

# Homicide Investigation Report into the death of a child

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

When serious incidents occur the National Health Service (NHS) has a responsibility to ensure that an appropriate investigation takes place. The purpose being to review the circumstances which may have led to the serious incident, identify root causes, and highlight areas where improvements can be made in order to minimise the risk of such events happening in the future (National Patient Safety Agency (NPSA) 2010 & NHS Commissioning Board (NCB) 2013).

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.

When this tragic incident occurred it was quickly identified that the alleged perpetrator, who for the purpose of the report will be referred to as P, had previously been known to the services of the Black Country Partnership Foundation NHS Trust (BCPFT) and Birmingham & Solihull Mental Health NHS Foundation Trust (BSMHFT).

At the time of the incident the available healthcare information indicated that P's most recent mental health contact appeared to have been with Birmingham & Solihull Mental Health Foundation Trust (via Prison In-Reach services in HMP Birmingham), and in light of this, the Patient Safety Team at NHS West Midlands Strategic Health Authority asked that BSMHFT take the lead for investigating this event, on the understanding that the Black Country Partnership NHS Foundation Trust would also contribute to the investigation process.

In accordance with the National Serious Incident Framework (NPSA 2010 and NCB 2013) Birmingham & Solihull Mental Health NHS Foundation Trust commenced a serious incident investigation into the circumstances surrounding the care and treatment of P.

As the Trust began to review events it rapidly became apparent that P had been known to a range of agencies. Hence it was identified that in order to effectively explore and identify the lessons which could be learnt from this incident, it would be essential to involve other key stakeholders.

In order to maximise learning for all agencies concerned, BSMHFT worked with their lead commissioner, Birmingham CrossCity Clinical Commissioning Group (BCC CCG), and employed a multi-agency independent investigative approach, similar to that utilised within a Domestic Homicide Review or Serious Case Review, to effectively explore key issues and areas for learning.

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.

It is noted that all key stakeholders who participated within this process, and have contributed towards the development of this report, have acknowledged the need to reflect upon the circumstances leading up to this tragic incident and to ensure that any lessons for improved practice identified are robustly embedded across all services and organisations.

Further to this, all key stakeholders have been advised that following completion of this report, a decision will need to be made as to whether an Independent Inquiry will be required. It is noted that following recent changes to the structure and commissioning of the NHS in April 2013, the responsibility for commissioning an Independent Inquiry following a mental health homicide has transferred to the NHS England Regional Homicide Investigation Team.

After completion, this report will be shared, via the Birmingham CrossCity CCG, with the Regional Homicide Investigation Team to inform their decision as to the most appropriate next steps.

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 investigation panel worked to the agreed Terms of Reference, but also addressed the questions raised in Court by The Honourable Mrs Justice Thirlwall DBE.

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. (Responses to these questions are detailed in section 4.8).

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?

The terms of reference were developed following a BSMHFT initial desk top review, held to identify which stakeholders were involved and key issues to be explored within the investigation. The Terms of Reference were agreed by the BSMHFT Chief Executive and Medical Director.

Due to the nature and complexity of this case, it was agreed that the investigation panel would need to consist of professionals external to the Trust and be chaired by a Consultant Forensic Psychiatrist in order to ensure appropriate rigour and challenge. The panel members were drawn from relevant agencies including the Police, Probation, Birmingham Safeguarding Children Board and Commissioners. An independent clinical panel member was also included.



## 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 Investigation Panel

The investigation panel membership was as follows:

- Alison Reed, Consultant Forensic Psychiatrist, Birmingham & Solihull Mental Health NHS Foundation Trust (Chair)
- Nigel Byford, Head of Public Protection, Staffordshire & West Midlands Probation Trust
- Elaine Thompson, Deputy Chief Nurse & Quality Officer, Birmingham CrossCity Clinical Commissioning Group
- Garry Billing, Assistant Director of Safeguarding, Birmingham City Council (Formerly Detective Chief Inspector, West Midlands Police) Full Board member of the Birmingham Safeguarding Children Board
- Paul Illingworth, Former Head of School of Nursing & Midwifery at Birmingham City University

The investigation panel were supported by the BSMHFT Head of Investigations and Investigations Officer.

The investigation panel convened for more than 30 sessions to conduct interviews and consider relevant documentation - some of these sessions entailed a full day meeting. Further sessions involved several investigation panel members working together and individual panel members meeting with other organisations.

Huddle (a cloud based secure collaboration and content management software package) was used to coordinate and share all the documents reviewed, including the secure storage, of records requested from other stakeholders. Interviews with more than 30 personnel were conducted and documented.

All interview notes were documented and sent to interviewees for comments on accuracy and agreement before their content was used to form the development of the final investigation report.

## 2.3 Stakeholders

Stakeholders included the following:

- Birmingham & Solihull Mental Health NHS Foundation Trust (BSMHFT) - also providers of offender healthcare to HMP Birmingham
- Black Country Partnership NHS Foundation Trust (BCPFT) \*from 2004 to 2009 the CAMHS service was under Sandwell Mental Health NHS Social Care Trust & from 2009 to 2011 the organisation was known as Sandwell Mental Health NHS & Social Care Foundation Trust. For the purpose of this report the organisation will be referred to as BCPFT throughout.
- Crown Prosecution Service
- HMP Birmingham (managed by G4S)

- HMP Hewell
- P's GP
- P's Secondary School
- Her Majesty's Court Tribunal Service (HMCTS)
- Sandwell Childrens Social Services
- Sandwell Womens' Aid
- West Midlands Police
- Worcestershire Health & Care NHS Trust – providers of offender healthcare to HMP Hewell

The investigation panel identified, from studying the supporting information and documentation, that P had had numerous contacts with agencies from his time of being at school to the time of his being released from HM Prison Birmingham in December 2012.

Significant personnel were identified via analysis of the relevant documentation gathered to form the chronology of events, and invited for interview by the investigation panel. All those interviewed were sent a copy of the Terms of Reference for the investigation prior to their interview.

Those who attended for interview were as follows:

- CAMHS Consultant Psychiatrist, Black Country Partnership NHS Foundation Trust
- Associate Specialist, Black Country Partnership NHS Foundation Trust
- CPN 1, Criminal Justice Team, Black Country Partnership NHS Foundation Trust
- AMHP, Black Country Partnership NHS Foundation Trust
- CPN 2, Criminal Justice Team, Black Country Partnership NHS Foundation Trust
- Team Leader, Crisis Team, Black Country Partnership NHS Foundation Trust
- Consultant Psychiatrist, Crisis Team, Black Country Partnership NHS Foundation Trust
- Sergeant, Major Incidents Team, West Midlands Police
- Forensic Specialist Registrar at BSMHFT (contracted to HMP Hewell) & also employed directly on a part time basis by HMP Hewell (Now Consultant Psychiatrist at another Trust)
- Ward Manager, PICU, BSMHFT
- Deputy Ward Manager PICU, BSMHFT
- Specialist Registrar ST6 (formerly ST-5 higher trainee doctor), PICU, BSMHFT
- General Practitioner of P
- Detective Chief Inspector – West Midlands Police
- Consultant Psychiatrist (and Clinical Director) PICU, BSMHFT
- Consultant Psychiatrist 1, HMP Birmingham
- Consultant Psychiatrist 2, HMP Birmingham
- Head of Offender Healthcare, HMP Birmingham
- CPN In-Reach Team, HMP Birmingham
- CPN Primary Care Gateway Worker, HMP Birmingham
- Consultant Forensic Psychiatrist, Forensic Medium Secure Services, BSMHFT and supporting psychiatrist to HMP Hewell

- Consultant Forensic Psychiatrist, (and Clinical Director) Forensic Medium Secure Services, BSMHFT
- Head of Offender Healthcare, HMP Hewell
- Independent Domestic Violence Advisor – Sandwell Womens’ Aid
- Administrator HMP Hewell (via questionnaire)
- Personal Assistant to PICU Consultant Psychiatrist BSMHFT (via questionnaire)
- Administrative staff for the BSMHFT PICU
- Legal Team Manager, Black Country Magistrates’ Courts (via teleconference)

The Head of Public Protection (Probation) on the investigation panel liaised directly with the Prison Deputy Controller at HMP Birmingham and a Director of G4S to assist with the investigation.

The completion of a questionnaire to support the investigation, in preference to interview, was completed by two administrative staff – one at HMP Hewell employed by Worcestershire Health & Care Trust and one at BSMHFT.

Invited to interview to support the discussion of key issues but declined, or were unable, to attend were as follows:

- Reverend at the Church Centre
- Vulnerable Persons Lead at the Crown Prosecution Service.
- The Head of Offender Healthcare at HMP Hewell was requested to identify a time when a Mental Health Nurse at HMP Hewell could be contacted by telephone. It was not possible for this to be achieved owing to sickness absence.

The investigation panel were unable to ascertain the whereabouts of a Social Worker from BCPFT, and the Social Worker at P’s Secondary School, who had both since left their previous employment.

The Specialist Registrar from CAMHS in BCPFT had left the employment of the service and the investigation panel interviewed his supervising CAMHS Consultant Psychiatrist.

The previous GP of P confirmed that all records had been transferred to P’s most recent GP.

## **2.4 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.

#### **2.4.1 Meeting held with the Family of Christina Edkins**

Christina's parents were supported by other family members and the West Midlands Police Family Liaison Officer (FLO) when they met with the investigation panel. They were given the option of being seen at home or to be seen by one or two members of the investigation panel only, but they opted to meet with the full investigation panel.

The investigation panel offered their sincere condolences to the family for the tragic loss of their daughter.

The family were advised that following the completion of the investigation a member of the investigation panel and commissioner representatives would be willing to meet with them to go through a summary of the findings of the report. The family were also advised that once completed, the report would be forwarded to the NHS England Regional Homicide Investigation Team to make a determination as to whether or not a further Inquiry will be commissioned.

The investigation panel also talked to the family about whether they wished for the report to include some personal information about Christina and the family welcomed and supported this proposal.

Key issues the family discussed with the investigation panel were as follows:

- The Investigation Process
- Organisations that had some previous involvement with P
- Key emerging themes from the investigation
- Reducing the incidence of further similar homicides

#### **2.4.2 Meeting held with the Family of P**

P's mother chose to meet with the full investigation panel and was supported by a friend. She submitted a written account of the questions she would like the investigation panel to address and these were considered during the investigation.

It was noted that P's mother had a meeting with the BSMHFT Medical Director soon after her son was admitted to a secure psychiatric hospital for treatment.

P's mother was advised that following the completion of the investigation a member of the investigation panel and commissioner representatives would be willing to meet with her to go through a summary of the findings of the report. P's mother was also advised that once completed, the investigation report would be forwarded to the NHS England Regional Homicide Investigation Team to make a determination as to whether or not a further Inquiry will be commissioned.

## **2.5 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.

In June 2014, 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**

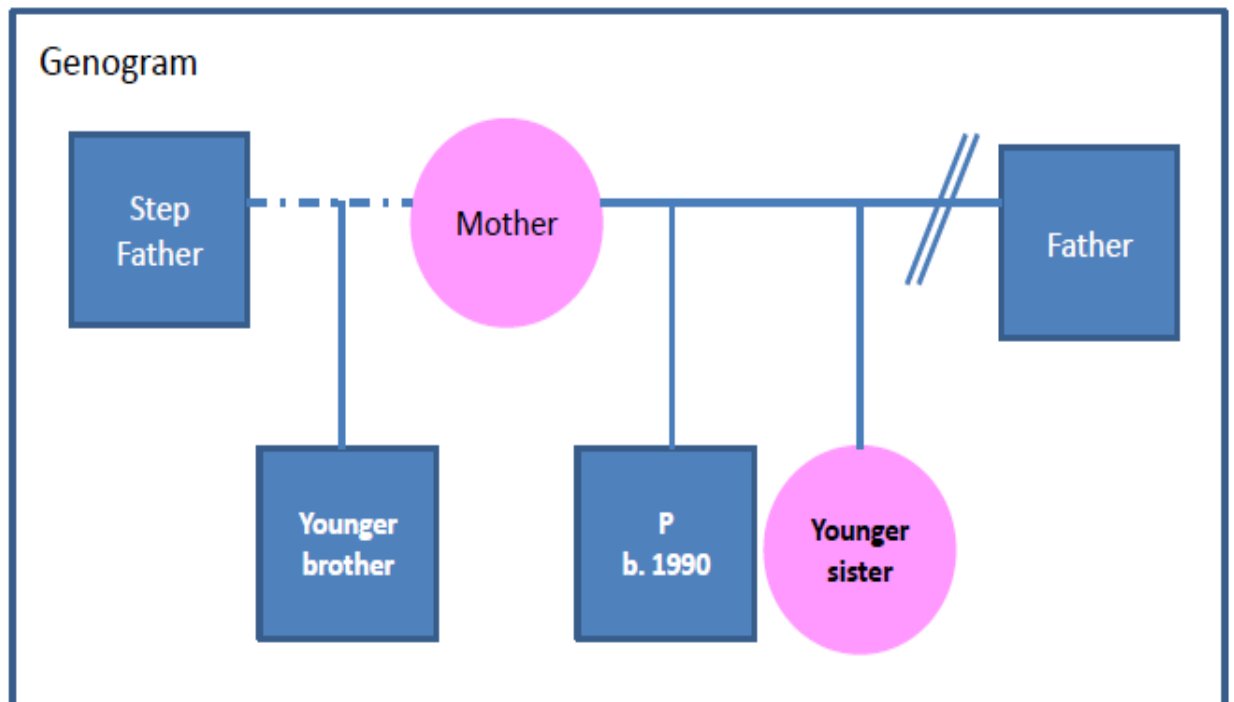
Christina was born in February 1997 and lived in Birmingham with her parents, her brother and sister. She came from a large extended family. She attended St. Edmunds RC School in Spring Hill, Birmingham and Leasowes High School in Halesowen, West Midlands. She was a good dancer, netball player and trampolinist. 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 Genogram (P)



### 3.3 Detailed History of P – Chronology of Events

1. P was born in Swaziland in August 1990 and came to England at the age of 12 years with his mother and his sister. His father, with whom he did not have a good relationship, remained in Swaziland and his biological parents separated in 1996.
2. P registered as a new patient with a general practice in October 2002 and a new patient health check was performed. In 2004, when he was having physical health checks, his weight was recorded as being on the 75<sup>th</sup> percentile, indicating that it was above average in contrast to his later presentation to mental health services as an adult.
3. P's school records confirm he developed difficulties at school in his teenage years, which his mother related to alleged bullying. He had several outbursts of temper noted. These outbursts of temper were attributed, by the school, to behavioural issues. P's mother described how he changed at this time from a hard working boy to someone who was reluctant to attend school. P was said to be a gifted mathematician, both by the school and his mother, but despite this, his schoolwork began to decline and his punctuality and attendance at school became inconsistent.
4. P had said to his mother that other pupils were after him and had threatened him. School records indicate that P's mother made several appointments to meet with teachers at the school to try and resolve the issue of bullying. This is also confirmed by his mother.
5. P's mother reported that P was frightened of what the other boys at school might do to him and that he had come home with bruises. Around this time, when his mother went to the

school to discuss her concerns, it was confirmed to her that 11 pupils had been expelled from the school in relation to bullying.

- 6 On 3 November 2004, school records indicate that P and his family moved house, but P remained at the same school.
- 7 It is alleged that P was involved in a fight with a boy at school in December 2004, which had escalated to the involvement of rival gangs of Somalian and Asian boys. P had to be taken home by a teacher. According to his mother P then became quite paranoid; not wanting to leave the house, fearing for his safety and worrying that he may be killed.
- 8 P's mother reported that P felt angry, confused, anxious and more withdrawn. He reported to his mother on 17 December 2004, that he had taken an overdose of medication he had found in her bedroom. He was taken to an A & E Department and subsequently admitted to hospital. The overdose was not sufficiently significant in volume to cause serious harm and paracetamol levels were noted to be below treatment level.
- 9 P was consequently assessed whilst in hospital on 20 December 2004 by a Community Psychiatric Nurse (CPN) from the BCPFT Child & Adolescent Mental Health (CAMHS) Team, which was attached to the Hospital site. The CPN assessment referred to P's problems with other boys at school and the build-up of tensions between various groups of boys at school in the week commencing 13 December 2004. Additionally, the assessment mentioned that P believed that something had been overheard about the threat of a fight at the end of the week and a boy had reported that P was going to get shot. P reported that there had been guns and knives passed around the school previously and it was felt by him to be a believable threat. P was upset as his girlfriend had become ill and fainted when she heard this news.
- 10 P told the CPN that when he took the overdose he had felt like he wanted to die. He was confused, angry, upset, and worried about his girlfriend. He also had thoughts about his father and his relationship with him and his sister when he was younger. The assessment recorded P as being alert, able to express his problems clearly with spontaneous speech and having good eye contact. He was reported to have smiled appropriately. He did not present as being clinically depressed. P reported to the CPN that he now regretted his act of deliberate self-harm and denied having any further suicidal intent or ideation. P stated to the CPN that approximately two years previously he had taken a 'number of drugs'. He reported that his mother was liaising with the Police regarding the event at school of the previous week and said that the Police were going to be meeting with him.
- 11 The CPN's assessment was documented in a letter and sent as a referral to the CAMHS Consultant Psychiatrist in the Black Country Partnership NHS Foundation Trust (BCPFT) and copied to P's GP. In this letter the CPN noted that P was not in their catchment area and on this basis would not be arranging to see him again herself. However, the CPN recommended follow up in a week. It does not appear that contact was made with P 's school at this point,



but the letter from the CPN to the BCPFT CAMHS Consultant indicated that P's mother planned to meet with the school and liaise with the Police to resolve the situation.

- 12 On 24 December 2004, a letter was sent from the BCPFT CAMHS Specialist Registrar to the parents of P inviting them to accompany P to an appointment on 31 December 2004.
- 13 P was seen with his mother on 31 December 2004 by a CAMHS Specialist Registrar, who noted there were no signs of depression or psychosis. P was said to have had good eye contact and a rapport was established. His speech was described as normal in rate, flow and content.

*On interview, the CAMHS Consultant Psychiatrist said that P had a working diagnosis of adjustment reaction. There were no suicidal thoughts recorded or any major mental illness, and no major risk ascertained in the assessment.*

- 14 P's mother reported to the CAMHS Specialist Registrar that P taking an overdose had been a shock. P described feeling vulnerable as the boys at school had said that they knew where he lived. He said he normally kept his personal home life to himself.
- 15 His mother reported that P used to fight when he was in Swaziland, but no more than anyone else and academically had always 'done ok'.
- 16 P reported that his father had always seemed to prefer his younger sister to himself and according to his mother P was always protective of his younger sister. P told the doctor that he still sometimes had flashbacks of his father's alleged physical aggression towards him. These tended to happen just before he got into a fight at school, but he claimed that the flashbacks were reducing in frequency. P was not having nightmares, though he still expressed a lot of anger towards his father. It was documented that he still had some anxiety regarding the future. P's mother said that P was due to receive counselling from a Youth Pastor at a charity based Church Centre, so he had declined therapeutic intervention from CAMHS. P's future attendance at the Centre was corroborated by his mother and the school Social Worker who had contacted them. The duration and details of P's subsequent contact with the Centre are unknown and although there is reference by the BCPFT CAMHS Specialist Registrar to contact the Church Centre, there is no record of this happening evident in the BCPFT records.
- 17 P's next CAMHS appointment was scheduled for 28 January 2005. P's mother agreed to let the CAMHS Specialist Registrar know what action the school would be taking to prevent similar occurrences of threats and fighting at school in future.
- 18 At his second appointment with the CAMHS Specialist Registrar, P attended alone and commented on the exclusion of a number of boys from his school, who had been causing him trouble previously. He reported that he was still having verbal arguments with boys at school, but had not been involved with any further incidents of physical aggression. P was found to

have no disturbance of his mood state and denied any further deliberate self-harm acts or ideation. The Specialist Registrar reported that P believed he was back to his pre-morbid state. P maintained good eye contact during the interview, but still appeared slightly wary. However, he smiled on a few occasions, and his speech was normal.

- 19 P reported that he believed that his school Social Worker 'had it in for him' and that despite improvement in his time-keeping in year 10 the Social Worker was still picking up on the few instances when he did not attend. P agreed for the CAMHS Specialist Registrar to contact the school. P reported that he was due to start his counselling sessions at the Church Centre in the week commencing 31 January 2005 and that he was continuing to attend the youth groups. The CAMHS Special Registrar asked for P to attend with his mother for his next CAMHS appointment in March 2005.
- 20 BCPFT CAMHS records document that P's school Social Worker had called and left a message for the CAMHS Consultant/Specialist Registrar on 23 February 2005. The Social Worker reported that she was concerned that P was very depressed and that he had hardly attended school since 17 January 2005, which his mother did not appear to be aware of.
- 21 A meeting was held in late February 2005 with the school Social Worker, P and his mother. The Social Worker had advised P's mother to take him to see his GP and stated that she would fax through a supporting letter that she had previously sent to the GP by post. The school Social Worker contacted the BCPFT CAMHS Specialist Registrar to let him know that P had reported that 'everything in school was horrible' and that he 'couldn't cope'. P had also stated that he felt 'got at by everyone and everything'.
- 22 On 8 March 2005, P saw the BCPFT CAMHS Specialist Registrar with his mother, as requested. The CAMHS Senior House Officer (SHO) was also in attendance, as this junior doctor would be reviewing P after the Special Registrar had left the service. It was noted that P had started counselling with the Church Centre and reported that he was finding this helpful. His mother said that she would ask the Church counsellor to make contact with the CAMHS service; however there is no evidence to support this contact taking place. The CAMHS Specialist Registrar had spoken to the Social Worker at P's school who had expressed concern about P's mental state and non-attendance at school. P denied any current deliberate self-harm ideation, flashbacks or nightmares. Symptoms suggestive of a depressive disorder could not be elicited. P denied feeling persistently low. His appetite had not changed, though he reported that he had been sleeping more.

*On interview, the BCPFT CAMHS Consultant Psychiatrist stated that the CAMHS Specialist Registrar had agreed with P and his mother that he should continue attending the Church Centre where he was receiving help with anger management and problem resolution skills.*

- 23 P had found a placement to undertake his work experience at an organisation that conducted medical research. It was recorded that P had been enjoying his work experience placement although he had some non-attendance. At that time his mother reported that a boy from school had been hospitalised following a fight outside the school grounds, having been injured by a brick. P's reluctance about going to school was noted to be understandable, although he had expressed his desire to return to finish his studies. P was advised by the CAMHS Specialist Registrar not to get drawn into trouble by taking it upon himself to try to stop fights at school. The CAMHS Specialist Registrar recorded a plan to see P again in April 2005. He intended to await contact from the Pastor at the Church Centre via P's mother and copy the details of the appointment to the GP, the school Social Worker and P's mother.
- 24 P had two further appointments with the BCPFT CAMHS service in 2005, which he attended with his step-father. On 26 April 2005, he was assessed by the CAMHS SHO. His step father reported that P was doing well, had joined a gym and was cheerful and happy. P said he was feeling more confident and denied any depressive symptoms. He reported to the CAMHS SHO that although the situation at school remained the same, he was now attending regularly. P had revealed the names of boys involved in the beating of another boy to the Head Teacher and although this was meant to have been confidential, it appeared P's name had been disclosed as the source and he feared retribution as a result of this. The boys involved had been excluded from the school; hence P was worried that they would return and harm him for reporting them to the Head Teacher.
- 25 On 19 July 2005 P was seen by the CAMHS SHO with his step-father and then alone. The SHO recorded that P appeared slightly dull and a little preoccupied. P reported that several weeks earlier he had been beaten up by a gang of boys and this had occurred around the corner from where he lived. He had been upset for several weeks following this incident, but reported that he had coped 'very well'. P reported to the CAMHS SHO that he was worried and anxious when he went out and was always looking over his shoulder to check if anyone was following him. He denied any depressive symptoms. The CAMHS SHO noted in the records that the session with P had focussed on P's current problems and solutions relating to his safety. There was a plan for the CAMHS SHO to follow him up in two months' time.

*On interview, the CAMHS Consultant Psychiatrist had felt that there was not a level of risk that would have triggered a higher holistic approach to P whether it was school, Police or other factors and there was nothing to trigger getting the agencies together.*

*'If P had been suffering in silence, he had been very clever at not showing it'.*

- 26 P was offered a further CAMHS appointment for 13 September 2005, just after his 15<sup>th</sup> birthday, which he did not attend. In a follow up letter sent for the attention of his parents on 25 November 2005, a further appointment was offered for 12 December 2005. P did not attend this appointment either. In view of his non-attendance, P was discharged from the BCPFT CAMHS service and his GP was notified. The GP records indicate that this letter was

received by the GP on 3 January 2006. The investigation panel ascertained that there was no CAMHS Service non-attendance (DNA) policy at that time.

*On interview, the CAMHS Consultant Psychiatrist stated that it was current policy that when a patient does not attend an appointment then the parents and GP are written to. If nothing is heard after 2 weeks then the patient is discharged, but a clinician reads the file first to identify if there is any risk to indicate that the patient should not be discharged.*

*In this case, the clinician reading the file did not see a major risk as P was reported to be doing reasonably well and the Police and school were taking care of other issues.*

- 27 On 2 February 2006, school records showed there was a parental visit to the school to address P's lack of attendance. The school 'special report form' noted, 'shows little organisation, no behavioural problems as such' and describes P as a pleasant and polite young man. His personal tutor stated that after all the work undertaken with P and his family the previous year, there did not appear to have been any change in his behaviour or attitude towards school. His form tutor reported concerns that P was very rarely in registration and was missing out on important letters, exam information and support for future plans after year 11.
- 28 The next day Police records show that P was encountered in the early hours on foot by Police, in a high crime area and could give no reason for being there at that time. However it was noted by the investigation panel that P previously lived in this street.
- 29 P's mother reported that P was not washing or getting out of bed and he complained of being tired all the time. She arranged for him to see the GP on 10 February 2006 and attended the GP surgery with P to convey her concerns about her son.
- 30 P attended the GP surgery on 7 March 2006 to discuss his blood results with the GP.
- 31 P received an end of year school report in June 2006 and obtained mainly mid-grades in achievement. It was noted that he had some difficulties with his memory and was easily distracted. P arranged to study during the summer in preparation for his GCSE exam resits. He did not obtain good exam grades. This was a surprise to his family as he was always believed to be clever and it was expected that he would do well.
- 32 The investigation panel noted that an Ofsted Inspection of the school in 2006 recorded that the school was located in a socially, economically and ethnically diverse part of the city and the school drew most of its students from areas of severe deprivation. An exceptionally high proportion of students were said to be newly arrived in the country from overseas and 123 were refugees and asylum seekers. A high number of students arrived unattached to their families and were in public care. Over half of the students were said to speak English as a second language, with a quarter of students recorded as beginners in English. The school were graded as 1 (Outstanding) for Care, Guidance & Support.

- 33 P attended the GP surgery on 26 January 2007 complaining of insomnia, stress at home and tension type headaches. He was supplied with a self-help advice leaflet.
- 34 In March 2007, P attended the GP surgery with a facial injury and told the doctor he had been punched. Records do not indicate who allegedly punched him. P was also complaining of headaches. He described that he had been punched to the left side of his face and stated he had lost consciousness for several minutes. There was nothing abnormal detected on examination.
- 35 At 00:10hrs on 22 April 2007 Police encountered P in a group with 4 other males on a street in Birmingham. He was spoken to and allegedly began to act in a suspicious manner. A section 1 PACE search was undertaken by the Police and P was found to be in possession of a brown handled lock knife with a 2 inch blade and also an amount of cannabis. Police records indicated P was under the influence of cannabis. P was arrested and reprimanded by the Police for being in possession of a bladed article. He was medically assessed by a Forensic Physician provided to West Midlands Police via Primecare and found to be fit to be interviewed. He subsequently accepted a Police Caution. This was the first time P had been known to carry a knife and a warning signal was placed on the Police National Computer record (PNC) regarding this possession.
- 36 On 8 May 2007 Police records stated that P and one other unknown male were found in the back garden of a house in Edgbaston, Birmingham with no lawful purpose for being there. They had been detained by members of the household. P gave his own address as being in Smethwick, West Midlands. He was arrested and taken into Police custody where it was recorded that a doctor was not required and no medical assessment was undertaken. No further details have been ascertained by the investigation panel and the outcome of the incident is not known.
- 37 According to his mother, P continued to attend the Church Centre and he received counselling sessions there until 2007. P reportedly felt that the sessions helped him.
- 38 On 23 September 2007 Police responded to reports that someone was acting suspiciously in Edgbaston, Birmingham. On attendance they encountered P, but eliminated him from any further enquiry.
- 39 P's mother reported that P enrolled at Bournville College, Birmingham at 17 years of age to undertake a music course, but only attended for a few weeks, claiming to have been threatened by a man with a gun and a dog. Police records note that the Police attended in response to P's report of this incident but no-one was found. From that point forward P refused to go back to College.

- 40 In March 2008 his mother noticed P to be talking to himself in his bedroom and was reportedly banging the walls and shouting in response to 'imaginary people'. He had become more confined to his room, refusing to leave.
- 41 Around this time, P caused a fire in his bedroom, requiring the house to be evacuated. The fire brigade attended the scene and reported significant smoke damage to the property, which resulted in the family being rehoused. It does not appear that the Police were notified of this incident at the time. According to P's mother, the fire had been caused by a lighted cigarette and clothing piled up on P's bed. He initially refused to leave his room whilst it was on fire, but his younger sister was able to get him out of the house, by refusing to leave unless he did too. The investigation panel were extremely concerned and could not understand why such a significant and potentially life threatening event resulted in no further exploration or intervention.
- 42 Several weeks following the fire at the house, P's mother called for the Police when P began smashing things in the house. His mother had made him an appointment with the GP, but again P refused to go.
- 43 P's mother contacted the GP again the following month to make a further appointment, as she was becoming increasingly concerned that her son was mentally ill. On 23 April 2008 P did not attend the planned appointment with the GP.
- 44 In May 2008 GP records indicate that P was now with a new GP owing to being 'out of area', having moved house.
- 45 At 22:47 on 29 May 2008 the out-of-hours GP (Primecare) was contacted by P's mother for advice as she was concerned that P was feeling suicidal and appeared depressed. He had written on the wall about dying. It was noted he was not under the care of any psychiatrist, had not been drinking alcohol and there was no history of drug abuse. The out of hours GP attempted to talk to P on the phone, but could not understand him. P stated that he didn't have a problem. The GP records document that in the absence of any prior mental health issues and given that P was at home under parental supervision, the GP advised P's mother to observe the situation throughout the night and call back if required, or to take P to his own GP in the morning.
- 46 The following day P's mother attended the GP surgery alone. P, who was still under 18 years of age, had refused to attend as he felt there was nothing wrong with him. P's mother was advised that the GP would need to review him in person. The GP records indicate that following a review of the information from Primecare it was decided that P should be called for an appointment.

*On interview, P's mother told the investigation panel was that she had asked the GP if he*

*could come to the house to see P, but she was told by the GP that this was not possible.*

- 47 On 12 August 2008 P reached 18 years of age.
- 48 On 19 August 2008, Police records show that P's mother again made contact, as P was threatening to harm her. The Police attended the home and told P's mother that they believed that P was mentally unwell. She was advised to seek medical attention for her son. No offence was recorded and it was documented in Police records that a Family Protection Report was made noting P's vulnerability.
- 49 In early 2009 his mother again contacted the GP as P was acting strangely and he had 'changed'. She again reported difficulty in encouraging P to attend to see the GP because he did not believe there was a need.
- 50 On 5 March 2009, P's mother called the Police as P had pushed his three year old brother into a wall at home. His younger brother was medically reviewed at hospital and it was noted that he had minor injuries. The Police offence report states that Police attended the hospital and the Duty Registrar said there were no concerns regarding the extent of the injury. P's younger brother was admitted to a ward as a place of safety. He was fully examined by a Duty Paediatrician, who was happy to discharge him, based on Social Services (Emergency Duty Team) and Police opinion that he was not in any danger. Social Services and the Police were satisfied that the home address could be considered a place of safety.
- 51 The younger brothers' father reported to Police that, at the time of the incident, he had been sleeping and had heard a disorder downstairs. As he went downstairs P had run out of the house. He stated that his stepson regularly caused trouble at home, but had never hurt anyone before. The family stated concerns for P's mental health and told Police that P had been extremely agitated due to voices in his head and he had been talking to himself. P was described as previously very loving toward his younger brother and the incident was said to be out of character.
- 52 P's mother told the Police that P wrote messages on the wall saying that he must kill himself and the demons. She often heard P talking and laughing when he was alone in his room and said that he sometimes screamed out incoherently in the night. She also reported that she had found bleach and vinegar under his bed. The investigation panel noted that there is a risk of producing harmful Chlorine gas if these two substances are combined. However, it is unclear whether P was aware of this risk, or why he would have placed bleach and vinegar under his bed in this manner.
- 53 Police recorded the assault against the younger brother as a Section 47 Assault. Officers arrested P and escorted him to the Police station. A doctor was called to assess P due to his

presentation and possible intoxication. Police records indicate that a mental health assessment was conducted twice by a Forensic Physician.

- 54 On the first assessment P was considered fit to be detained but not interviewed or charged, until reassessment regarding his mental health issues. He was found to be calm, compliant, orientated, not depressed and denied self-harming and/or suicidal thoughts, mental health issues or drug use. It was also noted that he had scars on both arms, was withdrawn and gave no eye contact. He was placed on level 4 observations, which are constant watch. The second time he was assessed his observations were reduced and the assessment recorded that there were no medical or mental health issues. Subsequently no further health intervention was required. P accepted a Police Caution for the offence and was returned to his home address. P's mother indicated to Police that she was happy for P to return home.
- 55 Social Services, having earlier been referred this matter, indicated that they would support P's mother with P's possible mental health issues and assist in referring him via his GP to obtain help. A Social Worker from the Social Services Emergency Duty Team (EDT) contacted P's GP on 6 March 2009 to inform him of the incident involving P and his younger brother. P's mother had told the Social Worker that she thought her son was depressed and appeared to have mood swings and became easily agitated. Following this, a referral for P was sent from the GP to the BCPFT Primary Care Liaison Team.
- 56 The Specialist Registrar in Paediatrics, who examined P's younger brother, completed a child protection medical assessment which was sent to the GP, the Social Worker from the EDT, and the health visitor for P's younger brother. A note was added to the report for the GPs attention requesting the GP to ensure that P received a psychiatric assessment. In addition, a footnote was made for the attention of the health visitor and social worker requesting that further assessments be undertaken to ensure the safety of the younger brother in his home.
- 57 According to P's mother, a Social Worker came to see her following this incident involving P's younger brother, and the Social Worker informed P's mother that they would be 'keeping an eye on things'. It is not clear whether the focus of this visit was for the safety planning of P's younger brother and sister, or the mental well-being of P, or both. P's mother reports that, apart from a subsequent telephone conversation, she had no further contact with the Social Worker, or any other Social Workers.
- 58 P attended the GP surgery on 10 March 2009 and the GP recorded that P had been 'having problems for months'. P was noted to be very quiet on assessment with unclear speech. He denied depression and/or feeling down and said that he liked to keep himself to himself. He reported that he now had fewer friends than previously. He denied any hallucinations or thought disorder and denied thoughts of death or self-harm. P's mother reported to the GP that P was verbally aggressive, but he had never harmed anyone before. It was noted that he had experienced some bullying in his final year at school. P reported sleeping difficulties and was prescribed a course of sleeping tablets to be taken at night for three nights. The GP



recorded his intention to review P's sleeping difficulties; however there is nothing in the GP records to confirm that a further review took place.

- 59 On 19 March 2009 P's mother called the Police at 02:45hrs to report that P had verbally abused her, was smashing ornaments and being hostile towards her. Police officers reported that P was very uncooperative and appeared to be in a state of intoxication. He was refusing to answer questions and was becoming aggressive. P's mother wanted P removed from the premises as she felt unsafe in his presence. The Police arrested P for a breach of the peace at his home address. According to Police records, when he was arrested P was resisting and hitting out at Officers. He was aggressive on arrival at the Police station and refused to answer questions.
- 60 P was subject to medical assessment in Police custody and was found to be vague with poor eye contact. P was assessed twice. The first assessment by the Forensic Physician found that P was fit to be detained, but not interviewed or charged, and he was placed on level 3 observations with constant CCTV. At the second assessment he was found fit to be detained and charged. P did not engage well during the examination and was placed on level 3 observations with CCTV. He was said to have had a poor understanding of the breach of the peace charge made against him.
- 61 P appeared in Warley Magistrates Court the same day to face the charge, but was first seen by the Criminal Justice Team (CJT), after concerns had been raised by custody staff. According to the CJT records, anecdotal evidence from P's mother was read out in Court stating that she was of the opinion that P had mental health problems. P appeared 'uncommunicative and pre-occupied'.
- 62 P could not be held as he was not facing criminal charges. He was arrested for a breach of the peace and there was no power to remand in custody. Following discussion with the CPN it was agreed that he would be offered an 'opt in' letter by the BCPFT Primary Care Liaison Team.
- 63 P's mother attended the GP without P on 20 March 2009, as he refused to attend. His mother reported that P could be aggressive and the Police had been called. She reported that P did not sleep well and then became noisy and aggressive. She was unsure if drugs were involved. She told the GP that P had tried going to college, but he could not cope.
- 64 The GP called P's mother on the telephone on 26 March 2009. There was a further discussion about whether P was involved with drugs, but she had not discovered any illicit substances. It was reported to the GP that P had admitted to using alcohol/cannabis in the past.
- 65 The GP recorded that the plan was to refer P to the BCPFT Community Mental Health Team and ask them to assess P soon. The BCPFT Oldbury & Smethwick Community Mental Health Team sent an 'opt in' letter to P on 1 April 2009 asking him to contact them to make a 'mutually convenient appointment' within the next 14 days. The letter also stated, 'If we do

not hear from you within two weeks, we will assume you do not need our service'. On the 20th April 2009 the team wrote back to the GP saying they had not had any response from P and were therefore discharging him back to the GPs care. The case was closed. P did not receive any written confirmation that his case had been closed.

*On interview, the GP stated that if a GP expressed concerns to a mental health specialist about a patient, then at the very least the patient should be seen.*

- 66 There did not appear to be any events of note recorded between April and October 2009.
- 67 On 5 October 2009 GP records document that P's mother again attended the GP surgery without P as she was concerned that he was becoming more withdrawn. P's mother reported to the GP that P was sleeping through the day and staying up at night. He was not leaving the house. P's mother felt that P was depressed. In the past she had reported that he had been responding to external stimuli, but said he was not any more. She stated that he was no longer aggressive, but she was worried that he would 'relapse'. P had neither expressed any thoughts of deliberate self-harm or suicide, nor any plans to harm others. It was noted by the GP that P had not engaged with what the GP referred to as the 'Home Treatment Team', but was in fact the Community Mental Health Team. The GP gave a letter to P's mother inviting P to make an appointment at the surgery with a view to assessing him. The clinical entry ended by saying, 'We need to see him and assess'. P's mother stated that she gave her son the letter but it is known that P did not make an appointment. No other action was taken by the GP surgery and no further concerns were expressed by P's mother to the GP.
- 68 In the following six months there was nothing untoward of note documented.
- 69 In July 2010, Police Officers encountered P 'hanging around' in the early hours of the morning in Edgbaston, Birmingham. He was searched, but nothing untoward was found and P was released.
- 70 In early 2011, P's stepfather left the family home and his mother reported that this coincided with P beginning to improve. It was said that he was looking after himself better, leaving the house and preparing for interviews with his Curriculum Vitae. However, in May 2011, P's mother had to contact the Police again. She alleged that P had been demanding money from her and had subsequently stolen her purse. Police Officers attended the home address and the purse was returned to P's mother with Police assistance. No further Police action was taken.
- 71 Between May 2011 and February 2012 the situation appeared relatively settled. In February 2012, P's mother was hospitalised for an operation and around this time P's maternal grandmother died in Swaziland. It was reported that P was very close to his grandmother. P's mother went to Swaziland and his maternal aunt looked after him. P's mother stated that P

began to deteriorate. He refused to leave his room and would not speak to anyone. His words became jumbled and did not make sense. He became more confrontational and violent towards his mother and believed that people were going to kill him. P reportedly moved out of his mother's house, with assistance from his mother, into shared accommodation in Erdington, Birmingham for which his mother paid.

- 72 According to Police records, P went to his mother's address on 10 May 2012 and made threats that he would stab her, as he believed she was withholding his benefits and had not fixed his computer. A call was made to the Police from his brother (who was 6 years old at the time) reporting that P had thrown an electric fire at his mother and it had struck her on the head. Police attended and removed P from the address and he was taken into Police custody. P was assessed twice by the Forensic Physician. The first assessment noted him to have poor eye contact and recorded that he was quiet, but he answered questions. He was placed on level 1 observation. The second assessment continued the level 1 observations and found P fit to be detained, interviewed and charged. He was arrested and charged with criminal damage, but not assault.
- 73 On 11 May 2012, P turned up at his mother's house and smashed a window at the property. It was reported that when the Police arrived P was hiding in the shed in the rear garden. An arrest was attempted by Police, but 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 drew a Taser and targeted P to gain control of the situation and to affect P's arrest. P was uncooperative whilst in custody and when he was medically assessed it was noted by the Forensic Physician that P was fit to be detained, interviewed and charged. It was recorded that no medication was required and he was placed on 30 minute level 1 observations with CCTV support. No further mental health action was deemed necessary and that there was no need for him to see the Crisis Team. He was subsequently charged with criminal damage.
- 74 The Police completed a Domestic Abuse, Stalking and Honour Based Violence (DASH) assessment regarding the domestic abuse incident. The DASH assessment indicated that there was no injury to P's mother, but she stated that she was frightened of P and afraid of being killed by him. On assessment, P's mother reported that the abuse from P was happening more often, but she did not consider any children to be at risk from P. She reported that P had never previously threatened to kill her but that he had been in trouble with the Police. She stated that P had not previously breached bail conditions.
- 75 The DASH assessment reported that there had been 6 calls logged to the Police from P's mother's address over the previous two days which resulted in P being arrested twice and also being removed from the property on a further occasion. It was recorded that P would be dealt with positively in custody and that stringent bail conditions would be considered.
- 76 The DASH risk assessment categorisation is based on the Offender Assessment System (OASys) developed by the Prison and Probation services. This tool measures 'serious harm' defined as

death or injury (either physical or psychological) which is life-threatening and/or traumatic and from which recovery is expected to be difficult, incomplete or impossible. The DASH levels are Standard, Medium and High. The risk to P's mother at this time was identified as 'Medium'.

- 77 The definition for medium risk is: *'that there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, e.g. failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse'.*
- 78 Reassurance and advice was given to P's mother and the DASH form was sent for the attention of the Police Adult Public Protection Unit. It is the understanding of the investigation panel that the risk was initially assessed as 'Standard' by the Police Adult Public Protection Unit and then raised to 'Medium' again during a Multi-Agency Risk Assessment Conference (MARAC) on 14 May 2012. (*Standard risk is defined (OASys) as, 'current evidence does not indicate likelihood of causing serious harm'*). A domestic violence referral was made to the Sandwell Independent Domestic Violence Advisor (IDVA).
- 79 Further to the incident on Saturday 12 May 2012 P pleaded guilty to criminal damage and was given a six month conditional discharge at Wolverhampton Magistrates Court.
- 80 On 13 May 2012 P went into Smethwick Police Station and requested a pen. He then wrote a note which he handed to Police Officers. The note stated his name and recorded that he had been sent by his parents to make an apology in order to get his accommodation back. Police Officers spoke with P, who was happy with the discussion and subsequently left the police station.
- 81 On 20 May 2012, for the third time in 10 days, Police records document that they were contacted by P's mother and Police subsequently attended the address. On arrival, Police Officers spoke to P's mother who was outside the property. She advised that P was inside the house and was in possession of a knife. She requested that he be removed from the house. The attending Police Officers entered the house and spoke to P, who was reported to be calm and compliant. He was searched and no knife was found. P was then placed in the rear of a Police vehicle to be removed back to his own home address in Erdington, Birmingham in order to prevent any further breach of the peace. P's mother reported to the Police that she had let P into her home and he had then taken a knife from the kitchen and grabbed her threatening her with the knife in front of his younger brother. P had then called the Police, putting his phone on loud speaker, stating that he was going to take matters into his own hands and kill his mother as he believed his mother was trying to kill him. P's mother managed to get away from P by saying that she wanted to see her younger son to the front door and allow him to leave the house. She then called the Police from her mobile phone outside the property.

- 82 A further DASH assessment was completed. The assessment recorded that P's mother had sustained a small cut to her right leg and she was frightened of P injuring her and/or her son further. She reported that P was becoming more violent – but not every day. On assessment she had said that P had previously thrown a heater at her face and threatened to kill her. It was also noted by P's mother that P had tried to commit suicide 6 years previously. The incident in which P had pushed his younger brother in March 2009 was also noted. The DASH Assessment concluded that the risk posed to the victim (P's mother) was 'Medium'.
- 83 The key evidence in the Police report details that on route to the Police Station a female Police Officer was sat in the rear of the vehicle with P. He was agitated and argumentative with Police Officers, stating that it should have been his mother and not him removed from the address. He then, without warning, punched the Police Officer sitting next to him on her left cheek on two occasions with a clenched fist. The driver had to stop the vehicle and remove P from the car in order to forcibly handcuff him. P was arrested for assault and transported to Smethwick Police Station where his detention was authorised. The investigation panel noted that it was normal practice at that time for individuals arrested by the Police to be handcuffed whilst in transit.
- 84 The Police report detailed that P was interviewed about the incident by the Police at 22:17 hours on 20 May 2012 at Smethwick Police Station. P stated that he had gone to his mother's address in order to get food and speak to her about broken windows at the address. His mother had let him in and he went to the kitchen to get some cornflakes. P denied any wrong doing. In relation to the assault on the Police Officer, P stated that he had accidentally pushed the Officer on the shoulder as he was being handcuffed. He answered 'no comment' to all other questions in relation to the matter. According to the Notification of Hearing at Sandwell Magistrates Court, P remained in custody overnight. He was assessed in custody by the Forensic Physician and placed on level 1 observation with CCTV. Police records and Staffordshire & West Midlands Probation Trust records, show that P was arrested and charged with a Common (Section 39) Assault on his mother and an assault on a Police Constable.
- 85 When Police Officers returned to speak to P's mother in order to complete the domestic violence paperwork, she disclosed that P had used a kitchen knife in a threatening manner, causing her to fear for her life. P's mother stated that she was frightened of P as he was unstable and she did not know what he might do. She reported that P was becoming more abusive and violent. The verbal abuse was said to be more common and was becoming a daily occurrence. She provided a statement of complaint to the Police in relation to the matter and requested victim support.
- 86 At his appearance in Sandwell Magistrates Court on 21 May 2012, P pleaded guilty to assaulting the constable and was sentenced to four weeks' imprisonment. P pleaded not guilty to the common assault on his mother. He was subsequently detained in HMP Hewell and the case was adjourned for trial (Set for 11 July 2012). P was remanded in custody to

appear back at Sandwell Magistrates Court, over the live TV link, on 30 May 2012 for a second bail application.

- 87 From his first day in HMP Hewell P was subject to assessment of his physical and mental health by the Worcestershire Health and Care NHS Trust, which provided primary healthcare to the Prison. Mental health issues were quickly identified by the Specialist Nurse Practitioner who referred P to the Prison GP. P was put on an ACCT (Assessment, Care & Custody in Treatment), which reflected concerns about his mental health. It was noted that he was not receiving any prescribed medication, but P admitted to using 'Khat'. He had stated that he did not want input from mental health services. P appeared distracted and hesitant and staff found him difficult to engage. He denied any thoughts of self-harm and he was commenced on the anti-psychotic medication Olanzapine by the Prison GP.
- 88 In the MARAC held on 23 May 2012 a Street Index Gazetteer (SIG) warning marker was authorised by the Police to be placed on P's mother's address. The address was added into 'Police Watch' (ensuring that the local neighbourhood Police team were aware of the presence of domestic abuse at a particular household and would seek to engage with the family at every opportunity).
- 89 On 24 May 2012 P received a 20 minute visit in HMP Hewell Prison from his mother. He had no other Prison visits, whilst in HMP Hewell.
- 90 On 29 May 2012 the ACCT was closed. The details relating to the reason for the ACCT being closed are not recorded in the healthcare records, Systm1.
- 91 On 30 May 2012 Court records show that the Crown Prosecution Service (CPS) made no objection to P having bail (he had served the four week sentence by then) and he was, therefore, conditionally bailed until his trial date on 11 July 2012. A bail address, in Walsall, was provided by the Bail Accommodation and Support Service (BASS). The bail conditions included a condition to keep away from his mother, keep out of Smethwick, and live and sleep each night at the Walsall address. The condition applied from 1 June 2012. The CPS have been unable to confirm the accuracy of the information provided by the Court as the CPS paper file which contained the prosecutor's record of the hearing, has not been located.
- 92 On 1 June 2012 P was released from HMP Hewell and it was recorded in Systm1 that he was being discharged to Erdington, Birmingham. However, he was in fact bailed to the address in Walsall, with a condition that he was not to attend his mother's address. Despite the earlier concerns about his mental health and prescription of Olanzapine it was noted on his release, and recorded in Systm1 medical records, that P had not yet been given a mental health diagnosis and would 'see his GP as required'.
- 93 The Bail Accommodation and Support Service contacted the Police later on 1 June 2012 to say that P had not arrived at the Walsall address as expected on his release from HMP Hewell. The

Police were therefore asked to carry out a safe and well check on his mother, which was undertaken and confirmed that all was well. P eventually arrived at the Walsall address at noon the following day. This amounted to a breach of bail.

- 94 On 11 July 2012, P answered his bail and was in Court for the trial of the alleged assault on his mother. The Independent Domestic Violence Advisor (IDVA) collected P's mother and brought her to Court. The trial proceeded with P's mother giving evidence. She had previously been supported in completing a Victim Personal Statement (VPS). The Magistrate raised a concern that P was not able to understand what was happening in Court, but was reportedly informed by the Defence Solicitor that P was 'naturally quiet'.
- 95 The trial progressed, but there was further concern about P's behaviour, demeanour and responses in Court. While giving evidence under oath it is reported that P stated that he would stab/kill his mother. The Court consequently requested an assessment of his mental health by the BCPFT Criminal Justice Team (CJT). It was also reported to the CJT that the Solicitor for P was unable to gain clear instructions.
- 96 On assessment by the CJT, P was said to have no insight into his situation and appeared non-cooperative, contradictory and confused. He had poor eye contact and only answered yes or no to questions. A full assessment was not, therefore, deemed possible. It was recorded that the risk to himself and others needed to be assessed by the BCPFT Crisis Team and a Mental Health Act Assessment. The CJT TAG (Threshold Assessment Grid) Risk Assessment rated P as a severe risk to others and included the comment 'Told Court he would kill his mom'.

*On interview, the IDVA stated that she remembered thinking that P was not well. She said that the Duty Solicitor was frustrated. 'P made no eye contact and kept his head down – he was mumbling and looking over his shoulder. His mumbling got louder, he was giggling to himself and looking behind him. He just seemed really unwell'.*

- 97 The CJT sought an adjournment to the next day, with the Court specifically requesting the intervention of the BCPFT Crisis Team to carry out an assessment. It was the preferred option by both the CJT and the Court to remand P to allow for further assessment. The CJT recommended this was appropriate to ensure the safety of P and the public. However, it was not considered possible to remand P overnight as the Prisoner escort staff (GEOAmeY) had already left the Court, allegedly released by an Usher. The Bench were concerned that no Prisoner escort staff were available. Although there was representation opposing bail from the Prosecution it is not possible to confirm this. If there was a representation then it is not clear how strong this representation was, and the Court ultimately took the decision to conditionally bail P.

*On interview the IDVA stated that the CPS did object to bail, and that the Court did not*

*share, or take note of her concerns, or those of the CPNs, Probation or CPS.*

P was bailed to his previous address in Walsall, with an overnight curfew between 19:00hrs and 09:00hrs, to return to Court the next morning. P then left the building.

*On interview, the CPN (2) from the Criminal Justice Team stated that the CPN (1) had gone back into Court to tell them he thought P needed a period of further assessment, and whilst making telephone calls regarding an assessment, the Court released P and did not come to tell the CPN (1) they had done so.*

- 98 Probation, the CJT and the IDVA discussed, and subsequently raised, their concerns about P's risk and mental health issues. His mother was contacted by the IDVA and told to keep her doors and windows locked and to call 999 in case of an emergency. Police were contacted, but they felt they could not take further action at that time as P had been legally bailed. Probation officers discovered that P had previously breached bail on 30 May 2012 for not reporting to the identified bail address and so documents were delivered to Walsall Police Station.
- 99 P failed to answer his bail on 12 July 2012 and a warrant without bail for his arrest was issued. The Legal Team Manager of the Black Country Magistrates' Courts confirmed that the Court specifically requested that this information be passed to the Police and should include the information that the defendant had mental health issues and would need assessment.
- 100 The Prisoner escort logs, prepared to inform P's transport from the Court to the Prison, carried warnings relating to self-harm and previous violence. P had previously had accommodation in Erdington, Birmingham and therefore the BCPFT Crisis Team CPNs advised the BSMHFT Erdington Home Treatment Team and Bed Management Team of P's breach of bail. They also contacted the BCPFT Safeguarding Team. As P's mother was a repeat victim of domestic violence, and P did not answer his bail, a Police panic alarm was fitted at his mothers' house by the Police the same day.
- 101 The warrant was executed by the Police and P was eventually located and arrested at the Erdington address on 13 July 2012. The possibility of mental health concerns were recorded in the escort log following his appearance at Sandwell Magistrates Court on 13 July 2012. The Crisis Team had arranged to undertake a Mental Health Act Assessment, but the Court remanded P over the weekend into custody, with an adjournment to 16 July 2012. P was remanded in HMP Hewell over the weekend, pending his next Court appearance. The Crisis Team contacted HMP Hewell to relay their concerns about P's mental health.
- 102 On reception at HMP Hewell, it was noted that P had not received any medication for his mental health problems. It was also noted that no medical/psychiatric report had been requested by the Court and that P had not received treatment from a psychiatrist outside of Prison.



- 103 Prison staff observed that P appeared to be 'shy and vulnerable'. He was assessed on 14 July 2012 and he reported to the nurse that he had heard voices for 3 years. He had consequently self-harmed on two occasions. The nurse was concerned that P was psychotic (suffering from a serious mental illness) and requested an urgent assessment from a psychiatrist.
- 104 P was assessed by the Forensic Specialist Registrar at HMP Hewell later the same day who noted that P appeared guarded, paranoid and suspicious. P denied suicidal ideation, but smiled when asked about paranoia. His weight was noted to be very low. He was put on an ACCT, admitted to the healthcare wing of the Prison and prescribed an anti-psychotic drug, Olanzapine. An electrocardiogram (ECG) and blood tests were also requested.
- 105 According to Prison records, P would not give signed consent for access to his medical records, but it was also noted that P was deemed not to have capacity and therefore his medical records were sought in his best interests. P agreed for his mother to be telephoned. The Forensic Specialist Registrar recorded that he believed P to have an acute paranoid psychotic disorder.
- 106 HMP Hewell Prison healthcare records recorded that P appeared withdrawn, apprehensive and anxious, although he was taking diet and fluids with prompting. He was referred for grief counselling on 14 July 2012 for the recent loss of his grandmother.
- 107 The Criminal Justice Team attended Court on 16 July 2012 and contacted the Crisis Team to undertake a Mental Health Act (MHA) Assessment, but P had not been transferred from HMP Hewell as he was not considered to be fit to appear in Court following assessment by the Forensic Specialist Registrar at HMP Hewell.

*On interview, this was confirmed by the Forensic Specialist Registrar from HMP Hewell.*

- 108 The Crisis Team received a call from the Criminal Justice Team reporting that P had been seen by a psychiatrist over the weekend who had questioned P's mental capacity. Attempts were then made by the Crisis Team to speak to the Forensic Specialist Registrar from HMP Hewell on 16 July 2012 at 11:50hrs. The next entry in the BCPFT records made at 12:15hrs cites receipt of a telephone call from the Criminal Justice Team stating that the Court had adjourned the assessment until 10.30hrs on 17 July 2012. Three further attempts were made by the Crisis Team on 16 July at 12:40, 14:10 and 14:15hrs to speak with the Forensic Specialist Registrar at HMP Hewell.
- 109 It was confirmed to the Court that the Mental Health Act Assessment could be arranged for 17 July 2012. The case was, therefore, adjourned again overnight and P was remanded in his absence to appear in Court the following day.

- 110 The following morning another message was left for the Forensic Specialist Registrar at HMP Hewell at 08:55hrs. A telephone conversation with a secretary recorded an apology that the Forensic Specialist Registrar had not returned their calls, stating that he was in Court that morning and would not be available until the afternoon.
- 111 At 09:15hrs on the 17 July 2012 a further message was left at HMP Hewell. At 10:00hrs it is recorded that the Crisis Team received a call from a Mental Health Nurse at HMP Hewell giving an update on P's presentation. They were informed that the Forensic Specialist Registrar felt P could have thought disorder or a paranoid psychotic episode. P was described as irritable, inconsistent with his responses, not interacting, nervous and mumbling.
- 112 Later on the 17 July 2012 P was escorted from HMP Hewell to Sandwell Magistrates Court arriving at 11.30hrs. An assessment by the BCPFT Crisis Team was undertaken. The team made contact with P's mother and she informed them that he had threatened her with a knife, had a poor sleep pattern (being up at night and sleeping during the day) and had a conviction for carrying a knife. The CJT informed the Crisis Team of the concern expressed by a psychiatrist at HMP Hewell over the weekend that P did not have capacity. The CJT clinical records were not reviewed by the Crisis Team.

*On interview, the Crisis Team Consultant Psychiatrist said he was aware that a Criminal Justice Team (CJT) CPN had assessed P. He stated that he did not speak with the CJT CPN or access any notes and was not aware where CJT notes were kept.*

- 113 The unanimous opinion of the Crisis Team that day was that P did not meet the criteria for admission to hospital under the Mental Health Act. However, he was deemed to require follow-up for his mental health and the BCPFT clinical records referred to the possibility of an early episode of mental illness. The Notification of Hearing at Sandwell Magistrates Court made by the Probation Court Officer records that the Crisis Team assessment identified that P may have personality issues, was vulnerable and may benefit from mental health services. The Crisis Team also queried whether P had a personality disorder with depressive traits.
- 114 The TAG risk assessment tool had been completed by the Crisis Team and it recorded that P was a severe risk to others and there were severe concerns about his survival skills.
- 115 The Crisis Team opinion was relayed to the Court. P was assessed as having capacity and deemed well enough to answer the charges. He pleaded guilty and received a twenty six week sentence of imprisonment for the assault on his mother and the Court made a restraining order in respect of his mother for a period of two years. P was given no separate penalty for the charge under the Bail Act for failing to attend Court on 12 July 2012.
- 116 P returned to HMP Hewell. The Crisis Team informed the GP of the outcome of the assessment. Following the assessment the Crisis Team received a telephone call from the

Forensic Specialist Registrar at HMP Hewell, who was surprised the assessment doctors did not think P was psychotic and requested that copies of the assessment be sent to HMP Hewell.

- 117 A nurse at HMP Hewell called the Crisis Team to let them know that P did not want his mother to be informed where he was serving his sentence. The Social Worker who was involved in the assessment reported to HMP Hewell healthcare staff that she did not believe that P was experiencing any psychotic symptoms. She stated further that the general theme of the assessment was one of vulnerability, social inadequacy and isolation.
- 118 P was discussed in the HMP Hewell Multi-Disciplinary Team (MDT) meeting on 19 July 2012 and it was recorded there was 'little change'. It was reported that P answered when spoken to, but did not initiate conversation. P had been observed to be responding to unseen stimuli and laughing to himself. He was also observed to be staring inappropriately and mumbling words under his breath. He was refusing to shower and was reluctant to leave his cell.
- 119 P was seen by the Forensic Specialist Registrar on 4 August 2012 who noted that he did not accept the conclusions reached by the BCPFT Crisis Team. His own assessment of P supported his belief that P had a mental disorder of 'a nature and degree which warrants detention for assessment in hospital in the interests of the patient's health protection and for the protection of others'. He recorded his intention to discuss P with the HMP Hewell MDT with a view to referring him to hospital. He felt that, whilst not requiring the condition of medium security, P could be admitted to a Psychiatric Intensive Care Unit (PICU). This planned referral of P to the PICU team at BSMHFT was discussed with his supervising Consultant Forensic Psychiatrist in the HMP Hewell MDT on 15 August 2012.
- 120 On 16 August 2012 it was noted that P's correct GP surgery and contact details had been identified and were listed in the Prison healthcare System1 records. The referral letter from the Forensic Specialist Registrar was sent on 4 September 2012. No response had been received by 10 September 2012 and it transpired that the BSMHFT PICU Consultant Psychiatrist was on annual leave. HMP Hewell called again about the referral the next day.
- 121 Following a call to the PICU Consultant Psychiatrist's personal assistant, it was confirmed that she had not received the referral letter from HMP Hewell and it was therefore sent again by fax on 12 September 2012.
- 122 The PICU Consultant Psychiatrist requested that his Specialist Registrar (ST-5) undertake the Prison assessment in conjunction with the PICU Ward Manager (a registered mental nurse). The Prison assessment was organised for 20 September 2012 and the PICU Deputy Ward Manager also arranged to attend to observe the assessment as a learning exercise, having never undertaken one previously.

- 123 The ST-5 doctor had never undertaken a Prison assessment and it was noted by the investigation panel that there was no template or written guidance for the undertaking of such an assessment specific to the Prison. The PICU Ward Manager, who had been in post one year, had only undertaken one previous Prison assessment. There was no record of any team briefing or planning discussion prior to the assessment.
- 124 The PICU nursing and medical assessment was jointly undertaken and it concluded that P did not present with any major psychotic symptoms, but was noted to have an 'at risk mental state for psychosis'. It was believed that he would benefit from some input from Early Intervention Services, as well as psychological therapy to look into aspects of his low self-esteem and social interactions.
- 125 As part of the assessment, the ST-5 doctor had identified that P had an eye movement issue and suggested that this needed to be investigated. P was not deemed to be detainable under the MHA, nor accepted for a PICU bed. This was later communicated in a letter to the Forensic Specialist Registrar, which was sent to HMP Hewell by post and fax.
- 126 Prior to the BSMHFT PICU Team leaving the Prison following the assessment, they indicated verbally to a nurse that P would not be admitted to the PICU. At the next HMP Hewell MDT meeting it was noted that the Prison would be unable to provide a psychological assessment, as recommended by the PICU team, in the time frame available before P's discharge on 15 October 2012. Healthcare staff in HMP Hewell noted that as P was due to be released in 2 weeks' time, they would ask P to consult his own GP on release for follow up and investigation of the eye movement issue.
- 127 The Forensic Specialist Registrar went to see P on 20 September 2012 in an attempt to talk to him but P gestured to the doctor to leave him alone. The Forensic Specialist Registrar did not agree with the outcome of the BSMHFT PICU assessment and made a note for P to be referred to a local Community Mental Health Team (CMHT) prior to his release from HMP Hewell. There is no record of this being done.
- 128 P continued to isolate himself in Prison and was not socialising with other prisoners. He was accepting medication. Staff reported that P needed prompting to wash and was sometimes reluctant to change his bedding. On 27 September 2012 P was observed to be setting fire to pieces of paper and sliding them under his cell door. He subsequently handed over the lighter to an officer on request, but was unable to say, when questioned, why he had been acting in this manner.
- 129 The response letter from the PICU assessment team had been posted and addressed to the Forensic Specialist Registrar at HMP Hewell. The Prison GP recorded in the Systm1 notes that the letter had been received and noted on 1 October 2012 at 15:54hrs. The Forensic Specialist Registrar did not appear to be aware of this.

- 130 A Systm1 entry on 4 October at 09:31hrs by an admin support worker stated, 'letter marked in error; wrong date entered. Recipient Prison GP'. It is also recorded by the same person as, 'scanned document'. Although unclear – this is likely to have been a reference to the BSMHFT PICU response letter.
- 131 Later the same day, the Forensic Specialist Registrar in the MDT meeting raised concerns about P's mental state. There was a discussion about re-referring P for further assessment, also indicating that the BSMHFT PICU Team should refer P to a Home Treatment Team if they remained of the opinion that P did not require hospital admission. The Forensic Specialist Registrar drafted a response letter to this effect, which was faxed to the ST-5 doctor on 8 October 2012. He confirmed in the letter that he had not seen a written response following the assessment.
- 132 A specific response to this second referral letter was not sent by the BSMHFT ST-5 doctor and P was not reassessed, but the ST-5 doctor again sent the original response letter (by fax on the 8 October 2012) to the Forensic Specialist Registrar. The re-referral letter from HMP Hewell, when received by the ST-5 doctor, was not discussed in the BSMHFT PICU MDT meeting or with his supervising Consultant Psychiatrist.
- 133 Whilst in HMP Hewell P continued to spend short periods of association outside his cell, but did not engage with the rest of his peers in Prison. It was noted that P was reluctant to wash at times. P remained on the healthcare wing for the duration of his stay at HMP Hewell. There was a Prison Officer on the healthcare wing and routine entries were made on P-NOMIS (Prisoner National Offender Management Information System).
- 134 P's mother stated that she had written a letter to the Prison Governor at HMP Hewell advising that she believed her son to be mentally ill. She also informed them that P was not allowed to return to her address owing to the restraining order which had been put in place at Sandwell Magistrates Court. No acknowledgment of the letter was received from the Prison and the investigation panel have not been able to corroborate that the letter was written or received.
- 135 P's mother had previously tried to arrange to visit her son and when it was explained that she needed P's permission for this and he had refused, she had enlisted the help of the Prison Chaplain. Although the Prison Chaplain visited P at his mother's request, P would not complete the required documentation to allow his mother to visit him. His mother believed that this was because he was mentally ill.
- 136 On 9 October 2012 the panic alarm, which had been in place at P's mothers' home address was removed by the Police. This was despite the fact that although P was in custody he was due for release on 15 October 2012. There was no rationale for the alarm to be removed or any evidence of a re-assessment of risk to P's mother and his family.

- 137 P was released from HMP Hewell on 15 October 2012. Healthcare had provided him with three days' supply of anti-psychotic medication (Olanzapine). The GP was not notified of his prescribed medication, his release from Prison or of P's identified physical and mental health needs. P had declined to accept a copy of his Inmate Medical Record (IMR) produced from System1.
- 138 On his release from Prison on 15 October 2012, P's mother went to collect him. She stated that she believed P was the 'best he had been'. She described him as, 'healthy, clean and in a better state of mind'.
- 139 A Police report documented that at approximately 21:20hrs on 20 October 2012 P was found by Police crouching down next to a secure parked vehicle in a small car park next to Walsall Police Station. Police Officers approached P and spoke to him and recorded that he appeared to be suffering from some sort of mental health condition. The Officers questioned him about why he was on Police property, but P made no response that could be understood. P was holding a small temperature gauge in his hand, which he then threw across the car park. He was searched and found to be in possession of a Class A drug (Cocaine) and 7 wraps, which P stated contained Cannabis. Police Officers noted that the rear windscreen wiper to the car had been pulled away from the screen, but was not damaged.
- 140 P was arrested on suspicion of possession of Class A drugs and vehicle interference and was transported to Bloxwich Police Station, where his detention was authorised. It was recorded that P made a 'no comment' interview. He was assessed twice by the Forensic Physician. Firstly, he was found fit to be detained, but not interviewed or charged. He denied self-harm or suicidal issues. At the second assessment P was found fit to be detained, interviewed and charged. It was stated that P did not need to be 'sectioned' and there was no need for further mental health assessment. P said he had self-harmed nine months previously, but he no longer had those thoughts. P denied any alcohol issues.
- 141 P appeared at Walsall & Aldridge Magistrates Court on 22 October 2012 and pleaded guilty to interfering with a motor vehicle. He was remanded into custody and transferred to HMP Birmingham to serve an additional 28 day custodial sentence for vehicle interference, with an 11 week sentence for re-offending whilst on license, which meant that the total time to be served in Prison was 105 days. (He served 59 days). There is no record of P being charged with drug offences on this occasion.
- 142 On admission to HMP Birmingham P was screened by a general nurse employed by Birmingham Community Healthcare Trust, who referred him for a first night mental health assessment because of concerns about his mental health. He was considered to be high risk, based on a Cell Sharing Risk Assessment (CSRA). P denied any mental illness or engagement with mental health services. He had appeared generally quiet, but otherwise nothing untoward was noted. According to P-NOMIS, P declined his free two minute telephone call.

- 143 The following day P was seen by the Primary Care Mental Health Team. He was said to be timid and quiet with poor eye contact and minimal responses to questions. He was discussed at the MDT where he was referred on to the Mental Health In-Reach Team. On 24 October 2012 an In-reach nurse key worker was allocated. P-NOMIS indicated that P was not participating in the second day induction and recorded that a short term resettlement plan was opened. (P was recorded in P-NOMIS as being ineligible for a home detention curfew on 21 November 2012 as he did not pass the eligibility checks).
- 144 Two days later, P was seen by the key worker. Again P was found to be quiet and was considered vulnerable for a Prison setting, though he was not said to be distressed.
- 145 Prison records show that P attended no activities whilst in HMP Birmingham and kept himself to himself. There is no record of any visits during his stay, or of any correspondence being received, or sent. Although P's mother stated that she had contacted the Prison Chaplain in an attempt to get help to visit her son, no entries have been found in the chaplaincy logs and there are no entries in P-NOMIS made by the Prison Chaplain. This is not to say there was no contact by P's mother, but nothing is recorded from that time and it would seem this is not uncommon.
- 146 P was discharged from the Primary Care Mental Health Team and fully handed over to the Mental Health In-Reach Team on 30 October 2012. P was scheduled to be assessed by the Consultant Psychiatrist on 7 November 2012, but he was not seen and this was recorded as a DNA (Did Not Attend). The reason for the DNA has not been ascertained. HMP Birmingham report that with regard to appointments with the Psychiatrist, prisoners are notified in advance that an appointment has been made. A Prison officer then goes to the prisoners' cell to escort him to healthcare. If the prisoner refuses then it is marked as 'did not attend' (DNA). It is possible for a prisoner to have left his cell to have gone out on general association and consequently not be there. If not nearby, the assumption will be that he is choosing not to attend.
- The Head of Offender Healthcare, HMP Birmingham, reported on interview that the DNA rate for appointments in HMP Birmingham was a significant issue and was around 50%. Sometimes Prisoners moved Wings and their appointment details did not necessarily follow them.*
- 147 P was discussed in the MDT on 13 November 2012 and it was recorded that he was difficult to engage and P denied any mental illness. A further appointment was made for P to see the Consultant Psychiatrist on 21 November 2012.
- 148 P was seen again by the In-Reach nursing team on 19 November 2012 and it was noted that he would be discussed in the next HMP Birmingham MDT. There is no record available of this MDT being held and this does not appear to have taken place.

*Email correspondence from HMP Birmingham to the investigation panel stated that, "the MDT on 20 November 2012, did not go ahead as planned as the Consultant Psychiatrist was required elsewhere, so a full discussion regarding every patient did not take place".*

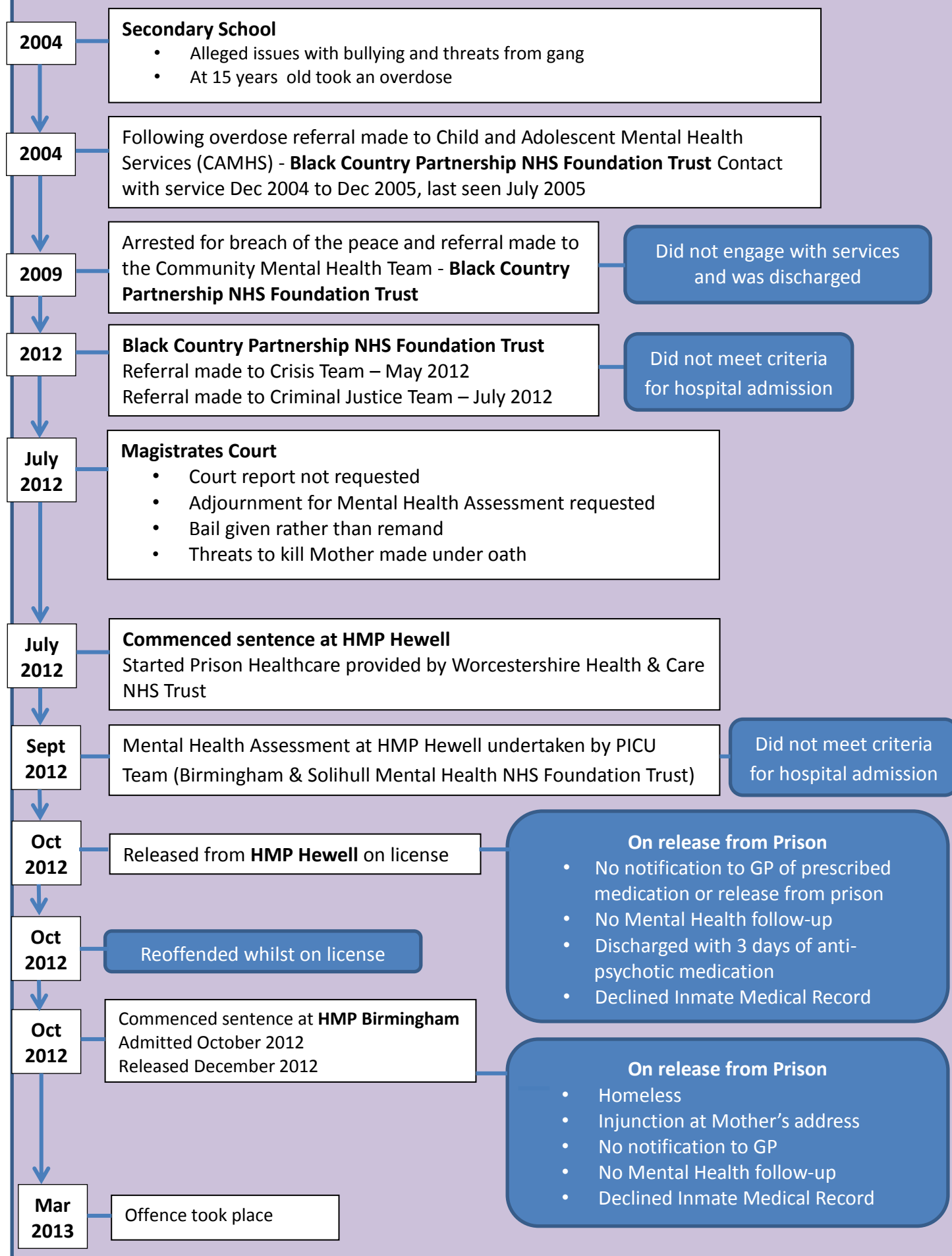
- 149 On 21 November 2012, P did not attend his appointment with the Consultant Psychiatrist and no reason for this is recorded in Prison healthcare Systm1 notes.
- 150 There is reference on Systm1 to an incident involving P that occurred on the Prison Wing on 28 November 2012. This incident apparently required the use of control and restraint (C & R) techniques to be applied by Prison officers. No injuries were noted or observed and no detail of what occurred is recorded in Systm1 records or available in P-NOMIS. The Duty Governor log for that day was reviewed. Whilst it shows there was a disturbance on the wing on that day, P was not listed as being involved and was not subject to C & R procedures. It is possible that P could have been encouraged back to his cell, but this does not cross the threshold for C & R recording by Prison officers.
- 151 P was seen on 5 December 2012 for review by his nurse key worker. P continued to deny any symptoms of mental illness and could not recall why he had been seen by the BSMHFT PICU Team whilst he was in HMP Hewell. Subjectively P stated that he was "ok". A further planned appointment was made for P to see the Consultant Psychiatrist on 12 December 2012.
- 152 P was seen jointly by the Consultant Psychiatrist and his nurse key worker from the In-Reach Team on 12 December 2012. When assessed, P denied any previous contact with mental health services, or hospital admissions. He said he was not hearing voices or having any abnormal experiences. He was not keen to discuss any problems and communicated in a few syllables and nods. It was difficult to engage him in any meaningful conversation. No active or acute problems were noted or any immediate risk of self-harm or suicide perceived. P remained very guarded in his engagement style.
- 153 It was recorded that the plan was to continue with his care and link with the BSMHFT Homeless Team on his release. P told the Consultant Psychiatrist that he had another few weeks to serve in Prison and the Consultant Psychiatrist had planned to read P's medical notes. However P was released from HMP Birmingham custody the next day. There is no recorded evidence that P's medical notes were reviewed before his release.

*On interview, the Head of Offender Healthcare in HMP Birmingham stated that if someone was being released directly from Healthcare in Prison, and they were resident in the local area, then a Home Treatment Team (HTT) would be asked to engage with them. P was never admitted to Healthcare in HMP Birmingham, so there was the issue on his release of not knowing where he was going, and of P not providing the information.*



- 154 HMP Birmingham Healthcare staff were not aware of P's imminent release from Prison when they assessed him on 12 December 2012. P was released on 13 December 2012 as an automatic unconditional release with no follow-up arrangements for his physical or mental health and well-being.
- 155 On his release he was seen by a general staff nurse from Birmingham Community Healthcare Trust. It was recorded, incorrectly, that P had no GP. The GP received no information from the Prison. It was recorded in Systm1 that P had no outstanding appointments, but had been seen by the mental health In-Reach Team whilst in Prison. He was noted to be inappropriately dressed in a sleeveless T-shirt and was reported to be very guarded and nervous looking. He declined a copy of his IMR.

### 3.4 Significant Events Flowchart



### **3.5 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).

#### **4.1.1 Information shared between HMP Hewell and HMP Birmingham**

Information relating to Prisoners in HM Prisons is stored electronically on the Prisoner National Offender Management Information System (P-NOMIS). Information held in offender healthcare in HMP Hewell and HMP Birmingham is stored on Systm1. Systm1 is a national healthcare record system used in all HM Prison healthcare centres in England & Wales. In addition, it is noted that some private Prisons are developing their own electronic records systems.

Both electronic recording systems, P-NOMIS and Systm1, provide a chronological recording of entries and events for each Prisoner. Information not on Systm1 or P-NOMIS would include a Prisoners' Wing Observation file. This is a handwritten document completed by Prison officers on the wing on a daily basis.

P was in HMP Hewell in May 2012 for a 4 week sentence and again from July to October 2012. On the second occasion he was in offender healthcare and receiving treatment under the care of a Forensic Specialist Registrar, supervised by a Consultant Forensic Psychiatrist. Clinical records were made on Systm1 and included the MDT meeting notes.

When P was subsequently imprisoned in HMP Birmingham in October 2012, the healthcare staff had access to the entirety of his Systm1 records relating to his previous healthcare at HMP Hewell. This was confirmed by entries made on Systm1 in the first few days by healthcare staff during the reception and mental health screening processes. The MDT records were kept separately and not included in Systm1, but they were made available to the investigation panel.

The MDT records from HMP Birmingham on 23 October 2012 document that P was considered to be mentally unwell and had been referred to BSMHFT PICU whilst previously in healthcare at HMP Hewell. It also details the first night assessment at HMP Birmingham and that the nurse undertaking the first night assessment was present at the subsequent MDT meeting. A Consultant Psychiatrist was also at the MDT meeting, but this was not the Consultant Psychiatrist who later assessed P, as at that time that Consultant was working on a part time basis.

There is nothing to suggest that there was any discussion or liaison between the healthcare staff at HMP Birmingham and the healthcare staff at HMP Hewell.

Although the HMP Hewell healthcare records were looked at in the earliest stage of his detention at HMP Birmingham, the Systm1 notes do not suggest that they were studied in sufficient detail by the In-Reach Team. It took almost three months for P to be seen by a psychiatrist and there was a plan recorded to study his notes after that appointment, but he was released the next day and there is no evidence to indicate a review of the notes took place.

In conclusion, the healthcare information from HMP Hewell was immediately available to healthcare staff in HMP Birmingham. However, evidence presented to the investigation panel indicated that this was not sufficiently examined by the In-Reach Team or Consultant Psychiatrist. The reasons for this are unclear. The investigation panel concluded that as a result there were missed opportunities to review the available records and build upon the mental health assessment of P undertaken at HMP Hewell. Had P seen the Consultant Psychiatrist at HMP Birmingham in a timelier manner there would have been a greater opportunity for him to review the notes prior to P's release. This would have made it more likely for P to have received appropriate treatment, including aftercare.

There was a failure of HMP Birmingham In-Reach staff to make direct contact with healthcare staff at HMP Hewell who could have provided valuable information in respect to P's mental health. Had they done so this could have led to P undergoing more thorough assessment and potentially re-commencing treatment with anti-psychotic medication.

It was noted by the investigation panel that there were differing ways of recording the MDT meeting minutes and the panel was of the opinion that these should be available within Systm1. A standardised approach to record keeping within Prisons should be developed and shared nationally. It was of concern to the investigation panel that information within P-NOMIS did not consistently tally with information recorded on Systm1 and was not regularly reviewed by healthcare staff to inform risk assessment and release planning. In addition, the panel were concerned to learn that some Prisons were developing additional systems introducing further complexity and potential opportunities for communication failings.

#### **4.1.2 Information presented by P's mother to the Prison authorities**

The mother of P was unable to ascertain where her son had been placed following the Sandwell Magistrates Court case in July 2012. She enlisted the help of the Independent Domestic Violence Advisor at Sandwell Women's Aid, who was able to determine that her son was detained in HMP Hewell in Redditch, Worcestershire.

Shortly after his reception into HMP Hewell P gave his mother's telephone number and permission for her to be contacted to the Forensic Specialist Registrar, who noted this as a task for nursing staff to progress. Within 24 hours (15 July 2012) a member of nursing staff attempted to contact P's mother unsuccessfully and recorded that a further attempt would be made later that day, but there was no record found of it taking place. If this contact had been established it would have been a valuable opportunity to gain information about his mental health and risk history, alleviate his mother's concern and may have helped to maintain a relationship between P and his mother during his detention.

P's mother gave evidence to the investigating panel that she subsequently wrote a letter to the Prison Governor at HMP Hewell outlining her concerns for her son. She stated that she notified the Prison authorities that he was unable to return to her home address on release from Prison. She said she did not receive a response from the HMP Hewell Prison Governor. This letter has not been located by either Prison during the course of the investigation.

*The Head of Offender Healthcare at HMP Hewell stated on interview that he was not aware of receipt of the letter from P's mother, and it had not been discussed at the Multi-disciplinary team (MDT) meeting.*

The HMP Hewell Prison Governor reported that the letter would probably have been transferred to HMP Birmingham with P's Core record, which is part of the offender management file, when P was detained there in October 2012.

In order to facilitate access to HMP Birmingham and HMP Hewell's Prison records, one of the investigation panel members (Head of Public Protection) was able to visit HMP Birmingham and meet with one of the G4S Directors and the Deputy Controller. He was able to review the

information held relating to P in his Prison records. He was also able to examine the Prison Chaplaincy records and Governor Logs.

Neither the paper record, nor the P-NOMIS electronic case management system had any note of correspondence from P's mother to the Governor at HMP Hewell. This is not to say that it was not received, but mail of that nature is not routinely recorded unless it is very specific, for example, identifying a risk of self-harm.

*On interview P's mother stated that when P was incarcerated in HMP Birmingham, she contacted the Prison Chaplain in an attempt to gain a visiting order to see her son.*

P's mother was informed that her son had to request a visit, but P did not want to see her. The Prison Chaplain went to see P to help him to complete a request for an order to be made, to no avail. P's mother did not manage to visit P in HMP Birmingham.

P's mother wanted to know her son's whereabouts when he was in Prison and to continue to see and support him. Seeking corroborative history from an informant, such as P's mother, was considered at HMP Hewell, but unfortunately was not achieved after one failed telephone call. P's mother would have been able to provide valuable information about his mental health and be reassured he was receiving healthcare. The importance of the family involvement in giving information for longitudinal assessment should not be under-estimated. Further, having a maintained positive social network would be likely to act as a protective factor for reducing the risk of future violence.

The absence of evidence of correspondence and contact with the Prisons from P's mother does not mean it did not take place; but that the systems for recording correspondence and telephone contact did not appear robust. The existence of two case management recording systems (P-NOMIS and Systm1 healthcare records) was a further complication. Where a letter may have impact on a Prisoner's health assessment and care, the letter should be routinely cross referenced with Systm1 records and made available to relevant offender health staff, but the investigation panel were not confident that the process for this to be achieved was reliable.

Information from the Prison Chaplaincy about declining visits from his mother was not recorded and readily available for healthcare staff. When a Prisoner has a mental disorder and is declining visits from family there should be consideration by healthcare of the person's capacity and whether further action or support is needed.

#### **4.1.3 Information shared between the Black Country Partnership NHS Foundation Trust and P's GP**

P had a GP from October 2002 to early in 2008 and then he changed to the GP, who was his primary healthcare provider at the time of Christina's death.

BCPFT CAMHS informed the GP by letter of their interventions with P whilst he was being seen in the CAMHS service between 2004 and 2005. GP records indicate that all such communication was received. The GP was also notified by letter when P was discharged from the CAMHS service following the failure of P to attend two further offered appointments in 2005.

When P was referred to the BCPFT Primary Care Liaison Team in March 2009, the GP was notified when P made no response to the 'opt in' letter sent to him by the team. The GP was also notified that the case had been closed, when they had not received a response from P within 14 days, as specified in their letter.

*On interview, the GP stated that the policy of sending out an [opt-in] letter asking a patient to make contact is wrong. He felt the patient should be contacted by them personally and further, that if someone did not engage, then the team should come back to the GP to discuss the way forward.*

There is no record of any verbal communication with the GP regarding the referral of P and his not having been assessed, nor is there any correspondence with the GP to offer P a further appointment. The GP in return did not contact the BCPFT Primary Care Liaison Team to discuss the case or make a re-referral.

*On interview, the GP stated that he had very little personal involvement with P and the GP practice had no contact with P after 2009.*

The Crisis Team assessed P in Sandwell Magistrates Court on 17 July 2012 and wrote a letter to the GP informing him of the assessment and indicating the outcome. The GP was notified of the following:

- P was on remand for on-going Court proceedings
- P was assessed under the Mental Health Act, but did not meet the criteria for compulsory detention
- P had mental capacity with regard to the charges
- P was given a custodial sentence
- P would need on-going mental health input

The GP had, therefore, been notified that P had received a custodial sentence, but was not aware of the length of the custodial sentence, nor informed of his release from Prison.

In conclusion, the investigation panel noted that whilst the BCPFT CAMHS Team initially wrote to P's GP to confirm that they had engaged with P during 2004 to early 2005 and shared their impressions of his mental state, they could have engaged more with P's GP when P eventually stopped attending. The investigation panel felt that this was a missed opportunity and that

further discussion with the GP at that time could have potentially served to re-establish P's contact with specialist mental health services.

Review of P's contacts with mental health services made it clear to the investigation panel that P had recurrent issues in respect to engagement with services, possibly because he failed to recognise his own mental health issues. Therefore, practices such as offering P 'opt-in' letters and expecting him to make contact independently within mental health services was likely to have a poor outcome. However, this approach was utilised repeatedly by services e.g. when P was referred to the BCPFT Primary Care Liaison Team in March 2009 and later by the Prison services when P was expected to independently make contact with his GP post-release.

In light of this observation, the investigation panel makes recommendations for all services to consider whether there is an over-reliance on mental health patients to facilitate their own service contact. There is also a need to review those individuals who have a known history of disengagement and to work with other agencies, including the patient's own GP, to ensure more robust mechanisms for establishing and maintaining service contact.

#### **4.1.4 Communication of the decisions by services not to treat, prior to P's admission to HMP Hewell in July 2012**

P was assessed in Sandwell Magistrates Court on 11 July 2012 by the Criminal Justice Team (CJT) from the BCPFT. The concerns about P's mental health were communicated to the Court by the CJT, who recommended that further assessment should take place. The Court was apparently minded to accept the plan to remand P, but in the absence of custody escorting staff he was released into the community on bail. There were then active communications with the CJT, Probation and the Independent Domestic Violence Advisor (IDVA), who were concerned by the outcome, given P's presentation and perceived risk. There was subsequently liaison with relevant people including the Police, his mother, HMP Hewell and the Crisis Team.

When P failed to answer bail on 12 July 2012 there were further communications by the CJT and IDVA, including to; the CPS, Public Protection Unit, Crisis Team, 'Access Sandwell', Safeguarding, Governance (Walsall), Walsall Communication Team, BCPFT Risk Management Team and the BCPFT Legal Advisor. The extent of the communications, including within BCPFT, appeared to demonstrate the gravity of the concerns by the CJT and the need to escalate that concern to relevant services.

Following the MHA assessment by the Crisis Team, which decided that P was not detainable under the Mental Health Act, there was communication to the Court and to his GP in writing. This confirmed that P needed on-going mental health input. A verbal report was given to the Forensic Specialist Registrar at HMP Hewell, his mother and the Crisis Team Manager. A copy of the MHA assessment paperwork was sent by fax on 18 July 2012 to HMP Hewell, as requested by the Forensic Specialist Registrar.



Whilst some of the decisions in Court can be questioned, communication by BCPFT was good in relation to this episode. In particular, following the release of P on bail on 11 July 2012, significant efforts were made by members of the CJT, in collaboration with others, to alert services/agencies to the risk P may pose to his mother and concerns about his mental health. This resulted in his mother being able to receive advice on protective measures, such as to lock her doors and windows and for the Police to be alerted and fit an alarm. However, it is not clear what actions were taken by all the parties contacted and whether a safeguarding alert was raised in relation to his mother and siblings. It was recorded that the Safeguarding Team at BCPFT were contacted on 12 July 2012 when P failed to arrive in Court. The investigation panel did not see or hear evidence to support that a safeguarding alert was completed and P's mother did not report contact at this time from Social Services. There were potential on-going significant risks to his mother and younger siblings, which were not addressed via direct support to P's family.

#### **4.1.5 Information sharing relating to the release/discharge from HMP Hewell in October 2012**

On 15 October 2012, P was released from HMP Hewell (Offender Healthcare). He had been in HMP Hewell healthcare and receiving treatment, including anti-psychotic medication, under the care of a Forensic Specialist Registrar, (who was supervised by a Consultant Forensic Psychiatrist via an MDT), for three months. Although an administrative assistant in HMP Hewell healthcare had managed to identify the name of P's GP and this had been recorded in the progress notes by the Forensic Specialist Registrar within Systm1, it was not included in his demographic details in the registration section. The GP was not notified by the prison of P's incarceration in HMP Hewell, nor copied into any correspondence with the BSMHFT PICU team. The GP was not alerted to concerns about P's mental health, or notified of his release from Prison.

P was discharged with three days' supply of medication, the expectation being that he would go to his GP for a further supply. There is no record of whether he was offered, or refused, a copy of his Inmate Medical Record. P did not go to his GP and as his GP had never been notified of his release from Prison, or of any prescribed treatment regime, he was therefore not aware of any requirement to prescribe medication for P. P's Systm1 records make reference to follow up being arranged, but no letter to his GP could be identified. Following P's release from HMP Hewell, the GP would also not have been aware of the address to which P had been released.

Following a referral, P was not admitted to the PICU, and follow-up with a Home Treatment Team was not arranged by either the BSMHFT PICU or the Prison.

*Both the Head of Offender Healthcare in HMP Hewell and the BSMHFT PICU higher trainee (ST-5) doctor stated on interview, that they each believed it to be the responsibility of the other to have made the referral for community mental health follow up.*

There was no verbal conversation to support the above assumption either way. There had been no verbal contact attempted between the two doctors throughout the referral process, despite there being a professional disagreement about the assessment and presentation of P. The Forensic Specialist Registrar at HMP Hewell did not consider community supervision to be the preferred option and the HMP Hewell team had firmly disagreed with the outcome of the BSMHFT PICU assessment. The MDT at HMP Hewell believed that the longitudinal assessment of P, whilst he was at HMP Hewell, had shown P to be psychotic and requiring assessment and treatment in hospital.

In response to the verbal outcome of the PICU assessment, a letter dated 8 October 2012, was sent to the PICU ST-5 assessing doctor, from the Forensic Specialist Registrar at HMP Hewell, requesting a re-assessment for admission. In the letter was a request that a referral be made to a Home Treatment Team by the PICU at BSMHFT, should P not, in their opinion, meet the criteria for psychiatric hospital detention.

This letter was sent 7 days before P's planned release date of 15 October 2012. Again, there was no verbal discussion between the two doctors and despite reference to the request of a referral to a Home Treatment Team, no address for P on release from Prison, or details of his GP, was stated in the letter. The PICU ST-5 doctor did not follow-up the re-assessment request, but instead faxed the original letter back to the Forensic Specialist Registrar and did not discuss the second letter with his supervising Consultant Psychiatrist or in the MDT. It was not routine practice to discuss such referrals in the MDT.

Guidance relating to the release and/or discharge of Prisoners is governed by a Ministry of Justice Prison service order **PSO 3050. Chapter 7, Release – discharge** states the following:

*'Where a Prisoner approaching release has mental health problems and does not already have a community based care coordinator, healthcare services in the establishment MUST consider whether there is a clinical need to make a referral to the local community mental health team. In some establishments, some other healthcare staff will be able to do this by referring the Prisoner to an in-reach team from a mental health Trust'.*

It may be that, had the referring doctor and the doctor undertaking the assessment discussed the case and their concerns, there would have been some joint understanding of the need for continuing mental health care and all options to secure continuity of care could have been discussed.

P's GP details were recorded within his Systm1 records; however they were not easily identifiable when P was released, owing to the fact that it was not recorded in the correct/usual place. The medical records did not consider P's capacity for consent for the release of information to his GP. As information concerning his mental health was not relayed to P's GP on his release, the requirement for continuity of treatment was unknown. Had the GP been in receipt of this information, the GP may have had the option of referring P to a

local HTT, or Early Intervention Service, and/or prescribing P the anti-psychotic medication he had been receiving for the previous three months whilst he was in Prison.

Concerns had been raised relating to a physical matter whilst P was in Prison. A note was made to say that if P was released prior to repeat testing, then P would need to sort this out with his own GP. The HMP Hewell GP asked that P be given a copy of his results on release for this purpose which did not happen.

PSO 3050 states that, *'through their contact with community health providers, healthcare staff are usually able to identify appropriate referral routes for individual Prisoners, aimed at maintaining continuity of health care on release. It is important that the healthcare centre is actively involved in planning for the discharge of all Prisoners where health care needs have been identified, so that adequate referral arrangements can be made and that the Prisoner can be told what these are. Where a Prisoner is receiving medical care which needs to continue after discharge, it is important, as set out in the Transfer and Release Section of the Health Services for Prisoners Standard, that information to ensure continuity of care is communicated, with the Prisoner's consent, to his or her GP and/or other responsible community agencies on discharge'*.

#### **4.1.6 Information sharing relating to the release/discharge from HMP Birmingham in December 2012**

The release of P from HMP Birmingham was said to be unexpected and at short notice. P had previously had two appointments scheduled to be seen by a Consultant Psychiatrist, which he did not attend. These are both recorded as DNA, but the reason for his non-attendance is not specified, e.g. it is not implied that he refused to attend.

*During interviews with Prison healthcare staff, it was noted that It took almost 3 months for P to see a psychiatrist. This was acknowledged to be longer than was normal.*

P was seen by the HMP Birmingham Prison In-Reach Team and the Prison Consultant Psychiatrist on the day before his release, (12 December 2012), but a comprehensive understanding of his previous assessments and treatment was not achieved by the time of his release. A note was made on Systm1 to 'link with other team on release', however it is not made clear in the records to which team this referred. That 'link' was never made and P was released the following day.

*Interviews with HMP Birmingham Healthcare staff have confirmed that the reference was intended to be to the BSMHFT Homeless Team.*

P's GP had been identified in HMP Hewell and recorded in the body of his Systm1 notes, but his Systm1 progress note recorded that he had no GP on discharge. The GP details were not

appearing in his demographic information. The GP was not notified of his release from HMP Birmingham and was not alerted to the concerns raised during his time in Prison.

Prison records state that P was spoken to early on about his release/discharge plans and P indicated that he would be returning to the Walsall address. As part of the routine prison process at that time, P was asked if he needed to secure housing benefit to retain this address and P had confirmed that he did. Housing benefit forms were completed by the prison and sent to the Walsall housing benefit office. This was a standard routine process. As a result the system showed him as having accommodation on release/discharge and he left Prison with a £46 discharge grant.

The address that P gave was in fact a bail address and as it was just a normal sounding address, it was not questioned. He was subsequently regarded by the Prison system as having an address to go to.

The Prison information regarding an address was not mentioned by the nurse assessing him in reception on his release, who had him recorded as no fixed abode (NFA). It was documented that he would be staying with a friend in Birmingham. The differing versions of events within HMP Birmingham would not have assisted with release/discharge planning for P, or receiving agencies.

#### **4.1.7 Information sharing relating to the assessment made for hospital admission to a PICU on 20 September 2012**

The Forensic Specialist Registrar, at HMP Hewell had referred P for an assessment for a PICU bed at BSMHFT in August 2012. A note of this request was made in the healthcare records, but this, however, went unnoticed for a month before the letter was actually sent. There was then some confusion at the BSMHFT PICU regarding receipt of the initial referral letter from HMP Hewell and where it had been sent, as it had not been received by the clinical team. It subsequently had to be sent a second time by fax. The second letter was received and the assessment was arranged for 20 September 2012.

The ST-5 doctor undertaking the Prison assessment had never undertaken a Prison assessment before. He was accompanied by the PICU Ward Manager, who had been in post for one year and had only previously undertaken one such assessment.

It would appear that no prior information was sought or collected by staff undertaking the assessment at HMP Hewell, though the original HMP Hewell letter had stated that further information was enclosed with the (original) letter.

*On interview, the Head of Offender Healthcare at HMP Hewell reported that a qualified mental health nurse from HMP Hewell healthcare was present throughout the BSMHFT PICU*

*assessment and provided open access to the Systm1 records for the assessing team.*

At the assessment undertaken by the PICU team, BSMHFT staff recalled being given a hand-out of Systm1 notes for the previous 3 to 4 weeks.

*On interview, the PICU Deputy Ward Manager stated that the Prison records were made available on a computer whilst staff went to fetch P and that the HMP Hewell Nurse did not stay during the assessment.*

Contemporaneous notes were not taken by medical or nursing staff from the BSMHFT PICU team during the assessment of P at HMP Hewell. Following the PICU assessment, the Forensic Specialist Registrar in HMP Hewell, expressed his disagreement at the MDT meeting with the verbal outcome of the PICU assessment, which had been shared with Prison staff. He wrote another letter to the BSMHFT PICU ST-5 doctor to make it clear that he did not agree with the outcome of the assessment and requested a further assessment be undertaken. There were no telephone calls or direct contact made between the doctors. The PICU ST-5 doctor received this second letter, which requested a re-assessment, but did not arrange a further assessment and did not discuss the letter, either with his supervising Consultant or in the PICU MDT. It should be noted that neither doctor copied any correspondence to P's GP.

*On interview, BSMHFT PICU staff stated that external referrals were not routinely discussed in the MDT.*

The PICU ST-5 doctor resent the original response letter to HMP Hewell, assuming that the first had not been received and arranged no further assessment of P or any release/discharge arrangements.

P was not registered electronically on the BSMHFT patient information system (RIO), therefore neither the referral letter, nor the letter relating to the outcome of the assessment, was recorded electronically. This meant no-one else had direct access to the information and no-one in BSMHFT would be aware that P had been assessed in HMP Hewell by the BSMHFT PICU Team, with the exception of the team.

RIO was BSMHFT's designated electronic storage for the professional contemporaneous notes of the assessment of P at HMP Hewell by the PICU team, had notes been taken.

A further concern identified, in terms of record-keeping, was the report to the investigation panel that PICU staff often typed their own letters and the letters were not subsequently centralised in a single location via administrative staff on RIO or elsewhere.

In the absence of an electronic record, it could have been expected that there would be a paper file storing information in relation to P's assessment, but there was not.

## **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.

### **4.2.1 Care and treatment received in relation to P's physical health in HMP Hewell**

On entering HMP Hewell on the 21 May 2012 P underwent a routine health screening and there was 'no concern' noted regarding his physical health. On 22 May 2012 it was recorded that his weight was 49kg and he had a Body Mass Index (BMI) of 16.71, which was very low, in contrast with his earlier BMI when he registered with his GP. Additionally, it was reported that P was, 'continually reaching to his shoulder and neck area as though there was some sort of irritation there'.

When it was discussed with P about some of the physical symptoms he had been experiencing, P admitted that he had been using 'Khat'.

On 14 July 2012, P was seen by the Forensic Specialist Registrar. P was weighed and an ECG and routine bloods were requested to be undertaken. P was described as being very emaciated. P described his weight as, 'normally around 50kg'.

It was recorded that P's BMI was below the recommended index mark and he was referred to the Prison GP for assessment for dietary supplements. P was encouraged to drink extra fluids, and a care plan for monitoring his diet and fluid intake was put in place. It was recorded that his weight would be monitored on a weekly basis and that he was at risk of dehydration and nutritional compromise. A care plan was developed which was to include:

- Weekly monitoring of weight
- Recording of BP and pulse (and blood sugar levels if there were prolonged periods of food/fluid refusal)
- Daily review by Prison GP
- Monitoring and recording of visual appearance of mouth/skin condition
- Active encouragement of fluids and diet. (To record all fluid and dietary intake including refusals, and ensuring that food is offered at meal times *and* in between these times)

His routine bloods were taken and results obtained. It was noted that P appeared physically weak.

On 18 July 2012, an ECG was requested and the following day P commenced on food supplements. P was said to be eating well and was accepting his supplements. It was recorded that at times he needed prompting as his dietary intake was erratic, but he did respond to encouragement.

In the MDT meeting on 19 July 2012, concerns were raised regarding P's diet, but by the following week his weight had increased by 3kg to 52kg and within 4 weeks it was recorded that P's weight had increased to 54.5kg.

Healthcare staff continued to make daily entries with regard to whether P accepted diet and fluids and monitored his weight as planned. P made good progress and by September 2012 his Body Mass Index had increased to 19.25.

On 27 September 2012, P was seen by the Prison GP and a physical health issue was recorded and a plan was made to repeat the assessment in 3-6 months' time. A note was made to say that if P was released by then, he would need to address with his own GP and therefore the Prison GP asked that P be given a copy of this specific information on his release.

On 1 October 2012 the BSMHFT PICU Team, who had assessed P, had recorded a query of P having a specific eye movement issue. As P was due to be released within two weeks, it was noted by HMP Hewell that P would be asked to consult his own GP about this on release, to enable follow-up and investigation.

On release from HMP Hewell, P weighed 62.25 kg and his BMI was 20.1. This was an increase in weight of 13.25kg and increased BMI of 3.4.

Whilst P appeared to receive good care and treatment in relation to his physical health at HMP Hewell, no information relating to P's physical health was provided to his GP on his release despite specific concerns having been identified.

#### **4.2.2 Care and treatment in relation to P's physical health in HMP Birmingham**

P was recalled to Prison and entered HMP Birmingham on the 22 October 2012, where he had a reception screening undertaken. It is recorded that P had 'no concerns over his physical health'. This contradicted the HMP Hewell Systm1 entries which had, for example, made reference to his low weight, concern over his eye movement and a health issue which needed to be re-investigated.

In response to the question as to whether P had a physical health condition, the reception record stated 'no', but the earlier Systm1 entry had suggested otherwise.

The screening tool recorded that P had been in HMP Hewell 'a few years ago', when in fact he had been in HMP Hewell 7 days previously. No detailed physical observation screening was recorded or apparent, including no record of his weight and/or BMI.

The Primary Care Mental Health Gateway Worker saw P on the 23 October 2012. This entry clearly indicates that the Systm1 records from HMP Hewell were available. The Gateway

Worker wrote a brief summary of P's time in HMP Hewell healthcare, which included the referral, assessment and outcome of the BSMHFT PICU assessment.

There is no reference to any physical health assessment at the time of P entering HMP Birmingham. Between the first entry on HMP Birmingham Systm1 and the first to make any reference to P's physical health, there were 18 entries.

There are few significant Systm1 entries that relate to P's physical health whilst in HMP Birmingham; though it should be noted that P was not in healthcare whilst in HMP Birmingham. The GP had been identified whilst P was at HMP Hewell and recorded in the Systm1 record, but no information went to his GP from HMP Birmingham.

P's weight on release was recorded as 59kg.

### **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 GEOAmeY's 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. According to the CPS the 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 CPS have reported that 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.

<b>Table 4 - Recommendations</b>	
<b>Organisation: Black Country Partnership NHS Foundation Trust</b>	
1	<p>BCPFT should ensure that there is a clear operational policy in place for the Criminal Justice Team. This document should outline:</p> <ul style="list-style-type: none"> <li>• roles, responsibilities and accountabilities within the team</li> <li>• guidance on undertaking risk and mental health assessments</li> <li>• agreed standards of record keeping and documenting outcomes of assessments</li> <li>• processes for information sharing with the wider MDT, GP and other internal and external services/agencies</li> </ul>
2	<p>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.</p>
3	<p>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.</p>
4	<p>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.</p>
5	<p>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:</p> <ul style="list-style-type: none"> <li>• the use of 'opt in' letters</li> <li>• engagement with carers prior to the patient's discharge</li> <li>• communication with the patient's GP</li> </ul>
6	<p>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</p> <ul style="list-style-type: none"> <li>• recognition of psychotic features (across all age groups)</li> <li>• the use of longitudinal risk assessment</li> <li>• hearing the voice of the Carer</li> <li>• implementation of the Mental Health Act</li> </ul>

**Organisation: Birmingham and Solihull Mental Health NHS Foundation Trust**

1	<p>BSMHFT should ensure that there are guidelines for PICU staff undertaking an assessment at a Prison. This process should include:</p> <ul style="list-style-type: none"> <li>• guidance on access to background information</li> <li>• who can/should undertake Prison assessments</li> <li>• risk assessment</li> <li>• Mental Health Act</li> <li>• agreed standards of record keeping and documentation information sharing with the wider MDT</li> <li>• supervision arrangements</li> <li>• what to do in the event of a re-referral</li> </ul>
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.

<b>Organisation: HMP Hewell and Worcestershire Health &amp; Care NHS Trust</b>	
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	<p>HMP Hewell (Healthcare) should review the local arrangements for requesting and managing physical and mental healthcare referrals and clarify:</p> <ul style="list-style-type: none"> <li>• roles and responsibilities</li> <li>• record keeping</li> <li>• system for production of correspondence, including administrative staff support</li> <li>• monitoring of timeliness of responses</li> <li>• noting and confirming follow-up arrangements</li> <li>• processes for escalating concerns</li> </ul>
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.
<b>Organisation: HMP Birmingham and Birmingham &amp; Solihull Mental Health NHS Foundation Trust</b>	
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: <ul style="list-style-type: none"> <li>• past identified diagnosis</li> <li>• past care and treatment management</li> <li>• past prescribed medications</li> <li>• past identified risks</li> </ul>
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.
<b>Organisation: General Practitioner</b>	
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.
<b>Organisation: West Midlands Police</b>	
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.
<b>Organisation: Social Services</b>	
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. <i>This recommendation should be passed to the Ministry of Justice for cross departmental consideration and would be relevant to all prison release/discharges.</i>
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.

## 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
System1	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

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16. Legal Aid, Sentencing and Punishment of Offenders Act (2012) *An Act to make provision about the legal aid, the sentencing of offenders, including provision of release, bail and about remand otherwise on bail*.
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18. Offender Rehabilitation Act (2014) *An Act to make provision about the release, and supervision after release, of offenders; to make provision about the extension period for extended sentence Prisoners; to make provision about community orders and suspended sentence orders; and for connected purposes*

### Investigation Panel Members

**Dr Alison Reed** (Chair) MBBS, MRCP, FRCPsych is a Consultant Forensic Psychiatrist working in Regional Medium Secure Services in Birmingham. She has over 25 years' experience of working in mental health, including in the settings of community, hospital, Police stations, Prisons and Courts.

Inherent to her role is the assessment and management of risk in mental health and the use of the Mental Health Act. As Clinical Lead, she also has additional management and leadership responsibilities including, clinical governance & learning lessons. She continues her interest in education and training, having formerly been a senior lecturer at the University of Birmingham, and Training Programme Director in Forensic Psychiatry.

**Nigel Byford** has worked within Probation for over 30 years following initial work with the voluntary sector and social services. His experience has included frontline and managerial experience in virtually all aspects of Probation work including periods of secondment within the Prison service. For the past 8 years he has been the lead Assistant Chief Officer for Public Protection in the West Midlands Probation Trust and subsequently merged Staffordshire and West Midlands Probation Trusts. He currently leads on Trust public protection policy with specific responsibilities for MAPPA, safeguarding children and adults approved premises, victims and seconded Probation staff in Prisons.

**Garry Billing** is currently Assistant Director for Safeguarding in the people directorate of Birmingham City Council. His primary role is strategic lead for child protection and children in care, and he also has oversight of the Local Authority Designated Officer service and children's rights and participation. He works closely with strategic lead colleagues across the directorate to ensure children across the city are safeguarded. Garry moved into his current role after leaving West Midland Police in December 2013. He served with West Midlands Police for 24 years and in the latter part of his service he was strategic lead for child abuse investigations in Birmingham. Garry is also a member of the Birmingham Safeguarding Children Board and the Serious Case Review Subcommittee. It is in his capacity as representative of the Safeguarding Board and agency representative of West Midlands Police that he joined the investigation panel.

**Elaine Thompson** is a Registered Mental Health Nurse who has worked extensively within a range of healthcare settings across the West Midlands. In 1997 she moved into working in Clinical Governance, taking a keen interest in patient safety and risk assessment. She became actively involved in policy development and staff training relating to the investigation and management of serious incidents, and took on the role of Suicide Prevention Lead, developing a number of related service based audits and strategies.

In 2011 she went to work at the West Midlands Strategic Health Authority where she continued her focus on patient safety and also undertook a lead role within mental health homicide investigations and domestic homicide reviews. Currently Elaine holds the position of Deputy

Chief Nurse and Quality Officer at Birmingham CrossCity Clinical Commissioning Group where she has worked since September 2013.

**Paul Illingworth** MA; BSc (Hons.); Dip Nursing; PG Cert Ed; RN has over 40 years' experience of working in the NHS, Prison Service College and Higher Education, 20 years at middle, senior & executive positions. He is a doubly registered nurse but most of his career has been related to mental health. He has a unique and extensive experience of clinical, operational, strategic, change & project management, quality assurance, independent homicide investigations/inquiries, NHS inquiries, Governor NHS Foundation Trust and Executive Board member. Paul has a vast experience of chairing meetings and conferences, conference and other public speaking, lecturing, facilitation, service & staff development and publishing. Paul is the former Head of School for Nursing & Midwifery at Birmingham City University, and is currently an Independent Nurse & Health Consultant.

**List of Stakeholders & Participating Organisations**

- Coordinating Clinical Commissioning Group – Birmingham CrossCity
- Birmingham & Solihull Mental Health NHS Foundation Trust – also providers of offender healthcare to HMP Birmingham
- Black Country Partnership NHS Foundation Trust
- Crown Prosecution Service
- HMP Birmingham
- HMP Hewell
- P's GP
- P's Secondary School
- Her Majesty's Court Tribunal Service (HMCTS)
- Sandwell Childrens Social Services
- Sandwell Womens' Aid
- West Midlands Police
- Worcestershire Health & Care NHS Trust – providers of offender healthcare to HMP Hewell