reference to specific actions concerning the risks posed to his siblings was seen by the investigation panel.

On 20 May 2012 P threatened his mother with a knife in front of his younger brother, talked of killing her and subsequently punched a female Police officer. There was a second DASH assessment and his mother was seen by the IDVA. There was also a further MARAC meeting and the level was deemed to be 'Medium'. A referral was made and sent to Sandwell Children Social Services in relation to the younger brother being in the household when a domestic abuse incident occurred, but there was no evidence of a risk assessment being undertaken in relation to the family whilst P was at large, apart from a safe and well check.

Following a brief sentence in HMP Hewell P was released on 1 June 2012 with a bail condition to keep away from his mother and reside in Walsall, West Midlands. He did not arrive at the bail address and a safe and well check was undertaken at his mother's address.

It was agreed by all the agencies concerned that the investigation panel could have access to the MARAC meeting minutes but these could not be located by the Police despite considerable efforts being made.

On 11 July 2012 P made further serious threats toward his mother while under oath in court and was bailed later that day. His mother was given safety planning advice by the IDVA and the BCPFT Safeguarding Team was contacted the next day. It is not clear from P's records what the subsequent actions of the Safeguarding Team entailed. P's family stayed at the home address despite the perceived risk and a panic alarm was fitted by the Police.

On 17 July 2012 he was seen by the BCPFT Crisis Team, which included social work representation and concluded he was not detainable under the MHA. The TAG risk assessment tool was completed by the Crisis Team and it recorded that P was a severe risk to others. The Care Programme Approach Common Assessment Tool recorded that there had been a threat to his mother with a knife in front of his six year old sibling and also recorded that he was not likely to have any contact with children. Also it is noted that the record stated there are no concerns about vulnerable adult issues including domestic violence. No known safeguarding or Social Services intervention was arranged in relation to the family following this assessment, beyond communication of the Crisis Team decision.

On each occasion that P was released from Prison there was limited, if any, risk assessment and associated safety planning in relation to the potential risks posed by him to his mother and siblings. Any attempt at safety planning would have been undermined in any event in the absence of a comprehensive understanding of his risk and mental health. The investigation panel understand that his mother and siblings were not subject to on-going social services monitoring or support, which might possibly have altered the course of events.

4.7 Carers Voice

The repeated attempts by P's mother to secure help and support for her son are extremely apparent and too often went unheeded. From his early problems with bullying at school she had arranged to meet with teachers, requested support, asked for action to be taken and expressed her fears for P's safety.

P's mother noted a change in him and she suspected that he was becoming mentally unwell and she made many attempts to encourage her son to see the GP. When this failed and P would not attend his appointments, she resorted to seeing the GP herself, in P's appointment slots. She expressed concerns about her son being unwell and repeatedly asked for help from the GP.

When P refused to see the GP, P's mother said she had asked the GP if it were possible to assess him at home, but she was told that it was not. It is clear that her son becoming an adult, further exacerbated her attempts to represent him and access help and treatment for him.

P's mother arranged for him to attend youth groups and receive counselling from a Church centre.

When P became aggressive towards his mother she often resorted to calling the Police for assistance and/or request that he be removed from the house. This coincided with his behaviour escalating and his presentation becoming more indicative of being mentally unwell. The Police supported P's mother's view that P was mentally unwell.

P's mother made the difficult decision to give evidence in Court in July 2012 and reported that she did this so that P could get the help and treatment he needed. However, the Crisis Team assessed that he did not meet the criteria for hospital admission under the MHA.

It was recognised by HMP Hewell that there was benefit in contacting P's mother but unfortunately contact was not achieved after one failed attempt.

On interview, his mother said that when P was incarcerated in HMP Hewell she wrote a letter to the Prison Governor stating that P was not allowed to return to her address and would need accommodation upon his release. She said she did not receive an acknowledgement or response to her letter.

In October 2012 when P was imprisoned in HMP Birmingham his mother was not aware of where he was located. She sought assistance from Sandwell Women's Aid to locate him, which they did. P's mother then contacted the Prison Chaplain to ask if he would help P to complete a visiting order. She stated that the Prison Chaplain could also see that P was not well.

In the absence of feedback supporting P's mothers' concerns about his mental health, she said that she began to doubt herself and believe there was some other cause for his instability.

P's mother recognised that her son needed help and made repeated efforts to gain support for him. She identified to others risks that he was posing to her and her younger son. However, although she spoke of him hearing voices to the Police, the investigation panel did not locate evidence of her reporting this to health care staff. The investigation panel acknowledges the dilemma that must have been faced by his mother during his escalation within the Criminal Justice System.

As his mother, it must have been distressing to experience the hostility and threats he was making and frustrating not being able to find or to be offered a solution to his needs. The investigation panel recognised that P's mother has also been a victim in this tragic case and the death of Christina has had a major impact on her and her family's life.

4.8 Response to Judges Questions

As identified in the Terms of Reference, the Trial Judge in Crown Court requested that questions be addressed by the investigation panel. The questions and responses are detailed below.

4.8.1 Why was P not admitted to hospital and why did the services he was involved with prior to HMP Hewell not deem him to require treatment?

P was not admitted to hospital as the two teams with the main opportunities to achieve psychiatric admission considered that he did not meet relevant criteria. P had been referred by professionals, who felt he did meet the admission threshold. The history supports the presence of mental illness at the time of the assessments by the Crisis Team and the PICU Team. Indeed, the strength of opinion regarding the presence of mental illness by HMP Hewell was sufficient such that he had already been started on anti-psychotic medication prior to both assessments. P was re-referred later by HMP Hewell to the BSMHFT PICU, but a further assessment never took place. The re-referral letter emphasising the differing opinion and the benefit of longitudinal knowledge was not discussed in the BSMHFT PICU team or with the PICU Consultant Psychiatrist. It seems self-evident that longitudinal knowledge is beneficial in comparison to a discrete single assessment and it was put to the investigation panel that this should be considered.

In evidence to the investigation panel the PICU Consultant Psychiatrist acknowledged the importance of wording in the re-referral letter, and said it would have led to him admitting P, had he seen it.

The full extent of the health and risk history was not known to either assessing team, but substantial information was available and known. The BCPFT Crisis Team and the BSMHFT PICU Team were aware of the past risk to his mother and brother, as well as his use of a knife. Not all of the available information was utilised, such as the BCPFT CJT records and the full Prison health records. The availability of information would have been facilitated if it was more readily available. Information known by the Police about P's conduct and their repeated concerns about his mental health were not known to either team. The investigation panel understands it is not standard practice to request for this information, or for it to be supplied by the Police.

The teams undertaking the assessments appeared to rely heavily on the report of P and the snapshot of his presentation and less on the broader assessment of relevant mental health factors at the time, including his presentation. Both teams identified some mental health issues, which they considered sufficient to require further input from professionals. The MHA Code of Practice 1983 (Amended 2007) identifies factors to consider when thinking about the protection of others including;

- The reliability of available evidence, including any relevant details of the patients' clinical history and past behaviour, such as contact with other agencies and (where relevant) criminal convictions and cautions.
- The willingness and ability of those who live with the patient and those who provide care and support to the patient, to cope with and manage the risk.
- Whether other methods of managing the risk are available.

The investigation panel reflected on the fact that the grounds for detention rely on the nature and/or degree of a disorder, and not just the degree.

4.8.2 Why was P released/ discharged from HMP Birmingham without follow up?

In HMP Birmingham the previous concerns about his mental health were identified at reception in October 2012, but not effectively acted upon and he was not seen by a psychiatrist until the day before his release, which amounted to a significant delay. The In-Reach Team and Consultant Psychiatrist had not managed to complete an assessment of his case by the time of his release. In the absence of an understanding of his past mental health presentation and treatment it was unlikely that he would be offered appropriate follow-up.

It is accepted that the offence of homicide was directly related to P's mental illness. On release from both Prisons no mental health follow-up was arranged despite this being considered appropriate by the psychiatrists who saw him. Advance planning for release and accurate information on the date of release appeared to be problematic and worthy of further consideration. The nurse assessment on release suggested that relevant information obtained during detention was not readily available and/or utilised. There was a reliance on P taking his Inmate Medical Record and seeking help for his own health needs, without any recorded consideration of his capacity.

It cannot be known whether mental health follow-up would have led to his admission to a psychiatric hospital, but would have made it more likely to happen and in addition, more likely that he would have received medication.

P did not visit his GP following release from Prison, but it is a concern that his GP received no information from either Prison despite the GP surgery having been identified.

4.9 Responsibility placed on P to participate in healthcare

There were a number of times during P's contact with services/agencies that he was expected to be motivated enough to seek care.

In the earliest days when he was a minor and his mental health problems were less severe, he accepted the support of his mother, so that he was able to establish contact with the BCPFT CAMHS service and the Church Centre. The sessions at BCPFT lasted for a while, but then he stopped attending and was discharged. It is unclear how long the intervention from Church Centre was, but that too came to an end.

Thereafter, he continued to have the support of his mother, but his mental health problems had become more serious and his mother tried in vain to persuade him to visit his GP. It is in the nature of psychosis when presenting acutely, that there is a disturbance of thought processes and perception, which can affect judgement and P did not seek help from his GP. It was reasonable for efforts to be made to try and get him to attend the GP surgery, but as his condition deteriorated and the risk escalated he still failed to establish direct contact with his GP surgery or psychiatric services.

Given his history at the time, he was unlikely to respond to an offered 'opt-in' appointment and he did not respond, leading to his discharge from the service without him having been seen, or his potential risk being assessed. This was despite the assessment referral stating it was 'urgent'. There was no alternative plan established and there did not seem to be consideration of him being seen at home by his GP or of there being discussion of his case with psychiatric services. It was left for P to go to the GP surgery when he wanted help or for there to be a presentation to other agencies or services, potentially when in crisis. When he was seen by the Police and there was concern about his mental health it was suggested to his mother that she got medical attention for him, but he was an adult without insight into his problems and was unlikely to co-operate. At other times P was assessed in Police custody by the Forensic Physician, but there was no subsequent communication with his GP.

On release from both Prisons there was no follow up arranged for P's physical or mental health despite this having been proposed during his detention. On release he was expected to go back to his GP and take a copy of his records, which he declined. The investigation panel was left wondering how often a copy of the IMR handed to a person being released from Prison does reach the GP. P had been assessed as being psychotic and in need of anti-psychotic medication, but consideration of his capacity did not appear to be part of the discharge process. Even if it was not possible to prevent his release or arrange for a further Mental Health Act assessment, which technically was possible, there could have been consideration as to whether his Prison GP records could have been sent to his GP in his best interests. The situation was, of course, compounded by the nurses on his release, believing incorrectly that he had no GP.

The investigation panel felt that it is important for the services and agencies to give due consideration to the likely effectiveness of their plans and likely ability of a service user to participate. When it is not likely that a person will be able to take on the responsibility for initiating or participating in their care, then alternatives should be established whenever possible.

5. Preventability and Predictability

5.1 Could the homicide have been predicted?

The homicide of Christina was clearly an unprovoked attack initiated by P. It was instantaneous and Christina and P did not know each other.

The investigation panel concluded that the homicide of Christina was not predictable.

It was clear from the evidence submitted to the investigation panel that the risk of violence by P towards others was escalating whilst he was suffering significant mental health issues. The propensity for violence had involved the use of weapons, including knives. However, the principal victim of his violent history was his mother, who repeatedly called the Police and sought help from the GP and other agencies. The investigation panel did note that there were other significant episodes of violence, one towards his younger brother and one on a Police Officer, but these episodes would not have indicated the potential for him committing such a devastating attack on a stranger.

It was predictable that P would have continued to be violent towards his mother and to a lesser extent his close family. At times the risk to his mother was identified by others, including the Police, Probation, the Independent Domestic Violence Advisor and the BCPFT Criminal Justice Team. His mother was given advice and interventions were put in place to help protect and support her. Nevertheless, the decision to grant bail from the Court on 11 July 2012, after he had been identified as needing further mental health assessment and spoken in open Court that day of stabbing his mother, is very concerning. The investigation panel has heard from agencies in the Court that they were very concerned for P's mothers' safety and worked with Police to put protective measures in place to reduce the risk of a serious incident.

5.2 Could the homicide have been prevented?

The homicide of Christina followed the identification of significant concerns regarding P's mental health. He had undergone mental health assessments on a number of occasions in the twelve months prior to the homicide. There was clearly conflict between mental health professionals over P's mental wellbeing and how, and if, he should be supported or treated. Some professionals believed he should have been admitted to hospital to enable a more thorough assessment and treatment. P was never admitted to hospital and never engaged in longer term treatment, either in the community or whilst in custody. Despite the conflicting opinions between health professionals, even within the same hospital Trusts, there was no evidence of escalation in an attempt to resolve the issues and address the concerns. Further, use of available information in clinical records, from professionals and others was apparently not fully utilised to assist in sound decision-making.

The investigation panel concluded that there were a number of opportunities where mental health treatment and follow-up could have been established.

P's history of violence to others had been escalating and he had been known to be in possession of knives and made reference in public to stabbing.

It is believed that the homicide of Christina by P was directly related to his mental illness and could have been prevented if his mental health needs had been identified and met.

6. Significant Points and Lessons Learned

6.1 Wider Cross Agency Professional Working Processes

It is widely accepted that effective communication is central to the coordination of good mental healthcare. Unfortunately there have been numerous inquiries reported nationally when such communication has failed, and that this has tragically resulted in harm (NCISH 2013).

One of the most common themes arising from Homicide or Serious Incident Reviews, whether it is around children, domestic violence, or vulnerable adults, is the lack of effective information sharing. This is particularly on an interagency basis.

In the case of P, it was clear that information was held within a collection of agencies on a variety of electronic and paper systems from when P was first considered to be requiring support at school. It is also clear that as a result of the way he has presented and his variable engagement, agencies were not able to form a clear diagnosis of his condition based on their individual contacts. There is no unified recording or information system that stores such detailed information across all agencies. Personal information is subject to control through legislation, guidance and protocols.

The Department of Health (2003) stated that 'staff must work within these [information sharing] protocols where they exist and within the spirit of the code where they do not'.

Individual agencies can ensure that within their own organisation there are common systems, and evidence submitted to this investigation has shown that there has been a move away from mixed paper and electronic systems by some agencies.

In the absence of a national linked system across agencies, it remains the case that individual professionals must remain 'curious' and questioning, so that the processing of an individual takes account not only of their presenting issues, but also the wider environment in which they live, and have lived. In that way, the opportunity to seek out/request additional information for evaluation and consideration can be met. The investigation panel accept that this is an ideal situation and resourcing across agencies will mean that there will always be prioritisation of effort. However, the need for all professionals to retain professional curiosity about those that they work and come into contact with, is a key element in helping to protect the public and ensuring individuals receive appropriate care and intervention.

The National Confidential Inquiry into Homicides and Suicides (2013) recommended that services should, 'collaborate with social care and child protection services'. Numerous agencies are involved in providing mental health care and not just those coming under the umbrella of health, social and child care. The Police have had increased involvement with mental health service users and recently there has been a development whereby mental health nurses travel with Police Officers (GOV 2013). Indeed the investigation panel interviewed a Chief Inspector who spoke of a current Government funded Triage Project, which is being piloted in Birmingham, whereby a Police Officer, a Mental Health Nurse and a Paramedic go in one car to respond to incidents.

The wider Criminal Justice Service; including Courts, Crown Prosecution Service and Probation have regular and significant contact with mental health service users. Additionally, many other agencies in the voluntary, third, private and statutory sectors (including primary care) have substantial involvement.

Such services have their own records for service users, which are not often or easily shared due to confidentiality issues and practical issues such as computer systems not being able to communicate with each other. Security is also a factor in that the Police, Health and Prison services, as do others, have internet firewalls which prevent people from outside the system

accessing it. However, even when working together, for example offender health and GPs, written requests are needed to obtain records, which can result in delays in assessment and treatment.

Urgent consideration needs to be given as to how all agencies can work more closely and more effectively together. Government needs to consider whether legislation is required to assist in communication/information sharing.

Lessons learned identified during the investigation process have been listed below, but should be considered in the context of the whole report. The points have been grouped, for ease of reference, into sections for the different agencies/services. Not all of the lessons identified would have had an impact on the management of P, or the outcome, but have been identified for consideration and learning.

6.2 Overarching lessons learned

1. A number of the services and departments involved in the care of P did not hold a review of their involvement with P to identify lessons learned.
2. Service design and delivery needs to be mindful of the fact that persons suffering from mental disorder will not always have capacity to initiate and participate in their care.
3. Provider organisations are failing to consistently and adequately listen to, respond to and support carers/significant others.
4. Organisations' information recording and storage arrangements were evidently not sufficiently robust to facilitate good care/management.
5. The accessing and sharing of information between key agencies was ineffective. Critically the GP was not consistently updated or considered as the primary care provider and record holder.
6. Longitudinal perspectives on assessment or management were not always utilised to the fullest extent to assist in sound decision-making and the provision of care.

6.3 Black Country Partnership NHS Foundation Trust

1. There was no operational policy for the Criminal Justice Team. The team were working to a service specification.
2. During P's attendance at BCPFT CAMHS there was no liaison with the Church Centre evident where P was receiving counselling and no records were requested or seen by the CAMHS Team.
3. The Criminal Justice Team (CJT) reported at interview making hand written notes at Court and clinical records being made subsequently at the CJT base. BCPFT has a computerised contact and alert system OASIS, but the detailed CJT records are not computerised, and

are not available at Court, or to others, including those working for BCPFT except by direct access of paperwork at the CJT base (approximately 3 miles from the Court) or on specific request.

4. The CJT referral to the Crisis Team was a verbal one. The CJT clinical notes were not requested or seen by the Crisis Team and it was reported that they do not ask very often for notes for other cases. Following the initial referral, there was time to access the records.

5. The recordings on OASIS relating to the CJT assessment appear confusing in terms of their content. For outcome on 11 July 2012, it is recorded no further appointment required, with no mention of the referral to the Crisis Team. OASIS also records, 'seen – no further appointment required' on 12 July 2012 when P was missing and was not seen by the CJT.

6. Contact by the Crisis Team was made with a staff nurse at HMP Hewell on 17 July 2012, but when interviewed the Consultant Psychiatrist stated he was not aware of this happening suggesting a communication problem.

7. BCPFT were unable to provide a copy of the CAMHS discharge/transfer policy for 2004, and the policy first developed in January 2006 (reviewed December 2007 & August 2009) makes no reference to 'did not attend' (DNA) and whether discharge should apply following two missed appointments.

8. Assessments of mental health before and after the Crisis Team assessment on 17 July 2012, identified symptoms of psychosis and the need for anti-psychotic medication, which had been commenced at HMP Hewell. It is likely that P was psychotic at the time of the assessment on 17 July 2012. The assessment appeared not to give due consideration to the background history and risk, but focused on the interview with P and his report.

9. The BCPFT Primary Care Liaison Team had a policy of sending an 'opt in' letter to patients referred by the GP for assessment and discharged patients back to the GP if the patient did not contact them to rearrange an appointment within 14 days. P was not contacted or notified of the discharge. Consideration needs to be given to the suitability of persons to receive 'opt in' letters. This is especially important given that the GP referral was recorded on the BCPFT OASIS computer system as urgent. P had been reluctant to attend his GP and had assaulted his younger brother, who had been taken to hospital.

6.4 Birmingham & Solihull Mental Health NHS Foundation Trust

1. There were no BSMHFT PICU guidelines for the undertaking of an assessment at a Prison. The PICU assessment was requested as the least restrictive option for obtaining a hospital admission for P, who was considered psychotic in longitudinal assessment by HMP Hewell and had been started on anti-psychotic medication. The PICU assessment appeared not to give due consideration to the background history and risk, but focused on the interview with P and his report. The assessing team did not access information from BCPFT, which would have been possible, but was complicated by the information not

being centralised. It is unclear as to how much consideration was taken of the Prison healthcare Systm1 notes during the assessment. It is likely that P was suffering from mental illness at the time of the PICU assessment and this was the opinion of HMP Hewell who re-referred P.

2. If fuller details of P's risk history had been sought/ known by the PICU team then it is more likely that a forensic psychiatry opinion may have been considered.

3. There was no specific PICU induction and training for the doctor or the nurse undertaking the Prison assessment.

4. The collective experience of Prison assessments by the assessing team from PICU was extremely limited and this was not recognised or acknowledged by the members of the team or the supervising Consultant Psychiatrist.

5. Prison assessments for admission to the PICU were not discussed and/or recorded in the PICU MDT meetings. No records of clinical discussions regarding the case were kept, so there was no evidence to support this taking place.

   Referrals from the Prison to the PICU were not documented, managed or stored robustly. There was no paper file for P opened by the PICU. The RIO clinical notes system was not utilised, so no electronic record was established. Correspondence, both incoming and outgoing, was not recorded or stored. Letters were typed by individual staff and not stored in a centralised manner.

6. The trainee ST-5 doctor received further correspondence from HMP Hewell requesting a repeat assessment. The letter very clearly raised the differing clinical opinion of HMP Hewell emphasising their longitudinal assessment. The letter stated, 'I would like to respectfully request that you re-assess'. A further assessment was not undertaken, and no comment was made on the letter, or any other action taken beyond re-sending the original assessment letter. The letter was not discussed in supervision with the Consultant.

7. There was no defined process, which detailed actions to be taken in situations where medical professionals disagree about a diagnosis and subsequent care provision.

8. No contemporaneous records were taken during the PICU assessment in HMP Hewell by either medical or nursing staff.

6.5 HMP Hewell

1. The IMR demographic record for P had no GP practice recorded and this did not change after the GP surgery was correctly identified in August 2012. It was only recorded in the continuation notes within Systm1. Staff assessing for release of P appeared to believe he

had no GP. The GP did not receive information from HMP Hewell after the two release dates.

2. On 14 July 2012, it was recorded that P did not have capacity to make a decision in relation to giving consent to access his medical records and it was felt this should be done in his best interests. There appears to be no record of this happening.

3. A number of physical health concerns were identified in his continuation records on Systm1, but they were not readily available or accessed on his release, or on his further detention in custody.

4. On his release P's capacity was not reviewed, nor was consideration given as to whether information should be sent to his GP with his agreement or in his best interests.

5. P was not taken to Court on 16 July 2012 where an assessment by the Crisis Team had been planned to take place. The reason for him not being presented in Court, relating to his capacity, was not clearly communicated.

6. The plan to contact P's mother was not achieved after one failed telephone call.

7. P's mother says that she wrote to the Governor of the Prison highlighting her concerns for P's health and well-being. It has been reported that such a letter would be filed in the Prison records rather than Systm1 healthcare records, but this letter has not been found.

8. P's mother reported contact with the Prison Chaplain, but there are no records of this contact and this absence was reported as not being unusual. A recording/log system needs to be considered/utilised.

9. The referral letter drafted to the BSMHFT PICU was contained in the body of the Systm1 notes and there was a delay in it being sent.

10. The reply from the BSMHFT PICU following the assessment arrived on 1 October 2012 and was commented on by a Prison GP in Systm1 notes that same day, but a re-referral was written in the Systm1 notes to the BSMHFT PICU on 6 October 2012 (sent by fax on 8 October 2012) indicating that a response following the PICU assessment had not been received. By 13 October 2012 the HMP Hewell Forensic Specialist Registrar was still not aware of the receipt of the PICU response, despite it being recorded as having been received and seen on 1 October 2012 by the Prison GP, although it had been addressed to the Forensic Specialist Registrar.

11. P was released without a discharge plan in relation to his mental health. He was given three days medication, but, given his mental state, it could have been anticipated that he would not continue his treatment on discharge. PICU had been informed of his release date and requested to refer to HTT if not admitted to hospital. PICU did not re-assess or refer to HTT. This was not established by HMP Hewell, who also made no referral for psychiatric follow up. During interviews there were differing views on who was

responsible for making a referral, but it could have been either. HMP Hewell had responsibility for his healthcare at the time of his release.

12. There was no consideration, at the time of P's release from Prison, of undertaking an urgent assessment under the Mental Health Act 1983 (As amended 2007) on the day of his release.

6.6 HMP Birmingham

1. P entered into custody at HMP Birmingham on 22 October 2012, but was not seen by a psychiatrist until 12 December 2012. This was despite his mental health issues being identified via the reception process and him correctly, and promptly, being referred via the Primary Care Mental Health Gateway Worker to the mental health In-Reach team.

2. The initial nursing assessment at reception screening in HMP Birmingham (22 October 2012) identified low mood and agitation. However it incorrectly stated that he had not received medication, not seen a doctor and had been at HMP Hewell a few years ago. It is probable that this incorrect information was based on P's responses, but the Systm1 notes were available and would have indicated otherwise.

3. Systm1 notes from HMP Hewell were read three and a half hours later the same day by the First Night Mental Health Nurse and then the next day by the Primary Care Mental Health Gateway Worker, who both identified and summarised interventions carried out at HMP Hewell. Systm1 entries suggest that P's records were not sufficiently studied by the In-Reach Team and the assessing psychiatrist.

4. Physical health checks on and after his reception into HMP Birmingham were limited and did not identify the previous concerns in HMP Hewell.

5. On 13 December 2012 P was released from HMP Birmingham custody. Healthcare staff were not informed of P's imminent release from Prison when the Consultant Psychiatrist assessed him on 12 December 2012. P had told the Consultant Psychiatrist that he had approximately another month in Prison custody before his release. It is not clear whether this was checked by healthcare staff. There appeared to be very limited planning ahead for P's release by In-Reach staff and no evident liaison with staff from Birmingham Community Healthcare Trust who would make the final contact with P before he left the prison.

6. Five days after P had been released, the HMP Birmingham MDT records were still recording that the key worker had concerns and that P was isolating himself. The MDT records of 8 January 2013 eventually record that P had been discharged from the In-Reach Team. There is no record in the MDT notes of P's release.

6.7 General Practitioner

1. There were four separate GP's involved in the care of P. These included an out of hours 'Primecare' GP, a Prison GP, the GP practice P was engaged with until 2008 and the GP practice that P was engaged with at the time of the incident (although this GP had had no direct contact with P since 2009).

2. P's mother attended P's most recent GP surgery on a number of occasions raising her concerns about her sons' mental health and informing the GP that P did not want to attend the GP surgery. There was no home visit to assess P and she was reportedly told this could not happen.

3. A recorded plan to review P's sleep after the prescription of a hypnotic did not appear to be fulfilled.

4. When P did not attend for an offered 'opt-in' appointment and was discharged by the BCPFT Primary Care Liaison Team no alternative arrangements were made for P to be assessed. There was no apparent liaison with the psychiatric team.

5. A letter was provided by the GP to P's mother encouraging P to attend for an appointment, but he did not attend. No other action was taken by the GP surgery and no further concerns were expressed by P's mother to the GP.

6. The GP was not copied into information from other healthcare providers engaging with P. Therefore his GP records were by no means as comprehensive as they should have been to potentially inform the GP, other providers and agencies.

6.8 West Midlands Police

1. Whenever P was subject of a health assessment in Police custody, the commissioned healthcare professionals did not communicate with P's GP and there was no sharing of information.

2. P was the focus of several violent incidents during 2007 onwards necessitating Police intervention and his arrests or removal to calm the situations. The initial reporting information indicated some extremely serious offences including assault, possession of a knife, criminal damage, threats to stab his mother, assault of a Police Officer, breach of licence and possession of a Class A drug. However, the resultant resolutions amounted to only relatively minor sanctions such as reprimand, caution, removal of him from the property and breach of the peace. The Report of the Inquiry into the Care and Treatment of Christopher Clunis, (Richie et al 1994), made recommendations to ensure that in such circumstances the 'potential seriousness of the offence and the public interest is always taken into account in deciding whether to charge'. The approach to P's criminal behaviour seemingly echoes the concerns that were raised in the case of Clunis twenty years ago.

6.9 CPS and the Courts

1. The offence on 20 May 2012 was heard in Court on 11 July 2012 and had involved P holding and jabbing a knife at his mother's stomach in front of his younger brother. She had been fearful for her safety and sought to get the younger son out of the home. P had been on speakerphone to the Police during the offence. He was arrested for threats to kill, but his Police National Computer (PNC) record documents sentencing for an offence of battery. It is difficult to reconcile that a battery conviction resulting in 26 weeks imprisonment reflects the gravity of the actions of P on that day. The subsequent lesser sentence also impacted on the length of time available to arrange P's possible admission to hospital. Again we refer to the Report of the Inquiry into the Care and Treatment of Christopher Clunis (Richie et al 1994) 'when a decision is made to charge a person who is suffering from mental illness, in our view it is important that the charge properly reflects the seriousness or potential seriousness of the offence'.

2. The Magistrate raised a concern that P was not able to understand what was happening in Court, but was reportedly told by the defence that he was naturally quiet. There was the possibility of P being considered unfit to plead and/or stand trial, however, the trial progressed and there was further concern about P's behaviour, demeanour and responses in Court.

3. Whilst giving evidence in open Court it was reported that P stated he wanted to stab/kill his mother. There is no record of any intervention by the Court in response to P's outburst and no apparent consideration of reporting further offences by the Legal staff present.

4. The Independent Domestic Violence Advisor supported P's mother in completing a Victim Personal Statement to ensure the Court had a clear understanding of her views. The CPS file has not been made available to the investigation panel. Records show that the CPS paper file was returned to the police in July 2012. West Midlands Police have confirmed to the CPS that this file can no longer be located. The police do still hold the file in electronic form but this cannot assist in clarifying what was recorded by the prosecutor at Court on 30 May 2012.

5. Following the CJT assessment it was the preferred option by the CJT and the Court to remand P into custody to facilitate further assessment. It is evident that the Court was not fully functional while hearing the case i.e. the escort staff had been allowed to leave whilst the Court was still in progress.

6. Given the mental health concerns and escalating violence the repeated decisions to bail P were at the least ill-informed and apparently unsafe. For example, there seems to be little doubt that had the escort arrangements been fulfilled P would have been remanded into custody. The investigation panel concluded that this episode amounted to a serious near miss.

6.10 Social Services & other agencies

1. It is well reported by P's mother and corroborated by others, that during P's teenage years he was experiencing problems at school, allegedly subjected to bullying and in the midst of gang violence. His engagement with agencies was variable. However when he did engage he gave consistent accounts of threats of violence towards him and him being in fear. There was no recorded consideration of convening a multi-agency strategy meeting to try to co-ordinate efforts to meet his needs seen by the investigation panel.

2. There were occasions in his early adolescence when P was an alleged victim of crime, a perpetrator and admitting taking drugs. At the same time his mother was expressing her concerns over his mental health and seeking help from anyone who was prepared to listen. The investigation panel accept that, in isolation, none of the individual concerns warranted Social Care interventions, but were concerned that the opportunity to review P's life experience during this period was not undertaken. The Social Worker at the school could have initiated that review.

3. Following the referral for social work follow-up by the EDT, after the assault on his younger brother, P's mother reported being told that Social Services would keep the situation under review. It is not clear whether the focus of the intervention was P or his sibling victim or both. Indeed there is also no reference to consideration of any assessment of risk to P's younger sister who also lived in the household. P's mother states that she only received one further telephone call. She did not report having been informed that Social Services had ended their involvement. The investigation panel acknowledges the potential for the incident to have been minimised and portrayed as a 'one off' by the family, including P's mother. However, the initial response indicates the agencies involved were treating it as very serious, but were then apparently prepared to de-escalate and withdraw on the family's say so. Had there been more of an engaged and detailed assessment of the family environment and any risk factors with P at the centre, such an assessment may well have initiated support and intervention that could have prevented the incident on 19 March 2009 when P's mother wanted him removed from the family home by the Police because she felt unsafe in his presence. Similarly, on 20 May 2012 there was a further serious incident involving P threatening his mother with a knife in front of his younger brother. His mother and siblings were not subject to on-going social services monitoring or support, which might possibly have altered the course of events.

4. On 17 July 2012, P was seen by the BCPFT Crisis Team at Court, which included social work representation and concluded he was not detainable under the MHA. The TAG risk assessment tool the team completed recorded that P was a severe risk to others. The assessment did not appear to link to P's previous involvement with social services or consider specific safeguarding action in relation to his mother or siblings despite reported risks.

7. Good Agency Practice

Good practice is identified where an individual or team is understood to have gone above and beyond what is standard practice. The following are considered to have fallen within this category.

1. The Forensic Specialist Registrar at HMP Hewell confidently diagnosed P as mentally unwell and was persistent in pursuing a healthcare treatment environment for P, despite other health professionals disagreeing with his opinion.

2. When P was bailed on 11 July 2012, the CJT and other agencies worked together to alert P's mother, the Police and key agencies of the bail and potential risks.

3. When P breached his bail on 12 July 2012, the IDVA contacted the police to advise them of the risk and the Police immediately went to the mothers' house and installed a panic alarm which was linked to the Police station.

8. Recommendations

It is in keeping with the wishes of Christina's family that lessons are learned as widely as possible to minimise the risk of any future similar tragedy.

The recommendations need to be considered more widely than each individual organisation. The investigation panel considers that this case has profound learning beyond the named organisations and recommends they are reviewed by all agencies in their entirety.

In addition, to identifying lessons learned for stakeholders, the investigation panel have considered recommendations (Table 4 below) that could have had an impact on the outcome, and/or could impact on the prevention of similar events in the future.

This investigation process entailed direct interviews with staff, but did not require the formal submission of individual agency reports and associated action plans; therefore it is considered appropriate that specific detailed recommendations are made for each agency.

Table 4 - Recommendations	
Organisation: Black Country Partnership NHS Foundation Trust	
1	BCPFT should ensure that there is a clear operational policy in place for the Criminal Justice Team. This document should outline: • roles, responsibilities and accountabilities within the team • guidance on undertaking risk and mental health assessments • agreed standards of record keeping and documenting outcomes of assessments • processes for information sharing with the wider MDT, GP and other internal and external services/agencies
2	BCPFT should ensure robust processes are in place when a patient is receiving counselling or any other form of mental health support from another service (private, charity or voluntary) that efforts are made to establish clear communications whenever possible with this service to monitor progress and that a written record is maintained to this effect.
3	BCPFT should ensure that the current arrangements for clinical record keeping within the Criminal Justice Team are reviewed as a matter of urgency considering the availability of records and Information Governance.
4	BCPFT should review the issue of availability and accuracy of Criminal Justice Team records on OASIS as a means of supporting effective communication and clinical risk management.
5	BCPFT should review, as a matter of urgency, their current arrangements and policy guidance within the service, across all teams, for the management of cases where a patient 'did not attend', paying particular attention to: • the use of 'opt in' letters • engagement with carers prior to the patient's discharge • communication with the patient's GP
6	BCPFT should review how the Criminal Justice Team and the Crisis Team work together, and with partners, to share information and ensure effective recognition of severe mental illness including psychosis. Such co-working should support • recognition of psychotic features (across all age groups) • the use of longitudinal risk assessment • hearing the voice of the Carer • implementation of the Mental Health Act

Organisation: Birmingham and Solihull Mental Health NHS Foundation Trust	
1	BSMHFT should ensure that there are guidelines for PICU staff undertaking an assessment at a Prison. This process should include: • guidance on access to background information • who can/should undertake Prison assessments • risk assessment • Mental Health Act • agreed standards of record keeping and documentation information sharing with the wider MDT • supervision arrangements • what to do in the event of a re-referral
2	BSMHFT should ensure that PICU induction and training for doctors and nurses includes how to undertake Prison assessments.
3	BSMHFT should ensure that there are appropriate arrangements for clinical supervision for all doctors and nurses undertaking Prison assessments.
4	BSMHFT should ensure that all Prison assessments for admission to the PICU are appropriately discussed and recorded within the PICU MDT meetings.
5	BSMHFT should ensure that all Prison referrals and their outcomes are documented in the clinical records.
6	BSMHFT should ensure that all clinical teams have a robust centralised process in place to ensure that all clinical correspondence (incoming and outgoing) is maintained appropriately and that such clinical correspondence can be accessed in the clinical records.
7	In all cases where there are disputes or concerns raised in respect to the outcome of a prison assessment BSMHFT must ensure that there is a robust escalation/resolution process in place and should consider the applicability of this recommendation to other assessments.
8	BSMHFT should ensure that all medical and nursing staff are advised of their individual professional responsibilities and accountability for maintaining contemporaneous records and those records must be made available in accordance with Trust policy.
9	BSMHFT should ensure that there are appropriate systems of clinical supervision and clinical audit in place to ensure that best practice across all professional groups in respect to clinical record keeping is maintained.

Organisation: HMP Hewell and Worcestershire Health & Care NHS Trust	
1	HMP Hewell (Healthcare) should ensure that when the GP is known that the information is recorded appropriately on Systm1 and noted on the IMR main demographic record.
2	HMP Hewell (Healthcare) should ensure a review of the process of healthcare assessment prior to release to ensure relevant healthcare information, which may have been found during detention, is identified.
3	HMP Hewell (Healthcare) should ensure that whenever possible a summary of the individual's Prison health records is provided to their GP on release from Prison.
4	HMP Hewell (Healthcare & Prison) should ensure that in all cases where there are concerns in respect to a prisoner not having the necessary capacity to make a significant decision, that the guidance outlined within the Mental Capacity Act is enacted and that a Best Interest decision is made. This should be recorded, maintained and shared as appropriate to Courts and other services.
5	HMP Hewell (Healthcare) should ensure that robust systems are in place for assessing, managing and communicating all known physical and mental health concerns at admission, transfer and release from Prison.
6	HMP Hewell should ensure that there is a robust system in place for recording letters to the Governor, which relate to the health, clinical risk assessment or wellbeing of a named Prisoner, and that a record of such communication is placed within the relevant Systm1 healthcare records.
7	HMP Hewell should give consideration to the development of a recording or log system for concerns raised by relatives to the Prison Chaplain.
8	HMP Hewell (Healthcare) should review the local arrangements for requesting and managing physical and mental healthcare referrals and clarify: • roles and responsibilities • record keeping • system for production of correspondence, including administrative staff support • monitoring of timeliness of responses • noting and confirming follow-up arrangements • processes for escalating concerns
9	HMP Hewell (Healthcare) should review the local arrangements for release of Prisoners with physical and/or mental healthcare needs, where there are significant concerns that an individual is likely to deteriorate on release, such as due to non-compliance. In such cases, as good practice, such concerns should be shared with the individual's GP whenever possible.
10	HMP Hewell (Healthcare) should ensure health screening on discharge includes reference and cross-checking between health and prison records systems.

11	In all cases where HMP Hewell has significant concerns at the time of release as to an individual's mental health and wellbeing , HMP Hewell (Healthcare) must ensure that appropriate consideration is given to undertaking an urgent assessment under the Mental Health Act 1983 (as amended 2007) and that a written record is maintained to this effect.
Organisation: HMP Birmingham and Birmingham & Solihull Mental Health NHS Foundation Trust	
1	HMP Birmingham (Healthcare) should ensure that prisoner self-disclosure of their past physical and/or mental health history is not the only resource of information utilised upon their reception to the Prison when other records are/could be available.
2	HMP Birmingham (Healthcare) should ensure that on reception a full check is made of Systm1 to identify whether a Prisoner has any previous significant physical and/or mental health history. This should include: • past identified diagnosis • past care and treatment management • past prescribed medications • past identified risks
3	HMP Birmingham (Healthcare) should ensure that in all cases where concerns are raised in respect to the mental health of a prisoner at the point of reception that this individual is seen by a Nurse Specialist within 24 hours and if recommended to see a Psychiatrist that this happens within a maximum of five working days.
4	In-Reach staff and Psychiatrists in HMP Birmingham (Healthcare) who are identified as having responsibility for assessment or management of cases should take the time to read relevant documentation and raise concerns if there is insufficient time for this to be achieved.
5	In-Reach staff and Psychiatrists in HMP Birmingham (Healthcare) who are identified as having responsibility for assessment or management of cases should consider discharge planning from an early stage and liaise with relevant providers and agencies, including staff from Birmingham Community Healthcare NHS Trust, which has the responsibility for the final assessment prior to release.
6	HMP Birmingham (Healthcare) should consider developing an agreed system for routinely auditing a random sample of healthcare records on Systm1, of prisoners who have recently been taken into custody, but who were deemed not to require the input of Prison healthcare. This system of on-going audit should be utilised to offer additional assurances of the robustness of the screening process at point of reception to the Prison.
7	HMP Birmingham should ensure that appropriate and timely communications take place to alert Prison healthcare when an individual is due to be released from detention.
8	HMP Birmingham (Healthcare) should ensure health screening on discharge to include reference and cross-checking between health and Prison records systems.

9	HMP Birmingham (Healthcare) should ensure, whenever possible, that a summary of the individual's Prison health records is provided to their GP routinely on release from Prison.
Organisation: General Practitioner	
1	The General Practitioner should review their local processes for responding to concerns raised by relatives/significant others, that an individual may be experiencing mental health issues.
2	The General Practitioner should ensure that in cases where relatives/significant others have been unable to persuade an individual, who may be experiencing mental health issues, to attend the GP surgery for assessment, that alternative arrangements for assessment are made.
3	If a secondary referral for mental health assessment is not completed due to non-attendance, there needs to be a General Practitioner review of the case and an action plan formed.
Organisation: West Midlands Police	
1	West Midlands Police should review pre-Court disposal arrangements where repeated concerns about mental health have been identified, and ensure that longitudinal background information is provided to health professionals undertaking fitness to plead assessments and to the Crown Prosecution Service where they are providing advice on charging and/or for Court process.
2	West Midlands Police should review the current information sharing protocol with BSMHFT to consider how to share information where concerns exist prior to a formal recorded diagnosis of psychosis. The Police had information which could have been of assistance to healthcare professionals beyond the recorded convictions and/or cautions.
3	Assessments undertaken in Police cells by Forensic Physicians for fitness to process should be routinely considered for sharing with the offender's GP by the healthcare professional undertaking the assessment. Contracting arrangements with healthcare providers should reflect this.
Organisation: Social Services	
1	Children and Adult Social Services should arrange a review of their involvement in the life of P and his family. This should include the social work contribution to the MHA assessment completed on 17 July 2012 to consider whether relevant issues were adequately addressed, particularly safeguarding.
2	Social Services should ensure that when there are safeguarding concerns regarding a child there is a clear written plan of action which wherever possible is shared with parents and relevant agencies.

National Recommendations (Owner: NHS England) Crown Prosecution Service, Courts, Police, Prisons, the Ministry of Justice and the Department of Health	
1	There should be consideration of a system in place nationally to ensure that all assessments undertaken by Forensic Physicians in Police cells for fitness to process are reported to the offenders GP by the healthcare professional undertaking the assessment.
2	In the light of this reports findings, and with a view to ensuring that in future all relevant information is available to prosecutors and Courts, the Crown Prosecution Service should review its current national legal guidance covering the law, policy and practice that prosecutors should apply when dealing with cases involving alleged offenders who have, or appear to have, a mental disorder. This review should consider whether additional guidance is required to ensure that relevant information is provided to and taken into account by prosecutors in those cases where there has been no formal diagnosis but where there are concerns held by the police or any other agency concerning an alleged offender's mental health.
3	Her Majesty's Court should ensure that fail-safe procedures are put in place to reinforce the existing rule that prisoner escort staff should remain whilst there is still a possibility of their services being required.
4	Providers of Probation Services, the National Probation Service and Police & Prison (Public and Private) Senior Managers must ensure that the new arrangements for the supervision of under 12 month Prisoners are implemented with active consideration given to how best to integrate health & prison release/discharge systems. *This recommendation should be passed to the Ministry of Justice for cross departmental consideration and would be relevant to all prison release/discharges.*
5	The Ministry of Justice and the Department of Health should review the current arrangements whereby a Prisoner can refuse access to their GP records.
6	The Ministry of Justice and the Department of Health should consider the development of a national system, which would ensure that Prison health records are routinely provided to GPs when a prisoner is released from detention.
7	All prisons must ensure that all Health appointments are routinely transferred when a prisoner moves wing or is transferred to another prison. The current DNA rate for health appointments, which is reported to be currently around 40 - 50 %, needs to be addressed.
National Recommendations All services	
1	All services should ensure that GPs are routinely copied in to all healthcare providers' clinical correspondence relating to an individual, allowing the person's primary healthcare provider to be kept fully informed and facilitating a central access point for healthcare information to others.

Appendix 1

Glossary

Abbreviation	Description
Access Sandwell	Access criteria for childrens' support services, Sandwell (Part of Sandwell Safeguarding Children Board)
ACCT	Assessment, Care in Custody & Treatment – On 1 April 2012 the 'Safer Custody' Prison Service Instruction 64/2011 came into force which replaces several Prison Service Orders relating to Safer Custody. Assessment, Care in Custody and Treatment (version 5) is a prisoner-centred flexible care-planning system which is designed to reduce the risk of suicide and self-harm. Those who manage offender health must adhere to the requirements of ACCT in order to manage individuals at risk of self-harm and suicide.
AMHP	Approved Mental Health Practitioner – a person responsible for organising and coordinating assessments under the Mental Health Act. The role is often held by specially trained social workers but can also be carried out by Occupational Therapists, Community Mental Health Nurses and Psychologists. This role replaced the role of an Approved Social Worker (ASW).
BASS	Bail Accommodation Support Service
BCPFT	Black Country Partnership Foundation Trust
BSMHFT	Birmingham & Solihull Mental Health Foundation Trust
CAMHS	Child & Adolescent Mental Health Services
CJT	Criminal Justice Team
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
CSRA	Cell sharing risk assessment
DASH Assessment	Domestic Abuse, Stalking and Honour Based Violence assessment
DNA	Did not attend
DoH	Department of Health
ECG	Electrocardiogram
EDT	Emergency Duty Team
FLO	Family Liaison Officer
FP	Forensic Physician
HMCTS	Her Majesty's Court Tribunal Service
HMP	Her Majesty's Prison
HMIP	Her Majesty's Inspector of Prisons
IDVA	Independent Domestic Violence Advisor
IMR	Inmate Medical Record
Khat	A plant native to parts of Africa and the Arabian Peninsula. In communities from these areas, khat chewing has a history as social custom dating back thousands of years. It is a stimulant that can make the user feel more alert, happy and talkative, but can also suppress appetite, induce insomnia, make existing mental health problems worse, and cause paranoid and psychotic reactions. The Government

	has decided to make Khat an illegal Class C drug with effect from 24 June 2014. Khat contains natural ingredients which are already controlled drugs both in the UK and nationally because they are harmful.
LSCB	Local Safeguarding Children Board
MAPPA	Multi - Agency Public Protection Agency
MARAC	Multi - Agency Risk Assessment Conference
MDT	Multidisciplinary Team
MHA	Mental Health Act 1983 (Amended 2007)
NCB	NHS Commissioning Board
NFA	No Fixed Abode
NPSA	National Patient Safety Agency
OASIS	BCPFT electronic patient information system
OASys	Offender Assessment System (Risk categorisation)
PACE	Police & Criminal Evidence Act 1984
PER	Prisoner Escort Record – Conveys information about assessed risks that others need to be aware of
PICU	Psychiatric Intensive Care Unit
Police Watch	Local neighbourhood team who are aware of domestic abuse households they may want to take opportunity to engage with
PNC	Police National Computer
P-NOMIS	Prisoner National Offender Management Information System
Primecare	Primecare is an independent provider of primary healthcare, including out of hours services GP
RC	Responsible Consultant
RIO	BSMHFT electronic patient information system
SCR	Serious Case Review
Section 37 MHA	A Hospital Order made in Court for the provision of treatment for a mental disorder
Section 41 MHA	A Restriction Order made in Court with a Hospital Order, requiring case oversight by the Ministry of Justice
SHO	Senior House Officer (Junior doctor)
SIG	Street Index Gazetteer (Significant Warning Marker on Police National Computer)
ST-5	Senior Trainee (Level 5) doctor
Systm1	HMP Healthcare patient information recording system
TAG	Threshold Assessment Grid – This is a short, quickly completed rating assessment of the severity of an individual's mental health problems. It was developed to help identify people who should be referred to community mental health services for adults and older people
VPS	Victim Personal Statement