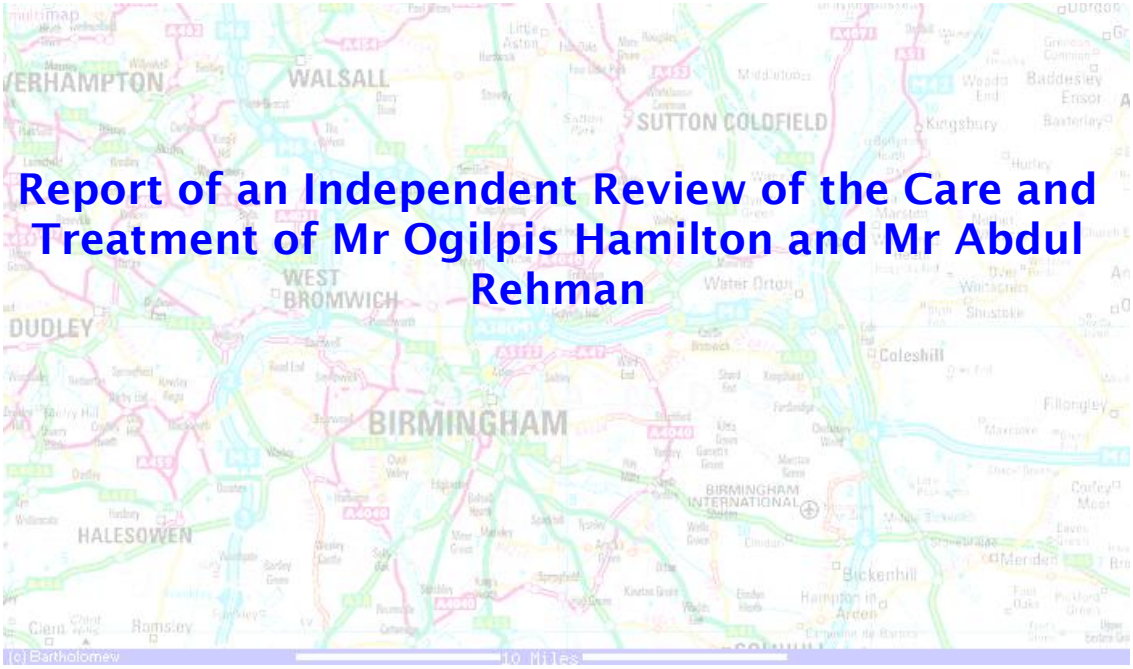


Report of an Independent Review of the Care and Treatment of Mr Ogilpis Hamilton and Mr Abdul Rehman

Commissioned by

Birmingham & The Black Country Health Authority

March 2004

FOREWORD

We have independently reviewed the care and treatment of two people in north Birmingham who were convicted of manslaughter on the grounds of diminished responsibility.

Our review was a further source of distress for the bereaved, and for the patients and their families. We particularly wish to acknowledge the way in which they helped us.

We also wish to acknowledge the candour and commitment of the professionals who cared for the patients. A constructive process is impossible without openness, but being open, when so many inquiries have been critical of individuals, took courage.

Such openness is to be encouraged, and is the ultimate test of professionalism. The mature professional who accepts that their practice, or local practice, can always be improved thereby ensures that the future direction of the service is based on a true understanding of its present state.

The function of an independent inquiry is thoroughly and objectively to review the patients' care and treatment, in order to ensure that the services provided to persons with such needs are safe, effective and responsive. The purpose is to learn any lessons that may minimise the possibility of further tragedies.

We make no reference to individual professionals: the value of such a process lies not in apportioning blame, but in identifying, and then gaining support for, feasible improvements to services.

Given the complexity of the subject-matter, our report is relatively short. It concerns the services for people in north Birmingham and we wish it to be available to, and read by, local people and professionals. With this in mind we hope that the Health Authority will ensure that it is generally available, both in English and Urdu.

As a final note, it needs to be emphasised that the enduring impression left after many years visiting psychiatric wards is for most people not one of fear or dangerousness, but of suffering and an often disarming kindness on the part of those who have lost their liberty. Although compelled to submit to the will of others, and forced to accept medication which may cause physical discomfort, most patients remain dignified and courteous, and retain the compassion to respond to the plight of others in a similarly unfortunate situation.

Anselm Eldergill (Chairperson)
Ian Blackie (Social work member)
Claire Murdoch (Nursing member)
Dr Stephen Wood (Medical member)

MAP OF BIRMINGHAM

TABLE OF CHAPTERS

TABLE OF CONTENTS

1 — INTRODUCTION

National Health Service Guidelines issued in May 1994 require that an independent inquiry is held when a person who has been in contact with mental health services takes another individual's life.

In this instance, the independent panel were asked to review the care and treatment of two patients who resided in north Birmingham:

Mr Ogilpis Hamilton killed his neighbour, Mr Lewis Hodge, on 5 July 1999. He later pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to life imprisonment. This sentence was mandatory because the homicide, which occurred at Mr Hamilton's flat in Erdington, was not his first serious offence. He was residing there informally, having been discharged from liability to detention in hospital fourteen years before. His medical diagnosis on discharge had been one of paranoid schizophrenia possibly complicated by a mild learning disability. Mr Hodge had also received in-patient treatment from the same NHS trust, and his name was on its supervision register. He too had a formal diagnosis of paranoid schizophrenia superimposed on a mild learning disability.

Mr Abdul Rehman was admitted to Highcroft Hospital in Birmingham on 22 January 2000, under section 2 of the Mental Health Act 1983. After nine days, he was transferred to Newbridge House. His wife obtained an anti-molestation order against him, which was served on 8 February 2000. On 10 February, he was granted three periods of thirty minutes unescorted community leave per day, in order to go to the local shops. Having been allowed half an hour's leave at around 7pm on 11 February, he returned to the family home in Alum Rock. There he stabbed and killed his wife, Mrs Shamim Akhtar, in front of their children. He later pleaded guilty at Birmingham Crown Court to manslaughter on the grounds of diminished responsibility. The court imposed hospital and restriction orders, under the Mental Health Act 1983, and ordered his admission to a medium secure unit.

Both patients lived within the area then served by BIRMINGHAM HEALTH AUTHORITY, BIRMINGHAM CITY COUNCIL SOCIAL SERVICES and the NORTHERN BIRMINGHAM MENTAL HEALTH NHS TRUST, and had received in-patient treatment in Birmingham. They were not, however, cared for by the same mental health team.

WHO CONDUCTED THE INQUIRY

The inquiry was undertaken by a panel of professionals from outside Birmingham:

Anselm Eldergill (Chairperson)	Solicitor. Visiting Professor in Mental Health Law, Northumbria University. Former Chairman of the Mental Health Act Commission's Legal & Ethics Committee. Author of *Mental Health Review Tribunals, Law and Practice*.
Ian Blackie (Social work member)	Manager, Emergency Duty Team, London Borough of Greenwich Social Services; Chairman, National Appropriate Adult Network; Social services consultant and trainer.

Claire Murdoch (Nursing member)	Executive Director of Nursing, Brent, Kensington, Chelsea & Westminster NHS Trust; Director of Operations, Westminster, Kensington & Chelsea. Co-author of *Psychopathy, the law and individual rights*.
Stephen Wood (Medical member)	Consultant psychiatrist. Medical Director, East Kent Community NHS Trust.

PURPOSE SERVED BY THE INQUIRY

The function of an independent inquiry is thoroughly and objectively to review the named patients' care and treatment, in order to ensure that the services provided to persons with such needs are safe, effective and responsive. The purpose is to learn any lessons which may minimise the possibility of further tragedies. This is why the report is made to the bodies that have power to change the way the service is provided. The outcome should be that any feasible improvements are made, for the future good of everyone.

Such inquiries serve important private and public needs. At a private level, individual tragedy requires a response, ideally determined by the individual circumstances: inquiries enable the bereaved to know that what happened is being fully and impartially investigated, and to be a party to that process. Equally, local people need to be reassured that the service is operating effectively. In such circumstances, it is wholly understandable, and wholly reasonable, that local people wish to be reassured that when family members come home, or friends or strangers return to their community, the risk of serious harm is minimal.

Although agencies outside the locality may draw useful lessons from an inquiry report, the cost and usefulness of the exercise does not require national justification. The value of the process lies in systematically examining the way in which a particular service, and group of professionals, operate and co-ordinate *their* efforts.

GUIDING PRINCIPLES

The inquiry panel were guided by the following principles:

1. A health and social services inquiry is a form of service review, and its main function is to learn lessons and bring about necessary change. Retribution, and the expiation of wrong-doing, are matters for the courts and for professional bodies.

2. The process is not concerned with establishing whether the victim's death was predictable or preventable, or who bears responsibility for it. Unless insane, the patient bears responsibility for it, and professional interventions and omissions only ever make certain events more or less likely.

3. Although always present, apprehension and fear on the part of those taking part should be minimised, so that the inquiry does not interfere with the service being provided to others.

4. The panel should seek to reduce the anguish and distress experienced by the bereaved and the patient's family by establishing early contact, sharing information, and, if requested, securing legal representation for them.

5. The personal nature of information about a patient and his family, plus the importance of uninhibited dialogue and minimising stress, makes privacy desirable, and meetings should be held in private.

6. An adversarial approach is incompatible with a review process which attempts to bring about change through uninhibited dialogue, partnership and consensus, and within which culpability is not an issue.

7. The process should be as informal as possible, developing into a partnership with those providing the services, and avoid the usual terminology of inquiries ('inquiry', 'witness', etc).

8. Candour should be encouraged because it ensures that the future direction of the service is based on a true, comprehensive, understanding of its current state.

9. Procedural fairness remains important even where a review is not directed at establishing responsibility and culpability, and the panel should impose on itself a set of procedures designed to ensure this (see below).

10. The report should be as short as possible and conclude with a summary of the main points; not disclose personal information unnecessarily; concentrate on the terms of reference and local services; set out what it is realistic for the public to expect in relation to treatment, care, risk, and discharge planning; accept that all discharge decisions involve risk; make clear the legislative and other constraints to which practitioners are subject, so that decisions are measured against a realistic yardstick; and recommend, or contain, a course of action for each significant problem.

11. The arrangements made for publishing the report should give priority to the needs and wishes of the families, the public and the press, and the report should be readily available. The public interest requires that the public know the state of their services, and public services perform no public service when they manage what the public know.

12. The implementation of the action plans set out in the report should be audited by the Health Authority, and the panel should contribute to that process.

THE TERMS OF REFERENCE

The terms of reference, which were drafted and agreed by BIRMINGHAM HEALTH AUTHORITY, were similar in both cases, and they required us to review each patient's care and various related matters. In particular, we were to consider in each case:

1. the quality and scope of their health, social care and risk assessments.

2. the suitability of their treatment, care and supervision in the context of

   — their actual and assessed health and social care needs;

   — the actual and assessed risk of potential harm to themselves or others;

   — the history of medication and compliance with that medication;

   — any previous psychiatric history, including alcohol and drug misuse;

   — any previous forensic history.

3. the extent to which their care complied with statutory obligations, the Mental Health Act Code of Practice, local operational policies, and relevant guidance from the Department of Health, including the care programme approach, and the guidelines on supervision registers and discharge planning.

4. the extent to which their prescribed treatment and care plans were adequate, documented, agreed with them, carried out, monitored, and complied with.

5. the adequacy of the risk assessment training of all staff involved;

6. the adequacy of the collaboration and communication between the agencies involved (the NORTHERN BIRMINGHAM MENTAL HEALTH NHS TRUST, BIRMINGHAM CITY COUNCIL and the general practitioners).

7. the adequacy of the support given to each patient's family by the community health team and other professionals.

8. Having done this, we were to prepare a report for the BIRMINGHAM AND THE BLACK COUNTRY STRATEGIC HEALTH AUTHORITY, BIRMINGHAM CITY COUNCIL and the NORTHERN BIRMINGHAM MENTAL HEALTH NHS TRUST. The report was to contain our findings and recommendations concerning the care and treatment available to mentally ill people, and the safety of mental health users, the public and staff.

OVERVIEW OF THE PROCESS

The ideal of a constructive review, which seeks to develop a partnership with the services and individuals affected, led to the following procedure being adopted:

1	**Introductions**	Pre-review meetings were held with family members and the teams, with the aim of discussing any concerns they had about the process.
2	**Documents**	As the documents were received, they were indexed and a chronology was prepared.
3	**Induction**	An induction week was held, during which the panel visited relevant sites; received presentations about local services and the implementation of legislation and departmental guidelines; and obtained a number of independent perspectives (e.g., from the Community Health Council and user groups). Having read the documents, visited the sites, and drawn on local expertise, the panel members defined the issues, identified the persons who they wished to see, or to receive statements from, and commissioned further documents.
4	**Meetings**	Meetings were held with those involved in each patient's care.
5	**Report**	A report was drafted, containing brief patient histories and the panel's findings and recommendations. This report was shared with the relevant agencies and the bereaved.
6	**Action**	Action plans were drawn up for inclusion in the final report.

7 **Follow-up** The panel will reconvene in due course, to assess the extent to which the action plans have been implemented, and to report further to the Health Authority.

In our opinion, the benefits of such a process are:

- ☐ that it seeks consensus;
- ☐ that it is productive (capable of producing necessary change); and
- ☐ that action is part of the process.

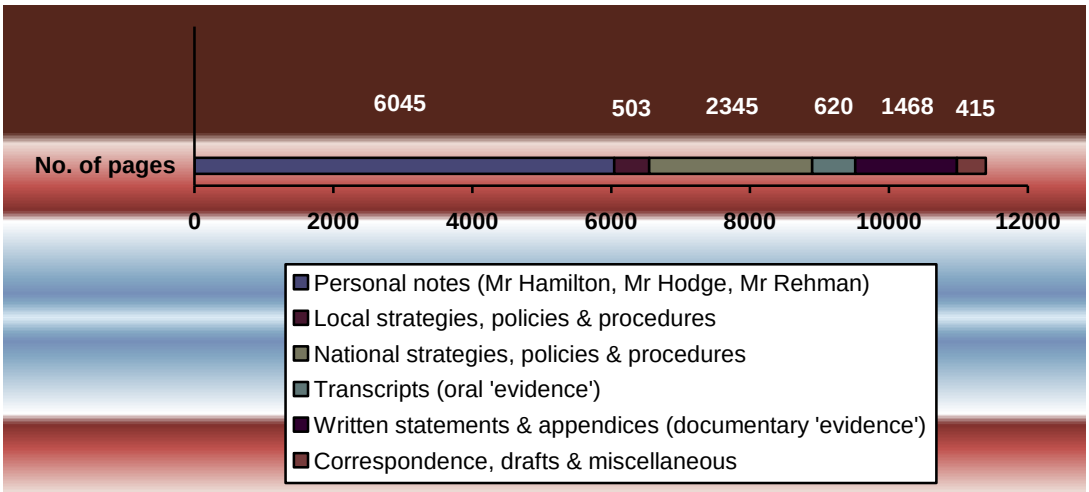
TIMETABLE

Mr Hamilton and Mr Rehman consented to the release of their medical and other records to the panel. Unfortunately, at this point, two of the original panel members had to be replaced because of their other commitments.

The new panel members met with the professionals involved in Mr Hamilton's case in July 2002 and those who cared for Mr Rehman in November and December 2002. Once underway, each review took approximately seven months. We finished our report in July 2003 and received an action plan from the local services in February 2004.

INFORMATION REVIEWED BY THE PANEL

The information in this report has been anonymised. However, it is important to emphasise that the review was thorough and searching. The following chart summarises the information on which our findings are based, amounting to almost 12,000 pages in all.



PROCEDURAL SAFEGUARDS

Although not part of the terms of reference, the review panel chose to adopt a set of procedures designed to ensure that those persons assisting them were treated fairly:

REVIEW PROCEDURES

1. *Every professional who provided treatment or care to the particular patient will receive a letter before meeting with the review team. This letter will ask them to provide a statement and inform them:*

    a. *of the terms of reference and the procedures adopted by the review panel;*

    b. *of the areas and matters to be covered with them;*

    c. *that when they attend the meeting they may raise any matter they wish relevant to the review;*

    d. *that they may bring with them a friend or relative, a member of a trade union, a lawyer or a member of a defence organisation, or anyone else they wish to accompany them, with the exception of another person who has been asked to meet with the review team;*

    e. *that it is the person invited who will be asked questions and who will be expected to answer;*

    f. *that what they say will be transcribed and a copy of the transcription will be sent to them afterwards for them to sign.*

2. *Persons attending meetings with the review team may be asked to confirm that what they have said in their statement and at their meeting is true.*

3. *Any points of potential criticism will be put to the individual affected, either verbally at their meeting with the review team, or in writing at a later time, and s/he will be given a full opportunity to respond.*

4. *Written representations may be invited from professional bodies and other parties as to what practices should be adopted for people in similar circumstances.*

5. *These professional bodies or parties may be asked to speak with the review team about their views and recommendations.*

6. *Anyone else who feels they may have something useful to contribute to the review may make written submissions for the panel's consideration and, at the chairman's discretion, be invited to speak with the review team.*

7. *All review meetings will be held in private.*

8. *The draft report will be made available to the relevant health and social services authorities and the local NHS trust, for their comments on points of fact.*

9. *Information submitted to the review panel either orally or in writing will not be made public by panel members, except insofar as it is disclosed within the body of their report.*

10. *Findings of fact will be made on the basis of the information received by the panel. Comments which appear within the narrative of the report and any recommendations will be based on those findings.*

2 — THE HUMAN FRAMEWORK

ABOUT THIS CHAPTER

The service that professionals can provide to people with mental health needs is influenced by resources and models of service delivery set nationally and locally. It is, however, also determined by many other factors, such as the chronic course of some mental disorders; the fact that most severe mental disorders cannot be cured; the limited efficacy of available treatments; and the speculative nature of all assessments of a person's future behaviour. The purpose of this chapter is briefly to describe some of these difficulties, and what it is realistic for the public to expect in relation to psychiatric care, so that professional decisions are measured against a realistic yardstick.

MENTAL DISORDER

Psychiatry is that branch of medicine concerned with the study, diagnosis, treatment and prevention of mental disorder. The term 'disorder' is not an exact term but simply implies the existence of a clinically recognisable set of symptoms or behaviour associated in most cases with distress and interference with personal functions. In practice, the classification of certain disorders as mental or psychiatric is largely determined by the historical fact that these conditions have generally been treated by psychiatrists.

RISKS ASSOCIATED WITH MENTAL DISORDERS

The current emphasis in mental health practice is very much on public safety. Nevertheless, it needs to be emphasised that the enduring impression left after many years visiting psychiatric wards is for most people not one of fear or dangerousness, but of suffering and an often disarming kindness on the part of those who have lost their liberty. Although compelled to submit to the will of others, and forced to accept medication which can cause severe physical discomfort, most patients remain dignified and courteous, and retain the compassion to respond to the plight of others in a similarly unfortunate situation.

The risk of suicide

Serious mental disorder has a marked effect on lifetime suicide rates. They have been estimated at schizophrenia 10%, affective (mood) disorder 15%, and personality disorder 15%. Suicide rates amongst young men with no known occupation are nearly four times those in social classes I and II; and the suicide rate in men is three times that in women. On average, one patient on each GP's list will commit suicide every five years.

In statistical terms, the risk that a mentally ill person will kill her or himself is substantially higher than the risk that s/he will kill another person. According to one study, persons suffering from schizophrenia are one hundred times more likely to kill themselves than another person, and persons with a mood disorder are one thousand times more likely (Häfner & Böker, *Crimes of violence by mentally disordered offenders,* Cambridge University Press, 1982).

The risk of homicide and violence to others

There are about 40 homicides per 100,000 psychiatric admissions, compared with 10 maternal deaths in child-birth per 100,000 deliveries (Tidmarsh, *Psychiatric risk, safety cultures and homicide inquiries*, The Journal of Forensic Psychiatry (1997) 8(1): 138–151).

Although the public have understandably been concerned about the closure of the old asylums and the discharge of patients into the community, the criminal statistics for England and Wales between 1957 and 1995 do not reveal any increase in the number of homicides committed by persons with mental health problems.

There has, in fact, been little fluctuation in the number of people with a mental illness who commit criminal homicide over the 38 years studied, and a three per cent annual decline in their contribution to the official statistics (Taylor & Gunn, *Homicides by people with mental illness: myth and reality*, British Journal of Psychiatry (1999) 174: 9–14).

Although research findings tend to demonstrate a positive relationship between mental illness and offending, including violence, this must be seen against the general level of prevailing violence in homes and public houses, and on the roads. Mentally ill people contribute proportionately very little to the general problem of dangerous behaviour. Measured against the full range of modern social hazards, the contribution to public safety of preventively confining persons with mental health problems is tiny, as also is the likely impact on the rates at which serious offences are committed.

It must also be borne in mind that in-patients are themselves members of the public. Practitioners therefore face the difficult task of ensuring both that members of the public are not unnecessarily detained and also that members of the public are protected from those who must necessarily be detained. Balancing these different considerations is a formidable task.

Good practice and risk management

There is much written and said nowadays about risk management, of which risk assessment is the first step. Risk management has become a sort of cure-all; as if, recently discovered, it holds the key to a safe future. In fact risk management has existed for years, simply as good practice. Good practice includes skills in communication and understanding; the capacities to listen, be flexible, and empathic; it is built on sound training, and effective supervision and support; it is not judgemental or discriminatory; it is broadly based, fair and thorough, and its policies and practices are the product of multi-disciplinary consensus. The same comments apply to the care programme approach (CPA) about which, again, much is said in this report.

WHY NO SERVICE CAN EVER BE TOTALLY SAFE

It is impossible for a mental health service to be totally safe. However, some of the principles which psychiatric practice takes account of, and which we have borne in mind, are that:

- ☐ there is tension within any resource limited service between the utilitarian ideal of producing the greatest good for the greatest number and the desire to perfect the care for individuals. A utilitarian service attempting to provide 'good enough' care for all will inevitably have some individuals experience a poor outcome. In practice, this usually means that there is subsequently a reworking of the poor outcome cases to a more thorough level.

- ☐ in-patients are members of the public, and at increased risk of being victims of violence for as long as they are detained on a psychiatric ward.

- ☐ risk cannot be avoided and even a very low risk from time to time becomes an actuality.

- ☐ every decision about the need to detain a person involves the assumption of a risk and, however careful the assessment, it is inevitable that some patients will later take their own lives or commit a serious offence.

- ☐ the purpose of compulsory powers is not to eliminate that element of risk in human life which is a consequence of being free to act, and to make choices and decisions; it is to protect the individual and others from risks that arise when a person's judgement of risk, or their capacity to control behaviour associated with serious risk, is significantly impaired by mental disorder.

- ☐ good practice relies on good morale and a feeling amongst practitioners that they will be supported if they act reasonably; it is unjust to criticise them when decisions properly made have unfortunate, even catastrophic, consequences.

- ☐ the occurrence of such tragedies does not *per se* demonstrate any error of judgement on the part of those who decided that allowing the patient their liberty did not involve unacceptable risks.

- ☐ an outcome often occurs as a result of a complex of events, and the choice of one particular causal factor may be arbitrary.

- ☐ small differences in one key variable can result in vastly different behaviours and outcomes: just as a sudden change in the physical state of water into steam or ice occurs with the rise or fall of temperature beyond a critical level, so the addition of a small additional stress on an individual may have a profound effect on their mental state or behaviour.

- ☐ unless the individual's propensity for violence has a simple and readily understandable trigger, it is impossible to identify all of the relevant situations; some of them lie in the future and will not yet have been encountered by the patient.

- ☐ understanding the situations in which a person has previously been dangerous, and avoiding their repetition, can give a false sense of security about the future.

- ☐ although life is understood backwards, it must be lived forwards, and the difference between explanation and prediction is therefore significant: explanation relies on hindsight, prediction on foresight, and the prediction of future risk involves more than an explanation of the past.

- ☐ predictions are most often founded not on fact but on 'retrospective predictions' of what occurred in the past ('retrodiction').

- ☐ a risk can in theory be measured and is the basis of actuarial prediction — in theory because in practice all of the critical variables never are known. While the risk depends on the situation, all of the situations in which the patient may find himself in the future can only be speculated upon.

- ☐ all violence takes place in the present, and the past is a past, and so unreliable, guide to present and future events.

- ☐ because future events can never be predicted, it is important to put in place an adequate system for supervising any individual whose own safety may potentially be at risk or who may pose a threat to the safety of others.

- this approach is not fail-safe: it is based on the assumption that most attacks do not erupt like thunderstorms from clear skies. In reality, as with weather systems, only the pattern of events for the next 24 hours can usually be forecast with some accuracy; and contact with supervisors is less regular.

- all human beings, regardless of their skills, abilities and specialist knowledge, make fallible decisions and commit unsafe acts, and this human propensity for committing errors and violating safety procedures can be moderated but never entirely eliminated.

- introducing the concept of 'hindsight bias' in a defensive way cannot justify a lack of reasonable foresight, or simple failure to think about what one is doing.

3 — THE NATIONAL FRAMEWORK

ABOUT THIS CHAPTER

Local practitioners work within a context set nationally. The purpose of this chapter is to explain briefly the national legislation and guidelines that guide, and sometimes limit, how they practise. One of the tasks given to the panel was to report on local compliance with the Mental Health Act and national and local policies and procedures.

MENTAL HEALTH ACT 1983

The vast majority of people who receive psychiatric treatment in hospital are treated without resort to formal legal powers, and they are known as 'informal patients'.

In a minority of cases, where an individual's actions are seriously jeopardising her or his welfare or that of others, the law countenances detention and treatment without consent.

The Mental Health Act 1983 includes a range of powers that authorise detention and restraint. Applications for a person to be detained under the Act must be founded on medical recommendations, and most of them are made by an approved social worker (or ASW), that is by a social worker who has completed special training.

The statutory criteria for detention always comprise at least two grounds:

- ☐ The first of them (*the diagnostic ground*) requires that the individual is suffering from a serious mental disorder.

- ☐ The second ground (*the risk ground*) requires that the individual's detention is 'necessary' or 'justified' on their own account (specifically for their health, safety or welfare) or that of others (in order to protect them).

Whether a particular person's detention is justified or necessary often depends on whether treatment outside hospital can be arranged. Here, their willingness to accept informal treatment, and their capacity to adhere to an agreed treatment programme, will be highly relevant.

Applications for assessment under section 2

Under section 2 of the 1983 Act, an individual's nearest relative or an approved social worker may apply for their detention in hospital for up to 28 days, so that their mental state can be assessed, and any treatment given which is assessed to be necessary. Such an application must be founded on two medical recommendations.

Emergency applications under section 4

In urgent cases, obtaining two medical recommendations may lead to undesirable delay in effecting admission. Section 4 sets out an emergency procedure which enables a person to be admitted for assessment on the basis of a single medical recommendation. If this procedure is adopted, the authority to detain the individual ceases after 72 hours unless the second recommendation has by then been received.

Applications for treatment under section 3

Detention beyond 28 days is generally only permissible if a fresh application, made under section 3, has been accepted by the managers of the relevant hospital. Their acceptance of an application under this section authorises them to detain and treat the person in hospital for up to six months. Where necessary, this authority to detain the patient may be renewed for a second period of six months, and thereafter for a year at a time.

Applications concerning care outside hospital

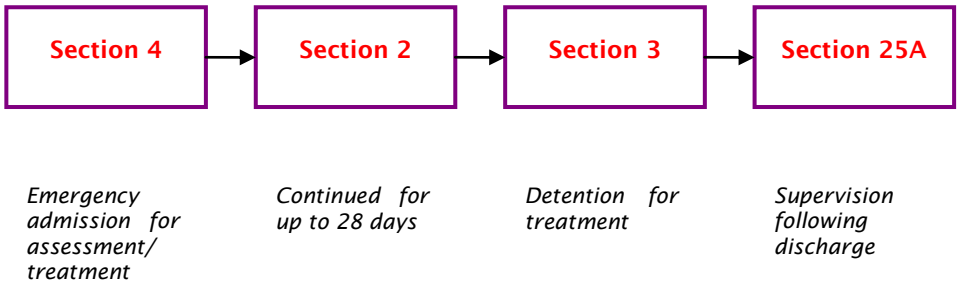
Section 7 provides that an application may be made for a person to be placed under the guardianship of a local social services authority or a private individual for up to six months.

Alternatively, where a patient is detained in hospital for treatment, section 25A provides that an application may be made for them to be supervised in the community upon leaving hospital.

As with section 3 applications, a supervisor's authority and a guardian's authority lapse after six months unless renewed for a further six months, and thereafter at yearly intervals.

Relationship between the different applications

The various powers just referred to are not mutually exclusive. In the first place, a person detained in hospital may be transferred into guardianship, and vice-versa. Secondly, it is common for one application to be replaced by another. For example, section 4 might be used to admit a person in an emergency. If the second medical recommendation required by section 2 is then received within the permitted 72 hour period, the patient may be detained for the remainder of the usual 28 day assessment period. A section 3 application will follow if, before the 28 days expires, it becomes clear that a more prolonged period of detention and treatment is necessary. If it then becomes apparent that the patient will require statutory supervision after s/he ceases to be detained under section 3 and leaves hospital, a supervision application may be made.



Short-term powers not exceeding 72 hours

The Act includes a number of short-term powers of detention, which enable a person to be detained so that her or his mental state and situation may be assessed and/or any necessary application made.

Removal from a public place to a place of safety under section 136

If a police constable finds in a public place a person who appears to be suffering from mental disorder, and to be in immediate need of care or control, the constable may remove that person to a place of safety, if s/he thinks it necessary to do so in that person's interests or to protect others.

The individual may be detained there for a period not exceeding 72 hours, for the dual purpose of, *firstly*, enabling her or him to be examined by a registered medical practitioner and to be interviewed by an approved social worker and, *secondly*, of making any necessary arrangements for their treatment or care. These arrangements not uncommonly involve making an application for the person's admission to hospital.

Powers of criminal courts

Section 37 provides that a court may direct that an offender be admitted to hospital for treatment or be received into guardianship. With minor exceptions, these orders have the same consequences as do applications for admission for treatment and guardianship under Part II of the Act. That is, they authorise the patient's detention or guardianship for up to six months, after which the continuance of the compulsory powers requires periodic renewal.

Restriction orders

Section 41 provides that the Crown may attach to a hospital order what is known as a restriction order. Such an order may be imposed only where one appears to be necessary in order to protect the public from serious harm.

The purpose of the restrictions is to restrict the circumstances and ways in which the patient may be allowed outside hospital. This objective is achieved in several ways. In the first place, the Home Secretary is involved in the management, but not the treatment, of a restricted patient. Such a patient may not be permitted to be absent from the hospital, or transferred to a less secure hospital, without the Home Secretary's consent. Nor, in effect, may s/he be discharged from hospital otherwise than by the Home Secretary or a mental health review tribunal. Furthermore, conditions may be attached to any discharge and a patient whose mental health deteriorates may be recalled to hospital by the Home Secretary. No fresh order is necessary.

Powers of the Home Secretary

The Mental Health Act also contains a number of other powers concerning patients involved in criminal proceedings. Under section 48, the Home Secretary can direct that a person who is in prison awaiting trial shall be transferred to hospital for treatment. This is known as a 'transfer direction'. A similar power in section 47 enables the Home Secretary to transfer to hospital persons serving a sentence of imprisonment.

The use made of powers of detention

Department of Health data shows that the number of formal admissions under the 1983 Act increased from 18,000 in 1990-91 to 26,700 in 2000-01. The rate of detentions in English NHS hospitals was 91 per 100,000 population.

As at 31 March 2001, 13,800 people were detained in hospital under the Act, of whom 1,200 were in high security psychiatric hospitals; 10,900 in other NHS facilities; and 1,700 in private mental nursing homes.

The number of men admitted to NHS facilities under sections 2, 3 and 4 increased by 76% between 1990-91 and 2000-01, from 7,100 to 12,500. The number of women admitted increased by only 34% during the same period, from 8,600 to 11,500.

In 2000-01, 20,500 people were formally detained under the Act after admission to hospital as informal patients, compared with 20,800 in 1999-00.

Between 31 March 1994 and 31 March 2001, the number of guardianship cases in force at the end of the year increased from 487 in 1994 to 1,035 in 2001, an increase of 113%. 10% (15 out of 150) of all local authorities accounted for 45% (461 out of 1035) of cases open at 31 March 2001.

Research studies suggest that, in urban populations at least, most patients with a psychotic illness who are known to general adult psychiatric services will be formally admitted at some point in the course of their illness. Psychiatrists may be most likely to recommend formal admissions, and ASWs more cautious. GP referrals may be less likely to lead to compulsory admissions. One paper reported that 63% of social worker assessments led to the patient being sectioned, and that a higher proportion of patients were sectioned (81%) when the request came from a psychiatrist.

With pressure on beds, admissions are likely to be shorter, which means that the same patients may be re-admitted later in the same year. It seems likely that psychiatrists reserve admission for patients with the most severe illness, a high proportion of whom are likely to require formal admissions.

One report showed an increasing number of assessments involving younger men with schizophrenia, commonly the same men repeatedly, suggesting this largely accounts for overall increases in the use of the Act.

Studies indicate that males are more likely to be sectioned than females; black individuals with psychiatric disorders are about twice as likely to be detained as their white counterparts; and those in unpaid employment constitute nearly three quarters of all those referred.

Court and prison admissions constitute less than 10% of formal admissions.

THE CODE OF PRACTICE

The Secretary of State publishes a code of practice concerning the use of the 1983 Act and the medical treatment of patients. The second edition of the code was in force until April 1999, when a new edition replaced it. According to the third edition, good practice now requires that greater emphasis is placed on risk assessment and management and less on the importance of individual liberty. For example, the new Code says that, 'Informal admission is usually appropriate when a mentally capable patient consents to admission, *but not if detention is necessary because of the danger the patient presents to him or herself or others*' (para. 2.7). It also states that, '*A risk of* physical harm, or serious persistent psychological harm, to others is an indicator of the need for compulsory admission' (para. 2.9).

HEALTH SERVICE GUIDELINES

The following guidelines concerning discharge, supervision, risk management, after-care and care programmes were issued between 1989 and February 2000:

(a) Discharge of Patients from Hospital, Health Circular HC(89)5

The circular states that no patient may be discharged until the doctors concerned have agreed, and management is satisfied, that everything reasonably practicable has been done to organise the care the patient will need in the community.

This includes making arrangements for any necessary follow-up treatment, travel to, and support in, the home or other place to which they are being discharged. They or their relatives must also be fully informed about such things as medication, lifestyle, diet, symptoms to watch for, and where to get help if it is needed. Important points must be confirmed in writing. Their ability to cope and access to emergency services and out-of-hours advice must be taken into account.

Responsibility for checking that the necessary action has been taken before a patient leaves the hospital should be given in one member of the staff caring for that patient. This person should have a check-list of what should have been done. If the completed check-list is filed in the patient's notes it will provide a permanent record of action taken before discharge.

In many cases the patient, family or friends, will be capable of making all the arrangements for the return home. All that will then be required of the nominated member of the hospital staff is to ensure that they and the general practitioner have been given all the information they need. In other cases much more will be required, a range of services will have to be organised in advance, and several agencies involved.

(b) Local Authority Circular LAC(89)7

Local Authority Circular LAC(89)7 draws the attention of local authorities to *Health Circular (89)5*, and asks them to review their existing procedures, so as to ensure that people do not leave hospital without adequate arrangements being made for their support in the community. The circular states that local authorities have a key role to play in ensuring that a range of services are available for patients who will need continuing care and support which cannot be provided by family and carers alone. Social workers can advise on the particular package of services available from statutory and non-statutory suppliers which will best meet the patients needs and preferences. Suitable accommodation is essential if people are to be able to resume independent living in the community. Social services departments should make sure that local authority housing departments are involved at an early stage in the planning process if the patient is not able to return to his or her former home.

(c) Care programme approach, Health Circular HC(90)23

The *care programme approach* applies to all patients who require psychiatric treatment or care, and it requires health and social services authorities to develop care programmes based on proper ‘systematic arrangements’ for treating patients in the community. The underlying purpose is to ensure the support of mentally ill people in the community, thereby minimising the risk of them losing contact with services, and maximising the effect of any therapeutic intervention.

All care programmes should include systematic arrangements for assessing the health care needs of patients who can potentially be treated in the community. A key worker should be appointed for the patient.

The key worker's role is to keep in close touch with the patient, and to monitor that the agreed health and social care is given. S/he should maintain sufficient contact with the patient, and advise professional colleagues of changes in circumstances which may require review and modification of the care programme. When the key worker is unavailable, proper arrangements should be made for an alternative point of contact for the patient and any carers. Every reasonable effort should be made to maintain contact with the patient and his carers, in order to find out what is happening, to sustain the therapeutic relationship, and to ensure that the patient and carer knows how to make contact with the key worker or other professional staff.

(d) Supervision registers, Health Service Guidelines HSG(94)5

Supervision registers were an extension of the care programme approach. The purpose of the registers is to enable NHS trusts, and other NHS provider units, to identify all individuals known 'to be at significant risk of committing serious violence or suicide or of serious self-neglect, as a result of severe and enduring mental illness.' Consideration for registration should take place as a 'normal part' of discussing a patient's care programme before he leaves hospital. The decision as to whether a patient is registered rests with the consultant, although other members of the mental health team, including the social worker, should be consulted. Judgements about risk should be based on detailed evidence, and the evidence be recorded in written form and available to relevant professionals.

(e) Guidance on Discharge, Health Service Guidelines HSG(94)27

The guidance seeks to ensure that psychiatric patients are discharged only when and if they are ready to leave hospital; that any risk to the public or to patients themselves is minimal; and that when patients are discharged they get the support and supervision they need from the responsible agencies.

According to the guidelines, the 'essential elements' of an effective care plan are systematic assessment, a care plan, the allocation of a key worker, and regular review. The professionals responsible for making discharge decisions must be satisfied that these conditions are fulfilled before any patient is discharged.

It is essential that arrangements for discharge and continuing care are agreed and understood by the patient and everyone else involved, including private carers. In particular, they should have a common understanding of the community care plan's first review date; information relating to any past violence or assessed risk of violence; the name of the key worker (prominently identified in clinical notes, computer records and the care plan); how the key worker or other service providers can be contacted if problems arise; and what to do if the patient fails to attend for treatment or to meet other requirements or commitments.

There must be a full risk assessment prior to discharge, which involves: (1) ensuring that relevant information is available; (2) conducting a full assessment of risk; (3) seeking expert help; and (4) assessing the risk of suicide. A proper assessment cannot be made in the absence of information about a patient's background, present mental state and social functioning, and also his or her past behaviour. It is essential to take account of all relevant information, whatever its source. Too often, it has been the case that information indicating an increased risk existed but was not communicated and acted upon.

(f) Introduction of the departmental after-care form (February 1995)

In February 1995, the Department of Health circulated an after-care form designed to be used for all patients discharged from psychiatric in-patient treatment, including those subject to section 117.

The use of the form, though not mandatory, was strongly recommended as constituting good practice, and was devised in response to a recommendation in the *Report of the Inquiry into the Care and Treatment of Christopher Clunis (North West London Mental Health NHS Trust, 1994)*.

The form contains a number of sections: (1) About the patient; (2) Patient's nominated contact; (3) Keyworker's details; (4) After-care plan; (5) Information to be included in the after-care plan; (6) Availability of information (7) Review; (8) Transfer of responsibility for patient's after-care; (9) Discharge from after-care.

(g) Building Bridges document (November 1995)

Building Bridges stressed that the care programme approach is the cornerstone of the Government's mental health policy. It also emphasised the need to adopt a tiered approach. The purpose of this is to focus the most resource-intensive assessment, care and treatment on the most severely mentally ill people, while ensuring that all patients in the care of the specialist psychiatric services receive the basic elements of CPA.

Patients with less complex needs should still receive systematic assessment, be assigned a key worker, and receive monitoring and review of a simple care plan. A minimal CPA would apply to patients who have limited disability/ health care needs arising from their illness and have low support needs which are likely to remain stable. They will often need regular attention from only one practitioner, who will also fulfil the key worker role.

Each patient's details should be entered on a CPA information system, and an initial needs assessment be carried out by a mental health professional ('pre-CPA assessment'). If a patient needs only a minimal CPA there will be no need for a multi-disciplinary meeting. It is important that the individual concerned and his or her carer(s) are involved as much as possible in the care planning process. All aspects of the care planning process should involve the user, his or her advocate, carers and/or interested relatives. A full assessment of risk, covering both risk to the patient and others, should be part and parcel of the assessment process. If the patient has been an in-patient, the keyworker should ensure before discharge that elements of the plan necessary for discharge are carried out. This will include the patient's needs for medication, therapy, supervision and accommodation. In particular, those taking decisions on discharge have a duty to consider both the safety of the patient and the protection of other people. No individual should be discharged from hospital unless and until those taking the decision are satisfied he or she can live safely in the community, and that proper treatment, supervision, support and care are available.

The keyworker is the linchpin of the CPA. S/he should be selected at the needs assessment meeting and, since s/he is vital to the success of the whole process, identified as soon as possible. This is particularly the case when patients are soon to be discharged from hospital. The decision as to who should be the key worker should take into account the patient's needs: if housing and financial concerns and family problems are uppermost, a social worker is likely to be the most suitable candidate. The patient will need to know that the key worker (or an alternative worker) is available when things are difficult. Therefore, the key worker should ensure that patients and their carers have a contact point which is always accessible. Keeping in touch must also be assertive and key workers should not rely on the patient contacting them.

(h) Modernising Mental Health Services (December 1998)

In December 1998, the Government promised to modernise mental health services by providing safe, sound and supportive services:

Safe	*Sound*	*Supportive*
• Good risk management	• 24 hour access	• Involvement of patients, service users and carers
• Early intervention	• Needs assessment	• Access to employment, education and housing
• Enough beds	• Good primary care	• Working in partnership
• Better outreach	• Effective treatment	• Better information
• Integrated forensic and secure provision	• Effective care processes	• Promoting good mental health and reducing stigma
• A modern legislative framework		

(i) Modernising the care programme approach (October 1999)

The booklet sets out important changes to the CPA which take account of available evidence and experience. Some of the key developments are the integration of the CPA and care management; the appointment of lead officers within each trust and local social services authority; the introduction of two CPA levels (standard and enhanced); the removal of the previous requirement to maintain a supervision register; and the use of the term 'care co-ordinator' in place of 'keyworker'.

(j) National Service Framework (November 1999)

The *National Service Framework* is the single most important guide to the challenges ahead for mental healthcare (and the deployment of resources in general) over the next 5–10 years. It sets seven key standards in five areas, which are expected to be delivered from April 2000:

Standard 1	• Mental health promotion
Standards 2 & 3	• Primary care and access to services
Standards 4 & 5	• Effective services for people with severe mental illness
Standard 6	• Caring about carers
Standard 7	• Preventing suicide

Each standard is supported by a rationale, by a narrative that addresses service models, and by an indication of performance assessment methods. Each standard also indicates the lead organisation and key partners.

Standards four and five aim to ensure that each person with severe mental illness receives the range of mental health services they need; that crises are anticipated or prevented where possible; to ensure prompt and effective help if a crisis does occur; and timely access to an appropriate and safe mental health place or hospital bed, including a secure bed, as close to home as possible.

The following represent some of the most significant standards set out in the framework:

Primary care

Any service user who contacts their primary health care team with a common mental health problem should have their mental health needs identified and assessed; and be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.

Access to services

Any individual with a common mental health problem should be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care.

Effective services (including CPA)

All mental health service users on the *Care Programme Approach* (CPA) should:

- receive care which optimises engagement, prevents or anticipates crisis, and reduces risk.
- have a copy of a written care plan which:
    i. includes the action to be taken in a crisis by service users, their carers and their care co-ordinators;
    ii. advises the GP how they should respond if the service users needs additional help;
    iii. is regularly reviewed by the care co-ordinator.
- be able to access services 24 hours a day, 365 days a year.

Each service user who is assessed as requiring a period of care away from their home should have a copy of a written after care plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis.

Caring about carers

All individuals who provide regular and substantial care for a person on CPA should have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis; have their own written care plan, which is given to them and implemented in discussion with them.

Performance is to be assessed at national level by measures that include the national psychiatric morbidity survey; reduction in suicide rates; access to psychological therapies; access to single sex accommodation; reduction in number of prisoners awaiting transfer to hospital; implementation of the 'caring for carers' action plans; and reduction in readmission rates.

The *proposed outcome indicators* for cases of severe mental illness include the prevalence of severe illness; the number of patients discharged from follow-up; CPA plans signed by service users; the incidence of serious physical injury; in-patient admissions; patients lost to follow-up; admissions of longer than 90 days duration; the prevalence of side effects from antipsychotics; user satisfaction measures; mortality amongst people with severe illness; and the number of homicides.

4 — THE LOCAL FRAMEWORK

ABOUT THIS CHAPTER

Chapters 2 and 3 explained the human and national frameworks within which mental health services are delivered. The purpose of this chapter is to explain the local framework, for the benefit of readers unfamiliar with it.

1 — INTRODUCTION

Birmingham lies 110 miles northwest of London and is the second largest city in the UK. It has a population of just under one million people spread over 103 square miles from Sutton Coldfield in the north to Longbridge in the south.

Birmingham remains the chief centre of Britain's light and medium industry, and is still sometimes described as 'the city of 1,001 different trades.' Although the key to the city's economic success has been its diverse industrial base, its service sector grew in size to rival the manufacturing sector during the 1970s and 1980s.

One of the city's most distinctive characteristics is its ethnic and cultural diversity. More than one in five of its inhabitants come from a black or minority ethnic community, and one in three 16 year-olds.

Ladywood and Handsworth have a relatively large black and African-Caribbean community, while Aston, Nechells, Sparkhill and Sparkbrook have a large proportion of people of South Asian origin.

There are wide variations in unemployment, deprivation and poverty levels across the city. Unemployment ranges from 2.7% in Sutton Four Oaks to 29.5% in Sparkbrook. Some areas of Birmingham are among the most deprived in the country, associated with which are high levels of mental ill health.

Erdington

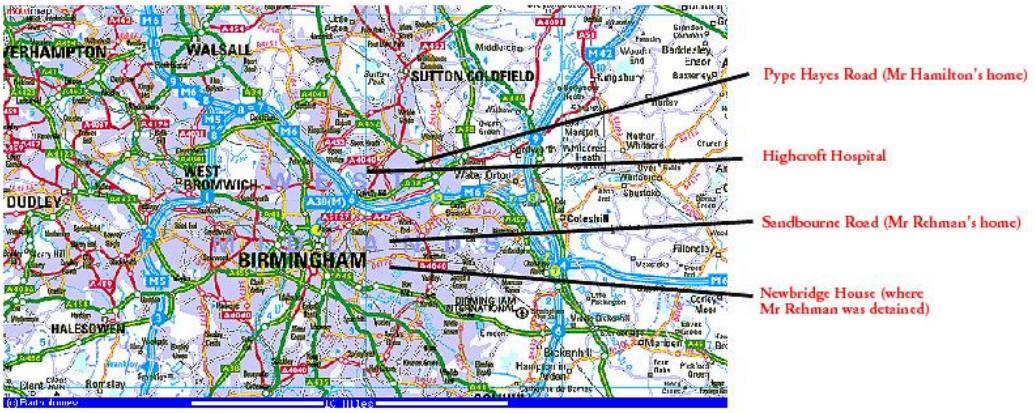
Mr Hamilton lived on Pype Hayes Road, in an area of Birmingham called Erdington, and he received in-patient treatment at Highcroft Hospital.

Pype Hayes Road is situated 8 kilometres from the city centre. It is wholly within the Erdington parliamentary constituency but straddles two council wards: Erdington and Kingsbury.

Once a rural village, Erdington is now a densely populated urban environment which has recently undergone extensive redevelopment. The area is served by several major roads, with the M6 and Kingsbury Road to the south, and Tyburn Road and Chester Road running through the middle. Many local industries are car related.

Alum Rock

Mr Rehman lived in the Alum Rock area, and he received in-patient treatment at both Highcroft Hospital and Newbridge House. Alum Rock is in the heart of Birmingham. It has a high proportion of people from minority ethnic groups, mainly the Indian sub-continent. The shopping area is nationally famous.



A DIVERSE POPULATION

Birmingham has one of the richest cultural, religious and ethnic mixes to be found anywhere in the country, a fact which requires particular attention if services are to be accessible and appropriate to the whole community.[1]

Census data

Over one-fifth of Birmingham's population is made up of people from the black and minority ethnic communities. There is, however, substantial variation across the city. In some parts of Birmingham, such as Ladywood, more than half the population is made up of people from the black and minority ethnic communities.

BIRMINGHAM POPULATION (1991 CENSUS)		
Community/descent	*Number of persons*	*% of population*
• Indian, Pakistani, Bangladeshi	129,899	13.5%
• African Caribbean	56,376	5.9%
• Born Irish Republic	44, 790	4.9%
• Other origins (incl. Chinese)	20,492	2.1%

Black and minority ethnic communities are not homogenous, and each group has its own distinct demography. In other words, different communities are concentrated in particular parts of the city. The Pakistani community tends to be concentrated in the south east of Birmingham, whilst those from the African-Caribbean community are largely concentrated in west Birmingham.

There are wide variations in culture (lifestyle, language and religion), so that minority communities in Birmingham differ not only from the majority population, but also from each other. These cultural differences affect their use of services, which are traditionally geared to the majority population. A diverse population requires diverse responses, and each group has particular needs that must be addressed by mental health services if people are to seek and accept help.

---

[1] Nazroo J, *The Health of Britain's Ethnic Minorities*. Policy Studies Institute, 1997.

Although most often unintentional, discrimination can manifest itself in the provision of services that are inappropriate, inaccessible or insensitive. Although people from minority ethnic communities have additional needs for interpretation and advocacy services, historically these needs have not been accounted for in the way in which resources have been allocated to primary care.

Because people from the black and minority ethnic communities are part of the population for which the local Health Authority and Primary Care Trusts are funded, health initiatives should ideally be funded through mainstream budgets.

Age trends

Analysis of the age structure of black and minority ethnic communities reveals a much younger population than the majority community. Almost 40% are under 16, compared to around 20% of the white population. Over half of the school population of Birmingham is composed of pupils from black and minority ethnic communities.

At present, only 18% of people from black and minority ethnic communities are aged 65 or over. However, this will increase significantly over the next few years, because they comprise 37% of those in the age band 45-59.

Socio-economic position

Inner city areas such as Ladywood, Small Heath, and Sparkbrook house some of the most socially and economically deprived people in Europe. A disproportionate number of people from black and minority ethnic groups live in the areas. Diseases of poverty, such as heart disease and higher rates of infant death, are particularly common.

Health inequalities

In 1998, Birmingham Health Authority produced a second action plan that addressed specifically the health care needs of black and minority ethnic communities.[2] The plan included interventions that address the causes of excess premature death and ill health.

Issues for mental health services

Birmingham's most recent Health Improvement Plan made the following observations about the provision and use of mental health services by people from different local communities:

- A disproportionate number of African-Caribbean people, in particular young men, have contact with mental health services, and their treatment may include higher dosages of anti-psychotic medication. Research has shown that those receiving mental health services are frequently more cut off from their families, and are less ready to consult their GP at the onset of their difficulties. Late presentation increases the likelihood of detention under the Mental Health Act. After treatment, they are less likely to remain in contact with health professionals, and more likely to stop taking medication. They are also less likely to be offered psychological therapies.

---

[2] Birmingham Health Authority, *Action Plan For Black & Minority Ethnic Communities*, November 1998-November 2001, Cynthia Bower & Moosa Patel, Directorate of Primary Care Development, November 1998. The first action plan was agreed in November 1996. It concentrated on understanding community needs (local and national research, consultation processes); commissioning, contracting and monitoring; and organisational development (how to be more effective in purchasing services for minority ethnic communities).

- People from the Indian sub-continent comprise a heterogeneous group often loosely referred to as 'the Asian community'. While it is important that service providers recognise the many differences between groups, some general observations need to be borne in mind in service development. The 'Asian community' is in general under-represented in mental health services, and this is attributed to a number of factors. Research has shown that families often care longer for an individual before seeking outside help. People from the Indian sub-continent are less likely to have their mental health problems identified by a GP, and are less likely to access specialist care services. Values and understanding of mental illness may be at variance with western models of intervention, and western methods of assessment may not translate across cultures. Services which are not planned in a sufficiently culturally sensitive manner will not readily attract service users. 'Asian' people are more likely than white people to be detained compulsorily, although the percentage is lower than for African-Caribbean people. Both Asian and African-Caribbean groups are likely to be told less about their illness and to be more dissatisfied with their care.

- Research indicates that Irish-born people have the highest rate of admission to hospital of any group, with the predominant reasons being depression or alcohol-related disorders.

- Suicide rates are high in some black and minority ethnic communities. The evidence indicates that women born in East Africa, Sri Lanka and India have higher than average suicide rates, while those born in Pakistan, the Caribbean or Bangladesh have lower rates. Among Irish people, the suicide rate is 1.5 times the average, a level similar to that quoted for East African born women.

- The stigma, social isolation, communication difficulties, poverty and poor housing that often affect people in poor mental health can be exacerbated if that person is from the black or minority ethnic community.

- It is important to design services that overcome the reasons behind delayed requests for help, and which are delivered in a manner and in a location which is acceptable to each community. Often this is best done by voluntary sector organisations within particular minority communities.

- Services should be staffed, in part at least, by people from the same ethnic community; and they should utilise service users in the planning, delivery, and monitoring of services.

- There 'are marked variations in the numbers of people with a learning disability from different ethnic groups and much of the need within the black and minority ethnic communities has not been met.'

SOCIAL-ECONOMIC DATA

Areas of high social deprivation correlate with an increased prevalence of mental illness and use of services, such as admission to hospital.

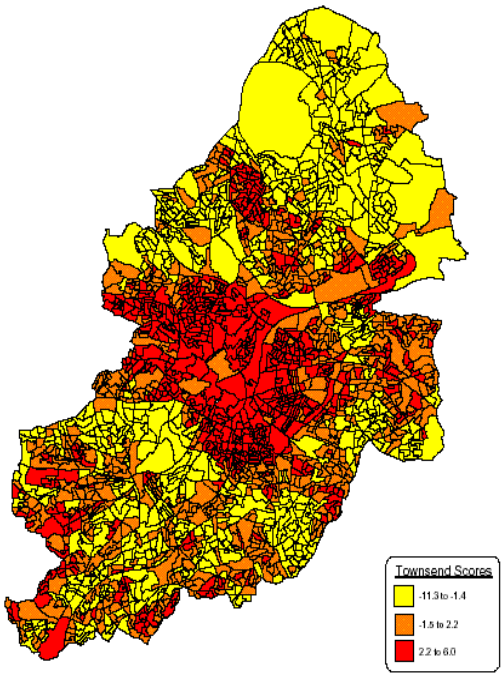
Birmingham is fifth in the country in the National Index of Local Deprivation; and, according to the recently published index of multiple deprivation, it ranks 23rd out of 354 local authorities in England (where a rank of one indicates most deprived).[3] The city ranks first on the income and employment dimensions of this index.

[3] Department of the Environment, Transport and the Regions, 2000.

36% of Birmingham's electoral wards are among the most deprived 10% in the country, indicating extremes of poverty.

There are two measures of deprivation frequently used, the Jarman and Townsend scores. The map on the right sets out the Townsend scores for Birmingham's electoral districts.

Figure 5 Townsend Scores: Birmingham EDs,



Homelessness

There are relatively high levels of homelessness in Birmingham, with 3.5 homeless households per 1000, compared with 1.3 per 1000 in England, and 1.5 per 1000 across the West Midlands.[4]

The number of people in Birmingham who are roofless is thought to be small (under 100), but counting is complicated by those who 'skipper' in disused warehouses etc, and are therefore hard to locate. In addition, the police have had a 'move on' policy in the city centre so many rough sleepers move to the outskirts.

There are over 500 bed spaces available in direct access hostels in Birmingham. It is thought that many hostel residents have mental health problems but are unknown to psychiatric services.

HEALTH INDICATORS

Birmingham's last two public health reports highlighted major health inequalities across the city.[5]

Health indicators demonstrate poorer general health in Birmingham than elsewhere in England, although the levels of ill-health are similar to those for other areas with similar social characteristics.

Compared with many cities, infant and child health is worse, and life expectancy is much shorter in areas of high unemployment, low incomes and social isolation. The city has slightly higher than average treatment rates for substance misuse, and suicide rates similar to the average.

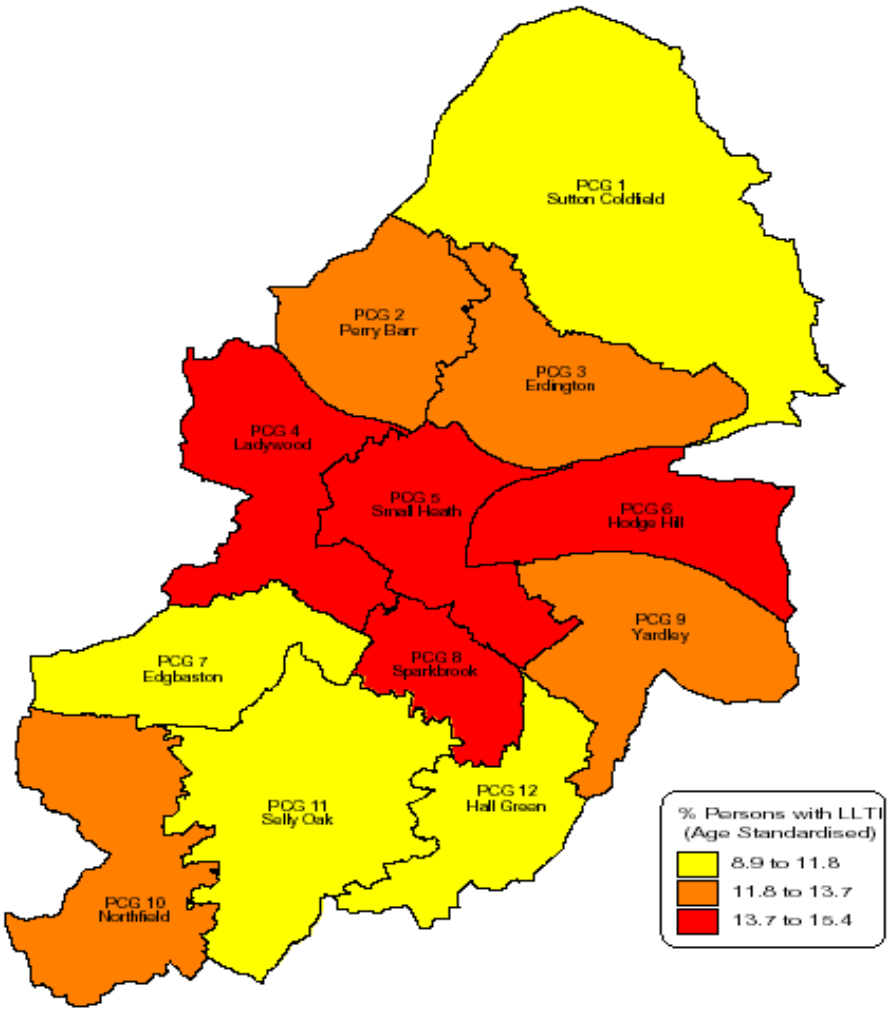
---

[4] Households accepted as homeless and in priority need. Statutory homelessness statistics, Department of the Environment, Transport and the Regions, 2000.

[5] *Closing the Gap, Ten Benchmarks for Equity and Quality in Health* (Birmingham Public Health Report, 1995); *Meeting the Needs?* (Birmingham Public Health Report 1996/97).

Varied health

There is considerable variation within the city. Birmingham includes some of the country's most deprived communities, and these have the poorest health indices.[6] The following map shows the percentage of city residents with a limiting long-term illness (by the then primary care group areas).



The Mental Illness Needs Index (MINI)

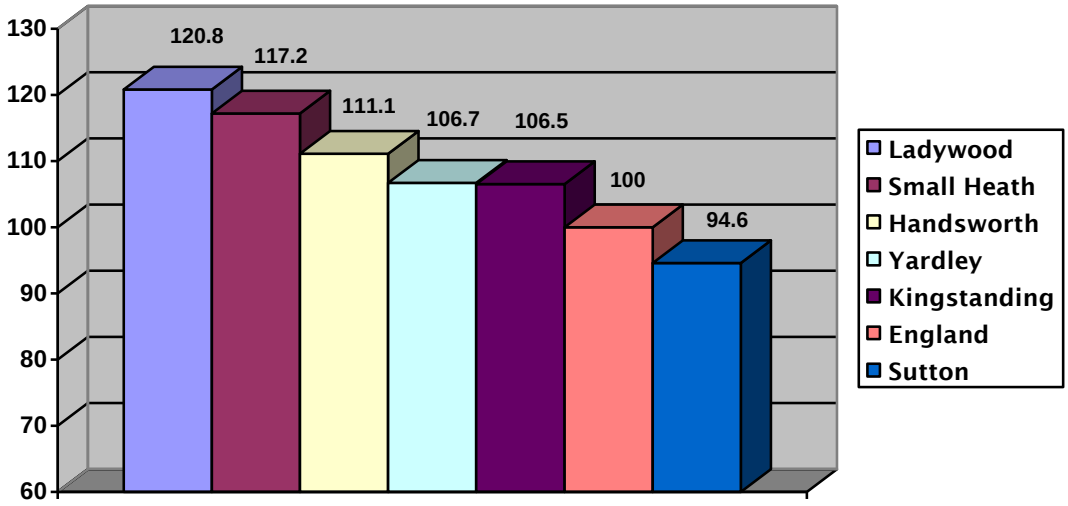
The Mental Illness Needs Index (MINI) estimates the level of mental illness expected within an area, by using factors known to lead to poorer mental health, such as unemployment, homelessness and low income. The average score for England and Wales is 100. Areas with a score above 100 are likely to have higher levels of mental illness than average (Hackney, in London, scores 120), those below 100 lower.

The electoral wards in north Birmingham include the most and least deprived in Birmingham: Aston, Sparkbrook and Small Heath are the most deprived, whilst Sutton Four Oaks, Sutton Vesey and Sutton New Hall are the most affluent.

---

[6] Benzeval M, Judge K, & Whitehead M, *Tackling Inequalities in Health: An Agenda for Action*. Kings Fund Institute, 1995.

BIRMINGHAM MINI SCORES



2 — OVERVIEW OF THE NHS IN BIRMINGHAM

Mr Hamilton and Mr Rehman both lived within the area then served by BIRMINGHAM HEALTH AUTHORITY, BIRMINGHAM CITY COUNCIL SOCIAL SERVICES and the NORTHERN BIRMINGHAM MENTAL HEALTH NHS TRUST, and received in-patient treatment in Birmingham.

On 1 April 2002, many aspects of the NHS in England were reorganised, and in Birmingham this resulted in the formation of a new health authority and four primary care trusts.

For the most part, the changes on 1 April 2002 did not affect the NHS trusts that manage NHS secondary services. However, on 1 April 2003, the NORTHERN BIRMINGHAM MENTAL HEALTH NHS TRUST merged with the SOUTH BIRMINGHAM MENTAL HEALTH NHS TRUST, to form the BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS TRUST.

BIRMINGHAM HEALTH AUTHORITY

On 1 April 1996, the former North Birmingham Health Authority, South Birmingham Health Authority and Birmingham Family Health Services Authority were merged to form BIRMINGHAM HEALTH AUTHORITY.

The local adult mental health strategy

An adult mental health strategy was agreed by Birmingham Health Authority and Birmingham City Council in December 1998. The main elements of the strategy are summarised in the following table.

BIRMINGHAM'S ADULT MENTAL HEALTH STRATEGY

Fundamental Strategic Principles

- ☐ The strategy should be comprehensive and inclusive, addressing the specific needs of different age groups, women and men, homeless people, and individuals from black and minority ethnic communities.
- ☐ It should have a sound epidemiological base, taking into account the characteristics of the population and indicators of mental health need.
- ☐ It should reflect current national guidance and thinking on best practice, evidence of the effectiveness of different interventions and service models, and the views of service users and carers.
- ☐ It should be consistent with the statutory obligations of the agencies.

Key Service Principles

- ☐ To enable people with mental health problems to lead an ordinary life as far as possible, and to enjoy the same rights as other citizens.
- ☐ To meet individual needs by being flexible, responsive and comprehensive, and to address specific needs related to age, culture, religion, gender, sexual orientation and disability.
- ☐ To provide services of a consistently high quality, based on standards agreed in consultation with service users, and which offer a degree of choice based on up-to-date information about services and effective interventions.
- ☐ To enable users of services and their representatives to be actively involved in the planning, delivery and monitoring of services.
- ☐ To give people a greater say in how they live their lives, and to ensure that advocacy services are available to facilitate this.
- ☐ To ensure, through effective partnerships between all relevant agencies, that well co-ordinated locally accessible services are available to respond quickly and flexibly to the mental health needs of the community.
- ☐ To continually evaluate services and to maximise cost-effectiveness, so that users achieve the best possible quality of life from the resources available.

Key Service Aims

- ☐ To promote recovery.
- ☐ To build on the strengths and independence of the individual by an emphasis on positive health and well-being rather than on disease and symptom control.
- ☐ To provide and actively evaluate a programme of treatment, care and support based on the needs and expressed wishes of the individual or his/her representative.
- ☐ To meet mental health needs in the least restrictive environment through a

fully co-ordinated multi-disciplinary service of properly trained staff.

- ☐ To provide an easily accessible local service and to develop a range of relevant support services in the community.
- ☐ To support the move of people in institutional care to community-based facilities based on their individual needs.
- ☐ To provide appropriate facilities for those who need higher levels of care than can be provided in community facilities.
- ☐ To provide services which meet the specific needs of women, homeless people, and individuals from black and minority ethnic communities.

Key Messages from Stakeholders

- ☐ User involvement.
- ☐ Culturally competent services.
- ☐ Changing public attitudes.
- ☐ Information.
- ☐ Accessible services.
- ☐ Money for those in poverty.
- ☐ Accommodation.
- ☐ Meaningful activity.

Health Improvement Programme

The local HImP identified several priority areas for action: coronary heart disease and stroke, infant and child health, promoting independence, modernising health and social care, and creating healthy, supportive environments.

Management arrangements

The Health Authority's management and commissioning arrangements did not, we think, give sufficient priority to mental health. Immediately prior to the authority's dissolution, the 'Senior Commissioning Manager for Mental Health & Learning Disability Services' reported to the Deputy Director for Performance & Strategy, who reported to the Executive Director for Performance & Strategy. Mental health commissioning was therefore positioned two tiers beneath board level.

Financial arrangements

We were informed that Birmingham Health Authority spent 11% of its budget on mental health services, compared with 22% in Southwark and Lambeth. Furthermore, the authority spent less than half the sum per head on mental health services spent in parts of inner London. If this is correct, it explains some of the significant service deficits described in our report.

Dissolution of Birmingham Health Authority

On 1 April 2002, Birmingham Health Authority and five adjacent Health Authorities (Dudley, Sandwell, Solihull, Walsall, and Wolverhampton) were dissolved and replaced by a single health authority, the BIRMINGHAM AND THE BLACK COUNTRY HEALTH AUTHORITY.

Birmingham & The Black Country Health Authority

The new 'Strategic Health Authority' covers a population of around 2.36 million people, over a dozen NHS trusts, and a similar number of primary care trusts. Its functions are more limited than those of its predecessor:

- ☐ PCTs are now the lead NHS organisations, and revenue allocations are made directly to them. They must assess need, plan and secure all health services, improve health in their localities, provide most community services and develop primary care.
- ☐ NHS trusts continue to provide most secondary care and specialist services in hospitals.
- ☐ Strategic Health Authorities will provide strategic leadership and seek to ensure that NHS organisations work together to deliver the NHS Plan and the devolution agenda.
- ☐ PCTs and NHS trusts are accountable to the Strategic Health Authorities, and performance managed by them through performance agreements.
- ☐ Strategic Health Authorities are, in turn, accountable to the Secretary of State for the performance of the NHS in their area.

STRATEGIC HEALTH AUTHORITIES

Performance Improvement Functions

- Encouraging greater autonomy for primary care trusts and NHS trusts.
- Supporting PCTs and NHS trusts in local strategic partnerships.
- Supporting the development of clinical networks and organisations.
- Ensuring proper leadership and the involvement of professional groups.
- Ensuring consultation on major service reconfigurations, and supporting local authorities in this area.
- Supporting clinical governance programmes.
- Managing the performance of 'cross-boundary programmes and networks.'
- Resolving conflicts.
- Creating cohesive strategies for capital investment, information management and the development of the workforce.

Contribution of Birmingham Health Authority

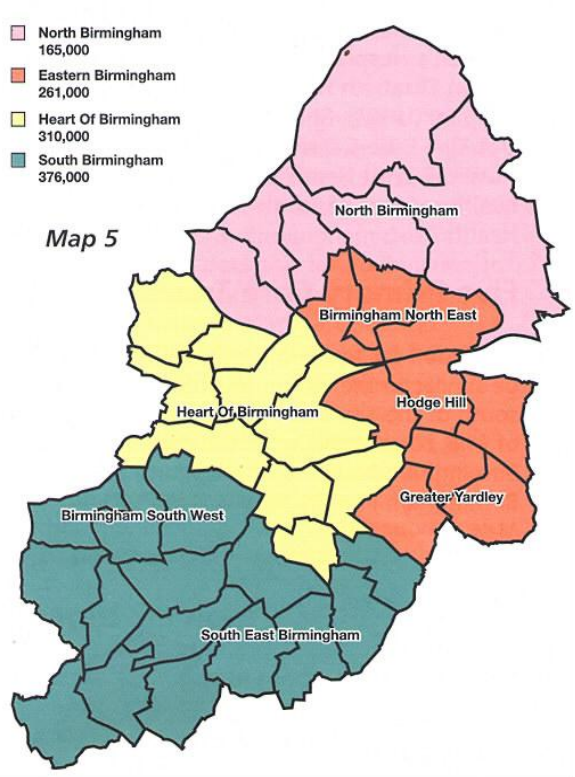
Birmingham Health Authority contributed to several important service developments during its six years in existence. These included the closure of the old asylums in south Birmingham; the development of locality-based functional teams in the north of the city (primary care liaison, emergency and home treatment, assertive outreach and continuing needs); assertive outreach services and rapid response services in the south; the development of crisis houses as an alternative to hospital admission; and the establishment of an early intervention service for those with a first psychotic episode.

BIRMINGHAM'S PRIMARY CARE GROUPS AND TRUSTS

Primary care trusts developed from pre-existing organisations with more limited powers called primary care groups. On 1 April 2002, four primary care trusts came into existence in Birmingham. They are now the lead NHS organisations.

Establishment of primary care groups

Twelve primary care groups were established in Birmingham in April 1999. These groups were sub-committees of Birmingham Health Authority. Their role was to improve the health of the local community; to reduce health inequalities; to develop primary care; and to commission, or to advise the authority on the commissioning of, local health services.



It soon became clear that this number of primary care groups was not sustainable, and they were replaced by five larger primary care groups in April 2001. In addition to these five groups there were also two pilot primary care trusts established in October 2000, in Greater Yardley and Birmingham North East.

The position in April 2001 was therefore that Birmingham was served by five primary care groups and two primary care trusts.

Establishment of primary care trusts

On 1 April 2002, these organisations were dissolved, as was the BIRMINGHAM SPECIALIST COMMUNITY HEALTH NHS TRUST, and most of the other trusts that provided community health services. They were replaced by four primary care trusts (see the above diagram).

Community health services are therefore now provided by PCTs, which also provide primary care services and commission secondary (specialist) services. The trusts have been given various functions and responsibilities that were not possessed by the primary care groups they replaced. For example, they can employ staff; own and manage property; enter into partnership arrangements with non-NHS agencies; provide community health services and (if appropriate) mental health services.

A primary care trust's key functions include:

- ☐ Improving the health of the community through community development, service planning, health promotion, health education, commissioning, occupational health and performance management. PCTs will identify the health needs of their local populations, develop plans for health improvement, lead the development of the local health strategy, and deliver it by providing and commissioning services from primary care practitioners and NHS Trusts.
- ☐ Securing the provision of:

  — primary care, community health, mental health and acute secondary care services;

  — personal medical services including out-of-hours and walk-in centres;

  — medical, dental, pharmaceutical and optical services;

  — emergency ambulance and patient transport services;

  — the health contribution to child protection services;

  — all primary care development.
- ☐ Regulating the contracts of all family health services providers.
- ☐ Managing clinical performance in the PCT.
- ☐ Developing a coherent modern nursing service.
- ☐ Implementing population screening.
- ☐ Ensuring the involvement of patients, public, voluntary sector and local communities in plans.
- ☐ Integrating local health and social care through the use of recent legislation. Where the local agencies agree, care trusts 'will be important vehicles for modernising both social and health care, helping to ensure that integrated services are focused on the needs of patients and users'.

Eastern Birmingham Primary Care Trust

Eastern Birmingham Primary Care Trust serves 261,000 people across nine wards. The area has 129 GPs in 62 practices, supported by over 500 practice staff; 59 pharmacies, 29 dental practices and 29 opticians.

The PCT holds over £200m to purchase hospital and community services for Eastern Birmingham.

PCTs and mental health

A MENTAL HEALTH CO-ORDINATING GROUP has been established by the four PCTs. However, each PCT commissions its own 'routine' mental health services.

BIRMINGHAM PRIMARY CARE TRUSTS		
PCT & POPULATION	**PREVIOUS PCGS/PCTS**	**NOTES**

Eastern Birmingham (260,000)	Hodge Hill (PCG), Birmingham North East (PCT), Greater Yardley (PCT). Acocks Green, Erdington, Hodge Hill, Kingsbury, Shard End, Sheldon, Stockland Green, Washwood Heath, Yardley.	The PCT now responsible for the addressess at which Mr Hamilton's and Mr Rehman's lived.
Heart of Birmingham (310,000)	Ladywood, Small Heath, Sparkbrook Aston, Handsworth, Ladywood, Nechells, Sandwell, Small Heath, Soho, Sparkbrook and Sparkhill.	This PCT area comprises a black and ethnic majority population, situated alongside the affluent city centre. High levels of deprivation across most communities. The population was served by both the Northern and South Birmingham Mental Health Trusts.
North Birmingham (186,000)	North Birmingham PCG. *Perry Barr, Oscott, Kingstanding and the Sutton Coldfield wards of New Hall, Four Oaks and Vesey, together with one practice in Erdington.*	Generally more affluent than the Birmingham average, but Kingstanding is one of the most deprived wards in the country. Predominantly white population (around 90–97% per ward). The two main minority ethnic groups are Black Caribbean who are primarily resident in Perry Barr (5% of ward population), Kingstanding (3% of ward population) and Oscott (2%), and Indian. Some of the population served by the mental health services of Northern Birmingham Mental Health Trust.
South Birmingham (376,000)	Birmingham South West and South East Birmingham Primary Care Groups. *Bartley Green, Billesley, Bournville, Brandwood, Edgbaston, Fox Hollies, Hall Green, Harborne, Kings Norton, Longbridge, Moseley, Northfield, Quinton, Selly Oak, Weoley.*	This PCT also provides a range of specialist city-wide community health services. Mental health services previously provided by the South Birmingham Mental Health Trust.

THE NORTHERN BIRMINGHAM MENTAL HEALTH NHS TRUST

The Northern Birmingham Mental Health NHS Trust was established in 1994 following the merger of three hospital units directly managed by the former North, East and West Birmingham District Health Authorities. It was dissolved on 1 April 2003 (see below).

The trust was a multi-site trust that provided a variety of mental health services for adults and older adults in north Birmingham. It also provided a city-wide substance misuse service and a city-wide service for the Chinese community.

The trust covered a population of approximately 562,906, amounting to just over a half of the total population of Birmingham, across six localities: Ladywood, Handsworth, Kingstanding, Sutton Coldfield, Yardley and Small Heath.

Resources

The trust had an annual income of £42.1 million in 2000/01. The number of staff that it employed is shown below:

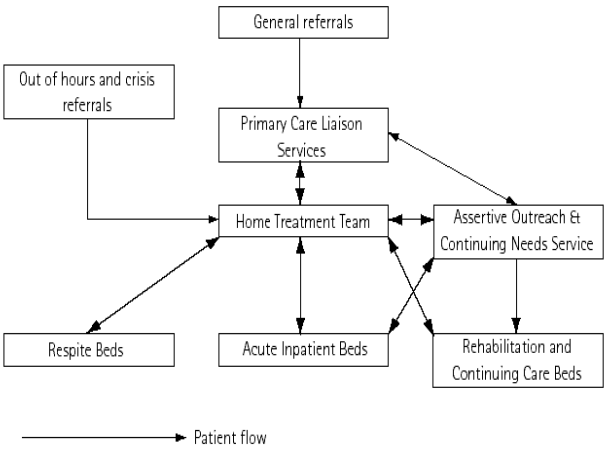
BREAKDOWN OF TRUST STAFF AS AT 31 MARCH 2000		
Staff group	Number of staff in post	Whole time equivalents
Ancillary	100	74.6
Clerical	267	253.0
Maintenance	11	10.9
Medical	84	75.7
Nursing	697	674.0
Professions allied to medicine	55	51.3
Scientists	42	38.5
TOTAL	1256	1178.0

The North Birmingham model

Until the early 1990s, almost all of the mental health services provided in north Birmingham were provided at three old Victorian hospitals.

In 1994, the first of them was closed and its services were replaced by an integrated locality system in Yardley and Small Heath. Since then, the trust has developed an integrated service model, replacing centralised in-patient facilities and multi-function community teams with single-function community teams.

Figure 3. Localities model – adult services



An integrated locality system has four principal components: home treatment, assertive outreach, rehabilitation and recovery, and primary care liaison. These components are backed up by day services and in-patient and respite beds.

The trust gained national recognition for its innovative services, and many elements of its service model feature in the National Service Framework for Mental Health Services.

A 'functionalised' model

The functional model of care is based on the idea that patients are best served by matching their need to a team whose core function is to satisfy that need. It involves three or four inter-locking community mental health teams in each locality:

1	Home treatment teams that provide acute care through crisis houses in the community. (The term 'crisis resolution team' implies that the resolution of the crisis is the end goal, but such crises are an ongoing situation for many patients. The trust's aim was to provide ongoing services.)
2	A continuing needs component. Assertive outreach is the most prominent aspect of this and, specifically, involves rehabilitation and recovery. Within each assertive outreach team and early intervention service one person is allocated to get people involved in mainstream employment.
3	A primary care mental health liaison service. Each locality has a GP liaison service.

The trust set up six home treatment teams and five assertive outreach teams in over six geographically discrete localities. The home treatment teams each serve one locality each. The same applies to the assertive outreach teams, with the exception of one team that covers two localities.

The home treatment service as a whole receives about 250 referrals each month (40–50 per team), and accepts around 40–50% of patients for home treatment, working with them on average for between 18 and 21 days. Approximately 80% of the people who come into contact with the trust's home treatment services manage to stay out of the hospital. Broadly speaking, there are three kinds of client:

- ☐ 'Fast recoverers', who are only involved with the service for 24–48 hours. Usually they have a very brief crisis involving a specific problem, such as housing or benefits.
- ☐ Long-term clients with often quite complex and intractable problems.
- ☐ A middle group of clients who may be acutely ill for three weeks or thereabouts. This group is by far the most common.

Consultant input varies because each catchment area has its own needs and demands. In an area with lower morbidity and demand, the consultant might undertake several functions. If the functions can be provided within a generic model then one consultant might span all five of the functional teams. In areas with greater morbidity, each functional team may have its own consultant. For example, Ladywood has a very high level of morbidity in relation to severe mental illness, and there home treatment, assertive outreach and primary care liaison teams were established with their own dedicated consultant.

The trust's in-patient services

During the period covered by our review, the trust provided in-patient services at four sites:

- ☐ Highcroft Hospital in Erdington;

- All Saints Hospital in Winson Green;
- Newbridge House in the Yardley Green/Hodge Hill locality; and
- Small Heath In-Patient Unit

The closure of the long-stay psychiatric hospitals in north Birmingham was more protracted than in the south of the city.

In 1995, the Health Authority approved the closure of All Saints and Highcroft Hospitals, and the reprovision of its services through small in-patient units, crisis houses, and comprehensive community services.

Implementation of the proposals was delayed because of the need to secure capital through the Private Finance Initiative. However, a full business case was eventually approved in 2000, and this involved vacating the All Saints site and building replacement in-patient units at Highcroft Hospital.

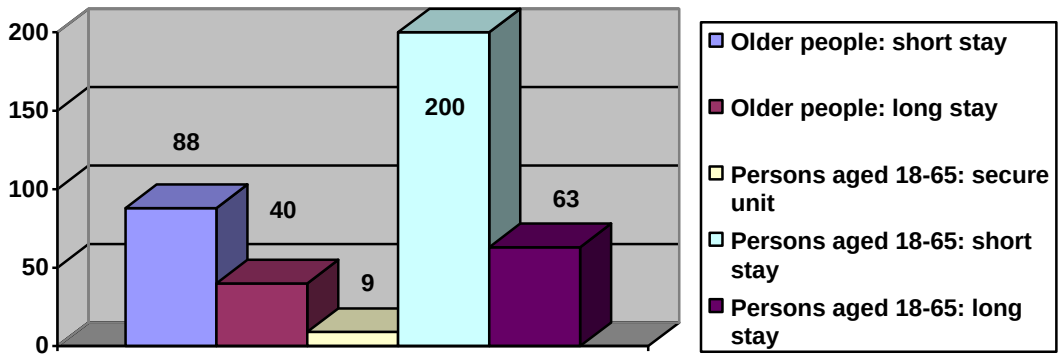
Birmingham Health Authority promised that all of the money released by the reprovision of services will stay in mental health.

It also agreed that 25% of the funds released for community services would be transferred to social services, to fund a range of additional social care services agreed between the two authorities.

Bed numbers and occupancy levels

The 'Körner returns' for 1999/2000 indicate that the trust had 400 beds at that time, as shown in the chart below. (It should be noted that sixteen of the 200 short-stay beds for persons aged 18–65 were beds used by the trust's addiction services.)

Northern Birmingham Mental Health NHS Trust: Number of beds, 1999/2000



Doubt has subsequently been cast on the accuracy of these formal returns. We have recently been told that there were only 98 short-stay acute beds at this time, not 200.

Approximately 2,200 inpatients were admitted that year, with a further 380 day-attenders using a bed. There were 42,000 regular day attenders; 2,993 ward attenders; and 13,000 outpatient attendances.

The Adult Mental Health Strategy agreed in 1998 acknowledged that 202 acute in-patient beds was below the predicted number for Birmingham's population, and that these beds were often under pressure. For example, on occasion people had been held in inappropriate settings, such as police stations or A&E departments, while a bed was sought and this needed to be addressed. However, it was anticipated that the pressure on acute beds would be relieved if well-managed 24-hour home treatment services and other alternatives to admission were available across the city. The strategy was to prioritise investment in alternatives to hospital rather than in increasing bed numbers.

In 2001, the Commission for Health Improvement commented on the high bed occupancy rates at Small Heath and Newbridge House. Small Heath's 14-bedded unit had 14 resident patients and 11 patients on leave, giving an occupancy rate of 178%. At Newbridge House's 20-bedded unit, there were 18 resident patients and 11 on leave (145%).

Intensive care

According to the mental health strategy in 1998, there were 24 intensive care beds in north Birmingham and 10 in south Birmingham. (However, we have since been told that there were only 12 intensive care beds in north Birmingham at the time.) The strategy was to maintain this level of provision.

High dependency (special needs) beds

These 24-hour nursed care places accommodate people who are highly dependent and have very severe and enduring mental health problems. A 26 bed unit has been built on the Highcroft site, and 18 of these beds are for Birmingham residents.

Rehabilitation services

Three functional groups of individuals with longer-term severe mental illness can be distinguished on the basis of need:

- ☐ People who are difficult to engage and either pose severe risks to others or are at risk of self-harm or social exclusion.

- ☐ People who are more likely to work with the service and pose relatively less risk. This group tends to split into two: those with high needs and those with less severe needs.

- ☐ People in the early stages of illness who are at risk of developing a long-term disability.

The mental health strategy in 1998 proposed 57 NHS adult rehabilitation beds. This was in addition to the existing 32 beds in rehabilitation units managed by voluntary organisations with statutory funding, and the other housing options supported by rehabilitation services. There are currently 24 rehabilitation beds.

Use of the 1983 Act

Because of the integrated locality system, only patients who cannot be cared for at home with intensive support are admitted to hospital. Consequently, a high proportion of these patients tend to be detained under the Mental Health Act.

In April 1999, the Mental Health Act Commission was concerned that there was not always evidence of section 17 leave being granted to patients, and nor were the reasons for leave always recorded. In August 2002, as a result of new trust guidance, the Commission noted a marked improvement in practice.

Community support services

The community support services developed over recent years include primary care liaison, home treatment, assertive outreach, and rehabilitation and recovery services. There were 140,503 community 'patient contacts' during 1999/2000:

COMMUNITY TEAMS WORKLOAD DURING 1999/2000

Primary care liaison	29,388
Home treatment	27,507
Assertive outreach	16,539
Occupational therapy	16,417
Rehabilitation and recovery	15,150
Physiotherapy	14,724
Other adult	13,826
Psychology	4,265
Art therapy	1,792
Frantz Fanon Centre (Afro-Caribbean services)	895
TOTAL NUMBER OF CONTACTS	140,503

Some people in crisis can be accommodated in crisis or respite houses whilst they receive intensive input from the home treatment team. The hospitals closure programme for north Birmingham included plans for 29 beds of this kind.

Services for minority ethnic groups

The trust provided a number of trust-wide services that reflected the ethnicity of the local population. For example, the Frantz Fanon Centre was established to provide mental health services for the African-Caribbean community. It now provides an outreach style approach for African-Caribbean clients.

The trust produced videos for Asian women, including ones on depression and suicide, provided a hospital befriending service, and held events for service users.

Other local iniatiatives included the implementation of a joint finance initiative for an African-Caribbean advocacy service, and the establishment of Chinese and Asian mental health projects to improve services to these communities.

CHI Report (July 2001)

The Commission for Health Improvement conducted a clinical governance review of the Northern Birmingham Mental Health NHS Trust between December 2000 and May 2001. According to the Commission:

- ☐ Personal safety was an area of concern for staff and service users.
- ☐ Between June and October 2000, 468 incidents of violence, abuse or harassment across the trust were reported via the Safecode incident reporting system. In August 2000, the trust was served with a health & safety improvement notice in respect of violence towards medical staff at Highcroft hospital.
- ☐ Staff interviewed on the wards at Small Heath and Yardley said they felt unsafe and reported difficulties getting back up when required.
- ☐ Violence was described as 'an everyday occurrence' at Newbridge House. It was thought that there were 'not enough staff in public areas to minimise the risk of violence by other patients'. Indeed, in-patients felt they were having to provide support to other service users because of low staffing levels at Newbridge House.
- ☐ Staff at Newbridge House felt vulnerable to violence from the local community.
- ☐ There was no regular training for staff in risk assessment and management, and attendance at basic health and safety training was not prioritised.
- ☐ The trust had no clinical risk strategy or structure, and no systematic risk assessment training was undertaken by staff. The trust needed to strengthen its risk management strategies.
- ☐ There was a good system in place for learning from suicides, and the trust was establishing systems for learning from other incidents.
- ☐ The trust had good links with other organisations, including social services and other health organisations.
- ☐ The clinical leadership was good in the medical directorate.

Financial pressures

The trust's income (turnover) was approximately £48m during 2001/02, compared with approximately £39.5m in 1998/99:

YEAR	TURNOVER
2001/2001	£45.69m
1999/2000	£42.84m
1998/1999	£39.44m

The trust experienced severe financial pressures during 2002–2003. It had a £1.4 million overspend in September 2002, which was thought to be partly due to the effects of bed blocking and ward staffing costs. As a result, the trust considered various responses, including freezing vacancies and cutbacks on drugs. It was later reported that the Chapman Road Day Centre in Small Heath had been due to close for five months.

The total NHS overspend in the West Midlands at this time was £7 million, almost all of which could be attributed to increased GP prescribing expenditure, and the overspend was predicted to rise to £11 million for the year as a whole.

Management arrangements

The reorganisation of senior management positions in 1999 saw the creation of a Director of Older Adult Services, who was also responsible for the implementation of the care programme approach, medical records, and Mental Health Act compliance matters. This director attended board meetings but did not have executive director status.

It will be seen that we were concerned about the implementation of the CPA, medical records, and Mental Health Act compliance, and we think an executive director ought to have been responsible for such important matters.

Dissolution of the Northern Birmingham Mental Health NHS Trust

Until 1 April 2003, Birmingham presently had two specialist mental health trusts, and their services were configured somewhat differently:

- The Northern Birmingham Mental Health NHS Trust was a multi-site trust that provided a variety of services for adults and older adults in north Birmingham. It also provided a city-wide substance misuse service.

- The South Birmingham Mental Health NHS Trust provided mental health services to 460,000 adults and older adults in south Birmingham and 205,000 people in Solihull. It also provided forensic mental health services (at the Reaside Clinic), mother and baby, eating disorder and neuropsychiatry services for West Midlands residents; and therapeutic community and deaf services for West Midlands residents and beyond.

On 1 April 2003, the NORTHERN BIRMINGHAM MENTAL HEALTH NHS TRUST merged with the SOUTH BIRMINGHAM MENTAL HEALTH NHS TRUST, to form the BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS TRUST.

This merger had been advocated by Birmingham Health Authority in 1998 on the grounds that:

- A single trust would underpin a common approach to service delivery, which remained a huge issue for service users;

- It would enable NHS mental health services in the city to develop a better interface with other significant agencies, most notably social services, but also the voluntary sector, employment and housing agencies, and the police;

- It would enable a consistent approach to the relationship with primary care to develop, the lack of which has been the subject of much frustration amongst general practitioners;

- It would allow city-wide approaches to the needs of particular communities, *e.g.* black and minority ethnic communities and outer city estate areas;

- It would reduce overhead costs, and this would enable additional investment in patient services.

4 — BIRMINGHAM CITY COUNCIL

Birmingham City Council has the largest social services department in Europe, and it provides a wide range of domiciliary, residential and centre-based services to people across the age spectrum.

Supporting the statutory organisations are 82 registered nursing homes, over 500 registered residential homes, and several hundred voluntary organisations.

Birmingham City Council shares the lead on mental health services, and areas such as cutting health inequalities and promoting independence. The social services department directly employs around 7,500 staff, including 289 in mental health.

MENTAL HEALTH SERVICES

Mental health services were taken out of the city's generic area structure in November 2000, and a separate city-wide mental health service was established. 103 social workers and 27 social worker assistants are now supported by seven mental health team managers and ten assistant team managers.

The managers do not carry cases. Their role consists of supervision, policy work, overseeing functional teams, attending team meetings, and financial management. On 1 April 2001, the mental health budget was devolved to team managers, and they are now responsible for all team budgets, including community care and external placements.

The council provides relatively few mental health services directly. It offers a range of day services but has only one residential home.

FINANCIAL ARRANGEMENTS

In 2000/01, Birmingham City Council had a budget of over £2 billion, of which some £233m was allocated to social services. £17.35m of this sum was allocated to mental health services, and £3.7m net of it to care management (including the social work teams).

A joint review of Birmingham Social Services conducted by the Audit Commission and the Social Services Inspectorate reported in July 2000. This report contained a number of observations about the council's social services budget:

- ☐ The authority was at the mid-point in terms of budget per head of population compared to other core cities;
- ☐ The budget for social services as a proportion of the total local authority budget was lower than for other core cities (it was the second lowest);
- ☐ Birmingham spent just over 5% above its Standard Spending Assessment (the amount the government considers necessary to provide a standard level of service). This was at the lower end of the scale in comparison with other core cities (some spent over 20% more);
- ☐ Birmingham spent proportionately more on older people and physical disabilities and less on mental health and learning disabilities.

ASW ARRANGEMENTS

In December 1996, Birmingham City Council employed 81 social workers who had been approved to exercise functions under the 1983 Act, of whom 70.9% were actually practising.

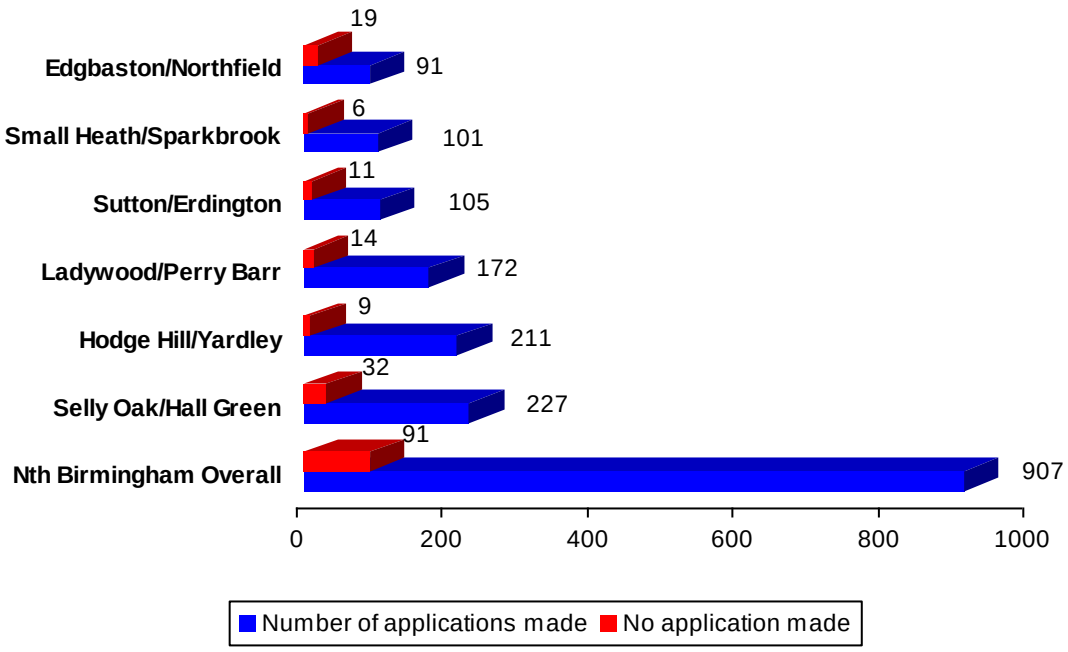
Only three of the 81 ASWs were Asian (two men and one woman).[7] One of them was attached to a CMHT, the other two being attached to day services and to the emergency duty team. There were only two male African-Caribbean ASWs.

By October 2001, the number of approved social workers had risen from 81 to 111.

ASW PRACTICE

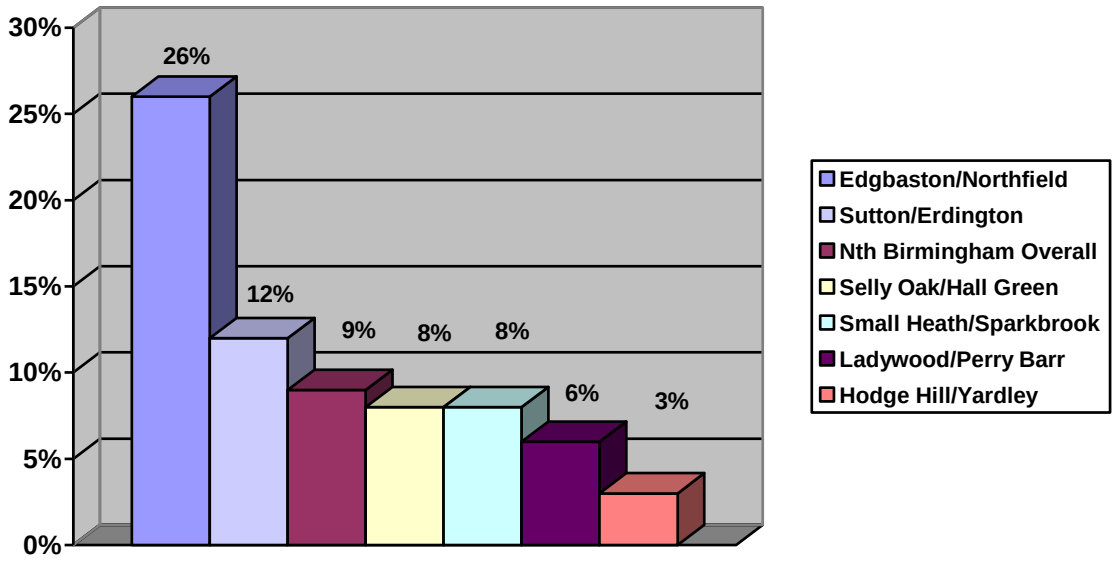
The following chart shows the number of applications for admission to hospital made by approved social workers, under sections 2-4 of the 1983 Act, during the period between 1 January 2000 and 30 September 2001.

As can be seen, 907 applications were made in all. If the data is accurate then one quarter of all of the applications for admission to hospital were made in Selly Oak/Hall Green (227 applications), compared with only 91 in Edgbaston/Northfield.



The percentage of Mental Health Act assessments that did not result in an ASW making an application for admission to hospital is set out in the next diagram.

[7] We have been informed that earlier in the year there were four Asian ASWs.



As can be seen, 26% of all assessments for admission in Edgbaston/Northfield did not result in compulsory admission to hospital, compared with only 3% in Hodge Hill and Yardley.

There could be many reasons for this: erroneous data, local practice, different levels of community resource, different pressures on local beds, etc. It is, however, possible that the relatively high number of compulsory admissions in Hodge Hill/Yardley, and the relatively low use of informal admission or of no admission to hospital at all, has added to the pressure on beds at Newbridge House. This needs to be investigated further.

5 — MR HAMILTON'S CARE AND TREATMENT

ABOUT THIS CHAPTER

The main purpose of this chapter is to summarise the most important aspects of Mr Hamilton's personal history, care and treatment, and our findings concerning his care and treatment.

Mr Ogilpis Hamilton killed his neighbour, Mr Lewis Hodge, on 5 July 1999. He later pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to life imprisonment. This sentence was mandatory because the offence was not his first serious offence.

The homicide took place at Mr Hamilton's flat in Erdington, Birmingham. He was residing there informally, having been discharged from liability to detention in hospital fourteen years before. His medical diagnosis on discharge had been 'paranoid schizophrenia possibly complicated by a mild learning disability.'

Mr Hodge received in-patient treatment from the same NHS trust, and his name was on its supervision register. He too had a formal diagnosis of paranoid schizophrenia superimposed on a mild learning disability.

MR HAMILTON'S CONTACT WITH SERVICES

Mr Ogilpis Hamilton was born in Jamaica on 13 June 1942. He was brought up in the countryside by his parents, and had one brother and at least one sister. He had no serious injuries or accidents as a child, and seems to have been in good health. He was educated at a Roman Catholic school in Kingston until the age of 13, and has retained strong religious beliefs. Having left school without any formal qualifications, he worked as a farm labourer, carpenter and welder. He came to the United Kingdom in 1966, at the age of 24, settling in the Midlands. He was hard-working, spending much time labouring in order to avoid unemployment, but also undertaking press work, tube joining and welding. He lived with a partner in Willenhall from 1972 until 1979, and the couple had three children.

On 14 January 1975, Mr Hamilton attacked a workmate with a knife, causing injuries to his shoulder and ribs. According to a subsequent social enquiry report, his victim and other people were continually provoking him at work. He was then accused of stealing £10 from his victim's wages. On the day of the assault, he felt provoked to such an extent that he began to weep, and in his distress he attacked his victim with a penknife that he carried with him.

Mr Hamilton was charged with wounding with intent but granted bail. Seven weeks later, on 4 March, he was admitted to Walsall General Hospital, having been found unconscious at home. It is recorded that he stopped breathing and, having been revived, a few minutes later experienced 'tonic type convulsions of the whole body … and frothed at the mouth and was incontinent'. He was still deeply unconscious when examined in hospital. Routine investigations, including a brain scan and a lumbar puncture, were normal, with the exception of his EEG which suggested low amplitude. He was discharged from hospital after three weeks, on 25 March, with a diagnosis of 'unconsciousness with epileptiform fits.' On 10 April, he appeared before Stafford Crown Court and received 30 months imprisonment for wounding with intent.

Mr Hamilton was released on parole in April 1976, and he resumed family life with his partner and their children. In August, he obtained full-time employment. Some three years later, in 1979, he left his wife and children and moved to a bedsit in Erdington. He may have became more socially withdrawn around this time, but he

obtained employment as a press operator in the autumn. Reports again say that he was hard-working, conscientious and industrious.

On 3 June 1980, after nine months with the firm, Mr Hamilton again attacked a workmate with a knife, and this time he was charged with attempted murder. It is recorded that he chased a fellow employee, and stabbed him across the face, back and shoulder with a lock knife he used to cut fruit. His victim, who required 90 stitches, was disfigured for life.

Following his arrest, Mr Hamilton said his victim had said that 'he was a police informer, that he was no good and should be killed.' He had been subjected to the same abuse at his workplace, on the bus, and in local pubs. This provocation caused him such distress that he lost his self-control, and attacked his victim with the lock knife that he routinely carried.

Having been remanded in custody, Mr Hamilton asked to be isolated in prison under Rule 43, because he believed that some prison officers might incite other prisoners to attack him. He was in fact transferred to the hospital wing, where his mental state and behaviour were considered to be unexceptional.

According to the court social enquiry report, the attack was out of keeping with his general presentation:

> *'In the past Mr Hamilton has been perceived as a very quiet, polite person, his demeanour being rather deferential, articulate yet superficial and often guarded in attitude.'*

However, his two offences shared 'identical features' that 'must give cause for grave concern.' The report concluded:

> *'… Mr Hamilton will ideally require care and supervision within a controlled environment for an unspecified period of time. Mr Hamilton's future may be determined by his response to the medical treatment that may be provided. There is no adequate family support available to him and one cannot envisage his early return to the community without stringent conditions.'*

In the event, the psychiatric evidence did not enable the court to order Mr Hamilton's detention for treatment under the Mental Health Act. The consultant who prepared a psychiatric report for the defence was not shown the witness statements. He concluded that there was no evidence of any mental condition requiring medical treatment, and that Mr Hamilton was fit for any disposal deemed appropriate by the court. On 4 November 1980, he was convicted at Birmingham Crown Court of wounding with intent, and was sentenced to six years imprisonment.

While serving his sentence, Mr Hamilton 'apparently showed unequivocal signs of a psychotic illness such as auditory hallucinations, somatic hallucinations and … delusional explanations of these experiences'. In May 1983, after serving 30 months, the Home Secretary transferred him from prison to the Beauchamp Interim Secure Unit at the Central Hospital in Warwick. It is recorded that he responded 'very well to treatment with depot neuroleptics'.

After more than a year at the unit, Mr Hamilton was transferred to Highcroft Hospital in Birmingham on 11 August 1984. There was no evidence of any 'florid psychotic symptoms' at the time of transfer. He was soon granted leave to reside at Flint Green House in Birmingham, and a Mental Health Review Tribunal released him from his liability to detention in March 1985. It seems that the tribunal accepted that there was no clear evidence that he had been mentally ill at the time of his two violent offences.

His consultant was not convinced, and she remained concerned about the possibilities of a relapse in his mental state and further dangerous behaviour:

> *'I think there is a real risk that without [medication] he may relapse over the next few months and if he does so he is potentially a dangerous man. We will endeavour to keep the closest possible eye on him to detect any signs of psychotic relapse and to take appropriate action if this occurs.'*

The period from 1985 until 1999

Having been discharged by the tribunal, Mr Hamilton refused further injections but remained at Flint Green House until 28 October 1985. He then moved into his own accommodation, and continued to live alone in Birmingham until Mr Hodge's death. His contact with mental health services was intermittent. He did not believe that he was mentally ill, mostly failed to attend the out-patient appointments offered to him, and (apart from five prescriptions issued by his GP) consistently refused medication. He was willing to be visited by psychiatric nurses and social workers, but only if they were not too intrusive. He had a good relationship with his general practitioner.

It is evident that Mr Hamilton's mental state deteriorated during 1991. In a letter to his GP, dated 20 August 1991, he complained of verbal abuse from neighbours 'that was also coming from the church and the bus'. A note made at the time records that he 'told the doctors that some neighbours were shouting abuse at him, but it was not racial abuse. The voices said, "They'll find out where I live and they shout abusive words at me, saying '£40,000 — you won't get away with it"'. These auditory hallucinations consisted of both male and female voices, and they had started three months previously.

From 1991 onwards, Mr Hamilton made numerous complaints about many of his neighbours, most of which involved allegations of racist abuse. In all, he complained about the occupants of eight addresses nearby, including all three of his neighbours in the small block of flats where he lived. He also complained about the behaviour of visitors and passers-by. His conduct caused others to be wary of him:

> *'People always tended to steer clear of Gil if they could because of his behaviour. If anyone ever spoke to him Gil would call them racists.'*

> *'Since I've known Gil I got to know that he's got a nasty temper. He used to play his guitar in his back garden at 4am in the morning. When people would complain to him he would shout back at them calling them racists.'*

During the 16-months between November 1991 and March 1993, Mr Hamilton's general practitioner issued him with five one month prescriptions of Roxiam (an oral antipsychotic) and Disipal.

In March 1993, Mr Hamilton's community psychiatric nurse discharged him from his caseload, informing his general practitioner that, 'I feel there is no alternative but to discharge this man from my caseload as contact with him appears virtually impossible.' The CPN told us that:

> *'It was very difficult keeping appointments with him because he always had things to do. I think in the end I had to discharge him because there was an unwritten policy that people who failed to keep two appointments were automatically discharged. I think that still exists to a large extent in many areas. And of course the risks were not identified. It would have been a normal procedure. The pressures and caseloads, and being expected to take on referrals as well, at the time prevented you from keeping a non-attendance an active case.'*

Mr Hamilton made a rash of complaints concerning the behaviour of neighbours and passers-by during the four months between 21 December 1993 and 29 April 1994.

During 1995, he was visited by a community nurse employed by social services. However, she went on sick leave towards the end of the year. When it became clear that she would be absent for some time, her team leader asked the trust's CPN service to provide cover. Mr Hamilton was allocated to an experienced community psychiatric nurse.

This nurse immediately raised serious concerns about his mental state, his need for supervision and the risk of violence, as a result of which Mr Hamilton made a formal complaint against him:

> *'I felt that this was a man who was capable of serious offending and that had been my impression from reading his history and certainly my contact with him. I was concerned with just how rigid and focused and slightly obsessed with the issue he was – and the fact that it was very difficult to get him to shift off the subject, to engage him elsewhere.'*

> *'I think it is fair to say that I was concerned about the arrangements for Mr Hamilton's care and I think that is reflected in the contents of my letter to [my manager] … My primary concern was that Mr Hamilton should be psychiatrically assessed, as my view was that given his history he was not adequately engaged with the mental health service.'*

> *'He was effectively saying that he did not want to see me again because he was unhappy with what I had done regarding his complaint with his neighbour.'*

A multi-disciplinary team meeting was convened in May 1996, and an experienced social worker was asked to take over Mr Hamilton's case. This social worker did not receive the medical and nursing notes, and knew little of the forensic history. He knew of Mr Hamilton's convictions, that a diagnosis of paranoid schizophrenia had been made, and of the medical view that he required medication.

By the beginning of 1996, the police were also expressing concerns about Mr Hamilton's health. Thirteen police officers had visited him in response to his frequent complaints of racial harassment, and his demeanour was sufficiently unsettling that they would not visit him alone. A police inspector who was following up a letter that he had sent to the Chief Constable concluded that he was 'not a well man' and that 'a lot of the things that he's saying don't make sense'.

As a result of the concerns expressed by his community psychiatric nurse and the police, Mr Hamilton was assessed for admission to hospital under the 1983 Act on 1 July 1996. He was not considered to be detainable. According to his social worker:

> *'I think it was just accepted that this was Mr Hamilton, that whatever he's done or whatever he's said, he will always continue saying that he's harassed, that he's racially harassed. All his complaints were always about white people.'*

Mr Hamilton agreed to visits from his new social worker, but only on his own terms. What he wanted was help with his complaints concerning the behaviour of his neighbours. He refused psychiatric follow-up, and no out-patient arrangements were made for him, nor was any medication prescribed. His social worker told us that:

'Mr Hamilton's case was considered low priority and not in need of any proactive input. He was not considered a risk and was seen as low priority. At no point in time did he show any obvious signs of mental illness and was never threatening or aggressive. He made it very clear that he knew when he was unwell and then he would not hesitate to go to his GP.'

After this brief flurry of activity during 1996, local mental health services assumed a more passive role until Mr Hodge's death. Mr Hamilton received occasional visits from his social worker, whose last visit was made on 15 April 1999. His social worker also attended a case conference on 21 March 1997 concerning his complaints of racism:

'... one of the reasons why there was the case conference [was] so that we could actually prove to Mr Hamilton that things [i.e., his complaints] were being taken seriously.'

The conference was convened because his complaint against the occupant of one of the four flats in his block became an on-going dispute between February 1995 and March 1997, and the focus of his attention. His concerns had been referred to the Birmingham Racial Attacks Monitoring Unit (BRAMU) in March 1995, and they were extensively investigated by the Council's Housing Committee. That he might have been paranoid about his neighbours, and that what he believed to be true might not be true, did occur to the housing officer. She realised that he had a mental health problem from things that he said, but did not consider that he had a severe mental health problem. However, she never felt at ease with him and would not visit alone.

Mr Hamilton had no contact with the consultant appointed to his catchment area on 1 October 1997. This consultant was, however, alerted to his case in 1998 by the CPN about whom Mr Hamilton had complained:

'[A new consultant] had been appointed to substantive post and we were talking one day. He was obviously trying to acclimatise himself to a new locality and the huge number of new patients. We were talking about risk, and I took the opportunity of bringing this up because I was a bit concerned he might not be aware of Mr Hamilton. In fact, I was fairly sure he was not aware of him. I had a strong feeling he would want to know so I took it upon myself to ask if he knew about him. As it happened, the notes were still at Patrick House. He read the notes and said it was something he needed to see. He said he was going to make contact with [the keyworker]. I was a bit concerned that he would be properly supervised by a psychiatrist.'

Having read some of the notes, the consultant wrote to Mr Hamilton's social worker suggesting that a CPA review be held. However, no review was held, because the consultant was on sick leave when attempts were made to arrange one, and the matter was subsequently not considered a priority. According to the new consultant:

'[Mr Hamilton's social worker] phoned me and we had a conversation ... He described to me the difficulties that there were with trying to organise appointments with a psychiatrist because of his antipathy, etc, and he gave the impression that it was best not to rock the boat and stir things up, and that if necessary he would call upon me as he saw fit ....'

'I was happy to accept his professional judgement ... on that basis; and then what happened was that I went off sick, and ... in reality I forgot about him. It wasn't on my 'things to do' list anywhere, because there was no time to be able to provide that. He had a key worker ... People assume CPA meetings need to occur with the client there. It would have been perfectly

appropriate for me and [the social worker] to sit down and just discuss it and discuss a plan, and have that as part of the plan; but I suppose I relied on [the social worker] to do that.'

By 1998, Mr Hamilton was an extremely frustrated man. On 1 April 1998, he wrote a 39-page letter to the Birmingham Racial Attacks Monitoring Unit Most of the letter was given over to expressing his belief that BRAMU were colluding with racism. He accused its chairman of covering up his case and of not supporting the Jamaican community:

'That anger then turned to us, and I forgot to the extent that it was … In the end, yes, his attention went straight to blaming us and colluding and so on and so on.'

Mr Hamilton's accusation was vigorously rebutted by its chairperson:

'To accuse me of not trying to help you is untrue and to make false accusations against me, which go as far as to suggest that I conspire with the establishment to hide racism, are also totally wrong. You make accusations against me which I find deeply offensive, considering the work I have put in for the community, and you have shown no concern for my feelings and integrity.'

Three aspects of this letter are particularly relevant to the subsequent attack on Mr Hodge. Firstly, the style and content differs from his early correspondence to BRAMU, and demonstrates a marked deterioration in his mental state. Secondly, on page 19, Mr Hamilton stated that he had bought a hose, which he connected every night because racists intended to burn down his flat:

'I have been treated so bad. That I of to bye a hose pipe. And every night. I of to try to remember. To connect it to the top. For the white racist peoples. Say that I cannot live there for I am a black man. And they are goin to burn my flat.'

Thirdly, Mr Hamilton's anger had turned on the Jamaican community, and his reasons for believing this take up most of the 39 pages. Two short passages suffice to give the flavour of the accusations:

'Mr [Enoch] Powell. He is better than most black people. The Jamaican people. Them with delt with racial harassment. Who work at the Racial Attacks Office. If those people did no what is there own shame and disgrace. They would cover up my case … When my case has been ropt up on the 22.3.1997 my white-racist neighbour come out is flat. And he stand up by the road side. And every white people pasting by he stop them. And he say to them. What we did want We get it From the Racial Attacks Office. So he says to the White People. What are we waiting for … And the White Peoples see that the time as come that they can get the full support from the Racial Attacks Office to torture me.'

'To you black people who work at the Racial Attacks Office. When you are reading this letter. I can see how much you are laughing. And rejoiceing. And saying to your self. Yes. We got him. We dig a pit for Hamilton. And he fell in to it. But I would like you to no that you can not get a way with it.'

MR HODGE'S CONTACT WITH SERVICES

Lewis Hodge was born on 26 April 1959, and his parents were from the Caribbean. He was periodically in care as a child and was placed in several care homes, where he was abused. As an adult, he often talked about these childhood experiences and his sense of anger. He did not attend a mainstream school, and throughout his life was troubled by the feeling that 'he was a stupid person.'

Despite early disadvantages, Mr Hodge developed into a popular, kind-hearted, man. He was 'just really nice', 'gentle', 'very polite [and] well-mannered', 'very likeable, always pleasant and jolly.' He had a fine sense of humour and was an excellent chef. He was also 'rather timid and anxious' and 'always edgy'. He tried deperately hard to be liked, and his sensitive disposition meant that 'if someone said something that hurt him he could develop that into something out of proportion.' At times he 'could be 'garrulous, restless and excitable': 'he was really up in your face, and I think that [some] people got quite irritated by that.'

Mr Hodge's first psychiatric admission was in January 1978, when he was aged 19. He was hallucinating at the time and his treatment included antipsychotics. His IQ was tested and recorded to be 75. Later that year, in October, he was admitted to hospital under section 136, after being found wandering across electrified railway lines. On examination, he had paranoid ideas about his workmates and was said to be thought disordered. He was again treated with antipsychotics.

In July 1981, Mr Hodge was briefly admitted to Highcroft Hospital after he became tense and agitated and complained of hearing voices. He took his own discharge and was followed up in the local outpatients' clinic.

In 1994, he had a 'row' with a neighbour. According to a contemporaneous medical note, his 'behaviour was not the result of his psychiatric symptoms but due to his underlying personality'.

In October 1995, he woke early one day because he felt that two men were going to hurt him. He jumped out of his bedroom window and fractured both ankles. Subsequently, he walked with a limp, and he would say that people 'took the Mickey out of him' because of how he walked, his crooked teeth and his mental health.

Mr Hodge said that he could not find a door when he woke, became highly anxious, and realised that the only way out of the room was through the window. He did not remember that he was on the first floor. He also stated that he had been 'annoyed' about the behaviour of one of his neighbours at the time.

Having been discharged from hospital, Mr Hodge was placed on the supervision register and complex CPA. In December 1997, his main concern was that his upstairs neighbours were difficult to live with, noisy, and causing problems. His consultant requested a priority transfer of accommodation. On 30 December 1997, he was reviewed by his consultant, who thought that he had definite paranoid ideas and offered him informal admission. He declined.

Mr Hodge continued to express paranoid thoughts about his neighbours, and he was now taking legal proceedings about the 'neighbour noise'. It is recorded that he may have had a tendency to see 'all his problems as coming from his neighbours', which if true is a tendency that Mr Hamilton seems to have shared.

On 17 March 1998, Mr Hodge attended Birmingham's City Hospital in a distressed and agitated state, complaining that his sleep was being disturbed by the behaviour of his neighbours. He said that they were threatening to kill him, and were shouting obscenities through the floorboards. He was informally admitted to Highcroft Hospital, 'for respite care'.

Shortly after admission, it transpired that he had been removed from his previous GP's practice list, because of 'verbal abuse to staff on several occasions'.

Mr Hodge was started on Clozaril and was also prescribed an anti-depressant because of his low mood. He spent a number of months living in the rehabilitation flat above the ward and was referred to a social worker. New accommodation was sought for him, and he was offered one of the four flats in the block where Mr Hamilton lived. He was frightened to move, and needed considerable reassurance from staff and his closest friend:

> *'… He had the flat but he was not sure whether he should take it, because he was asking what are the neighbours like … I remember that I had a conversation with people in housing asking them about the neighbours just to reassure him … He wanted reassurance whether the neighbours were troublesome, whether they played music late at night and, if I remember rightly, I was reassured that at the time there weren't any problems with the neighbours. He was reluctant to take the flat because of his fear.'*

There were, however, general problems of anti-social criminal conduct at the block of flats. Between 1997 and 1999, the police received several telephone calls from Mr Hamilton and his neighbours about the frightening behaviour of local youths. These youths, who called themselves the 'Doghouse Gang', were observed throwing stones at houses, breaking into a house, and running up and down the stairs to the flats, 'terrorising local residents'.

Mr Hodge was discharged on 4 November 1998, after spending trial periods at the flat. He remained on the supervision register and subject to complex CPA. On 19 November 1998, his consultant referred him to the assertive outreach team, but was told that 'due to lack of resources, referrals are on a waiting list'.

He was followed up in the outpatients' clinic by a locum consultant, on 10 March and 30 June 1999. He seemed to be complying with medication, and no abnormal beliefs or experiences were noted. A CPA review scheduled for 10 May 1999 could not take place because a permanent consultant had not been appointed to the catchment area post.

Mr Hodge received home visits from his social worker and community psychiatric nurse. He also often called in on the latter at his office:

> *'[He]was someone who was always at [the] Underwood [Centre] even if he did not have an appointment. He always wanted reassurance that everything would be okay. He kept coming back to me and saying, "Are you sure the flat will be okay, are you sure that the neighbours won't get me?", and all this sort of thing.'*

MR HODGE'S DEATH

It seems that Mr Hodge was advised by 'neighbours' to keep away from Mr Hamilton, and that the two of them had little contact before his death. They would say hello in passing but never conversed.

Relatively little is known of this period. On 9 December 1998, the Housing Department sent a warning letter to Mr Hodge, notifying him of a complaint about his dog, but who made the complaint is not recorded. On 13 April 1999, Mr Hodge was upset by two 'kids' banging on his door one Sunday evening, and asked the Housing Department to fit Chubb locks. On 5 May 1999, Mr Hamilton made a

complaint to the housing office concerning the overgrown state of Mr Hodge's garden. A housing officer visited on 10 May, and she noticed that Mr Hamilton had erected a fence around his garden, and had 'stuck nails along the top of the fencing.' He was advised to remedy this.

Mr Hodge was used to burning rubbish in his garden, which was a habit he got from his father but one to which Mr Hamilton took exception. On Sunday 4 July 1999, he was burning rubbish in the garden and, when he opened the back door to the flats, the wind blew the smoke into the block. For a man who connected up a hose every night because he feared that his flat would be burnt down, this must have provoked tremendous anxiety:

> *'Yes, I could remember, I say to the officers, that my neighbour, a few days ago, he lit a fire around the back garden. When I say back garden – just beside the flat, and it was … the fire was life threatening, as it could burn down the property … [On] Sunday night, he lit another fire there, an even bigger fire, so it was windy, and the back door of the property, the entrance opened and all the smoke come straight inside the building. I go down there and see my neighbour … I say this to my neighbour, you have got a big back garden there … lighting a fire here, it is wrong.'*

According to Mr Hamilton, Mr Hodge immediately became angry and started to shout at him. Mr Hamilton retreated to the passageway in his own flat. Mr Hodge followed him, carrying a hammer, which he threw at Mr Hamilton. Mr Hamilton says that he remembers picking up a chair and cushion to protect himself but then 'blacked out', in the sense that he cannot remember how Mr Hodge sustained his fatal injuries. When Mr Hamilton 'came to', he found Mr Hodge lying on the carpet in his flat, and assumed that he must have suffered a heart attack. He went to a public telephone booth and telephoned for an ambulance and the police.

Mr Hamilton seems to accept now that he must have killed Mr Hodge, and that he cannot recall his actions because the event is too distressing. He says that he had experienced a 'nervous breakdown' brought about by persistent racial abuse:

> *'I really needed help. I was in the community and I needed help. I have been badly treated by racism until I came to a stage and it was like I couldn't cope any more …. My white racist neighbour from upstairs was abusing me. I go to social services and asked for help but the social workers and doctors never took it seriously'.*
>
> *'I had a nervous breakdown because during that period of time if I had an appointment to see my doctor I would have to print it on a piece of paper and stick it up in my flat so that every day I could see it, or else I would forget about my appointment.'*

He tried to explain to us how he felt just before Mr Hodge's death:

> *'It is hard to explain to you. It is like being in your home and someone just coming through the window or your door raping you. You get such a shock that you don't know what to do. Although you are going to explain it and tell people what has happened, they don't know because they don't have personal experience of this.'*
>
> *'I am extremely sorry to know that it ended up that way and that man got hurt. I am really, really sorry …. to know he got hurt and died. I never went on the road to attack anyone with an offensive weapon. If I went on*

the road with an offensive weapon and attacked anyone that would be a different matter, but it was in my own house and there was nothing more I could do. I never had time to jump through the window. The door can't lock in my lounge because the only lock was on the front door. I am really, really sorry to know it ended up that way. I never intended to hurt anyone.'

EVENTS FOLLOWING MR HAMILTON'S ARREST

Mr Hamilton was arrested and taken to Queen's Road Police Station. He received a full Mental Health Act assessment on 6 July 1999, during the course of which he demonstrated fixed delusional beliefs regarding racist threats and taunts from his neighbours, the radio and television. However,

'he was alert and orientated, he showed quite a good memory, he was talking about self-defence. Reluctant to accept that he had suffered any mental illness, although he did talk about having an abnormal state of mind because of the psychological effects of racial abuse upon him. He talked about having a blackout, a struggle, a panic.'

The outcome of this assessment was that Mr Hamilton did not meet the criteria for being detained in hospital under the 1983 Act. He was charged with murder and remanded in custody. While in prison he continued to experience 'racist taunts', both from prison officers and inmates acting at their behest. His persecutors said that 'they will cut up my skin, and bad language.'

In May 2000, Mr Hamilton was transferred to the Reaside Clinic pending trial and sentence, under sections 48 and 49 of the 1983 Act. In October 2000, he was sentenced to life imprisonment, and his tariff was set at four years and two months. In the course of sentencing him, Mr Justice Newman expressed the following important concerns:

'Of course anybody knowing the background would not need to know a great deal about the background. They would merely need to know that he was somebody who suffered from paranoid schizophrenia, who required medication, that when he is on medication things are all right, and if things are not all right it is an indication he is not on medication, and by reason of his mental condition when things are not all right he is a danger … and all that was required was somebody — and there is nobody as it happens who can fulfil the role — who would detect that this was the downward spiral which you have drawn to my attention … Then presumably doctors could intervene and he could be sectioned … and made to take the medication.'

§

'In 1984 you were discharged into the community. As long as you maintained your medication for your mental illness you were apparently no danger to the public, but you did not maintain your medication. You were followed up in the community, but it is a fact that there has been no contact by you with psychiatric authorities since 1996. It has not been necessary for this court to ascertain the details of the follow-up which you received. I have been informed that it is likely that there will be a statutory inquiry into the circumstances, including the extent and nature of the supervision you received in the community. Such a course will serve to assuage the concern to which these facts give rise.

'For reasons which on the face of it appear surprising, despite concern about your condition, an assessment by a single consultant psychiatrist did not recommend your return to hospital even though it would seem your delusional state was advanced and was positively consistent with the fact that you were not taking any medication. Your past history had demonstrated that you were a risk to the community. On 5th July 1999 you hacked your neighbour to death with a machete. It was a horrendous attack.'

Having been sentenced, Mr Hamilton remained at the Reaside Clinic for a further ten months, under sections 47 and 49 of the 1983 Act. It is recorded that he had 'a long history of chronic paranoid schizophrenia characterised by persecutory delusions and auditory hallucinations' and 'violence associated with his mental illness …' His symptoms included 'fixed delusions of racist abuse'.

In August 2001, his consultant reported to the Home Secretary that he no longer required medical treatment or that no effective treatment could be given. He was therefore remitted to prison, to serve out his sentence:

'We got him onto some medication and found that he generally settled, became more pleasant and less concerned about the staff but he still would not engage with us in any meaningful way … they had probably gone about as far as they could at the moment. I believe that with Mr Hamilton's consent he went back to prison.'

FINDINGS

Our findings are presented in the following order, and under the following headings:

1 **The Index Offence**

2 **Mental Health Act issues**

3 **Risk management**

4 **Care Programme Approach and After-care**

5 **Multidisciplinary team working**

6 **Supervision arrangements**

7 **Support for the bereaved**

8 **Support for Mr Hamilton**

1 — THE INDEX OFFENCE

Mr Hamilton was not thought to be detainable under the Mental Health Act when he was assessed in the police station shortly after his arrest.

Different opinions were expressed as to the extent to which his offence, his previous offending, and his irregular compliance with treatment are best explained by long-standing mental illness.

If he suffered from schizophrenia or a delusional disorder, this could account for his irregular compliance with treatment and his record of violence. If he did not have such a diagnosis, it is hardly surprising that he resented the intrusion of mental health services, and the causes of his offending must be sought elsewhere.

It is important therefore to consider whether there is evidence that he had a serious mental illness between 1985 and 1999, and if so what part it played in the homicide. Mr Hodge was also black, so the relationship between Mr Hamilton's complaints of racist persecution and the killing cannot be straightforward, if there is a connection at all.

MR HAMILTON'S PERSONALITY

Mr Hamilton sees himself as a God-fearing man who keeps himself to himself and avoids confrontation or conflict. He has sought comfort in religion, attempted to solve his complaints lawfully, by enlisting the help of people in authority, and tried to avoid direct confrontation with his persecutors (whether neighbours or mental health professionals).

His consultant in 1984, and his community psychiatric nurse in 1996, expressed significant concerns about his mental health and propensity for violence. However, most of their colleagues saw his behaviour not only as unremarkable but as rather endearing. They variously described him as quiet, polite, charming, respectful, and generous:

> *'I remember him having a barrow in his living room and he said he was collecting clothes to send to the Caribbean. He was making certain items. I remember his having some artistic qualities, he would make things and he was very interested in sharing his skills with other people who attended the occupational therapy sessions in how to make decorations. He would send these off to the Caribbean in barrows and he said this was the second barrow he had sent.'*
>
> *'Apart from the fact that he was very tall and towered over me, he was one of the gentlest, most courteous individuals I have ever met, very softly spoken, very polite.'*
>
> *'He was not an aggressive individual to speak to; you did not think he was likely to do anything very unpredictable, put it that way.'*
>
> *'He always seemed pleasant enough and didn't particularly stand out.'*
>
> *'He never appeared to be hostile in any way.'*
>
> *'He was a gentle giant'.*

Mr Hamilton was indeed 'a gentle giant' for most of the time, but he was 'a gentle giant' who had committed two serious offences of wounding, one of which was charged as attempted murder, and who later killed another person. His CPN in the early 1990s was struck by the incongruity:

> *'I remember him being a very placid man, and I was shocked when I learned of his forensic history. He was always fairly placid and calm.'*

Although most professionals thought of him as a solitary man, he says that he had some friends and never felt lonely. He was certainly an extremely private man who was unwilling to share personal information with them. He avoided discussing unpleasant or emotionally-charged questions, often by diverting the conversation. This partly explains the lack of social history in his files:

> *'[He was] diverting us from asking questions about what we really wanted to know about very skilfully, he is very good at avoiding issues.'*

He was willing to engage with nurses and social workers on his own terms, such as when seeking help with his complaints, but not otherwise. He chose not to remember, or to discuss, his mental health or his psychiatric or forensic history. He took the view that he had been punished for his two offences, one of which was in any case self-defence, and that was that. He now wanted to forget the incidents and move on with his life. On the only occasion he was challenged about his mental state and offending, he lodged a formal complaint.

He particularly disliked contact with psychiatrists, and was very anti-psychiatry. He did not accept that he had had a serious mental illness, such as schizophrenia, or that his offending might be associated with such an illness.

The overall impression is of a kind-hearted, naturally passive, man who is mentally very sensitive to emotionally-charged conflict, both within himself and with others, and who lives alone in order to avoid confrontation. He has found it less threatening to his self-esteem and self-image to avoid or deny thoughts and emotions that sit uneasily with his Christian beliefs, and to externalise accusatory thoughts by attributing his unhappiness to the behaviour of others and the world outside.

MR HAMILTON'S MENTAL STATE

Mr Hamilton is dismissive of the possibility that he has ever experienced a serious mental illness. However, his opinion cannot easily be reconciled with some of the facts recorded over the years:

- ☐ The prosecution statements concerning his offence in 1975 are no longer available, although they ought to have been retained in his medical notes. It is, however, recorded that his two offences of wounding shared 'identical features' and that this caused 'grave concern'. Mr Hamilton believed that he had unjustly been accused of stealing £10 and he attacked his accuser with a knife on arriving at work. It may be true that he was falsely accused, and that this injustice preyed on his mind and contributed to him becoming ill (in 1991, he heard neighbours saying, "£40,000 — you won't get away with it"), or it may be that the accusation was self-generated, that is an auditory hallucination.

- ☐ Whatever the situation in 1975, the prosecution witness statements reveal that he was mentally ill when he committed his second offence in 1980. He believed that his victim had said that 'he was a police informer, that he was no good and should be killed', and that he had been subjected to the same abuse on the bus and in local pubs. He had previously got on with his victim, attacked him without provocation, and his eyes were glazed and trance-like at

the time. The attack was so ferocious that his victim required 90 stitches. Having been taken into custody, he believed that prison officers might incite other prisoners to attack him. The superficial psychiatric report prepared for the defence, and the tribunal's finding in 1985, cannot be reconciled with this evidence.

- In 1983, while in prison, Mr Hamilton 'showed unequivocal signs of a psychotic illness, such as auditory hallucinations, somatic hallucinations and … delusional explanations of these experiences'. He responded 'very well to treatment with depot neuroleptics'.

- In August 1991, he complained of verbal abuse from his neighbours 'that was also coming from the church and the bus'. A contemporaneous note records that he 'told the doctors that some neighbours were shouting abuse at him, but it was not racial abuse. The voices said, "They'll find out where I live and they shout abusive words at me, saying '£40,000 — you won't get away with it"'. These auditory hallucinations consisted of male and female voices, and they had started three months previously.

- From 1991 onwards, Mr Hamilton made numerous complaints about many of his neighbours, most of which involved allegations of racist abuse. In all, he complained about the occupants of eight addresses nearby(the occupants at nos. 119, 166, 167, 168, 169, 170, 174, 183), including all three of his neighbours in the small block of flats where he lived. He also complained about the behaviour of visitors and passers-by. Video and audio equipment were installed but revealed nothing. One neighbour in his block obtained a transfer to alternative accommodation on account of his behaviour.

- By the beginning of 1996, local police officers were expressing concerns about his mental state. His demeanour was sufficiently unsettling that they would not visit alone. A police inspector reported that he was 'not a well man' and that 'a lot of the things that he's saying don't make sense'.

- On 24 April 1998, he wrote a 37-page letter to BRAMU, accusing its chairman of covering up his case and of not supporting the Jamaican community. The style and content of this letter revealed a marked deterioration in his mental state.

- On 6 July 1999, he demonstrated fixed delusional beliefs regarding racist threats and taunts from neighbours, the radio and television. While in prison he continued to experience 'racist taunts', both from prison officers and inmates acting at their behest. His persecutors said that 'they will cut up my skin, and bad language.'

- It seems that Mr Hamilton's feelings of persecution lessened when he was receiving antipsychotic medication:

  'When I eventually went through the notes, I noted that at times when he was thought to be more unwell, his reports of racist abuse seem to come to the fore, and when he took some medication they seem to diminish.'

There are gaps between these records, which probably signifies only that he was not often rigorously assessed. The overriding likelihood is that he continued to hold the beliefs that he expressed both in 1991 and at the time of Mr Hodge's death in 1999 during the intervening years.

THE ATTACK ON MR HODGE

There were striking parallels between Mr Hodge's situation and that of Mr Hamilton. Both of them were diagnosed as having paranoid schizophrenia with a mild learning disability; both of them tended to see their neighbours as the main source of their problems; both of them had attributed the obscene and accusatory voices they heard to their neighbours; and both of them were now neighbours living in close proximity.

Because Mr Hodge did not survive the attack, we have only Mr Hamilton's account of what happened, together with some forensic evidence and witness statements.

Unfortunately, Mr Hamilton has often given mental health practitioners inaccurate information over the years. For example, he has given many different accounts about his children and family circumstances, and at best only one of them can be true. Without corroboration, it is impossible therefore to rely on what he says happened.

What can be corroborated is that Mr Hodge was burning rubbish next to the flats, Mr Hamilton connected up a hose every night because he feared that his flat would be burnt down, Mr Hodge was killed in Mr Hamilton's flat rather than his own, the door to Mr Hamilton's flat was badly damaged, and the weapon belonged to Mr Hamilton.

This evidence supports that part of Mr Hamilton's account which says that Mr Hodge became anxious and animated when he was approached by Mr Hamilton, and that he followed Mr Hamilton to his flat:

> *'Lewis was the kind of person who, if you did not say what he wanted you to say, would become quite anxious … He wanted you to say what he wanted you to say, he wanted you to do what he wanted you to do … He would gesticulate, his hands were all over the place. He used to raise his voice.'*

Mr Hamilton was also perpetually on edge about the behaviour of his neighbours. He was frightened that racists intended to burn down his flat and angry that some black people locally were colluding with his main persecutor, his 'white racist neighbour'. He responded to this perceived intrusion and threat by launching a ferocious attack on Mr Hodge. His attack probably contained a great deal of displaced aggression that had been building up over many years:

> *'He felt that he was being persecuted 24 hours a day, that no-one was listening … and … taking him seriously … in the police station he [talked of] … voices swearing at him with racist abuse. If that has been going on for some time, it is hard to imagine anyone coping with that without feeling very aggravated, perhaps aggressive and irritable. I wonder whether the unfortunate Mr Hodge had in some way aggravated or provoked him unbeknown to him, and that there was a lot of displaced aggression placed upon this one man.'*

2 — MENTAL HEALTH ACT ISSUES

The key Mental Health Act issue is whether Mr Hamilton satisfied the legal criteria for detention in hospital between 1985 and 1999, and whether he ought to have been detained for his own health or safety or to protect others.

The answer to this question turns partly on legal considerations — the threshold for detention and treatment without consent under the 1983 Act — and partly on professional judgements about how best to manage identified risks, the advantages of community-based care, and the practical benefits of establishing or maintaining some voluntary contact and therapeutic rapport with clients.

WAS COMPULSION NECESSARY

When a person in contact with mental health services kills another individual, it is natural to ask why those professionals in contact with the patient did not intervene before the tragedy, or take a more assertive approach to the patient's care. One of the functions of our review is to address these important concerns.

The constitutional position

Those we describe as 'patients' are themselves members of the public, so that the law must seek to ensure that members of the public are not unnecessarily detained, and also that they are protected from those who must necessarily be detained.

The use of compulsion has generally been permitted where significant harm is foreseeable if an individual remains at liberty. Its purpose is to protect the individual or others from those risks that arise when a person's capacity to judge risks, or to control the behaviour giving rise to them, is impaired by mental disorder.

Other risks are, constitutionally, matters for citizens to weigh in their own minds. The purpose of compulsion is not to eliminate that element of risk in human life that is simply part of being free to act and to make choices and decisions. People who obeys our laws are entitled to place a high premium on their liberty, even to value it more highly than their health. Subject to the above limits, they are entitled to make what others regard as errors of judgement, and to behave in a manner which a doctor regards as not being in their best interests, in the sense that it does not best promote their health.

The threshold for compulsory admission is, quite properly, a high one. Admission under section 2 requires that the individual is suffering from a mental disorder which is sufficiently serious to warrant their detention for assessment and treatment for up to 28 days. Furthermore, their detention must be justified with a view to their own health or safety or the protection of others. Some of the legal issues in Mr Hamilton's case are therefore:

- ☐ Whether he had the right to refuse medical treatment and social care?
- ☐ Whether he had the right to act autonomously?
- ☐ Whether the risks were such that they warranted compulsory admission?

Was Mr Hamilton's mental disorder of such a nature or degree?

Because of the possibility of compulsory admission, Mr Hamilton was understandably guarded about what he told mental health professionals. Consequently, it was almost always difficult for them to determine whether, or to what extent, he was experiencing symptoms of mental illness.

There is, however, clear evidence that he was suffering from a mental disorder from 1991 onwards. In particular, he was experiencing auditory hallucinations of a persecutory nature, and he believed that television and radio programmes were referring to his situation.

Whether Mr Hamilton's belief that he was being subjected to constant racist abuse or harassment was a symptom of mental illness is a matter of interpretation. His belief had some factual basis, and it can hardly be said that every unfounded or exaggerated belief that one is being persecuted or treated disrespectfully because of one's race, colour, culture or religion constitutes a delusional interpretation of events. Socially or economically disadvantaged people from all cultures naturally develop hardened feelings of resentment when their situation does not improve over many years, and at times these may be all-consuming. That is a political truth across the world. Some beliefs of this kind may be false — in the sense that the motives or actions attributed to others are not supported by evidence or only by evidence that a bystander would regard as patently insufficient for the connection being drawn — but they constitute nothing more than extreme value judgements.

It is also true though that an hallucination may sometimes give rise to a 'secondary' delusional belief that the perception is true: it was 'so real, it must be true'. In Mr Hamilton's case, the fixed nature of his belief that he was being persecuted by all of his immediate neighbours seems to have followed on from, and to have been secondary to, the persecutory auditory hallucinations he was experiencing.

Our view is that Mr Hamilton's experiences of British society help to explain why he became distressed. However, as he became more distressed, he lost the capacity to distinguish between those experiences that corresponded to the actions of others and those generated by his distress and feelings about those experiences (auditory hallucinations and television programmes sending him messages):

> *'Someone who is a devout Catholic can go to church and have a lot of religious beliefs. However, when they have a mental illness, it may be that those beliefs perhaps become extreme and their religious experiences go beyond their normal experiences and start adversely affecting their lives and the lives of others around them, causing them to behave in ways they would not normally do. If you treat their psychotic mental illness, they come back and have their persisting religious beliefs. I am not saying that their religious beliefs are part of their illness but I am saying that, when they are unwell, they may be exaggerated, they may begin to misjudge things and put all their experiences down to some sort of religious phenomenon and behave in a way that is detrimental to themselves and to others. I have certainly seen that both in this country and in others, and I cannot see why people from ethnic minorities will not incorporate the real experience of their lives into their delusional system when they are unwell.'*

Was detention justified for his own health or safety or to protect others?

If it is true that Mr Hamilton's range of experiences, and his interpretation of them, can properly be described as a form of mental illness, on its own this still does not justify compulsory admission and treatment. The risks associated with the thoughts and perceptions must be sufficiently serious to justify such a step.

One must therefore consider whether any identifiable risks in Mr Hamilton's case were such as to warrant compulsory admission and treatment?

The Mental Health Act Commission has already considered how the Mental Health Act applies to citizens whose health is beginning to deteriorate. In a discussion document called, 'The Falling Shadow Report and the Deteriorating Patient', the Chairman of this review panel gave the following opinion, which was endorsed by the Commission's Legal and Ethical Committee, of which he was Chairman at the time:

1. A person who has suffered from schizophrenia, mania or depression and whose symptoms are merely controlled by medication still 'suffers from' mental illness specifically and mental disorder generally.[8] Furthermore, the fact that a person is in remission, and there are no longer any symptoms or signs of mental disorder, is not proof that the underlying disorder is not of a severe nature.

2. In the case of admission under section 2, it does not suffice that two medical practitioners are of the opinion that the individual is presently suffering from mental disorder notwithstanding the absence of any symptoms or signs of mental disorder. Any disorder present must be of a nature or degree which warrants his detention in hospital for assessment. It must also be the case that he ought to be detained for assessment in the interests of his own health or safety or with a view to the protection of other persons.

3. The present degree of mental disorder being nil, it follows that the individual cannot be detained for assessment in hospital unless the nature of his disorder warrants this.

4. The nature of a person's disorder is revealed by its history and, if the historical evidence is particularly compelling, the law would permit early intervention. Nevertheless, the right to liberty is highly prized by English law. The 'unsoundness of mind, whose presence is essential to justify a compulsory order, manifestly means more than mental illness which qualifies a person to be a voluntary patient ... in ordinary language "certifiable" is perhaps more likely to be used to express the same idea.'[9]

5. That being so, and given the present absence of any symptoms and signs of unsoundness of mind, there must be reliable evidence of a continuing unsoundness of mind the nature of which warrants compulsory detention for assessment. That evidence would need to be sufficiently compelling that it could properly be said that the individual 'ought to be' deprived of his liberty in the interests of his own health or safety or with a view to protecting others.

6. At the very least, there would need to be reliable evidence (a) that the patient's symptoms are merely being controlled by the residual effect of the medication he has recently ceased taking; (b) that he therefore continues to suffer from mental disorder; (c) that the natural course (i.e. the nature) of that disorder is that relapse inevitably follows the discontinuation of medication; (d) that his health or safety, or other persons, are significantly at risk when the manifestations of his disorder are not controlled; and (e) that these risks justify depriving him of his general right to liberty, including his freedom to refuse medical advice and treatment.

7. In addition, it is probably the case that there must be some evidence that the patient's mental health has begun to deteriorate. That is, there must be some

---

[8] Whether that person's symptoms are merely being controlled by medication or whether there has been an improvement in the underlying condition may, of course, be difficult to determine.

[9] *Buxton v. Jayne* [1960] 2 All ER 688 at 697, *per* Devlin LJ: "The term 'mental illness' is not defined. Its interpretation is a matter for medical judgment, but it is expected that when it is qualified by the words 'of a nature or degree which warrants the detention of the patient in hospital for medical treatment' ... it will be taken as equivalent to the phrase 'a person of unsound mind' which has been in use hitherto in connection with compulsory detention ... When it is not qualified by these limiting words, however, the term ... carries its normal (much wider) meaning." Mental Health Act 1959: Memorandum on Parts I, IV to VII and IX, (D.H.S.S., 1960), para. 40.

evidence of an abnormality of mental functioning which enables a doctor to reach an opinion on evidence, rather than pure conjecture, that this familiar chain of events is once more in motion. Only if there is evidence of the continuing existence of a disorder which has this nature, and which is developing along its natural course, could one be justified in concluding that future events will follow the previous pattern if not checked, so that deprivation of liberty is justified. Certainly, the Commission would need clear statutory or judicial authority before it accepted that Parliament intended that persons whose mental functioning was not abnormal could be detained in a hospital for treatment. Holding otherwise would mean that persons whose mental functioning is not presently abnormal may be denied their liberty and compelled to accept treatment.

8. The group therefore further concludes that detention under section 2 also requires reliable evidence (f) of abnormality of mental functioning of a kind known to be associated with the underlying disorder when it is not controlled by medication. There does not need to be evidence that the patient is psychotic in the sense that hallucinations, delusions, or severely abnormal behaviour is apparent provided that it is clear that the disorder is beginning to manifest itself in the familiar way.

9. Subject to judicial supervision and guidance, the group concludes that, if a medical practitioner is of the opinion that conditions (a) to (f) exist, s/he may lawfully complete a section 2 medical recommendation. The underlying purpose would no doubt be to assess the current situation, and in particular the risk to others, in the light of the recent, familiar, deterioration in the patient's mental health. That is not to say that there is a duty to give a recommendation in those circumstances or that it would be negligent not to do so. The Act allows mental health professionals a considerable discretion in terms of how best to help the patient and how best to manage the situation facing them.

10. If two medical recommendations are forthcoming in such a case, the focus shifts to the prospective applicant, who will usually be the approved social worker asked to assess the appropriateness of compulsory admission. It is that professional's business, rather than the doctors, 'to see that the statutory powers are not used unless the circumstances warrant it.'[10] That being so, an approved social worker must, before making any application, 'satisfy himself that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.'[11] More particularly, such a person is only ever under a duty to make an application if satisfied that such an application ought to be made and of the opinion that it is necessary or proper for the application to be made by her/him.[12]

11. Again, it would, we suggest, be lawful to make a section 2 application provided that conditions (a) to (f) exist but, equally, it would be lawful not to do so if the social worker was not satisfied that such an application ought to be made and was not of the opinion that detention in a hospital was the most appropriate way of providing any care and medical treatment of which the patient stood in need.

12. To this extent, the group agree with the [Falling Shadow Report] Committee of Inquiry that the legal and clinical constraints must be distinguished.

---

[10] Buxton v. Jayne [1960] 1 W.L.R. 783, per Devlin L.J.

[11] Mental Health Act 1983, s.13(2).

[12] Mental Health Act 1983, s.13(1).

Although there may be no legal reason why an application may not be made, the professionals may properly conclude that such an application is not appropriate, because of the need to maintain a relationship with the patient and to continue attempts to establish a framework for her/his care in the community.

13. Turning to admissions under section 3, the considerations are similar to those applicable in assessment cases. It again does not suffice that two medical practitioners are of the opinion that the individual is presently suffering from mental illness notwithstanding the absence of any symptoms or signs. That mental illness must be of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital. Furthermore, it must be the case that it is necessary for the individual's health or safety, or for the protection of others, that s/he should receive in-patient treatment, which cannot be provided unless s/he is detained under section 3.

14. A section 3 medical recommendation must set out the grounds for the doctor's opinion that these statutory conditions are satisfied. More particularly, it must also state the reasons for the doctor's opinion, firstly, that it is necessary for the patient's health or safety, or to protect others, that s/he should receive medical treatment in a hospital and, secondly, that such treatment cannot be provided unless s/he is detained under the section. That statement must specify whether other methods of dealing with the patient are available and, if so, why they are not appropriate.

15. The present degree of mental disorder being nil, it follows that in-patient treatment could only be appropriate if the nature of the patient's mental illness makes this appropriate. As already noted, the nature of a person's mental illness is revealed by its history and, if the historical evidence is particularly compelling, the law would permit early intervention.

16. However, the use of the word ‘necessary’ in the section 3 admission criteria indicates that nothing short of in-patient treatment will adequately safeguard the patient's health or safety, or protect others, and that in-patient treatment cannot be provided except by recourse to section 3. This is a stronger test than that which applies under section 2 and the group is of the opinion that, where a person is detained on the ground that the nature but not the degree of his disorder requires this, detention for a short defined period of assessment will usually be more appropriate.

17. In Andrew Robinson’s case [the patient whose care was the subject of the Falling Shadow Report], he was ‘highly co-operative’ during his period under guardianship which ended in July 1992 and, following that ‘successful period of treatment,’ his doctor was struck on 25 January 1993 by how well he seemed. He noted that Andrew showed some insight into his condition and that he accepted the need to be under the care of a consultant psychiatrist. That being the doctor’s opinion, it is difficult to see how he could properly have completed a medical recommendation at that time. The more so since the recommendation would have had to specify his reasons for considering that in-patient treatment was necessary and he could hardly recite that he was struck by how well the patient seemed.

18. However, by 18 February 1993, Andrew Robinson appeared to be more agitated, with a paranoid flavour to the content of his speech, and to have lost the earlier insight. He had failed to keep his out-patient appointment and there had been police reports that he had been following a boy. Later still, on 3 March, he sent a letter which indicated that he was preoccupied with killing again whilst, on 12 March, a doctor found that he was "evidently deteriorating." The situation on 18 February was therefore that the patient's

history was strong evidence (a) that the nature of his disorder was such that a cessation of medication was soon followed by relapse; (b) that relapse led to psychosis; and (c) that, when psychotic, he had a proven capacity for extremely dangerous behaviour. In addition, (d) there was evidence that he was relapsing, i.e. there was evidence of an abnormality of mind and that the familiar chain or pattern of events was in motion.

19. The group's opinion is therefore that it would have been lawful at this point for a medical practitioner to complete a recommendation on the basis that the nature of his disorder warranted his detention in hospital for assessment and that he ought to be detained with a view to the protection of others. That is not to say that it was negligent not to do so for the Act allows professionals a discretion and they might properly have thought that the situation was retrievable. For the reasons given, the group is not persuaded that it would have been lawful to have detained him in October 1992, simply because he refused half his prescribed medication, or on 3 January 1993, when he refused his depot injection in its entirety.

Subsequently, this view was expressed in a textbook on mental health law written by the Chairman, and endorsed by the High Court in a case called *R v MHRT for the South Thames Region, ex p. Smith*, The Times Law Reports, 9 December 1998:

The nature or degree of the disorder

Where there is evidence of mental disorder, the use of compulsory powers requires that it is of a 'nature or degree' which either makes in-patient treatment appropriate or warrants the patient's detention for assessment or reception into guardianship ("the diagnostic question"). Practitioners and tribunals commonly confine their consideration of a patient's mental state to the degree of mental disorder present, seemingly interpreting the words "nature" and "degree" as essentially interchangeable. Accordingly, a patient is considered not to be detainable if his condition has responded to medication and is no longer acute. This approach takes no real account of the nature of the particular disorder and mistakenly equates its "degree" with its "severity." As such, there is a failure to give due weight to the chronicity of the disorder and the prognosis.

'Degree'

The word "degree" focuses attention on the extent to which the person's mental disorder is currently active. If a patient is acutely ill, his condition characterised by obvious and gross abnormalities in his mental state, the degree of mental disorder present will generally be of a level which satisfies the first ground of application. It is noteworthy that the emergency power to detain a patient for six hours under section 5(4) is exercisable by a nurse only if it appears to him that the patient is suffering from mental disorder "to such a degree that it is necessary for his health or safety or for the protection of others for him to be immediately restrained from leaving the hospital." The criteria do not refer to the nature of the patient's disorder. This reflects the fact that the purpose of the power is immediate restraint and reinforces the view that the word "degree" is directed towards the present exacerbations and manifestations of a patient's disorder, rather its nature as revealed by its longer-term consequences.

'Nature'

Many mental disorders wax and wane because they are cyclical in nature, because the patient enjoys periods of remission — for example, during

periods of low stress — or because they are intermittently alleviated by a course of treatment. A particular patient may have a long history of readmissions indicative of a severe, chronic condition which is resistant to treatment or a record of poor compliance with informal treatment following previous discharges. Although the degree of disorder may be quite low at any given time, either in absolute terms or relative to his known optimum level of functioning, the serious nature of the disorder is revealed by its historical course. Likewise, with illnesses of recent onset, the prognosis associated with the diagnosis may point strongly towards the probability of a serious, further deterioration of the patient's condition in the near future. In both instances, it may be the nature of the disorder rather than its degree which brings the patient within the first of the grounds for making an application.

Relapsing patients

Where a patient with a chronic condition decides not to continue with medication and his condition is deteriorating, it is often said by those assessing or examining him that he is 'not sectionable.' By this it is usually meant that the degree of mental disorder falls below what is considered to be the threshold for detention, albeit that the rapidity of the patient's decline suggests that his disorder will soon be of such a degree. In fact, because the nature of the disorder allows such a confident prognosis to be made about its future degree in the absence of any therapeutic intervention, it is not necessary as a matter of law to wait until the condition becomes acute before compelling the patient to receive the treatment which will prevent the otherwise inevitable further decline.

The case for compulsion

Having regard to the above considerations, we believe that Mr Hamilton's admission and detention under section 2 would have been lawful and justifiable during most of the period between 1991 and 1999.[13] This was for several reasons:

- There were clear signs that his mental health had deteriorated and that he was again mentally ill. During this time, he experienced auditory hallucinations, ideas of reference and persecutory feelings over a period of many years. These experiences caused him significant suffering, and their duration was evidence that his suffering was likely to persist indefinitely unless he received anti-psychotic medication.

- The unfounded allegations associated with his illness caused many of his neighbours great distress, so much so that one of them moved home. By the mid-1990s, he was in conflict with all of his immediate neighbours, even those with whom he had enjoyed a good relationship previously. They now avoided him, which made him more isolated and increased his feelings of persecution. This self-sustaining deterioration in his mental health and social situation was unlikely to be halted without treatment.

- Mr Hamilton did not believe that the voices he heard or the messages from the television were the products of his own mind and he had a pronounced dislike and distrust of psychiatry and psychiatrists. His personal interest in obtaining professional help was limited to enlisting support for his claims of harassment. After all, he believed that his social problems and his distress would be cured, not by medical treatment or any discussion about the extent to which his

[13] We say for 'most of the period' because of the possibility that he enjoyed some, probably relatively brief, periods when his illness was not causing him significant distress.

concerns were matters that he needed to address, but by vanquishing his persecutors.

☐ There was no real prospect that he would see a psychiatrist voluntarily or that informal assessment and treatment was feasible. Any notion that he could be persuaded to accept medical treatment was unrealistic. It would be dishonest of us to suggest that mental health practitioners could have overcome his opposition had they tried harder to engage him:

'The fact that he did not want to see a psychiatrist and, with hindsight, the fact that I was trying to get him to see a psychiatrist did not help our relationship.' (CPN)

'I had from the outset very little opportunity to develop a rapport with Mr Hamilton given the nature of his requirements of me in respect of handling his complaints regarding his neighbour. My efforts to try to talk with him on other matters were not particularly successful.' (CPN)

☐ He had two previous convictions for wounding, one of which was clearly attributable to mental illness and required his victim to have 90 stitches. This was proof that he could be dangerous when unwell. His two victims had been workmates, which suggested that those in close contact with him might be most at risk of paranoid violence.

☐ He was unwilling to talk about his experiences or to disclose information about himself, which meant that the risks were difficult to gauge. Indeed, it is not going too far to say that he was only willing to 'engage' with mental health services on the basis that his mental state and behaviour were not assessed or engaged:

'Engagement with this man was traded on lack of scrutiny but if you did not scrutinize, or probe or put him under any sort of pressure, you might gain access to him. But if at any point you scrutinized him in the way that you did … I suspect that he quickly became quite defensive and excluded you from his care. That may have been the professional trade off…'

☐ His previous offences had been totally unexpected by those with whom he was in close daily contact, and he had remained generally affable even immediately before his offence in 1980:

'I recall reading in the notes a comment that possibly the original offences in 1980, which brought him to the attention of the criminal justice system and subsequently of the mental health system was the thought that he had been incubating for some time these paranoid ideas. I think he had stabbed two people before. I guess that what concerned me was that clearly he had not demonstrated anything overt that would have alerted people to the deterioration in his mental health state, yet he'd been able to act on those thoughts. The concern was that maybe he'd been able to present a reasonable picture but it was difficult to know what was going on – one was not getting the full picture.' (CPN)

☐ He was known to respond to antipsychotic medication but had not received regular medication since 1985. It could only be administered under section because of his objections.

☐ A more intrusive approach was justified by personal and public safety considerations:

'We did not do him many favours by enabling him to commit a serious offence, ending up back in prison , and all the disruption that has caused to him; let alone the terrible trauma to his victim and the family of his victim and the concern that that generates in the community, undermining people's confidence in mental health services.'

In short, it was documented that he was mentally ill and distressed; that without medication he was capable of serious violence; that he was unwilling to take medication voluntarily; and that he had responded to medication in the past.

Counter-arguments

The arguments are not all one way, and the case against compulsory admission during this period may be summarised as follows:

- ☐ Mr Hamilton's last offence of any kind had been in 1980, nineteen years before Mr Hodge's death. Since then, there was no reliable evidence that he had placed anyone at significant risk of serious violence:[14].

- ☐ The seemingly tragically accurate prognosis made by his consultant in 1985, about the risk of relapse and violence without prophylactic medication, was in fact inaccurate. She believed that there was 'a real risk that without [medication] he may relapse over the next few months and if he does so he is potentially a dangerous man.' He did not relapse within a few months, and had not been violent during the many years since then. It was possible that there had been a 'sea-change' in his mental condition:

  'When I come out of prison I try my best. It was nearly 20 years before I got into this trouble. At all times I try my best, regardless of circumstances, to keep out of trouble.'

- ☐ Although Mr Hamilton made numerous allegations against his neighbours, he always tried to resolve these by lawful means without resort to violence. Mr Hodge was black, and the professional view that Mr Hamilton was unlikely to resort to violence as a way of settling his complaints of harassment was to this extent borne out. In particular, he never attacked the white neighbour he saw as his main persecutor for many years:

  'I recall on a number of occasions discussing very specifically with Mr Hamilton whether or not he felt that he would confront his neighbour and also raised with him the offences which he had committed in 1980 and the risk that he may be to his neighbour. My recollection is that Mr Hamilton told me that he had no intention of taking matters into his own hands and if anything was taking steps to actively avoid this man rather than confront him.' (CPN, 1996)

  'He was able to reassure me about his neighbour because I specifically asked if he was thinking about confronting this man and his behaviour. He said, 'I am not going to do that. I do not want any hassle with him. I just want it sorted out'. I felt he was genuine and not seeking to confront this man himself. If anything, I felt he was probably more inclined to avoid him.'

---

[14] This argument carried less weight in 1991. Between January 1975 and January 1985, Mr Hamilton was in custody or liable to detention for 5½ years. He committed two offences of wounding during the other 4½ years. Having been discharged in 1985, he lived in the community informally for five years before it was apparent that he was again mentally ill.

- A court, in the form of a mental health review tribunal, had found that his two offences of violence were not associated with mental illness. Once one relied on that finding, his offending was by implication 'ordinary' violence unrelated to psychiatric illness, and so was not to be understood in terms of untreated mental illness.[15]

- By July 1999, Mr Hamilton was aged 57 and had only ever had one admission to hospital for the treatment of a mental illness. That involved a transfer from prison. It was not unreasonable to take the view that this episode constituted a psychotic reaction to incarceration in prison conditions, and that for 57 years he had always functioned sufficiently well in the community without medical intervention.[16]

- He presented quite well in many respects: he was living in his own flat; his benefits had been arranged, he could care for himself; and he had some friends. Thus, although he had some symptoms of mental ill-health, they were not disabling.

- In practice, the professionals were bound to give some weight to his generally affable or agreeable presentation:

  'I think he always felt threatened but he didn't express any aggression or anger either to me – he certainly didn't express that about anyone else, and nobody in the community who might have known him (or any of his neighbours for that matter) ever came in and said something about him that was saying there was a problem.'

- He had been seen and assessed by his general practitioner and a number of consultant psychiatrists since 1985, none of whom was of the opinion that he required compulsory admission and treatment.[17]

- Given his antipathy towards psychiatrists, and his refusal to have drug treatment, compulsory treatment in hospital (which was the only option available) might be counter-productive. It might result in him then refusing all contact with services. Furthermore, drug treatment between 1983 and 1985 had not resulted in any 'insight' on his part in terms of voluntarily complying with medication once he was no longer under section. In 1985, he refused medication as soon as released by the tribunal. (His subsequent period of treatment at the Reaside Clinic similarly did not produce any 'insight' concerning the need for medical treatment):[18]

  'I have patients like this who won't see me, they won't see the rest of the team but might just let the social worker see them occasionally. They are not detainable, I know they have an ongoing risk of violence but what can I do? I can't force myself inside their house. When does assertive

---

[15] A reading of the prosecution statements would, however, have rather undermined the tribunal's finding.

[16] Again, a reading of the prosecution statements would have rather undermined the tribunal's finding.

[17] There is, however, no evidence that any of them systematically reviewed the forensic history or undertook a reasonably detailed risk assessment. Indeed, the medical entries are Spartan.

[18] Treatment did, however, have an effect on his persecutory beliefs, which seem to have been the trigger for his violence. Furthermore, he did not receive any home treatment or assertive care. Indeed, with only one admission to hospital in over fifty years, and no serious offending for up to nineteen years, Mr Hamilton was unlikely to qualify for assertive outreach.

outreach or assertive follow-up become harassment?' (Forensic psychiatrist)

'How do you judge whether this person requires to be taken through a medical model for other people's own safety, perhaps to the detriment of their own psychological functioning and inner health, or the judgment that they would be much better off in a multi-cultural Frantz Fanon-type assertive outreach team who could engage with them at a level where they will accept some sort of service, which then may go on to reduce their likelihood of acting out on their delusions.'

'The whole point with the assertive outreach model is that is exactly what it does. You engage people in order to build a relationship by which you can then negotiate with them about how they minimise their risk to themselves and to others.'

☐ He had experienced marked tremor when on antipsychotic medication, so the possible benefits of antipsychotic medication without consent needed to be balanced against the physical discomfort it was likely to cause him.

☐ His numerous complaints of racist persecution from 1991 onwards had a foundation in fact, and can be explained by his cultural and social experiences:[19]

'What perhaps has influenced me was my work in Ladywood was … what lay behind their behaviour, and what might be influences on them that was causing them to come out with these beliefs.'

CONCLUSIONS

Legitimate arguments can be raised in favour of compulsory admission and against its use during the period from 1991 until 1999.

We believe that there was a strong case in favour of compulsory admission in 1991. However, by the time he attacked Mr Hodge nineteen years had elapsed since his last offence of violence. The likelihood of him seriously harming someone else if he was not detained and treated against his will was by then not so apparent as to obviously necessitate compulsory admission. In other words, it was not unreasonable to decide that any risk to others did not justify detention, particularly given the pressure on local hospital beds and the more immediate and obvious risks presented by other patients. Having said that, we also think that Mr Hamilton's experiences caused him prolonged suffering over many years and his quality of life was poor. This suffering was likely to persist indefinitely unless he received antipsychotic medication, and he would have benefited from a defined period of treatment in hospital.

In our analysis, we have tried to be fair and to define the case against compulsion. It must be acknowledged, however, that Mr Hamilton's professional carers did not assess and balance the competing risks in similar terms. Nor did they have or agree a plan for assessing and managing obvious risks, whether in hospital or in the

[19] This is unconvincing. The factual basis was slight. Furthermore, the fact a person's mental or physical illness is understandable, and constitutes a normal reaction to their environment, does not mean that therefore they are not mentally ill. Disease processes most often involve the body's normal responses to abnormal environmental influences; for example, the body's reaction to noxious external influences such as pathogenic organisms and dietary deficiencies. The fact that certain circumstances are sufficiently common for the body's reaction to them to be regarded as diseases does not detract from this concept.

community. We therefore turn now to the more general issue of how the risks were assessed and managed.

3 — RISK MANAGEMENT

Whether professional decisions to intervene or not are supportable depends on the quality of their assessments of the identifiable risks.

A compehensive assessment may support a conclusion that these risks are not so great as to warrant intervention. Such decisions should be supported even when, as occasionally happens, an identified low risk later materialises.

The converse situation is that professionals who do not assess or manage obvious risks are usually not called to account, simply because tragic outcomes are relatively uncommon. They run risks but 'get away with it'. Nevertheless, a fortuitous outcome is no more evidence of good practice than a tragic outcome is evidence of poor practice.

In Mr Hamilton's case, the key risk management issues were whether compulsory admission was indicated and, if it wasn't, how any identifiable risks needed to be managed while he resided at home informally.

Once compulsory admission had been ruled out, there were two possible strategies:

1. To formally discharge him, and to close his medical and social work files, on the grounds that nothing useful could be achieved by mental health services. Routine psychiatric support was a 'non-starter', given his refusal to attend out-patient appointments and to take medication; and he had no particular social problems other than his complaints of harassment, with which he was being fully supported by many agencies.

2. To provide some element of supervision and support, so as to be better placed to intervene if it became apparent that his mental state, behaviour or social circumstances were deteriorating. The rationale of this strategy was that he had a mental illness that was causing him significant distress; that his mental health had deteriorated; that he was in conflict with his neighbours; that he did not recognise he was ill; and that he had previously committed serious violence against people with whom he was in close daily contact.

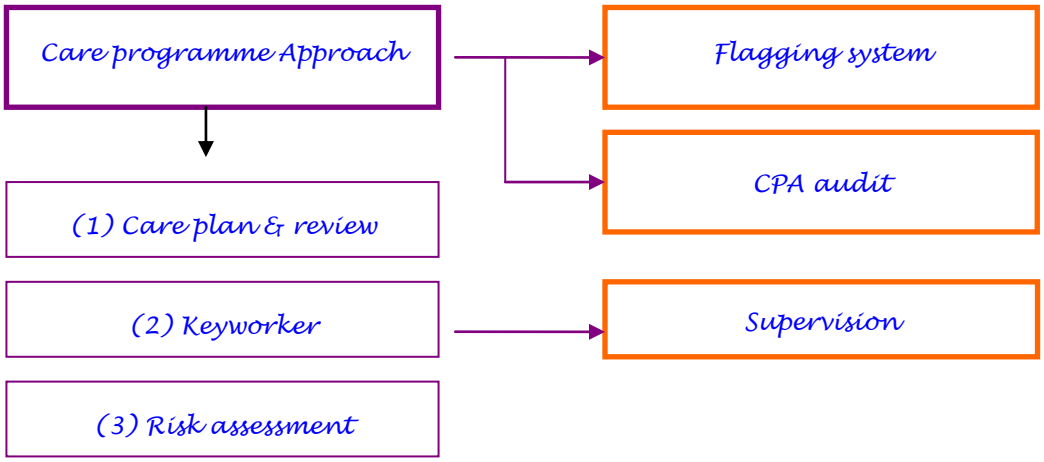
In our opinion, it is self-evident that the second strategy was the only defensible approach once compulsory admission was assessed to be unwarranted.

The consequence should have been that Mr Hamilton was supervised, and where necessary supported and treated, systematically. The benefit of being systematic is simply to ensure that clients do not 'slip through the net' because of competing demands on professional time. A simple system, such as the CPA, helps to ensure that changes in their circumstances, and individual professional judgements or omissions, are noticed and discussed before they have unfortunate or tragic consequences:

> *'It seems that you can have the kind of low key, informal contact with him, such as social services have been providing but all the more need then for a structured system to take that back and periodically review how things are going. That seems the bit that was missing. The face to face contact part may have been acceptable or understandable, since he was so rejecting of*

more formal contact. But then, to me that seems like the need for more formal structure to review what was happening periodically.'

Such a system does not need to involve a great deal of paperwork. Mr Hamilton required an agreed, recorded, care plan that was periodically reviewed and, as part of this, periodic risk assessment. That this was happening should have been verified through supervision and CPA audits.



Medical involvement in a CPA and risk assessment process of this kind was possible. Even if Mr Hamilton could not be persuaded to meet his new consultant, his consultant could have reviewed the psychiatric and forensic history; been kept informed of developments, and been asked to give advice about their significance; have given advice about his support and supervision; and have participated in care programme meetings and risk assessments, and in decisions about the need to conduct a further statutory assessment. Furthermore, Mr Hamilton had an excellent relationship with his general practitioner, who he saw quite often. This doctor could have been asked to examine him and to report periodically on his mental state. Given the history, at some stage it may also have been beneficial to have sought an opinion from a forensic psychiatrist.

In the event, there was no simple risk management system in place:

- ☐ Mr Hamilton's last consultant accepted that no care plan was agreed and no risk assessment process was undertaken.
- ☐ There was (in fact) no clearly identified keyworker or proper CPA process in place (see below).
- ☐ No one was responsible for collecting information about his mental health and forensic history. The consequence was that decisions about the need for compulsory admission were made in the context of limited and unconfirmed information about the risk of violence to others.
- ☐ Although some contact was maintained with his social worker, the approach was unduly hands-off and low-key.
- ☐ Mr Hamilton's complaints were accepted at face value for some considerable time, to the detriment of his mental health. No multi-disciplinary meetings were convened, and his social worker became accustomed to how he presented. No one questioned his assumptions and judgements about Mr

Hamilton's state of mental health and the significance of his forensic history and complaints.

- There was seemingly a discrepancy between Mr Hamilton's 'gentle giant' status and his forensic history but, apart from his consultant in 1985 and his CPN in 1996, no one assessed or tried to explain its significance, or raised questions such as:

  What were the circumstances in which he had previously been dangerous, and in which he might be dangerous again unless there had been some fundamental change in his personality, mental state or circumstances?

  Had there been a 'sea-change' in his personality or mental state, or was there a continuing risk of serious violence?

  If his offending was not to be explained in terms of mental illness, what were the precipitants of violence?

  Had he been generally pleasant and affable at the time of his two serious offences?

  To what extent was his surface affability a reliable guide to his mental health? He was certainly less than affable when challenged, for example by his CPN in early 1996, and less than affable in his dealings with his neighbours.

- Because there was no team approach to his care or risk management, the professionals involved with him (consultants, community psychiatric nurses, social workers and housing officers) kept separate files, and communication was poor. There are only two passing references to his previous violence in the letters sent to his GP over many years. His social worker did not receive a medical or forensic history. His CPN in the early 1990s did not have access to the medical notes, received only a three line referral from his consultant, and was unaware of his history of hallucinations and delusional beliefs. The police did not share with mental health services, and the latter did not seek, information about his behaviour towards neighbours and passers-by. The Housing Department did not receive any information from his general practitioner or specialist mental health services about his mental state or forensic history. Nor was it told that Mr Hodge had thrown himself out of the window at a previous property when he became afraid of his neighbours. In short, information about Mr Hamilton's mental state and the risks was mostly not shared, and each professional had only a partial understanding of his mental state and history.

- Not only was important information of this kind not provided, it was not sought by those responsible for assessing and monitoring Mr Hamilton.

- These problems were compounded by the fact that files containing important information about his history went missing. For example, the social services file passed to his social worker in 1996 contained only documentation from 1995 onwards. However, his social worker from 1984 until the late 1980s told us that he had 'a huge file' concerning Mr Hamilton.

- The problems were further compounded by the disorganised state of some files and the lack of detailed, easily digestible, summaries.

4 — CARE PROGRAMME APPROACH & AFTER-CARE

Because Mr Hamilton had been detained in hospital for treatment, he was entitled to after-care services, under section 117 of the 1983 Act, until the relevant authorities were satisfied that he no longer required such services.

In terms of the care programme approach, he was someone who required multi-disciplinary ongoing review:

> *'For Mr Hamilton's care, there was an issue of the care being low key. Anybody who has a mental health issue needs to be on the CPA programme, and whether the reviews are three-monthly or six-monthly, they need to be continuous with an RMO until it is agreed … that the reviews can be extended or even stopped.'*

As a minimum, services should have been organised which sought to:

1. support him;

2. engage him;

3. monitor any change in his mental state and the risk to others (in particular his neighbours);

4. encourage him to accept treatment.

Even a minimal service of this kind necessitated a proper and adequate care plan, regular psychiatric advice and review; GP involvement; the sharing of information; systematic risk assessment; and keyworker support and co-ordination.

Unfortunately, Mr Hamilton did not have a care plan, and his after-care needs were not periodically reviewed and revised. Nor were the supervision register guidelines implemented. His case drifted, in keeping with its status as a low-profile, low priority, case. It was neither closed nor actively worked on.

THE KEYWORKER ARRANGEMENTS

Only one person believed that CPA and keyworker arrangements were made when Mr Hamilton's CPN was replaced by the social worker in 1996. All of the remaining evidence was to the effect that no proper CPA arrangements were made, and that the social worker involved between 1996 and 1999 was not asked to fulfil a keyworker role.

MEDICAL INPUT

Mr Hamilton received only social support from 1996 onwards. The consultant who was appointed in October 1997 accepted that he had no contact with his general practitioner, and no meaningful contact with his keyworker.

It was generally acknowledged that consultant and other medical posts in the locality were under-resourced at the time. More particularly, Mr Hamilton's consultant had a heavy workload, and he lacked systematic support. These were problems that he raised at the time, in particular in a letter to the trust on 10 April 1998.

Eventually, on 10 September 2001, the consultant wrote to the Medical Director, resigning his post as a consultant psychiatrist with the trust. The lack of staffing

and leadership in the locality had taken its toll on him, he said, and progress had been frustratingly slow and disorganised. He was responsible for a catchment area population of 52,000 people, an average of 12 patients on home treatment, and in-patients in five different locations, as well as being the RMO to primary care liaison and rehabilitation and recovery teams. The in-patient service was a 'chaotic shambles' and an 'often counter-therapeutic environment'. There were no multidisciplinary ward rounds, and ward staff were often unable to attend them. While fully supportive of the trust's strategy, the working conditions had become increasingly difficult, although he now had an SCMO. As matters stood, he had reached the end of what it was possible for him to achieve in Sutton.

Mr Hamilton's consultant

It was to the service's detriment that Mr Hamilton's consultant could not continue in his post, and that he was lost to the private sector. Despite the lack of CPA planning in this instance, he was committed to the care programme approach and he made strenuous efforts to improve its implementation locally.

Mr Hamilton's consultant did much good work during the time he was in post, and he can be proud of what he achieved. In addition to the usual duties of a consultant, he disbanded the Stockland Clinic at Highcroft Hospital and transferred its patients to care programmes; arranged appointments at GP surgeries; helped to develop a primary care liaison service; established a monthly clinic at the Castle Vale Health Centre; helped to establish a rapid assessment service; and set up twice weekly team meetings for the discussion of complex cases and new referrals. It would be unfair to criticise him for being unable to do more.

THE CPA AND MR HODGE

At the time of his death, Mr Hodge was being supported by a social services keyworker and a community psychiatric nurse, but had been without a permanent consultant psychiatrist for around six months, since the beginning of 1999.

Mr Hodge had regular CPA meetings on the ward prior to discharge from hospital, but none after he moved into the community. A CPA review scheduled for 10 May 1999 was not held because a consultant had yet to be appointed to the catchment area post.

The fact that Mr Hodge's care programme was better organised than Mr Hamilton's seems to have been due in part to the fact that he was on the supervision register.

The psychiatric input provided after Mr Hodge was discharged in November 1998 comprised two 15 or 20 minute out-patient appointments with a locum consultant. Mr Hodge's medical notes were not available for the initial three-monthly review on 10 March 1999, which was the first time the locum had met him.

The fact that the same social services team was working with Mr Hamilton and Mr Hodge was not picked up, even though the same two managers supervised both of their social workers. These workers were unaware that two men with histories of serious mental illness and a fear of their neighbours had been placed as neighbours in the same small housing complex, and they did not have the opportunity to consult each other, or to undertake any joint working:

> *'Q. So you have two people living next-door to each other both of whom were receiving services from the same team, both of whom had a history of paranoia associated with their neighbours … I suppose there is the issue of whether there was some sort of system in place that allows for an assessment*

to be made of the suitability of discharging somebody to a particular address. It is only in retrospect that it is a very explosive mixture.

A. Yes, I agree.'

The block of flats at which Mr Hamilton and Mr Hodge lived had significant social problems, and a disproportionate number of people leaving hospital may have been accommodated there.

UNDERLYING CAUSES

Mr Hamilton's situation was not atypical and we were told of several reasons for the very patchy implementation locally of the care programme approach:

- ☐ There was no clear section 117 policy to which both health and social services professionals worked in this part of Birmingham.

- ☐ There was no single CPA policy and set of procedures to which both health and social services professionals worked in this part of Birmingham.

- ☐ The appointment of keyworkers could be very informal, so much so that it was not always clear to the relevant professional that s/he was being appointed as a keyworker. Mr Hamilton's 'keyworker' from 1996 to 1999 was allocated the case in a corridor and had little background information. His role was described as 'a low-level monitoring role'.

- ☐ Medical input was a problem. Consultant workloads were heavy, and the locality seems to have had difficulties recruiting and retaining consultant psychiatrists. The turnover of consultants resulted in a lack of continuity in both Mr Hamilton's and Mr Hodge's medical care, and difficulties for others in co-ordinating different aspects of their care.

- ☐ The conduct of CPA reviews tended to be *ad hoc*. The trust data system was inadequate in this respect, and there was no system that flagged up people who had not had a CPA, or had not seen a psychiatrist, for some time. Where CPA reviews occurred, they were most often an extension of an outpatient appointment. Mr Hamilton's case should have been closed by agreement with the trust or a CPA meeting set up with NHS colleagues.

- ☐ Mr Hamilton's case was passed back and forth between health and social service teams, but the services were not well-integrated and they used different sets of documentation. This added to the confusion.

- ☐ CPA forms were only partially completely.

- ☐ Managerial fighting was rife, and responsible for much of this inconsistency and the limited implementation of CPA procedures. Clear messages were given by senior social services managers to follow a care management route rather than care programme approach guidelines, and there was similar resistance to integration. Some professionals were antagonistic to change and committed to what were referred to as 'old school' practices.

SUBSEQUENT PROGRESS

Since July 1999, a CPA co-ordinator has been appointed across north and south Birmingham. He has brought about noticeable improvements, although work remains to be done:

> *'The other big thing that's good news … is [the] appointment of a CPA lead. He's really changing things and he's bringing about team training because we didn't have team training in the past.'*

> *'[The CPA lead] has made good changes in bringing us together and helping us to work together, and the CPA training. Training as a team you couldn't get, and that's happening as well now, so … lots of things probably have happened in recent months.'*

> *'There is a policy – a CPA policy – so there is a bit of guidance. The system is perhaps not as robust as they had planned it; that would be my personal view. It remains a somewhat paper system of care. 'Have you done the risk assessment?', which means, 'Have you filled in a form?'. The care plan does not inform decision-making in the day-to-day care of patients. In fact, in my experience it is rarely referred to; it is referred to, sadly, on days like this. The issues about sitting round and discussing patients' needs in a systematic way rarely happened. It is not even a matter of sitting down and saying, 'Who is going to be the care co-ordinator?' I guess if you are the nurse involved, the implication is that it is expected you will be the care co-ordinator, and it is left to that person to go and fill in forms, do the risk assessment. So it happens but it does not really reflect the spirit of good multi disciplinary team work. It is very variable. There are individuals in the team who will commit to it more robustly than others. It is seen by some as a form filling exercise … It is sometimes difficult to get people to agree to the CPA review meetings, for instance. Very often it is necessary to simply book these into routine patient appointments with the consultants because the consultants say, 'We're too busy for that'.'*

CPA Audit (December 2000)

A city-wide case note audit and service user survey of the implementation of the CPA across Birmingham was published in December 2000. It was commissioned by the Health Authority, Birmingham Social Services, and the two local mental health trusts.

The study looked only at the circumstances of a large randomised sample of patients on enhanced CPA.

The published report did not analyse the data by trust, although we were told that the two trusts implemented the care programme approach differently. In particular, the Northern Birmingham trust had some 9,000 patients on CPA, of whom 3,000 were subject to enhanced CPA. The trust in the south of the city had 15,000 patients on CPA, only 600 of whom were subject to enhanced CPA.

Bearing in mind that the study was confined to clients subject to enhanced CPA, the results were mixed:

- ☐ The name of the care co-ordinator (keyworker) was identifiable in 81% of cases;
- ☐ The care co-ordinator's contact details were identifiable in 74% of cases;

- 68% of care co-ordinators were nurses, and only 9% of them were social workers and 2% doctors (which rather undermines the doctors' protests that they find the paperwork too time-consuming);

- A date for discharge was set prior to discharge in only 31% of cases;

- Discharge was discussed by the multi-disciplinary team in 43% of cases;

- The care co-ordinator was consulted prior to discharge in 43% of cases;

- There was an assessment summary in 67% of cases; a summary of the warning signs and risk history in 68%; community care details in 60%; a community care plan in 73%, and a relapse and risk management plan in 67%.

5 — MULTI-DISCIPLINARY TEAM WORKING

It will be understood from what we have written about risk management and the care programme approach that practitioners from all disciplines experienced significant problems with joint working.

Whether mental health services, even operating optimally, could have succeeded in ensuring that Mr Hamilton was adequately treated and supervised in the community on an informal basis is a matter of opinion. However, any chances of success were severely reduced by an almost complete lack of systems promoting multi-disciplinary team working. Not only was there a three-fold structural split, there were serious divisions from the top downwards.

Had helpful structures existed, it would have been easier to pool expertise and information, and to agree a shared plan for Mr Hamilton's on-going support. Some of the most worrying practical aspects of the fragmentation were:

- A lack of shared information about Mr Hamilton's previous offences. The social services practitioners did not know how serious his past offences were, the circumstances of his offending, or the way in which he had presented at the time.

- The lack of a properly implemented CPA process, which meant that he did not have a clearly identified keyworker in the years leading up to the homicide.

- The lack of a system within which individual workers could practice as a team, maximizing and co-ordinating their inputs, sharing their skills, views and expertise, and minimizing the professional risks to themselves.

- A lack of coterminosity between the social services and health teams. Health services were GP aligned and social services were geographically aligned. It 'was rather arbitrary which clients came to the social services team and which [were referred] to the CPN team … things had developed in a rather higgledy-piggledy fashion.'

UNDERLYING CAUSES

Many factors contributed to the difficulties that practitioners experienced when they tried to work in a multidisciplinary way:

Organisational suspicion and hostility

The evidence of suspicion, and sometimes hostility, between key health and social services managers is incontrovertible, and Sutton and Erdington was worst affected.

This hostility either found expression in, or was the expression of, a failure of the local social services team to engage in multidisciplinary working, the implementation of the care programme approach, and the functionalisation of services.

There is some evidence that the City Council's Social Services Committee was at the very least aware of the situation, and at worst considered it advantageous to delay the integration of mental health teams.

Indeed, during the period reviewed by us, there was some 'disintegration' of local services. The community mental health team developed its own community nursing service, and the nurse who visited Mr Hamilton during 1995, before going on long-term sick leave, was a member of this social services team.

This lack of co-operation and partnership permeated down to the ground, had a demoralising effect on front-line staff, and hampered their attempts to focus on client needs. Where individuals worked in a multi-disciplinary way, they did so despite the system, not because of it. The faults and weaknesses were much more top-down, not bottom-up.

High staff turnover

There was evidence of high turnover and instability in key management posts, and this seems to have undermined the capacity and ability of managers to lead major service changes. Social services in particular had an enormous number of managers acting up in different posts throughout the period. Those in senior positions often lacked knowledge and experience of mental health services.

The NHS trust was also affected by staff turnover.

Different models and professional perspectives

Effective multidisciplinary working was not only made difficult by tensions between the trust and social services at managerial level. Ideological battles were being fought within the organisations about the direction of local mental health services.

There was resistance in some quarters to the relocation of Highcroft Hospital based services (such as psychology services) to community settings. There was also some discomfort about the trust's attempts to develop a more social model of psychiatry. This left a number of psychiatrists feeling marginalised, which may have contributed to them feeling unappreciated, and problems with their recruitment and retention.

There were differences of opinion about the merits of functionalising services. Although Mr Hamilton's final consultant clearly supported functionalisation, other consultants did not, and some of them were reluctant to become more involved with community teams.

The trust board was throughout fully committed to implementing the functionalised model of care developed and pioneered by it. This model has many benefits, and trust staff may properly be proud of the work they have done. At the same time, there is evidence that implementing the model came at a price, which some practitioners viewed as the unavoidable cost of necessary change:

- The need to prioritise scarce resources led to the physical environment of Highcroft Hospital becoming unacceptably poor for the patients who had to use it.[20]

- Management and clinical capacity focused on the areas being functionalised, and the community teams in Sutton & Erdington were relatively unsupported until it was their turn to functionalise.

- Birmingham City Council seems not to have felt a full partner in decisions to remodel mental health services, and to have withheld some goodwill from the trust's shared service development and integration agenda. The council gave out confusing and ambiguous messages about integration (see e.g., the memorandum referred to above).

- Both organisations failed to monitor and support services adequately during this period of great transition. In particular, they failed to take proper account of the capacity, experience and ability of local managers to uphold procedures basic to good practice while organisational structures were changing. While some individuals in other parts of the city were ignoring unhelpful directives from senior managers and forging links with NHS staff, this may be because they had more experience in mental health.

- Both organisations had excellent, committed, members of staff, some early on in their careers, who they failed to properly guide and support.

Lastly, there were concerns about the emphasis placed on 'empowering' clients and patients, and it may be that some practitioners found it difficult to balance this agenda with the national drive for safer services:

> *'Q. Did it go too far? In a sense one does not want to empower people like Mr Hamilton. We might be empowering them to act on that line of thought.*
>
> *A. There never really was a balance. There is a tension that exists between those two things … certainly [when it comes to] the notion of rolling all this into a ball and saying we are going to look at safety and risk and also at empowering users and also look at carers' perspectives. A lot of this is aspirational. Operationally some of it is extremely difficult and very dubious and potentially one has a list to achieve, but actually there is often quite a conflict between what the user might perceive as what they need -and the accountability and concern of professionals.'*

Although all of these debates are common to mental health services across the country, locally there seems to have been an excess of ideology and a dearth of consensus. Battles within and between teams were sometimes fought with considerable venom, which added to the prevaling dysharmony and culture of distrust. This further limited the contribution that individual practitioners could make to what was agreed to be the common goal of patient-focused services.

Resource problems

Developing functionalised services is resource-intensive, and there is considerable evidence that the local trust was under-resourced during the period reviewed by us.

---

[20] The trust has been been criticised severely in the recent past for the state of its buildings and wards at Highcroft Hospital, which were unacceptable. New units, including acute units, have since been built.

The view that Sutton is 'a quiet backwater' with little severe mental illness was 'widely held', although it takes in Highcroft Hospital and a number of former in-patients have settled there. At any rate, the locality was a relatively low priority, and 'relatively less was put into getting that service right'. The innovative teams that the trust was developing to such acclaim in other localities had mostly still not been implemented there by the summer of 1999.

For most of the period covered by our review, the conditions at Highcroft were very poor but there were few local alternatives to in-patient treatment. The trust was unwilling to shut the hospital until it had developed suitable community alternatives but developing them sector by sector was impossible if available money was chanelled into the in-patient service.

By 1999, a 'bastard mix' of systems was in operation in Sutton and Erdington. A home treatment team had been established without dedicated consultants, and it could have assessed Mr Hamilton had the need arisen or been identified. A fledgling assertive outreach team had also been created, but it also lacked a dedicated consultant, and seems not to have worked to an assertive outreach model. The rest of the services were provided on a CMHT minus social services model, to which three consultants were attached from August 1998. There were no services directed specifically at engaging mentally ill single men with a forensic history.

Management of the Sutton Mental Health Team

The management of social services' Sutton Mental Health Team was unsatisfactory. Because the team manager lacked experience and expertise in mental health, she interpreted her role as chairing team meetings and fulfilling a 'strategic position in the team', with all operational matters being delegated to the assistant team manager. She justified this by saying that he 'was good at dealing with the crisis stuff and bits of paper.'

The fact that the assistant team manager, who was undertaking his first post at this level, had to see to all operational matters was unfair and unwise. He was required to be in the duty room during his working day, to supervise the staff, to be on ASW call one day each week, to brief the team manager on managerial matters, and (initially) to allocate cases.

In practice, he was the team manager for the Underwood Centre, and it was to him that workers would go if they had any problems: 'everything to do with the team was down to [him].' He 'was always there, he was always around'.

From 15 September 1997, he took on additional managerial duties when the team manager went on an ASW training course. He supervised the whole team for this period, and in theory was himself supervised by the locality manager. The team manager said that he 'now had 75% managerial responsibility, because she wanted to keep 25%.'

The team held meetings, but referrals and allocations were not discussed at them. A system of self-allocation generally operated 'which meant that the two baskets — one for Erdington, one for Sutton — were piled high … A social worker would come in, say that he was ready to take a case, and look through the basket. We were getting incoming calls constantly asking when cases were going to be referred … Some of the cases had been in the basket for months.'

When the assistant team manager took up his post at beginning of 1997, he protested that this was 'not management of any kind' and he began directly allocating work, placing files in the pigeon-holes of social workers who were thought to have some spare capacity. This 'caused a lot of friction within the team', and 'a lot

of social workers felt very angry … They felt that cases were given to them with very little discussion, which was true.'

At a still later stage, the team did hold their own social services allocation meetings, but without health service personnel.

Throughout the period reviewed by us, therefore, social services had its own duty and allocation system and accepted referrals from any source, and this bypassed the trust's CPA procedures.

The team dynamics were unhelpful, particularly with regard to joint working. One professional went so far as to describe the culture within the team as one of 'embedded dysfunctionality'.

SUBSEQUENT PROGRESS

Since 1999, there has been a considerable improvement in the quality of multi-disciplinary working in Sutton and Erdington. This improvement was universally acknowledged across organisational boundaries and by professionals at all levels.

The City Council's Senior Service Manager for Mental Health (who was variously referred to as the 'specialist mental health lead officer' and as the 'mental health director') started work in August 2000. She has made an extremely positive contribution in this respect, and comes away with much credit.

There is now:

☐ More multi-disciplinary working:

'The social workers are more integrated with the team now. They come to the meetings and they are more actively involved. Certainly, this is the most I have known social services and health to be integrated. It has been a big step forward.'

'We have social workers and RMOs there, the psychologist, and all these disciplines are invited to the meetings and regularly attend. Therefore, it is operating more as a multi-disciplinary team.'

'It has transformed. Since we have had multi-disciplinary teams, supervision is totally different. We do not have many problems. It is a totally different experience. I was with the rehab and recovery team, so we jointly managed health. We shared the same office with the consultant. It is a totally different environment.'

☐ Better integration of health and social services teams, although they still lack integrated management structures, and separate case notes and forms are still kept:

'Things are markedly better and leaders give messages of confidence of a moving forward service.'

'We have a formal agreement … to use Health Act flexibilities and integrate all our social care staff formally with the NHS … Hopefully that will help resolve some of the issues that you are raising in terms of joint notes and joint IT. There are a million project groups under the merger and integration looking at all different aspects of the implications of using the Health Act flexibilities in terms of provider integration.'

'The present mental health service is much more integrated and structured with many more services available, like assertive outreach teams, home treatment, rehabilitation and recovery, primary care liaison, etc.'

'There is now one access point, a joint primary care liaison duty system managed by an 'H' grade CPN and an assistant team manager from social services. The home treatment team has recruited social workers and the rehabilitation and recovery staff have moved to a single base.'

'I believe it has improved considerably from what it was, and the appointment of the specialist mental health lead officer has been proved to be positive.'

'Until [the Senior Service Manager for Mental Health] came on the scene, we weren't an integrated mental health service. All the mental health teams were part of adults, so the philosophy of care management in adult care, we were very much wedded to that. In a sense, it stood in the way of integration because we were not a unified mental health service.'

'The appointment to the post of mental health director … was a positive step and has proved to be very useful in bringing the two organisations closer together. For example, the people who work to her work very closely with our senior managers. Things are improving but not to such an extent that we are prepared to consummate the relationship through a care trust.'

'I believe that it is moving forward and that it is improving. We are working more as a team, incorporating both health and social services. The duty system is joint. On the referrals, we have a handover meeting every day, so that everybody knows about the clients. We have an allocations meeting on a Tuesday, which management attend as well, and again we are discussing the clients with the RMO. Therefore, it is greatly improved to what it was a couple of years ago … but we are still in the early stages of it, because it has only recently happened.'

'We've still got our own initial contact forms. We've got different ones for health, for referrals and so on. We're not using the same files.'

'The only agreed joint records we have are of CPA paperwork. We don't have a formal policy of joint records that has been agreed. What has tended to happen on the ground floor is that within the teams different practices have developed. Some of the teams photostat everything and put it on each of the files, in some of the teams they only write on the health one and they do a bit on the CPA paperwork. Birmingham is poor and we haven't cracked joint records at all, and there are different practices.'

'We have had the restructuring of directorates … but within that there are still the different professional disciplines with their own professional heads … It is difficult to see where the boundaries lie, and where another begins, particularly because people still have their own professional guidelines, and sometimes adhere to a team model and sometimes not. That is not absolutely clear either.'

'We have looked at care trusts in detail. It is not off the agenda but currently the choice is to use Health Act flexibilities and in the future

reconsider care trust as and when. From the city council point of view, … there was an unexpectedly huge vote against transferring the housing in the housing department to a voluntary sector not-for-profit provider. We [also] failed in trying to move out our older people's homes into a voluntary sector not-for-profit provider. Within the city, there isn't the local political support to transfer things out … The city council have made efforts but in that wider context the possibility of getting a successfully agreed care trust is difficult. That is why one of the decisions is Health Act flexibilities.'

- ☐ Greater functionalisation of services. However, some of these services are not yet wholly effective. We were told that the Sutton Rehabilitation and Recovery Team is not well integrated with primary care and the local primary care liaison team. The assertive outreach team is said to be slow at taking on patients, and the home treatment service was said to be 'very difficult to access'.

  'We probably have some options that were certainly not available in 1996, one of which is that we have access to an assertive outreach team that we could ask to engage. We also have a specialist service — the Frantz Fanon service — especially dedicated to people of Afro-Caribbean background, which again would be something we could offer Mr Hamilton.'

  'There remains a wait of three to six months for assertive outreach, now possibly longer. People are discharged while waiting for the service. Clients must have had two admissions. Some clients may go to the top of the queue, be prioritised.'

  'At the moment, we have somebody on our books who has been waiting for assertive outreach for a very long time. It is being made more difficult because we are in the process of trying to transfer over the service.'

  'Trying to access services in north Birmingham seems to be quite complicated. They are an over-burdened service; they are struggling with a number of referrals and they could probably have an assertive outreach team twice the size and still be full.'

- ☐ Coterminous health & social services boundaries, based on GP alignment:

  'From my point of view, things have improved a great deal because we are actually working the same boundaries. This is great, because before we were not. We were working constituency boundaries; our colleagues were working GP boundaries which in itself brought tremendous problems.'

6 — SUPERVISION ARRANGEMENTS

Ideally, the absence of a care programme and risk assessment in Mr Hamilton's case would have been noticed and remedied during his social worker's supervision.

Although the council had set supervision procedures, the local social services team had no clear supervision procedures in place.

It was, however, universally understood by team members that social workers should receive monthly supervision.

Monthly supervision often did not take place because of workload pressures. There could be lengthy intervals between supervision sessions, so that it was not unusual for six or seven months to pass without a supervision meeting being held.

The local social services team manager underwent ASW training between September 1997 until July 1998. One effect of her absence was that Mr Hamilton's social worker received no supervision between 19 September 1997 and 22 September 1998.

It was impossible for the assistant team manager to attend fully to all of the additional responsibilities generated by her absence.

The supervision that did take place was not effective in terms of identifiying non-compliance with the care programme approach and the lack of any systematic risk assessment. The managers who supervised Mr Hamilton's social worker did not query the lack of a care plan, risk assessment or CPA procedures. His social worker received only passive supervision.

Supervision notes were often not shared with the caseworker, who was not required to sign and confirm the accuracy of the record. This was the position in the case of Mr Hodge's social worker.

SUBSEQUENT DEVELOPMENTS

We were told that the supervision format is now much tighter in terms of case management, and it involves discussing each case and any problems with them. Social work standards have also been developed that involve examining files, the quality of the file, and factual information that has been collected.

7 — SUPPORT FOR THE BEREAVED

After Mr Hodge's death, his family were supported by the police and victim support services. They did not receive any kind of organised support from the NHS trust or social services. Perhaps in part because of this, they were not hopeful that our review would unearth any new information:

> *'I am not confident that you are going to get accurate information all along the way ... They've had time now to put things together, but how do you know it is going to be accurate information?'*

8 — SUPPORT FOR MR HAMILTON

Mr Hamilton was remanded in custody following Mr Hodge's death. On 22 July 1999, his behaviour in prison was described as being as 'very bizarre', and he needed to be urgently reviewed by a psychiatrist. This did not take place for seven months, and Mr Hamilton remained 'on normal location' for the whole of this time:

The arrangements at HMP Winson Green have been overhauled since the time Mr Hamilton was there. In particular, a new healthcare centre has been opened;

psychiatric assessments usually take place within a fortnight; and the appointment of a half-time general psychiatrist is being arranged with the new mental health trust.

6 — MR REHMAN'S CARE AND TREATMENT

ABOUT THIS CHAPTER

The main purpose of this chapter is to summarise the most important aspects of Mr Rehman's personal history, care and treatment, and our findings concerning his care and treatment.

On 11 February 2000, Mr Abdul Rehman was given permission to leave the hospital at which he was being detained under section 2 of the 1983 Act, in order to go to the local shops. He returned to the family home in Alum Rock, Birmingham, and stabbed and killed his wife, Mrs Shamim Akhtar, in front of their children.

Mr Rehman later pleaded guilty at Birmingham Crown Court to manslaughter on the grounds of diminished responsibility. The court imposed hospital and restriction orders, under the Mental Health Act 1983, and ordered his admission to a medium secure unit.

MR REHMAN'S CHILDHOOD

Mr Abdul Rehman was born in the Mirpur region of Pakistan on 12 December 1960. Mirpur lies in the part of Kashmir under Pakistani control also known as Azad (free) Kashmir. The language of Mirpur Panjabi speakers is distinct from, but related to, Western Punjabi. The district comprises plain and hilly areas, and its hot climate and other geographical conditions closely resemble those of Jhelum and Gujrat, the adjoining districts of Pakistan. Many of its people are farmers. Since the 1960s, a large number of people from the district have gone abroad, especially to the United Kingdom and the Middle East, often for economic reasons. Around 50,000 people were moved from the district in the mid-sixties to make way for the construction of Mangla Dam, and some of them resettled in the United Kingdom.

Little is known of Mr Rehman's childhood. It is recorded that he attended a boarding school at the age of six, in order to learn the Koran, and that his father was 'a holy man in the Mosque'. He is said to have 'hated' being hugged by his affectionate mother, and to have been irritable and prone to outbursts of temper. He was an isolated boy who did not play with other children, and indeed hit them if they tried to play with him.

THE PERIOD FROM 1974 TO 1989

Mr Rehman came to England when he was 14 years old, in 1974 or 1975. On arriving in England, his father's first cousin, who lived in Alum Rock, became his 'adoptive father'.

Mr Rehman left secondary school with no qualifications. After a short period without work, he obtained a job with an engineering firm. He then worked as a packer in a bakery for five years, from around 1978 to 1983, by which time he was 22 years of age. He has been unemployed since then, and unresolved problems with his health seem to have led him to leave the bakery. In particular, he was troubled by a number of physical symptoms thought to be associated with autonomic arousal (excessive sweating, especially over his back; an 'excess of body heat'; dizziness; and intensely dry skin).

These symptoms were intensively investigated, and the possibility that they had an underlying psychological cause was raised by a consultant physician in early June 1982. This doctor found him to be 'very withdrawn and depressed about something … I found it difficult to get through to him that in fact there was no evidence for any disease, and I was left with the impression that he had emotional problems. I would suggest that this be explored as I am quite sure we are not dealing with undiagnosed organic illness.'

When Mr Rehman saw a psychiatrist on 13 June, no evidence of a mental illness or anxiety state could be found, although it is worth noting that his general practitioner prescribed him Chlorpromazine 25mg tds in September.

Over the following years, Mr Rehman was referred on numerous occasions to an array of hospital consultants, for the investigation of complaints concerning his physical health. An EEG and CT scan were normal, as were other investigations.

For reasons that are not recorded, Mr Rehman moved out of his adoptive father's home in 1983, and went to live with his uncle close-by.

In 1984, he married his first cousin, Shamim Akhtar, by family arrangement, and she came to England from Pakistan. Mrs Akhtar, who was born on 12 December 1962, was 'much more forward-thinking and much more intelligent than her husband. She was articulate, … able to manage her affairs, and looked after the children extremely well … She was very nice.'

Despite these considerable virtues, Mrs Akhtar was — from the day of her marriage onwards — subjected to severe sexual, physical, verbal and psychological abuse by her husband, who also kept her short of money.

A daughter was born in 1985 and a son in 1987. Mr Rehman was not violent to them. He was a conscientious parent, taking them to hospital if they were ill, and attending to their basic daily needs. However, in keeping with what is known of his own childhood, it is said that he did not hug them.

On 11 September 1986, Mr Rehman was convicted of fraud 'and kindred offences' relating to making false representations in order to obtain benefit. He received a fine and was ordered to pay £92 in compensation. This was his only conviction prior to his wife's death.

In 1988, it was discovered that he has one copy of the thalassaemia gene. This has no health consequences, because thalassaemia major only develops if a person inherits the gene from both parents. For persons with thalassaemia major, their on-going treatment includes regular blood transfusions to boost haemoglobin levels.

Although the situation was explained to Mr Rehman on many occasions, and he was given constant reassurance, he became convinced that he had a serious disease and required a blood transfusion.

It is perhaps understandable that he should asssociate in his own mind the disabling symptoms of thalassaemia major (severe anaemia, pallor, sleep difficulties, poor appetite, failure to grow and thrive) with those he was experiencing. At this time, he was lying on the sofa for most of the day, feeling ill.

The belief that he was seriously ill, and was being denied appropriate treatment, quickly took over his life. In addition to believing that he had a serious blood disorder that required a blood transfusion, he became convinced that he had a brain lesion, and complained of electric shocks entering his head, and of something crawling inside his brain. He spent 'hours and days telephoning, writing letters and visiting personally health officials, the police, local MPs and the Health Minister'; and was described as an odd character who travelled around hospitals in the region, expressing the conviction that he had a brain tumour.

It was now obvious that Mr Rehman had unresolved mental health problems, and he was again referred to a consultant psychiatrist. He did not attend his appointment in August 1988, but did see a psychiatrist in Nottingham the following month, while on a family visit. He complained of depression and forgetfulness, and of being too quiet. It was thought that he might be 'depressed and/or paranoid', and that he had a low IQ. In November, his general practitioner prescribed chlorpromazine but his symptoms did not abate, and he was referred to a consultant psychiatrist at Highcroft Hospital.

Mr Rehman saw the consultant in January 1989, and he told her that his brain was 'not working because he is forgetful and does not talk much'. He was concerned that he kept losing his temper and that his sleep was disturbed. He had a serious blood disorder which required treatment, and he 'knew' that his CT scan had been abnormal 'because of the way the doctor frowned and looked worried when looking at it on the x-ray screen'.

The consultant summarised her initial impression by recording that he was suffering from 'depression with hypochondriacal ideation of almost delusional intensity'. She warned his GP that 'he is extremely paranoid and could possibly be quite threatening or even dangerous, so I would suggest that you and your surgery staff bear this in mind if he comes in.'

Mr Rehman was prescribed antipsychotic and antidepressant medication, but by April 1989 he had stopped taking the former because it 'made no difference'. This was probably true, since his community psychiatric nurse later observed that anti-psychotic medication 'never made any difference to his mental state in terms of his thinking about a transfusion.' Mr Rehman refused injectable medication, and in May was removed from his GP's list.

FIRST ADMISSION TO HIGHCROFT HOSPITAL

Because there had been no improvement in his mental state, Mr Rehman was admitted to hospital on 29 September 1989. Although he accepted admission, it is recorded that he believed that he was in hospital 'for treatment for his blood'. He was given ECT on three occasions. Abreaction was also tried (narcoanalysis with sodium amytal) but it revealed nothing new. He absented himself from hospital early in November, but returned. On 20 November, he again went absent and returned home. He was formally discharged in his absence on 23 November. His last comment was that he would go to another town, in order to obtain a blood transfusion. His consultant noted that there had been 'no improvement whatsoever' in his symptoms and that the prognosis was very poor. She added that there was 'little else we can do for him'. Consistent with this, three days later a relative telephoned his general practitioner to say that he was as 'unwell as before'.

SECOND ADMISSION TO HIGHCROFT HOSPITAL

In January 1990, Mr Rehman was thought by his general practitioner to be depressed. He was assessed at home by the psychiatric emergency (PET) team in February. In April he attended a casualty department in Nottingham, complaining of a tumour on the right-side of his face, that his brain was not working, and that he had bad blood. He was variously prescribed Pimozide, Clomipramine and Largactil, although the extent to which he complied with these prescriptions is unknown.

During the autumn of 1990, he telephoned his consultant's secretary almost every day, requesting treatment for his brain and blood condition. In October, his consultant arranged for his CPN keyworker to talk to his wife, in order to establish if there were 'any aspects of his behaviour which put himself or anyone else at risk and/or whether she thinks that his condition is deteriorating'. Matters came to a head shortly after this. On 3 November, Mr Rehman became angry when he discovered his wife talking on the telephone with a relative who had called to find out how he was treating her. According to his wife, he grabbed the telephone:

> *'He then slapped me and I fell to the floor, he started kicking me, then he kept saying he was going to kill me, the children were screaming. Finally I managed to get up and ran out of the house. I went to my neighbour's house and she called the police. The police came [and] asked me a few questions and then went and asked Rehman a few things and then left.*

They didn't do much. I rang my uncle, he came with Rehman's father and brother. They tried to talk some sense into him but he just hurled abuse at them. Finally he calmed down and said I could come back. I didn't want to go back but this was his last chance. Over the next two weeks things started getting bad again. He kept telling me to get out and leave, he said he was going to divorce me.

I rang his cousin's sister and told her the situation was getting worse. She said she would come to Birmingham and try to talk to him. On Saturday 17 November, she came down from Nottingham with her husband and another cousin. When they arrived he seemed quite pleased to see them. They chatted together. That night at 10pm, … Rehman came round to my uncle's house. As soon as he sat down, he said 'What have you done?', then pulled a knife from his pocket and tried to stab my uncle; luckily they managed to stop him and then called the police.'

Mr Rehman was arrested for causing a breach of the peace during the early hours of 18 November, and taken to Stechford Police Station, from where he was informally admitted to St Barnabas I Ward at Highcroft Hospital. He was aged 29.

It is well recorded that he was telephoning home, and threatening to kill his wife, during the period immediately following admission. He absconded from hospital, which naturally caused his wife and family grave concern. When he returned, and then on 21 November tried to leave hospital again, he was detained for up to 72 hours under section 5(2). The doctor who invoked the power recorded:

'Recent history of violence to wife and now trying to abscond to harm his wife further", therefore section 5(2). He has also displayed threatening and violent behaviour towards his wife and relatives, witnessed by his GP and the police… He has no insight and is unpredictable.'

On 22 November, an approved social worker authorised his detention under section 2, for up to 28 days. The supporting medical recommendations state that he had assaulted his wife and relatives, was threatening to kill his wife and children, and that he was a potential danger both to his family and to himself.

Once more, there was no improvement in Mr Rehman's mental state during the course of his treatment in hospital. He continued to believe that his brain was not working and that he needed a blood transfusion. He was now also expressing a belief that there was a conspiracy against him. Having seen Kenneth Clarke MP on the television, he 'realised' that it had been Mr Clarke who had spoken with him on the telephone about a hospital appointment two days previously. Over time, this 'realisation' developed into a belief that the failure to give him the blood transfusion he required was because of a conspiracy involving the British Government. The facial expressions and gestures of well-known politicians and television presenters were interpreted by him as signals that they were aware of this conspiracy to deny him treatment.

A section 3 application was made on 18 December 1990. His consultant recorded in her medical recommendation that 'there was a 'risk of harm to himself or his family if he leaves hospital. Cannot be relied on to stay informally.'

Treatment with depixol 100mg i/m weekly, prothiaden and procyclidine did not produce any noticeable improvement. At a case conference on 16 January 1991, his consultant explained to Mrs Akhtar's family:

'that there were some conditions which were not amenable to treatment and that this would mean that eventually he would have to return home, even though there remained an element of risk to his wife and family in his behaviour.'

She added, in her tribunal medical report of 25 January, that 'he remains a danger to his wife but this is likely to be an on-going situation.'

Mrs Akhtar obtained an injunction, which was served on her husband on 14 February 1991, and the order was later extended following liaison with the consultant.

In March 1991, Mr Rehman saw a consultant who specialised in learning disabilities. He was not thought to be autistic, but there was a possibility that he had a mild learning disability. On 18 March, he was discharged with a diagnosis of 'simple schizophrenia with a degree of learning disability'.

THE PERIOD FROM MARCH 1991 TO JANUARY 2000

Having been discharged from hospital, Mr Rehman went to Pakistan between April and July 1991. He refused depot medication on his return, as a result of which he was discharged from his community psychiatric nurse's caseload and that of his new consultant. Despite this, he maintained irregular contact with mental health services, seeing a nurse from the Asian Support Team, and occasionally attending out-patient appointments, but probably not complying with prescriptions issued to him.

Mr Rehman continued to see his general practitioner regularly, but he remained unable to accept the true nature of his illness:

'He was offered treatment all the time … He was non-compliant, he refused everything. As you can see he was always saying we were not treating him for his blood disorder … He would not come to hospital, it was a complete waste of time … He never accepted help at any stage.'

'Two of the children had eczema, so he would come every two weeks to get a prescription for his wife, for the children. All the time, his question was, 'doctor, what are you doing about me?' That was the only question. He always wanted to know what I was doing for him.'

The consultant responsible for Mr Rehman's care at the time of his wife's death took over in 1995. They had little contact because Mr Rehman was seen by a middle-grade Urdu-speaking psychiatrist whenever he attended the out-patient clinic. Having been prescribed antipsychotic medication in 3 March 1998, he refused to attend the follow-up appointment, returning the letter with the inscription, 'Formal letter of refusal. Please cancel the appointment. This is a[n] order.'

Mr Rehman had no further contact with psychiatric services until 21 January 2000. For several reasons it was decided not to follow him up during the two-year period between March 1998 and January 2000:

- ☐ His mental condition had not changed for many years. He continued to believe that he had a physical illness, and he felt generally unwell. There was no evidence of any other persecutory delusions or of any other abnormal phenomena, such as auditory hallucinations.

- ☐ Treatment with anti-psychotic medication and ECT had not brought about any appreciable change in his mental state or delusional beliefs. Conversely, there had been no noticeable deterioration while he was not taking medication.

- ☐ There had been no recent reported incidents of self-harm or harm to others, and he had not expressed any such thoughts or intentions. Although he and his psychiatrist had not established a good rapport, he was always polite.

- ☐ He was unwilling to take any medication, or to accept any treatment other than a 'total blood transfusion', and was dismayed by the doctors' apparent unwillingness to provide this necessary treatment.

- ☐ His attendance at outpatient appointments was poor.

- ☐ He had refused the doctor permission to talk with any of his close relatives or friends, saying that it was he, not they, who had the illness.

- ☐ He was not neglecting his self-care or hygiene.

- ☐ He continued to carry out his routine domestic chores.

- ☐ His family had fair access to the general practitioner, who saw Mr Rehman regularly.

- ☐ Assertive intervention was unwarranted, and might be counter-productive.

The matrimonial relationship continued much as before, and at times it seems that Mrs Akhtar was effectively imprisoned within her own house:

> *'She mentioned that when he lost his temper he would pick up a chair and throw it, anything that would come into his hand. He would stop her going out physically, so she was a hostage in her own house.'*

> *'She was quite close to her own family and he prevented her from seeing them, and disliked her family and disliked her seeing them.'*

On 6 November 1990, Mr Rehman's and Mrs Akhtar's 14-year old daughter died of acute pneumonia. This event was especially traumatic for her mother, who often said that her daughter was the only friend with whom she could talk openly.

Mr Rehman's own grief was not outwardly visible. However, his mental health and behaviour certainly deteriorated from this time onwards. According to one relative, he 'started talking a lot and during a conversation he would also laugh'. According to another, he would start writing as soon as he woke up, on one occasion saying that he was writing down the names of all the people 'who came last night'. He accused his wife of 'going with strangers, talking to other people about their personal matters, and denying family access to him.' He swore at her and threatened her with divorce. He was suspicious, and taped her telephone conversations. He also forced her to have sexual intercourse against her will.

THIRD ADMISSION TO HIGHCROFT

On Friday 21 January 2000, Mrs Akhtar contacted the family GP about her husband's deteriorating behaviour. She was very frightened. When the doctor arrived at their home, Mr Rehman was 'very high in his behaviour, as if he was ready to attack.' He questioned the doctor about why he had come and who had called him. This was uncharacteristic, because he respected the doctor and usually welcomed him.

The general practitioner recommended Mr Rehman's admission to hospital under section 2. The relevant statutory form states: 'Very aggressive. Abusive to his family,

refusing to take any medication. He won't be safe if left at home and is a danger to his family'. He also contacted the Yardley/Hodge Hill Home Treatment Team at Newbridge House, at around 11am, and asked them to visit Mr Rehman urgently.

A psychiatrist, community psychiatric nurse and support worker from the Home Treatment Team left for the house within ten or 15 minutes of receiving the call. Mr Rehman opened the door, recognised the psychiatrist, and immediately became hostile and abusive. He refused his visitors entry to the premises, said that he was physically not mentally ill, swore angrily, and slammed the door on them.

Because of the history, and because Mr Rehman's attitude to the psychiatrist was also uncharacteristic, it was decided that a formal Mental Health Act assessment should be undertaken as soon as possible. The situation was passed to the on-call psychiatrist and social services' duty system at Washwood Heath Road. The Home Treatment Team had no further involvement. They assumed that Mr Rehman would be admitted later that day; and, by inference, they did not consider that any risk to Mrs Akhtar or her children was sufficiently immediate and serious to warrant calling the police to the premises in advance of that assessment.

The duty approved social worker was not available to assess Mr Rehman at the suggested time of 3.30pm, because she was busy with two other Mental Health Act assessments. She did notify the ambulance service and the police of the pending assessment, and was told that the police would be unable to provide any assistance for several hours because of their other commitments.

At 6.00pm, the duty ASW and the on-call psychiatrist spoke together, and they decided to meet at Newbridge House, and to visit the Rehman household without police assistance at 7.00pm.

Mr Rehman was in the kitchen when they called, and it was Mrs Akhtar who opened the door. She spoke with the on-call psychiatrist in Punjabi, and explained that her husband would be angered by the visit. Mr Rehman was 'menacing' and 'a bit excited'. He immediately asked in English why they had called, demanded to know who they were, and to see some form of identification. He then said, 'Get away from here. I have nothing wrong with me. Just get out of here.' He moved towards his visitors in a threatening manner, effectively chasing them out of the house. They retreated, and he slammed the door before the last of them had quite left. An attempt to converse with him through the letterbox met with a similar response.

The social worker and psychiatrist discussed how to proceed. They decided that a section 2 application was appropriate, given the information received from Mr Rehman's general practitioner, his demeanour, his refusal to engage with the Home Treatment Team, the history of domestic violence, and the fact that Mrs Akhtar was in danger and very frightened.

The on-call psychiatrist completed a medical recommendation, and this states: 'Very agitated and potentially aggressive. Has no insight and has not been complying with his medication. Difficult to engage with psychiatric services. Needs to be detained for his health and others' safety.'

The approved social worker then completed a section 2 application. At this stage the hope was that the police would be able to assist with Mr Rehman's removal and conveyance without undue further delay. If so, the approved social worker would return to the house with them and convey Mr Rehman to Newbridge House, where a bed was available. Faced with a police presence, Mr Rehman would 'come quietly' so that a warrant to enter the premises would not be necessary.

Unfortunately, by 9.30pm, it became clear that the police would not be able to provide any assistance until after midnight. The social worker therefore left the

section papers at Newbridge House, where a bed had been identified for Mr Rehman, and arranged for social services' out-of-hours emergency duty team to complete the admission process. Before going off-duty, she made an entry in the medical notes, stating 'A doctor needs to do a risk assessment. Someone with knowledge [of] him.'

In the event, Mr Rehman was not admitted to hospital for another 24-hours. By then, the bed set aside for him at Newbridge House had been used to admit another patient, and he was admitted to Highcroft Hospital instead.

Why Mr Rehman's admission was so delayed was not documented at the time. Three possible reasons for the delay are that the police remained unable to assist with his conveyance, the emergency duty team did not have anyone available to supervise his conveyance, and that it took a long time to free a bed for him once the previously identified bed had been used. The evidence suggests that after midnight the main reason for the delay was the lack of an available bed:

> *'My understanding is that the lack of beds was the reason he did not go in until the next day.'*

The next recorded, verifiable, event in the admissions process took place 15 hours later. Between midday and 1.00pm on Saturday 22 January, an off-duty approved social worker was telephoned at home by a social services' emergency duty worker, who asked if she would be able to convey a male patient to George Ward at Highcroft Hospital. She was told that the section 2 papers were already on the ward, the reasons for conveying him, and that domestic violence was an issue. She was asked to contact Mrs Akhtar directly, in order to find out when her husband would be at home. It was in fact only when she called Mrs Akhtar for a third time, at around 6.00pm, that Mr Rehman was at home, and that a firm arrangement could be made with the police, which was to conduct a joint visit at 9.00pm.

Mrs Akhtar went to the home of one of her neighbours following her husband's return, and was told when the visit would take place.

At 9.00pm, the social worker went to the neighbour's house, and was shown the bruising on the side of Mrs Akhtar's face. Mrs Akhtar said that she wanted the hospital to inform her if Mr Rehman was going to be given any leave to be absent from hospital.

Mrs Akhtar identified her husband when he was brought out of the home by the police. He was quite calm on this occasion. He invited the social worker and police into his home, saying 'There's nothing wrong with me but I'll come with you.' He got a coat on and came out. He was then conveyed to George Ward, and admitted there at 10.30pm on Saturday 22 January. On arrival, the approved social worker informed the nurse in charge of Mrs Akhtar's concern about her husband's violent conduct, and of her wish to be contacted if leave was granted to him. The emergency duty team was notified of his successful conveyance to hospital.

The period at Highcroft Hospital

Mr Rehman's catchment area consultant was on leave until 31 January, with the consequence that a second consultant deputised for him between 22 January and 31 January 2000.

On 25 January, this deputy granted Mr Rehman periods of escorted leave.

On 31 January, a bed at Newbridge House became available, and Mr Rehman was transferred from George Ward. Newbridge House is situated within one mile of what was then the Rehman family home.

The period at Newbridge House

Mr Rehman's catchment area consultant returned from leave on 31 January, which was the day of Mr Rehman's transfer to Newbridge House. He was told of a number of new in-patients under his care, of whom Mr Rehman was one. Unfortunately, Mr Rehman's previous medical notes were not available.

Following Mr Rehman's admission, his wife commenced proceedings at Birmingham County Court under the Family Law Act 1996. An anti-molestation order, to which a power of arrest was attached, was made by a District Judge on 7 February. This was served on Mr Rehman in hospital on 8 February. Mr Rehman was given notice of a further hearing on 11 February, but he indicated on 9 February that he would be unable to attend.

On Wednesday 9 February, Mr Rehman's consultant at last received his previous psychiatric notes. He read through them on Thursday 10 February and, having done so, interviewed Mrs Akhtar and Mr Rehman at Newbridge House.

Mr Rehman continued to believe that he had a serious physical illness and that he had been promised a full blood transfusion by John Major under an Anglo-American agreement. His mental state was otherwise normal, and he was generally pleasant. He was aware that his wife had taken out an injunction, and said that he would respect the court's order. He was willing to live with a friend in the same area.

Mrs Akhtar was then seen on the ward without her husband's knowledge but in the company of a female friend. While she was on the ward, Mr Rehman was kept in his room, with a nurse outside his room to prevent him from coming out. Over the course of an hour, she discussed with the consultant in Urdu her husband's illness, the injunction and the history of domestic violence. Mrs Akhtar told the consultant that Mr Rehman was using the telephone quite a lot to make upsetting phone calls. This information was relayed to the nursing staff, who 'asked him not to do that and … in particular [they] tried to prevent him from going up to the area where the public phone was. He seemed to co-operate with that requirement.'

The consultant explained that Mr Rehman had been non-compliant with medication in the past, and that the use of section 3 and injectable depot medication was indicated. They discussed section 17 leave. Mrs Akhtar was willing for her husband to stay with his friend, who she knew, but she did not want him coming to the family home. She was also willing for him to have short periods of community leave.

Having interviewed Mrs Akhtar, the consultant saw her husband again. Mr Rehman promised not to keep telephoning his wife, and said that he would only ring her once a day to speak to the children, which was the agreement with Mrs Akhtar. Although he did not think that he had a psychiatric illness, he agreed to take oral medication as a way of avoiding an injection. He was told that he needed to remain in hospital until he had been stabilised on treatment, at which point consideration would be given to sending him on extended leave to his friend's house. In the meantime, he could have periods of half an hour's leave at a time, in order to go to the local shops.

Having completed his review, Mr Rehman's consultant started him on amisulpride, and authorised three 30 minute periods of unescorted leave daily, either in the hospital grounds or for the purpose of going to the local shops, and subject to a condition that he was 'not to go to his house (wife has taken out an injunction).' The leave arrangements were to continue until they were reviewed on or before 24 February, which was the day on which the section 2 application was due to expire.

On Friday 11 February, Mr Rehman was allowed half an hour's community leave at around 7pm. He returned to the family home and stabbed his wife to death in front of their children, before turning the knife on himself.

Having unsuccessfully tried to intervene, a neighbour made a 999 call to the police at 7.11pm.

Mr Rehman's failure to return to the ward at 7.30pm was noted by the staff at Newbridge House. At 8.15pm, a call was received on the ward from Queen's Road Police Station, notifying staff that Mr Rehman had attacked his wife and that she was unlikely to survive.

Mr Rehman was admitted to Heartlands Hospital, so that his own injuries could be treated, and a section 3 application was made on 17 February. On 18 February, he was noted to be calm and devoid of emotional expression. He was then discharged from Heartlands Hospital, and admitted to the Reaside Clinic, on 22 February.

On 30 March 2000, Mr Rehman was questioned about the offence at Queen's Road Police Station, in the presence of an appropriate adult, and then charged. On 3 April, he appeared before Birmingham Magistrates' Court. He was remanded in custody but, by prior arrangement with the Home Secretary, he remained at the Reaside Clinic pending trial and sentence, under sections 48 and 49 of the 1983 Act. On 8 May, his case was transferred to Birmingham Crown Court, where he was later sentenced.

Since his admission to the Reaside Clinic, he has expressed the beliefs that his brain and bodily organs are dead and that he requires a brain transplant. He does not appreciate that these beliefs are signs of a mental illness. The administration of ECT and medication has variously been authorised by a doctor appointed by the Mental Health Act Commission, due to the fact that he has been incapable of understanding their nature, purpose and likely effects.

FINDINGS

Our findings are presented in the following order, and under the following headings:

1 **The Index Offence**

2 **Mental Health Act Issues**

3 **Newbridge House**

1 — THE INDEX OFFENCE

We have considered carefully the extent to which Mrs Akhtar's death, the history of domestic violence, and Mr Rehman's irregular compliance with treatment are best understood and explained by reference to his mental illness, his personality, marital incompatibility and other factors.

It has been suggested that Mr Rehman's mental illness was not a significant factor in Mrs Akhtar's death. According to this view, her death was simply the terrible final act of a brutal husband who had subjected her to years of domestic violence and abuse. He was shamed and enraged when his wife obtained a court order ejecting him from his home, and his offence was motivated by anger, resentment, loss of status and a desire to get even.

We accept that Mr Rehman's personality and behaviour, and the unhappy state of the marriage, cannot be understood only in terms of severe and enduring mental illness.

Nevertheless, having acknowledged this, we do not believe that Mr Rehman would have killed his wife had he not had a serious and enduring mental illness.

In the first place, his mental illness was a significant factor in the breakdown of his relationship with his wife, and in his treatment of her. Part of his exasperation, and anger towards her, stemmed from her continual failure to understand that there was indeed a government-level conspiracy to deny him the blood transfusion he required. Treatment he needed in order to be well, to work, and to fulfil his role as a respected head of the family. To him this would have seemed obtuse at best, at worst disloyal or conspiratorial:

> *'He said that she is being stubborn, she is not listening to me.'*

There was a seething resentment over the years that his wife just could not see the validity of his point of view, and the true cause of his despair and their unhappiness. When, instead of sympathising with him, and helping him to get the treatment he required, she initiated his admission to a psychiatric unit, and had him ejected from the family home, he must have felt tremendous anger, and that she was siding with others against him:

> *'There would have been a sense of despair that was welling up inside this man over the years, partly as a result of his unusual ideas about his physical health, his inability to get appropriate treatment for that.'*

In the second place, it seems clear that Mr Rehman's illness caused him to have quite explicit paranoid thoughts concerning his wife. He accused her of 'going with strangers, talking to other people about their personal matters, and denying family access to him.' He swore at her, threatened her with divorce, was suspicious, and taped her telephone conversations.

In the third place, Mr Rehman 'had a serious medical illness to the point that he had lost touch with reality':

> *'It was very clear that he was having major problems in terms of controlling his thinking. He was acting in a way that was inconsistent with what I would have expected of him even if he had some disabilities in relation to his intelligence.'*

In the fourth place, it is likely that Mr Rehman's severe and enduring mental illness contributed to his affect, and undermined the degree of self-control that he was able to exert in relation to his thoughts and actions:

> *'The mental illness affected his impulse control and triggered violence that he might otherwise have been able to contain. There is therefore a clear association between his mental illness and his offence.'*

The possibility that Mr Rehman may be autistic or have a learning disability must also be borne in mind. This was discussed but never thoroughly investigated. Hence the evidence is inconclusive, and we do not know whether such factors influenced his personality development and behaviour.

What is clear is that he did not form an affectionate bond with his mother or wife, or with other children when young. He was noticeably less intelligent than the average person; from the outset regarded his wife almost as a chattel; was incapable of appreciating her kindness, intelligence and many other virtues; and felt relatively little remorse about his violent conduct, which he mostly denied.

2 — MENTAL HEALTH ACT ISSUES

The issues concerning the way in which the 1983 Act was applied are dealt with in the following order:

- ☐ The section 2 application made on 21 January 2000;
- ☐ The section 3 application made on 19 February 2000.

THE SECTION 2 APPLICATION

Mr Rehman's conveyance to Highcroft Hospital on 22 January 2000, and his admission and detention there, were unlawful. This is because an application made under section 2 confers authority only for the patient's conveyance and admission to the hospital named in the application (in this case, Newbridge House).

Because the section 2 papers were sent ahead to the hospital, the approved social worker who conveyed him to Highcroft Hospital was not in a position to verify that the application was properly made out and that the conveyance was lawful.

The delay in effecting Mr Rehman's admission

After the section 2 application had been made, at around 7.30pm on 21 January, it took 27 hours to take Mr Rehman into custody and to convey him to hospital. The evidence indicates that Mrs Akhtar, and possibly other members of her family, were at significant risk of violence during this period.

The period of delay had four distinct stages: between 7.00pm on Friday 21 January 2000 and the early hours of Saturday 22 January 2000, the police were unable to assist with Mr Rehman's detention and conveyance; from the early hours of Saturday 22 January until noon that day, a bed was not available; between noon and 6pm, Mr Rehman was absent from the family home; between 6pm and 9pm, arrangements were being made for the police to attend the premises.

Admission would have taken place safely and promptly had the police been available to attend the statutory assessment which took place at 7.00pm on 21 January, at which time there was a bed available for Mr Rehman at Newbridge House:

> *'If the police had been available right at the start [we would] not have been thrown out but left with them.'*

The decision to assess Mr Rehman without police assistance

The fact that the police were unable to provide any support for several hours during the evening of 21 January placed Mrs Akhtar, the duty approved social worker and the on-call psychiatrist in a difficult and rather dangerous situation. The predicament that faced the two professionals is one with which they and their colleagues are familiar:

> *'[The duty approved social worker] did not want to go without the help of the police or somebody really, but they could not manage it. It was terrible — sometimes the police are so busy that they can't.'*
>
> *'It says that the social worker has to be in charge of the 'stage management' of section assessments, but you can't because things are taken out of your hands. I can't commandeer a policeman.'*
>
> *'There are problems obtaining police assistance. There are four-hour waits.'*
>
> *'I did the same thing yesterday. We had the police booked for two o'clock and they didn't come. We had a similar possible scenario to this one. We went ahead and did the assessment and by four o'clock, as we were leaving, the police still hadn't come … The particular man we were assessing was on probation for violence to his wife.'*
>
> *'It was the most awful situation to be in. The domestic violence [service] would have been an option, but we are talking Friday night, you can't get any police and at a certain point domestic violence goes on answerphone.'*
>
> *'We advise our ASWs to ring 999 if it's a dire situation. This has cropped up since this occasion but there have been occasions when ASWs have dialled 999 and the [police] haven't responded; and there was one that responded about 45 minutes later and the social worker was assaulted in the meantime.'*

It was known that Mr Rehman had been violent to his wife and that the situation was urgent for Mrs Akhtar. That the two professionals decided to try to deal with the situation without police assistance was understandable, selfless and courageous:

> *'So we just thought, both of us, let's just see. I know the language and can find out from the wife how serious is the situation, and we can always come back and call the police. We just really wanted to have a little go.'*

> *'Obviously I've thought about Mrs Akhtar and what we could perhaps have done; should I have gone and done the assessment. The only thing I can come up with is that I should have gone, but it leaves us in a very vulnerable position.'*

Whether in retrospect this was wise, as well as understandable and courageous, is a difficult question.

The two professionals thought that it was necessary to assess first-hand what was happening in order to be able to decide what level and kind of intervention was required. It was thought unlikely that Mr Rehman would accede to the assessment or agree to informal admission. If he refused them admission to the premises (as in the case of the Home Treatment Team), or became agitated or violent, the intention was to withdraw, and in all probability to arrange for compulsory admission with police assistance. In such circumstances, his prompt detention would hopefully mean that his family were then free of the risk of violence until he was better and/or the risks had receded:

> *'I didn't think we'd be able to cajole him at all but I felt I had to do the assessment. I feel it would have been worse just to have left it.'*

> *'[The duty approved social worker] went through the notes and she said that there is risk of violence, so before going in we had a little idea, yes. That was why as soon as he took a step forward, we ran back, for defence reasons. You will say that it was silly to go in, but sometimes there are professional obligations.'*

> *'I felt that his levels were increasing. We had already decided that at the first sign we would get out so we weren't going to hang around and continue when he'd asked us to leave. We went out.'*

Other the other side of the equation, turning up at someone's house to do an assessment can have a powerful impact on their behaviour and life at home after the professionals leave. The risks associated with the strategy were that the danger to Mrs Akhtar might be exacerbated by an attempt to conduct a statutory assessment that ended with the professionals withdrawing but she and the children remaining in the house with her husband. Since withdrawal would be the consequence of agitated or violent behaviour on his part, which the police would not be there to deal with, and were not staffed to respond to promptly, and since he might rightly infer that his wife had initiated the visit, Mrs Akhtar might then be at increased risk of violence. How Mrs Akhtar and her children could be protected until Mr Rehman could be taken into custody was not thought through:

> *'… the impact of us going to his house may have angered him even more. I would imagine that he would have figured out that his wife had alerted the person who had contacted us.'*

> *'I am not aware of any steps taken to protect Mrs Akhtar and her children during this time'*

'I am not aware that anybody thought about the children and leaving the children and her with him.'

'Because we were thinking that the patient was ill and needed to be assessed, that we perhaps did not even think about the wife at that point. It was a case of getting him assessed and seen. We were not sure if she was in the house. I think that it is fair to say that we did not even look at the wider implications of the fact that he would not let us in and just shut the door. We did not know that the wife was in there, although clearly she was, and perhaps children as well ….'

'Looking back, we clearly did not think it through enough.' (Home treatment team)

On balance, our view is that it would have been better to have waited until the police were able to attend. Because the need to withdraw was anticipated, and there was no real prospect of Mr Rehman being removed from the home without police assistance, there was no clear advantage to assessing him in advance of them being present. Bringing forward the assessment would not bring forward his removal from the premises, which was the event that would reduce the identified risk to Mrs Akhtar, and it might increase the risk by further angering Mr Rehman, in addition to carrying a risk for the two professionals themselves.

Having stated our view, with future practice in mind, we would emphasise that it is unfair to expect professionals to have to grapple with such a situation, and therefore also unfair to criticise them for grappling with it. The duty approved social worker who assessed Mr Rehman had been on duty without a break since 9.00am. It was greatly to her credit that she remained on duty until 9.30pm, and sought to deal with the situation herself rather than to pass it to the out-of-hours team. The two professionals who undertook the assessment were brave, selfless and professional throughout, and we commend them.

Information sharing

The approved social worker and the duty psychiatrist who assessed Mr Rehman did not have access to his previous hospital and social services notes. It is probable that they would not have visited Mr Rehman without police assistance had they been fully aware of his record of violence, which is another way of saying that they were unaware of the risks that they were taking. This observation is not a criticism of them, and is intended merely to draw attention to the importance of ensuring that the relevant history is readily available to those who assess patients for admission to hospital.

The approved social worker who conveyed Mr Rehman to hospital was given no background information other than that admission had not taken place the previous evening. She was not told of the previous incidents of violence, and she did not have the admission papers with her, which summarised some of the known risks.

THE SECTION 3 APPLICATION

The section 3 assessment was not arranged until the 28th day of the section 2 period, as a result of which it was impracticable for the approved social worker to consult the nearest relative before making the application.

3 — NEWBRIDGE HOUSE

Newbridge House serves Acocks Green, Sheldon, Yardley, Hodge Hill and Washwood Heath. It provides a service to persons aged 18–70 with the entire range of mental health diagnoses.

The home treatment team has been operating in the locality since 1994, and it commenced operating at the same time that Newbridge House was opened.

The building of Newbridge House and the establishment of a local home treatment team resulted in a reduction in the number of beds available to local residents from 44 to 20.

YARDLEY/HODGE HILL HOME TREATMENT TEAM

Home Treatment differs from traditional community mental health services in that it provides for the urgent assessment of people experiencing crises, and it can offer a 24 hour, 365 day, service to people who might otherwise have to receive their treatment in hospital.

Home treatment services have been provided in Alum Rock since 1994, and the local team provides a service to the four consultants based at Newbridge House.

Initially, the team was essentially a crisis intervention team; 'an emergency team that assessed clients who would ordinarily have been admitted to hospital, often under section'. The change in the team's name reflects the fact that its focus is now wider than before. For example, it provides a service for people who have been discharged from hospital and for whom the immediate crisis may be over. It also supports clients whose medication is being changed, or who are showing some early signs of relapse.

The home treatment team currently has an establishment of 13 staff, although 4.5 of these posts, that is 35%, were vacant at the end of November 2002.

In January 2000, the home treatment team, the in-patient unit and the day care service at Newbridge House were all managed by an acute services manager, who reported to a locality manager.

At the time it was possible for general practitioners to refer patients to the team. Although general practitioners may still refer patients out of hours, there is now a single point of entry to the service between 9am and 5pm. This is through the duty system operated by the local primary care mental health team. The primary care team performs a basic telephone screening, and then decides whether to refer the patient to the home treatment team.

The arrangements were modified because it was felt that some general practitioners were using the home treatment team inappropriately:

> *'Many GPs would raise the stakes and try to short circuit the system by mentioning danger of suicide and so on. Then they knew that the person would be seen within an hour. If they went down the normal community health team route, they might have to wait a few days.'*

Not surprisingly, the new arrangements are not universally popular with general practitioners:

'You used to be able to phone a consultant, but there is a different system [now] … which I am not happy about.' (General practitioner)

'In the Asian community which I am serving, depression can result in a crisis. When you go into a crisis that is too late.' (General practitioner)

'Suppose a patient we know is suffering from depression, and I trying my best to treat him and he wants a second opinion from a psychiatrist. Over the years, I used to ring the secretary and the consultant would come and give him an appointment. That satisfied the patient. But [now] … they ask you 100 questions first. They ask things like 'have you seen the patient?' which is a silly question to ask. Then they ask things like 'is he suicidal?' Again, that is an irrelevant question. No patient will tell you that he is going to commit suicide; he just commits suicide. People can see if he is suicidal. He needs an expert opinion so that he can be followed up. This is what is causing the problems.' (General practitioner)

Unless the individual is detained in a police station, or there are other special circumstances, persons referred to the home treatment team are assessed at home by a medical practitioner and one or two members of the team (two nurses, a nurse and social worker, or a nurse and support worker).

At the end of the assessment a decision is made as to the best course of action. The decision may be that the individual should be followed up as an out-patient, that s/he requires home treatment, that s/he requires admission to hospital, or that s/he does not require a service from the trust. The level of risk is usually the main factor that determines whether whether admission or home treatment is more appropriate.

Trust policy now is that there can be no admission to hospital without the home treatment team being involved. Consistent with this approach, the home treatment team tries to be involved in all Mental Health Act assessments, and is often involved in conveying known clients to hospital. In particular, the team's social worker will be involved in Mental Health Act assessments of existing clients where it is deemed that home treatment is not working and that they need hospital admission.

The current policy was criticised as being unnecessarily rigid:

'That can sometimes be a nonsense in the middle of the night when the psychiatric consultant or SCMO is called to a police station because a person is unwell and needs to be in hospital. The bed manager will say "Have home treatment seen them?", "No, because they are not home treatable or they have not got a home." Then we can be dragged out of bed to take a look at someone and that is bureaucracy gone mad …. It was always good practice that home treatment see them, but there are occasions when it is plain to everyone that hospital admission is required, be it formal or detained. Why go through the farce of home treatment seeing them?'

Resource issues

There is a feeling among some workers that community resources are not equitably distributed across north Birmingham, partly because of a failure to appreciate the geographical demands and resources necessary to operate a home treatment service outside small inner city areas such as Ladywood:

'[Ladywood is] a very small compact area where you can cross from one end of the locality to the other in five minutes, with high rise flats and so

on. We work in a different area, and we cannot work in the same way. I struggle with the fact that we have to try to implement a particular model and not adapt it to the local population and be flexible enough to do that.'

'The Ladywood Home Treatment Team go to all the ward rounds, so although I like [that] way of working, we have six consultants to work with — six ward rounds, six MDTs or more and that makes it difficult. [Their consultant] will say that everyone who is in hospital is still formally on home treatment … When people are in hospital, the home treatment staff will still go and see them, maybe a couple of times a week. That is great. I would love to do that, but we can't practically do it. Also everyone who is in hospital, when they come out on leave or discharge automatically then go back onto home treatment. We could not physically do that because we would have over 100 people on our books … Everyone who has either been on home treatment or in hospital within the past six weeks will still have automatic access to the home treatment team out of hours. You could be talking about over 100 people having direct access. We believe in them having access and in having a crisis line. They have one in Ladywood, but we do not have one where we are. We are denied access to that.'

As can be seen, there is also a feeling that the trust has not been sufficiently flexible with regard to the development of home treatment services:

'… There is a dislocation between the model that is being pushed at board level and what can practically done on the ground. To some extent, although people are not quite rebelling, they are nevertheless saying that in the face of realities, they have to do it differently and find a way of working that is not too far removed from what is expected, but is also practical. There is a tension there.'

'The model that we follow, and which broadly the rest of the trust have taken on board, is one that John Hoult set up. This was very well researched by the Sainsbury's Centre over a three year period. I am not saying that we had it right because you learn and take best practice from colleagues, that is simply common sense, but I think there is a belief that we have strayed from the path …. … What I find frustrating is that … rather than the tribalism between health and social services, what tends to happen is that there is tribalism between teams.'

Whether or not this is so, there is certainly a belief that the characteristics and needs of the population served by Newbridge House and the Hodge Hill and Yardley teams, and the level of resources available, make it impossible to satisfy Board expectations

Information sharing

The home treatment team often do not know whether Children & Family Services are involved with a household; communication 'is quite poor in that respect'. The team 'do not have any access to social services computers … Often we have no idea and it will come out, perhaps in the middle of a visit one day when a social worker from the children and family team turns up at the door.'

PRESSURE ON BEDS

Mr Rehman was admitted to Highcroft Hospital on 22 January 2000 because a bed was not available at Newbridge House. Because his admission was disrupted by bed

pressures, we spoke with many professionals about the adequacy of in-patient facilities in north Birmingham.

The bed statistics for Newbridge House regularly show an occupancy level of 140–150%. This calculation includes patients on extended leave. When someone on leave is assigned to the home treatment or assertive outreach team, the ward remains responsible for them for up to seven days. Where care is provided instead by the primary care or rehabilitation and recovery team, it remains responsible for 28 days.

In real terms, no ward can have more than 100 per cent occupancy, because there is a finite number of beds. Newbridge House almost always operates at around 100 per cent bed occupancy. A 20 bed unit should have at least two beds that are available for emergency admissions, otherwise there is a risk of inappropriate discharges to free a bed or escalating financial pressures.

Newbridge House is the last unit in north Birmingham to go over to single-sex areas, and it is possible that these pressures will worsen once gender-specific beds are identified. At present, the relevant consultants have agreed that 'it is inappropriate to transfer people in and out purely for making gender-specific beds.'

With one exception, it was universally acknowledged that the hospital bed pressures in north Birmingham are intolerable. They compromise patient care and require staff to make decisions and compromises which they ought not to have to make.

It would appear that the in-patient units in south Birmingham experience similar pressures.

Consequences of the pressure on beds

The pressure on in-patient beds has had significant consequences for patient care. In particular, there is evidence that:

1. The mental state and behaviour of the in-patient population is now more disturbed, so that for all or some patients the environment is less conducive to recovery:

   'With the success of the community teams there is a higher concentration of more disturbed people within our wards. The incidents of aggression have probably increased over the last couple of years.'

   'If you have a lady who is just depressed or something like that, and they go on a ward that is very disruptive with lots of psychotic patients, it's very distressing for them and it puts them off the service. It is a problem.'

2. The bed pressures have led to some in-patients being discharged before this is therapeutically appropriate. In September 2002, the Newbridge House ward manager wrote to her operational manager indicating that she was unable to support sending patients home early without appropriate after-care in order to create beds. She and her staff were also unwilling to co-operate with the movement of patients between wards for bed management purposes, and the use of short term leave beds:

   'I believe that there is pressure to get people out of hospital before they are ready, and the home treatment team is often used to doing that. Home treatment works very well in facilitating early discharge, there is no doubt about that … At the same time, there is pressure for people to come out of hospital too early and, although it is not often the case, they can end up

being re-admitted. If they go out on what is called 'leave', their bed is actually gone and whilst it is still warm, someone else is in it.'

'There appears to be no logic … to decisions as to which patient should be discharged early.'

'A lot of our decisions have been overriden by managers or medics, and it is not as multidisciplinary as I would like it to be.'

'There can be a very subjective view - "They are not that bad. They are playing table tennis. I saw them laughing and joking in the TV room, they can't be that ill. Let's get them out." I know that can happen anywhere. We can all be judgmental, I'm fully aware of that, but planning is often not done in the structured way it should be, in line with CPA.'

'It is often a case of one in, one out. Understandably, if there are six consultants in the area with 20 acute beds that are not assigned to anyone in particular, they are simply used as they become available. Often if a particular consultant wants to admit, they will tell him or her that they need to get one of their patients out. It is as crude as that.'

Indeed, Mr Rehman's consultant at Newbridge House was under pressure to discharge him prematurely in order to vacate a bed:

'I was under pressure from my in-patient staff and the patient for him to be discharged. The staff said there was nothing wrong with him and that they needed the bed for someone else. I was unwilling to discharge him until I had looked at the notes and seen his presentation on the ward ….'

3. Graduated discharge, commencing with periods of weekend leave, becomes difficult or impossible:

'Weekend leave is something that doesn't exist any more because if anybody goes on leave there is no likelihood of them ever returning to a bed.'

4. Patients may be discharged before their section 117 after-care needs, and the risks involved in discharge, have been fully assessed and managed:

'I believe the practices I have outlined to be unsafe. They increase the likelihood of omissions or errors in delivery of care, increase the dangers associated with risk management. Therapeutic relationships take time to develop, [and] movement causes unnecessary disruption to this process.'

5. The in-patient team are expected to operate a systematic, well thought through care programme approach to patient assessment and discharge, but the pressure on beds makes this difficult, and sometimes impossible:

'Staff are still named nurses for all the people on the ward who have care plans, and they can come in to find that [their patient] has gone.'

'My understanding of discharge planning, although it might be something of a cliché, is that it starts the moment someone is admitted. You look at their needs and how they can be addressed, and what needs to take place before they are ready for leave or discharge; and home treatment to be involved to support discharge or leave. Unfortunately, … it is often, though not in all cases, driven by the need for beds - "We need a bed. Who can go?" They will look down the ward and say, "So and so is doing okay. Phone

home treatment. Can you come down and screen this lady? Can you get her out?" We have put in place some guidelines for the ward staff – a checklist – of things such as "Has a section 117 been done if it is required?" "Have the family been consulted?", "Are they aware and happy for them to go?", "What's in place at home? Have they got electricity and gas, and is the house fit to go to?" These are things that should be done even before they consider referring patients to us. It often does not happen, but it is not the ward staff's fault.'

6. Transfers between hospital units for bed management reasons are a regular occurrence. For example, eight Newbridge House area patients were transferred between wards in October 2002. While small local in-patient units offer the possibility of localised care linked to the local community teams, bed management on small units is more difficult, and the approach is undermined if it often proves necessary to admit people outside their locality with a view to transferring them at a later date:

'The difficulties come when you move away from the old institution type of hospitals where everything is there, you can draw upon one another for support, if you have a problem on one ward you have another ward where you get staff from, there is a lot of support in that kind of set-up. However, when you move away from that, and you want to have units in the community where your community is, you are left with very isolated units. If there are problems in that unit, you have to deal with them. We have our Small Heath unit which is very isolated. We have Newbridge House which is isolated, and you now have some units here and some there.'

7. Patients may be transferred between hospital sites at short notice, including at night sometimes, without a full multi-disciplinary discussion and assessment of the risks. One of the dangers of transferring patients, particularly at short notice, is that some understanding of the patient and some information about her or him, maybe very important information, is lost:

'The bed pressures go to the very heart of fracturing any sense of continuity of care whoever you are and whichever community you come from, which continues to contribute to this sense of the likelihood of you being admitted to one unit and then transferred to another to complete your stay, as happened to Mr Rehman … Whatever assessment has been done, however wonderful it is or adequate it is, you instantly undermine it. You are constantly juggling.'

'It would have been beneficial had Mr Rehman been admitted to Newbridge House and spent his entire time on that unit.'

'The trust is operating a multi-disciplinary approach, therefore why is it only the RMO's decision as to whether a patient could or should be moved?'

8. Patients and their families have been understandably upset by sudden transfers between hospital sites:

'Sometimes you have patients begging you not to send them, or when they go to bed they say, "You won't wake me up to move me.""

'My staff … have spend vast periods of time placating patients and relatives regarding decisions to be moved, sent on leave or discharged at short notice.'

9. There is a danger that the perception of what is an acceptable risk becomes skewed over time if units always operate with a high level of bed occupancy:

'How ill you need to be to justify admission becomes skewed, and what is an acceptable risk becomes skewed. There can be a danger of that. There is a perception of risk and what is influencing your decisions around that may well in some circumstances be "Is there a bed available?" That may be one of the things that is influencing your decision, and this may be for somebody who has been assessed in the community. If the person goes out and sees them, and knows there is no bed available, their perception of risk may be completely different to if they know there is a bed available. This pressure on beds is constant.'

'There is pressure [on the home treatment team] to take people who need hospital admission and you have to take some risks in the community, but while you cannot admit everyone who says they feel like killing themselves, you have to take those risks based upon assessment and proper risk analysis.'

The reasons for the pressure on beds

The trust has developed a protocol to help manage these pressures, and a bed management group has been set up. However, it is not clear that the longer-term issues that contribute to bed pressures have yet been effectively addressed.

There are two main schools of thought concerning the source of the problem and the adequacy of bed numbers at Newbridge House, having regard to the catchment area and the home treatment and other community services which the trust provides.

Bed pressures caused by inadequate community provision

One view is that the bed provision is adequate, and that it would be inappropriate to expend resources on increasing bed numbers. According to this view, the service deficits lie elsewhere, and expanding the acute bed base will not solve any of them. In particular:

- There are no proper residential rehabilitation facilities locally, and there is a lack of intermediate residential facilities that can provide fairly intensive care for people with longer-term mental illnesses. Indeed, the number of such places in Birmingham has fallen significantly because of budgetary constraints and a lack of agreement about who is responsible for investing in them. This places severe pressure on the in-patient service.[21]

- Home treatment teams are most effective when they have access to crisis facilities but many teams lack such a facility. This lacuna places in-patient services under pressure, because it necessitates inappropriate admissions and causes unnecessary delays in discharging patients.

  'The feeling from my perspective was that we were able to manage with 20 beds [but] the pressure of trying to get people out of hospital sometimes is very difficult.'

---

[21] We note that an analysis of need in Birmingham undertaken by the Task Group on Accommodation identified an under-provision of supported accommodation, especially 24-hour staffed homes. Core and cluster style provision was suggested as a means of providing this.

'Even in the last two years, there has been a substantial reduction … in the amount of money social services spend purely on residential accommodation for people with long-term illness. The actual number of places they have available has shrunk by at least 30% in two years, without the NHS or any other provider picking that up … Nobody will claim to have consciously decided to disadvantage an already disadvantaged group. They will say that there were other priorities for the social service budget. Within the city, the social service budget has been over-spending and they have to get it right. And each director who comes in says that the priority is child and family issues, or childcare issues, and that is where the money is going. The other services are left behind. There is a rationalisation of resources and these facilities are shut down.'

'There is a view that our inpatient numbers are in the lowest quadrant nationally, in terms of beds per 100,000 population … [However,] we will have 98 acute in-patient beds, not counting the 12 ICU beds, for a population of just over 600,000 people … We are not as well resourced in terms of inpatient beds as some of the other services in the country, but we are somewhere in the middle if you look at the per-100,000 population figures.'

'We are not looking for an increase in in-patient beds. We are looking at improving the quality of our in-patient services, and also the follow-on facilities for people who are in our in-patient facilities. At any time, because of the difficulties with follow-on accommodation and social issues, something like 25% to 30% of our patients … are stuck in our services.'

☐ The services are under-funded.

☐ The commissioning of mental health services is inadequate.

Bed levels set too low

The alternative view accepts that mental health services are under-resourced, and inadequately commissioned, but also holds that the number of beds was set at too low a level when the trust developed its innovative community services. Furthermore, the existing in-patient and community resources are inequitably distributed across the areas served by the trust:

'The number of beds was set at a very low level. There are only 20 beds in Newbridge House, there are only 15 beds in Small Heath, and these 35 beds plus some beds in Solihull replaced a full mental hospital of over 1,000 beds.'

'There has been a reduction in acute beds. We are an area of getting on for 170,000 [people] and we have 20 acute beds.'

'Ladywood has a population of 35,000 and 20 beds, Hodge Hill and Yardley 170,000 people and 20 beds.'

'When the home treatment team was first set up in the Yardley/Hodge Hill area, the consultant involved was a fierce advocate of home treatment and wanted to prove that it could be successful. One of the measures of the success of the team – which in some ways became the main one – was a reduction in hospital admissions and reducing the number of acute beds. There has been too much emphasis placed upon that.'

'At one time there was an unspoken philosophy that they should be kept out of hospital at all costs.'

' ... there is also pressure for us to take people out earlier before they are ready. Because the home treatment team is available 24 hours a day — although it is an on-call system, with only two staff overnight — it is a case of "Well you've got the same level of input in the community." Clearly we have not, because the staff are not there all the time. Out of hours, if we are paged, it can be an hour before we are able to respond, because people are in bed and they have to get up, drive in and so on.'

'The hope is that if you have 150 per cent bed occupancy the extra 50 per cent will eventually be adequately treated in the community ... On the other hand, one might say that is artificial, that you just have too few beds at the end of the day.'

OTHER IN-PATIENT ISSUES

The in-patient staff who work at Newbridge House are also affected by a number of other pressures.

The in-patient staff mix

The in-patient units lack the ideal skill mix. For example, they lack adequate support from occupational therapists and psychologists, so that patients receive more multidisciplinary care from home treatment teams.

Mary Secole House is a good example of this problem. It is a new unit, with single rooms and en suite bathrooms, but the care regime is 'just nursing and containing the medical situation.'

The in-patient nursing establishment

In November 2002, the budgeted nursing establishment for the in-patient unit was equivalent to 26 whole-time nursing staff. It comprised 1 H grade nurse; 1 G grade; 5 F grades; 7.5 E grades; 3.5 D grades; 2 B grades; and 6 A grades.

Although this nursing establishment is satisfactory, it masks the fact that the unit had five E grade staff vacancies, and had been operating with between three and five qualified nursing vacancies for some time.

Because of the number of vacant senior staff nurse posts, newly qualified staff may be expected to (and, indeed, expect to) take on a senior staff nurse role within six months. This is not wholly satisfactory.

Another consequence is that there 'is a lot of pressure [on nursing staff], and a lot of the newly qualified staff find it difficult; they go off to jobs in the community where they are usually rewarded better financially.'

The fact that the trust did not have a Director of Nursing for two years was said to have resulted in a lack of clear leadership in areas such as nurse recruitment and retention and training.

Nurse training

The in-patient nursing team arranges some in-house training for itself. For example, training on controlled drugs has been provided in collaboration with colleagues from

the pharmacy department. However, they do not have adequate opportunities to receive refresher and update training in important areas such as risk management.

There was a general impression that the trust has not seen risk management training for them as imperative:

> *'Training on risk assessment and management is not routinely available within the trust.'*
>
> *'There is little regular training for staff on risk assessment, or assessment generally.'*
>
> *'I have received, along with my colleagues, regular training on the Mental Health Act, [but] I do not recall receiving any training on risk assessment or risk management.'*
>
> *'There has been very little training or development for nurses. All the time they go from crisis to crisis, acute management ... people are busy doing shifts covering each other because of the shortage of staff, so they have to do extra shifts. There is very little training and any talk about risk assessment training, risk management training is just on paper.'*
>
> *'With in-patient staff, you cannot close the ward, so they can never have an away day or any kind of training where all of them are there, so it is very difficult.'*
>
> *'If I get time as a consultant to go to conferences to look at teaching programmes which the medical fraternity has organised, others do not have this opportunity and I feel bad about that ... You meet people and you reflect on your service and your practice at conferences and meetings, which is essential to stop burn-out, as well as to develop yourself. If other staff are not getting those opportunities, it is bad.'*

Although some risk assessment training was arranged through the Sainsbury Centre during 1997/98, there was no formal process for ensuring that staff received that training. Half of the risk assessment training sessions arranged for Newbridge House nursing staff were cancelled at short notice or without notice.

There is a perception that community-based staff do not experience the same intrinsic problems obtaining appropriate training:

> *'The community nurses are slightly more fortunate in that they can go to conferences and courses, because they work nine to five. They work in a structure where they can take days out and have away days every six months, and you can hold the patients with appointments off for that day in the community.'*

Having noted this, in fact it seems that none of the local assertive outreach team workers 'has had much training either in risk assessment management or for general development.' Similarly, a member of the home treatment team was 'unable to determine which members of the locality team have undergone training.'

Security arrangements

We discussed the security arrangements at Newbridge House because of a reference in the court sentencing transcipt to Mr Rehman having been absent *without* leave at the time of his wife's death.

The front door to the building is locked at around 5 or 5.30pm. The receptionist usually leaves by 5pm, after which time the security guard in reception or, if he is not there, a member of the ward staff must let the patient or visitor out. There is an entryphone button on the ward and a CCTV camera.

We discussed these arrangements, and their applicability in Mr Rehman's case, but heard no concrete evidence to indicate that Mr Rehman was absent from hospital without leave at that time. We did receive a substantial body of evidence which demonstrates that the security arrangements at Newbridge House are inadequate:

> *'Newbridge is an open ward within a deprived part of the city. We have a high crime rate around the area of Newbridge House. It is not particularly well lit or a particularly safe area. There are numerous car break-ins, car damage and vandalism that goes on. We have a security [guard] cum porter who is based largely within Newbridge House but his job also takes him away from the area. It is an open ward and people come and go.'*
>
> *'Within the premises over the last couple of years we have had people breaking in through the rooftops, coming through the ceilings, stealing all the computers, people with pellet guns getting up on the roof, trying to stone patients with bricks, getting into the bedrooms via certain windows and stealing property. We have had numerous car break-ins or damage to staff cars.'*
>
> *'It is not difficult for patients to leave the ward without staff knowing it.'*
>
> *'I wouldn't have the front door open so that all and sundry can wander in and potentially do harm to our patients. I would look at the logic of having one security man who calls upon possibly nobody when he is doing his round. Anything could happen to him. Security within Newbridge House is also a problem. There is an expectation that anything could happen to the patients and the staff would have to deal with it, which is not always the case.'*

Consultant staffing

We were informed that the locality responsible for Mr Rehman is the only locality in north Birmingham that has not experienced significant difficulties in recruiting consultant psychiatrists. It has therefore benefitted from a very stable medical input.

4 — MR REHMAN'S TREATMENT OUTSIDE HOSPITAL

Mr Rehman's consultant at the time of his wife's death took over responsibility for his care in October 1995. Mr Rehman was, however, seen as an out-patient by a middle grade Urdu-speaking doctor from the consultant's team, rather than by the consultant himself.

We have already noted that Mr Rehman's attendance at out-patient appointments was irregular. Furthermore, having been prescribed antipsychotic medication on 3 March 1998, he refused to attend the follow-up appointment, returning the letter to him with the inscription, 'Formal letter of refusal. Please cancel the appointment. This is a[n] order.' Although he remained in regular contact with his general practitioner, he

had no further contact with psychiatric services until 21 January 2000. It was decided not to follow him up for reasons that have already been set out.

There does not appear to have been any formal section 117 process during the period between March 1998 and January 2000, or any formal decision by the trust and the local authority to the effect that they were satisfied that Mr Rehman no longer required after-care services. Indeed, social services do not appear to have been involved in his care at all.

Nor is there any evidence that the care programme approach was implemented during this period, or that Mr Rehman had a keyworker.

We accept that Mr Rehman's delusional disorder did not respond to medication and that there was no effective treatment for it. Nevertheless, the fact that his condition was essentially untreatable also means that the risk of harm to his wife could not be managed or reduced medically.

The need for a more assertive approach ought to have been reviewed periodically during this period, and attempts made by a keyworker — perhaps with or through the general practitioner — to assess the risks to his wife and the support that she, and their children, needed in order to cope with his behaviour.

As it was, the onus was left on Mrs Akhtar to deal with or report problems that arose. This was unsupportive, and probably unrealistic, because she was at times effectively imprisoned in her own house, and there were social pressures on her not to report any deterioration in his mental state or behaviour.

A more supportive approach was adopted in the early 1990s by Mr Rehman's then keyworker:

> *'She could only speak to me when Abdul wasn't there, although I was always accompanied by a female support worker. I asked one of the female support workers to go and support the wife, just supporting visits to see if she was okay.'*
>
> *'Although the wife moved I was still supporting Mr Rehman in a way. At times he said, 'I want my wife back.' I said, 'When things get better, when you don't hit and beat your wife up, then we can look at it.' Although I instigated it I don't think he knew that I was the main instigator of the whole thing. I didn't say, 'I'm going to remove your wife.' It was done in a way that the wife moved.'*
>
> *'I remember the wife saying that at times when he gets absolutely worked up he becomes very much aggressive. This was physical as well as verbal. If I recall, I think she said he had also thrown chairs at her … At that particular time the wife then went to live with her uncle. At that time I was quite satisfied that at least the children and the wife were safe and we could work with Abdul's delusions; he can wander around and do what he wants to do as long as the wife was safe.'*
>
> *'The other concern was that … if he did not attend the appointment he was discharged. Then in the next few days you would hear from casualty he has appeared there and people had to tap into it. For me, I had never decided to discharge him. If he did not come I would visit him at home. It was very important to keep in touch with this man and his family to see if they were okay. There were issues around practices that everybody needs to learn from*

it. If people are well they will always keep the appointments. The whole idea of us chasing them is because they are unwell.'

'I really felt for the wife, because here is this woman who has been subjected to the most horrendous beatings and domestic violence and where was the assessment of her needs in a community that attaches a lot of stigma to mental illness.' (Asian Services Directorate)

More generally, we were informed that local general practitioners are invited to CPA meetings but they do not always receive copies of their patients' care plans.

We were also told that there continues to be local resistance to the care programme approach, in particular from psychiatrists.

5 — MR REHMAN'S TREATMENT IN HOSPITAL

Mr Rehman's catchment area consultant at Newbridge House was on leave from 22 January 2000 until 31 January 2000, during which period Mr Rehman was in any case receiving his in-patient treatment at Highcroft Hospital.

MEDICAL ASSESSMENT & TREATMENT

No risk assessment was carried out, or risk management plan formulated, following Mr Rehman's admission to George Ward. This is of some concern given that the admitting nurse recorded on the CPA admission form that there was a significant but stable risk of significant harm or violence to other people.

According to the Code of Practice, on admission all patients should be assessed for immediate and potential risks of going missing, suicide, self harm and self neglect, taking into account their social and clinical history. Individual care plans should include, *inter alia*, the measures required to manage the risk safely.

There seems to be a reluctance on the part of local psychiatrists to complete risk histories and assessments.

During the time that Mr Rehman's catchment-area consultant was on leave, another consultant was responsible for him under the holiday cover arrangements that had been agreed.

This consultant, who had his own patients to attend to, cannot remember seeing Mr Rehman. This is not ideal and not unusual when the catchment area consultant is on holiday.

The consultant did, however, grant Mr Rehman escorted section 17 leave on 25 January. We do not think this was appropriate given the history, and the fact that the consultant had not examined Mr Rehman or assessed the risks involved in granting him leave:

Following his transfer to Newbridge House, Mr Rehman was comprehensively assessed by his catchment-area consultant, who had a background in forensic psychiatry.

The completion of this assessment was, however, severely delayed by the fact that Mr Rehman's medical notes were not available until Wednesday 9 February. This was

some three weeks after his admission to hospital under section 2, during which time he was only seen once by a senior clinician, and then only briefly.

We note in particular that Mr Rehman's consultant at Newbridge House:

- ☐ Received a verbal report on him at the ward round on 3 February 2000;
- ☐ Delayed granting leave, or any consideration of discharge, until the notes were available and he had interviewed Mr Rehman and Mrs Akhtar;
- ☐ Contacted Mr Rehman's wife and her solicitor, discussing with them the court proceedings for a non-molestation order;
- ☐ Having eventually received the medical notes on 9 February, spent a great deal of time studying them, and much of the next two days on his case;
- ☐ Interviewed Mr Rehman on 10 February, and spent an hour and a half on his case, even though he had more than ten other cases;
- ☐ Interviewed Mrs Akhtar for an hour without her husband's knowledge, and obtained her consent to the grant of short periods of leave;
- ☐ Recorded the grant of section 17 leave, and the conditions to which it was subject.

Obtaining previous medical notes

The prompt retrieval of in-patients' previous medical notes apparently remains an on-going problem, although the situation has improved.

THE NURSING ASSESSMENT

Mr Rehman had two named nurses on the ward, neither of whom spoke his first language.

A short, basic, nursing plan is located in Mr Rehman's notes but in our view it was not sufficiently developed.

Mr Rehman's first language was recorded on the Minimum Data Set for Acute Services form (MIDAS) as being Urdu. The way in which his cultural and language needs were assessed by nursing staff was not recorded.

The sections on the MIDAS form which are to be used to record any dangerous behaviour to others were left blank. The section which is to be used to record the state of the patient's relationship with his partner states, '2. Positive relationship but significant difficulties or limitations in support, e.g. infrequent contact/stressed relationship', rather than '3. Major difficulties' or '4. Relationship has broken down.'

Neither of the named nurses made contact with Mrs Akhtar, despite the rift in the marriage. In the case of Mrs Akhtar, an interpreter would have been required. It was accepted that this was an omission.

No discharge care planning was undertaken prior to 10 February, and there was no contact with social services, the local home treatment team or Mr Rehman's general practitioner.

Mr Rehman does not seem to have benefited from a programme of recreational or therapeutic activities.

Despite the service of a non-molestation order, it is not clear that the relevant nurses on the in-patient unit were fully appreciative of the on-going risk of violence to Mrs Akhtar. They lacked an understanding of the history of domestic violence, and in particular whether the recent violence was a single incident or part of a pattern of violence over many years.

The fact that the injunction had a power of arrest attached to it, and was therefore the most serious form of injunction, meant nothing to the named nurse. He read what it said 'from a nursing perspective'.

We think that Mr Rehman's mild and deferential manner, and the fact that he kept to himself and was not a management problem, may have partially obscured the fact that his mental condition, which had not been treated, was essentially unchanged since the time of his admission. He was courteous and deferential to professionals, quiet, unaggressive, and 'based on the way he was presenting, you could never have expected such an event to occur.' But he was a quiet man with a long history of domestic violence and, given the history, any violence that he committed was likely to be perpetrated against his wife:

> *'A. The first thing is that it was a totally unexpected incident – how would you ever expect something like this too happen – based on the way this chap was presenting.*
>
> *Q. Hang on. An injunction had been served on him two days before. He made threats to kill his wife and there was domestic violence. How was that unexpected?*
>
> *A. That information had been given to the unit that the injunction had been served. I was not aware that we had details of the injunction and the issues around –*
>
> *Q. It was served while he was on the ward.*
>
> *A. It was. I hadn't seen the papers and I'm not sure if the staff had copies of the papers or if it just went to him. In terms of his presentation within the unit, there was no evidence that this man was aggressive and was going to be violent and would go and attack somebody.' (Acute Services Manager)*

THE DECISION TO AUTHORISE SECTION 17 LEAVE

The risk that someone who has been violent will again be violent can be managed but not eliminated. After such a tragedy, there is, however, a natural tendency to judge the quality of the patient's care according to the outcome. On reflection, it is obvious that even the best available treatment of a devastating illness, such as cancer or schizophrenia, does not preclude a devastating outcome. Conversely, natural remission may mask poor treatment. While poor treatment often reduces the chances of a favourable outcome, most often it does not lead to loss of life.

In every other branch of medicine the tragic outcome is the loss of the patient's life. In psychiatry, it may be that a family member or a person who has no connection with the patient, who has not consented to any risks taken in treating the illness, loses their life. That is uniquely tragic, but is no more proof that the patient's treatment was poor than the death of a patient with cancer.

These points are important because our belief is that the decision to grant Mr Rehman section 17 leave was justifiable. Given the evidence, which has not been contradicted, it is necessary to conclude that leave was only granted after a careful consideration of the patient's file, after a mental state examination, and after discussion with the person who both knew him best and was most at risk:

> *'It was entirely appropriate to delay decisions about leave until we had the necessary information because we didn't have anything available to us that suggested about his previous treatment or diagnosis or management. It was entirely appropriate that [his consultant] delayed making any decision about leave until he had access to the notes and had consulted his family, which is why it was several days into his transfer to us that that was arranged.' (Ward manager)*

The risk of violence to Mrs Akhtar was managed in the same way it was when Mr Rehman had last been in hospital: by his compulsory admission and detention; the use of antipsychotic medication; the grant of short periods of leave before giving any consideration to extended leave or discharge; and court proceedings involving the use of a non-molestation order. It would therefore not be just or appropriate to criticise the consultant for adopting the same strategy. Any criticism of him for granting leave would be tantamount to berating him for the outcome, rather than the strategy.

We should add that some members of Mrs Akhtar's family are not convinced that she knew that her husband was being granted leave. In particular, they think that she would have talked to them about the decision had she been aware of it. We understand their surprise but we are satisfied that the leave arrangements were discussed with her:

> *'She was … agreeable to him having leave as long as he didn't go to her. She was quite happy for him to go to his friend's house. We didn't really know who his friend was but he was going to be making himself known to us, from what I can recall, for [the consultant] to see whether that was appropriate for him to go.' (Nurse)*

> *'She would get very scared in case he may just kill her because due to the court order Abdul Rehman got very upset and kept saying that she had been very unfair to him. Due to these reasons we advised Shamim to move house for her safety or at least to change the house's locks. Shamim replied in her answer that whatever is written in my destiny will happen, you cannot change destiny. That is why moving house or [changing] the house's locks would not make any difference.'(Relative)*

> *'On Sunday 6th February … I asked Shamim if she remembered the incident 8-9 years ago when Abdul … produced a knife. Shamim replied that she was not scared and that she had faith in her destiny. Whatever happens will happen.' (Another relative)*

In reaching this finding, we have at all times tried to be independent, thorough and objective. We hope that the individuals who have been personally affected by this tragedy will accept this, even if they do not accept our finding or everything in the report.

THE DECISION TO ALLOW MR REHMAN LEAVE

Once Mr Rehman's consultant had authorised short periods of unescorted leave, it was for the named nurse to decide whether leave should be allowed on any particular occasion, in accordance with the authorisation.

On this occasion, one of the named nurses says that he allowed Mr Rehman half-an-hour's unescorted community leave at around 7pm on 11 February 2000. He cannot, however, remember if Mr Rehman said where he was going:

> *'I wasn't present at the ward round itself. It was handed over to me that he had been granted unescorted leave three times a day for up to half-an-hour. He had taken that the previous evening and come back without a problem. He did so again during the day of the incident and came back without a problem. His mood and demeanour hadn't changed. I didn't feel there would be any reason for me not to give him that leave on that occasion, although I was aware that I had that power not to grant the leave.'*

> *'The decision to grant section 17 leave was not difficult, as he had this leave the previous evening and earlier that day without any problems. His mood and demeanour were as usual. I did not foresee the terrible events that occurred.'*

> *'He didn't seem in any way different from the way he normally was. He asked appropriately. There was nothing to suggest what would have occurred – we couldn't see it. He came into the ward office where all the nurses were and he asked.'*

The nurses remembers that Mr Rehman was visited on the ward by his brother at around 7.20pm. His named nurse was writing up case notes at the time, in preparation for handing over to the night staff at 8.00pm. When Mr Rehman had not returned by 7.30pm, a search was mounted and a telephone call was made to the family home, 'to find out what was happening.' The nurse cannot remember why he telephoned the family home immediately, although it seems likely that he wished to alert Mrs Akhtar. The shift handover commenced at 8.00pm. At 8.15pm, the ward received a telephone call from the police, notifying staff that there had been 'a serious incident'.

Despite this clear account of the sequence of events, there remains some uncertainty as to whether Mr Rehman was granted unescorted leave at 7.00pm or sometime before then:

> *'I have heard it mentioned that people were not sure exactly what time he was given leave or what time he left the unit, because it happened soon after seven o'clock, so he could not have got to his house that quickly … We were told that they had given him leave but they were not sure about the timing.'*

The fact that a 999 call was made to the police by Mrs Akhtar's neighbour at 7.11pm, and that Mr Rehman must therefore have arrived home some minutes before then, suggests that he left the ward before 7.00pm. That this was so is borne out by one of the cleaners at Newbridge House, who says in her police statement that she saw him leaving the unit at about 6.45pm.

It is also the case that Mr Rehman's brother told the police at the time that he visited the hospital after attending his Mosque, arriving on the ward at 7.40pm. He says that he was asked to wait a while because Mr Rehman had gone out for a walk:

> *'On Friday 11th February at 7.40pm, I went to Newbridge House and Abdul Rehman was not in his room. I asked the staff where he was and they replied that he had gone out for a walk, and just wait a little while. During this time I got a phone call from my uncle saying that Abdul Rehman has come home and could you please come home immediately,*

and I did so … When I arrived the police were already there. I found out that Abdul Rehman and Shamim Akhtar had been taken to Heartlands Hospital…'

Two other significant facts emerge from the police witness statements. Firstly, two knives similar to that used to kill Mrs Akhtar were purchased from a shop situated close to the gate of Newbridge House, one on Thursday 10 February, and one on Friday 11 February. Secondly, the security guards remember Mr Rehman leaving Newbridge House on several occasions.

We note also that the prosecutor at Mr Rehman's sentencing hearing summarised the relevant facts on the basis that he had been absent from Newbridge House without leave when he killed his wife. This is said to have been simply an error on the lawyer's part. However, it adds to the impression that the security at Newbridge House, and the management and recording of section 17 leave, need to be tightened.[22]

It can be seen that Mr Rehman's mental state was not assessed by a nurse before he was allowed leave shortly before 7.00pm on Friday 11 February. Whilst this is the norm in practice, we think that more care is required where an injunction is in force, there is a history of recent domestic violence, the patient has been in contact with his partner by telephone (in breach of the injunction), and the family home is nearby.

Where an injunction is in force, or there is a recent history of recent violence, the mimumum standard ought to be that the patient's mental state is properly assessed on each occasion by one of his named nurses before leave is allowed, and the terms of the injunction reinforced.

6 — LOCAL COMMUNITY ISSUES

Alum Rock is economically deprived area situated in the heart of Birmingham. The families of many of the people who live there originally came to England from the Indian sub-continent. Historically, a considerable proportion of its citizens seem to have found it difficult to access local health services.

LANGUAGE

Urdu and Punjabi are the two languages spoken by the majority of people in the local community. Mr Rehman's first language is Mirpuri. This is distinct from, but related to, the Western Punjabi dialect:

'I was born and brought up in Punjab and when you are practising medicine there, you come across many dialects … we deal with people who have Mirpuri dialect, but I have never found it difficult to understand. It is basically a twisted form of Punjabi.'

[22] We note that in December 2002 a a verdict of misadventure was recorded in respect of a detained patient at Highcroft Hospital who left George Ward without permission and was subsequently found dead in an alley way close to the hospital, having taken alcohol and solvents. It was reported that neither the hospital nor the police followed the correct procedures once the patient went missing.

'The national language is Urdu and although he is not fluent – he was not educated – he is familiar with those words, from being bombarded with them in the streets of his neighbourhood.'

Mr Rehman can communicate at a basic level in English, but he is far from fluent:

'His English was very basic, grammatically incorrect but it was sufficient to communicate with anyone who speaks English. It was more than sufficient to communicate at a very ordinary level. However, when he became ill or he was very distressed and anxious, he preferred to speak in his own mother tongue … a lot of people do that. Most of the time he could speak English, so when I saw him I did not have the necessity for an interpreter. When other people saw him, and if he was in an anxious state, they would need an interpreter.'

'For people who do not speak the language, people like him pretend at times that they do not know English but other times he would be happy to speak English.'

Mr Rehman and Mrs Akhtar spoke with his consultant in a language familiar to them, and they benefited from that. However, one disadvantage was that other members of the ward team were not parties to the interviews, so that his treatment plan, and the decision to grant leave, were not the result of a full multidisciplinary discussion:

'A nurse was in that ward round but couldn't say what they were talking about because they spoke in their own language … They (sic) couldn't comment on the conversation.'

'There was no interpreter present at the time from my recollection, so that interview was between [the consultant] and the wife, and although the nursing staff were in the room they would not have been party to the discussion that took place. Whether the interview was set up at short notice and we weren't able to get somebody, that is something that shouldn't have happened. If you have a multidisciplinary team making a decision, that multidisciplinary team has to be party to the appropriate information. It doesn't seem that that was the case.'

Mr Rehman seemed a rather isolated figure at Newbridge House. He did not engage in conversation with the nursing staff and, when approached, he would simply say 'that he was fine, he wanted to go home, … that sort of thing.'

Only a small proportion of the nursing establishment at Newbridge House speak an Asian language, and the internal review panel were concerned about the contribution that linguistic barriers may have made to his sense of isolation:

'His sense of loneliness and his sense of isolation within the in-patient unit stood out to us as a significant factor. We do make a critical remark about the inability or unwillingness to use interpreters or someone to facilitate that process … I believe any communication between him and staff was limited because he could not express his feelings and thoughts clearly in English … My recollection is that no interpreter was used at any time during Mr Rehman's admission, which I find to be unsatisfactory.'

There is considerable evidence that Mr Rehman was a very isolated figure within his own community, and we believe that his mental illness was the most significant factor in his isolation, and sense of isolation, from other people. His isolation and loneliness extended beyond not communicating with nursing staff:

'He was on his own on the road all the time. He wouldn't talk to anyone else, just go to the shops to buy things …' (General practitioner)

'He tended to isolate himself. He would sit in the communal area but he wouldn't communicate much with the other patients.'

We agree that when a mentally ill person is very preoccupied with and troubled by his own thoughts, experiences and distress, and consequently is isolated, it is especially important that professional carers are able to discuss, sympathise with and assess these feelings in theperson's own language. This is commonsense — for it can hardly be claimed that an English-speaking person's sense of isolation would not be exacerbated by being detained in the company of Mirpuri-speaking patients; or that their experiences could be adequately understood and assessed by means of a conversation circumscribed by their understanding of Mirpuri. Nor could the significance of their experiences easily be understood by someone without a sympathetic understanding of the values and experiences which have shaped their personality, development and goals in life.

It was suggested to us that trying to conduct a mental state examination or to nurse a patient in a language foreign to them is 'like operating blind'. The truth of this observation is, we think, inescapable. Most professionals said that that they would welcome more help from support workers and healthcare assistants who can speak a range of local languages, so that patients are always assessed in their first language. At present, there is also an urgent need also for psychologists and specialist nurses who are proficient in the languages spoken locally:

'If you speak the same language, you can express yourself more freely, whereas if it is someone else, you don't get the full picture.'

'[We need] … a service that is more geared to the local population. Ideally they would need to put more money into that.'

'We probably need people who can speak their own language. Several times I have used my language skills to convince the patient and talk to them; probably because they do understand when we are speaking in their own language, and they will follow our advice. Also the patient sometimes does not know any English at all.'

'[The] best way to do it [is] to interview the patient in his or her own language … to find people who speak the language and perhaps have knowledge of the field of psychiatry or illnesses to be able to interpret adequately what the patient is saying or describing, rather than relying on lay interpreters who do not have the knowledge of symptomatology. The difficulty is that you try to interpret words from one language to another and when you try to do that, if you are not careful you can alter the meaning.'

'It is not only about the languages but it is also about somebody having a knowledge of mental health. If somebody is absolutely hypomanic and saying a lot of things and going through flights of ideas, it is not easy to translate.'

'In the Punjabi language, there isn't a word for "depression". There is a word for feeling sad but there isn't a word for "depression" as such. There are different ways of describing the phenomenon but you cannot interpret the word "depression" into an Indian language as there isn't such a word

… There are problems when you are using interpreters in how you interpret the words into the English language.'

'There is definitely a lack of resources, a lack of qualified consultants and some language barriers suitable to the local cultural needs, which should be addressed.' (General practitioner).

CULTURE

The significance of what the patient is saying can sometimes only be appreciated if one is familiar with the social context within which the experiences have developed. Similarly, whether a service is relevant partly depends on the extent to which it is accessible to individuals, acceptable to them, and tailored to their needs. Again, this is virtually axiomatic:

'Some of the symptoms, which are symptoms of illness, can very often be interpreted as being normal to the culture whereas that may not be true. It may not be normal to the culture or the degree to which symptoms are being presented is not normal to the culture. Therefore, there is very often an issue where we say we think this is culture, and often I believe that symptoms of illnesses are misinterpreted because there is a belief that it is cultural, whereas it is not necessarily cultural unless you really understand the culture.'

'He was admitted under section 2 but many of this kind of patient will present with somatic or physical symptoms and if it is a mental illness, it still carries quite a big stigma and people will look at alternative ways of treating, so it can go untreated or undetected for a very long time. Much depends on their contact with the general practitioner and how understanding he is. 'Physicalising' symptoms is one way of making them more acceptable.'

'Unfortunately, some of the communities are closed communities. They have some cultural barriers. If someone is suffering depression – a daughter-in-law for example – she doesn't get a chance to express it because she is being ruled by somebody, generally her mother-in-law. It would only be when she was in crisis they would get help.'

'The family gets together. They try to avoid telling anyone that this person was under stress, was depressed. It stays within the family.' (General practitioner)

The local NHS trust is, of course, fully aware of the need to further develop its services in this area, as these quotations demonstrate. Progress has, however, been limited by recruitment and resource problems, and by a lack of commitment in some quarters.

STAFF RECRUITMENT

Recruiting qualified nurses with Asian language skills has proved to be very difficult:[23]

[23] This is consistent with the national picture. According to the Department of Health, Asian people are particularly under-represented in nursing. Although they constitute 4% of the general working population, they account for only 1.4% of nurses. Bradford University

'The teams have tried on several occasions to recruit people with Asian language skills, including by placing advertisements in the local Asian press, but have tended to get no applications.'

'We have not had an Asian CPN in our team since I joined the trust seven years ago. I have struggled to get an Asian CPN to work in a team that covers 90% of the population, 90% of the patients we have in that community. We have not had one Asian CPN of that community.'

'It is well acknowledged that there is a problem about recruiting qualified nurses from a South Asian background. It is not surprising given that there are very few South Asian people who go into nursing so if you are looking to recruit such nurses you will not find many people.'

'The area has no Asian-speaking nurses. The families are not being supported, people are only working with the patients, they give them their injections and go away, and the family has to cope with all the aftermath if something goes wrong.'

In the case of the local home treatment team, it has recruited a nursing assistant and community support workers with Asian language skills, but 'two of them left and the money for one post was gobbled up.'

Recruiting qualified nurses from abroad is seen as objectionable on ethical grounds; and, in any case, there are major cultural differences between the South Asian people living here and in South Asia. This is sometimes overlooked.

The trust and University of Central England have developed a scheme which enables nursing assistants to move on to nurse training, and a number of people will qualify this year as a result of that initiative:

'What has happened over the past few years is that we have increased some of the support workers. We have had support workers who are unqualified nurses and we have encouraged them to go into nursing even if they do not have sufficient grades. The local university, the University of Central England, has a nursing course and they have also been very good about that. In the last three years, we have sent 15 or 20 of these Asian support workers to do their nurse training, and the first of those who went from our area comes back in March after having completed her training. In fact she is currently in our team working as a student until March and she wants to stay with our team. There is some progress, but I have waited seven years for someone who could speak the language but who also has the experience of a qualified nurse.'

'It is not very easy to find qualified staff from ethnic minority backgrounds but the plan is that we are including people who have the potential as a healthcare assistant and train them for six months and hopefully send them on secondment so we have a roll-on.'

'My own view is that we should not try and fix that problem by continuing to seek nurses to come and work in such services. We should look at local

---

looked at the reasons why Asian students are under-represented on healthcare courses and 'identified some cultural issues, such as reluctance on the part of some women to nurse men and more men regarding nursing as a woman's job. It seems that there is also a negative attitude from parents, who consider that the pay and status of nurses is too low.'

resources and try and provide an entry point in the mental health services for people from the local community who may not have the professional training to work as nurses or doctors but who have considerable skills which will help us in making our services culturally more appropriate.'

'We have recruited people to healthcare assistant posts who effectively work within the team and they are extremely useful allies and also aids to the general process of the assessment and treatment of people. There has to be a creative way of looking at it … There was the national launch of a recruitment of South Asian people into nursing that took place here and we produced a number of visual aids and it has had an impact and the number of people going into nurse training has increased substantially. Many of the healthcare assistants who came to work with us have now been fast-tracked into psychiatric nurse training through the local university. It is a longer game in one sense and we feel that we have to get such people into nursing. It is not going to happen on the basis of just telling people about the wonders of psychiatric nursing because it is not something that many Asian families would see as a preferred career option.'

RESOURCE ISSUES

There is therefore a general acknowledgement that the trust's services ought to be able to meet the cultural and linguistic needs of the local population but it lacks the resources and personnel within its teams to meet the need:

'There are no specific services being provided by the trust to the South Asian communities as such … We have Asian staff in pockets here and there. I am not saying that if you have Asian staff they are going to provide a decent service; it is very important also that these people are very well trained and supervised.'

'… The services that are available to South Asian people … are woefully inadequate. That is not just in Birmingham … South Asian people are disadvantaged to a greater degree than any other group because of this lack of investment in the workforce.'

'In the African-Caribbean group that problem has somehow been turned to the community's advantage … The same focus and the same attention is sometimes lacking in relation to supporting South Asian services because the problems here are around access, not getting appropriate assessment. It is very rare for someone like Mr Rehman to have had this blow out, a major incident; for South Asian people that is somewhat unusual. The investment hasn't followed, that we have to invest in this community.'

The trust audited the competency of the services it provided to South Asian people. This audit examined matters such as access to an interpreter and the background of professionals within teams. The results were 'very depressing'. Many teams, especially in areas such as Hodge Hill and Yardley, 'did not appear to have any resources that would help them do that business properly. Nor did there appear to be a commitment that this was a serious issue.' The recommendations arising out of the audit have mostly not been implemented, mainly because of issues relating to resources and selective recruitment.

Interpreting services have improved. However, obtaining an interpreter is often very difficult when a person has to be assessed at short notice, particularly out of hours. For example, where he or she is at a casualty unit.

There is also evidence of unassessed and therefore unmet need at primary care level. Mr Rehman's general practitioner has only ten patients with a diagnosed major mental health problem, out of a total list of 2,500.

LOCAL STRATEGIES

The trust's recruitment policy has been considered. On a wider level, an Asian Service Development Strategy was ratified by the trust board in April 1999, but the funding available for improving services in this area has been very limited since then.

An Asian Services Strategic Plan was accepted by the City Council and the two mental health trusts, but it 'hasn't grown beyond that':

> *'Everybody thinks it is a wonderful idea but that was three years ago and nothing has materialised.'*

Asian Services Directorate

An Asian Services Development Manager was appointed in December 1998. In October 1999, a CPN was seconded to the service, and a secretary was appointed in November 1999.

Once the service had been established, a decision was made not to take on case work or keyworker responsibilities, because of funding limitations. These were quite severe, and not entirely foreseen:

> *'My understanding was that we had managed to attract a grant from the health authority to try to develop this service which was supposed to be matched by the trust. So there was supposed to be an equal amount of funding going in, something like £50,000 in the first year and £100,000 the next year .... Within a matter of months, it became apparent that that money did not exist. We had received some money from the health authority but much of it had been spent prior to ... the beginning of December, ... not necessarily ... on Asian Services development ... The funding that the trust were going to put into the service never materialised, because at the time there was an overspend and the money was used to cover those sort of expenditures ... It took ... nine months to even appoint a secretary because the funding could not be released and the trust was overspending.'*

It seems that the directorate has not met the needs or expectations of clinicians. They wanted one thing but the directorate provided another:

> *'What they wanted, it seemed to me all of the time, was a service where they could refer Asian clients. If they had complex cases, they wanted to be able to refer to this service who would come up with this wonderful therapy or wonderful creative option for particular individuals. The reality was that we did not even have any clinical staff and only one CPN within the service; all we could offer was a consultancy service. So they could support teams in looking at other options or exploring what was available outside the trust for individuals. That created a real resentment against the service.'*

> *'Clinicians on the ground do want that type of support but I question whether that in its entirety would solve anything. There are far bigger issues here ... Even if somebody speaks the same language, if they are still working within a culture of a particular team that refused to acknowledge*

people's cultural, religious and linguistic needs, I am not sure that a huge amount of difference is made. Very frequently we have had to challenge Asian workers, because their values and principles can be very similar to the rest of the team and they are not really able to identify that many different things impact on an individual's mental health such as their experience of racism, their immigration history, the housing and social deprivation.'

'People did not consider our input to be supportive but rather very threatening.'

'Unfortunately the Asian services did not provide any clinical services …'

'In our trust we have Asian Services but this is more to do with health promotion, they produce videos but they do not actually do anything. I have asked them several times if they will help with this situation and they say, no, they cannot, or when I refer a patient, they say they cannot help.'

Recent developments

An Asian support team was established in 1984, which consisted of a clinical nurse and three support workers. This team was dismantled in around 1994 but the local PCT and NHS trust, on the initiative of Mr Rehman's consultant, are now funding a similar initiative. This involves employing the nurse who managed the old Asian support team and a number of support workers, who will be able to work with the mental health teams and help to carry out assessments:

'In cases where this kind of issue exists, they can go and deal with the families and talk to the families. At the moment, if I ask one of my existing CPNs or someone else, they say, sorry, we do not have time for that. If I ask Asian Services, they say we do not do that, or they have some volunteers and they say we do not know what to do with that. There are one or two voluntary agencies and they do not want to get involved in this, unless it gets to such a point that you want the wife to be put in a safe haven. Then the safe haven team transition services come into action but it is very rare that this community will ask for that.'

'They are now asking me to go back to my old job that I did in 1984, to redevelop the whole thing again with that particular area (Washwood Heath). They are asking me to work with the primary care GPs because they are dissatisfied with the kind of services they are getting in terms of patients not assessed properly, long waiting lists and so forth.'

'My experience over the past 30-odd years is that I do not feel they need special or separate services but everybody needs to have a very appropriate assessment to give an appropriate intervention. In order to do that we need to have people who have the skill, who can be trained in terms of doing a good assessment and then having a good care plan … I agree to a point that we do not like to have a segregated service but we need to have services that should meet the needs of these particular communities … When you have four or five Asian staff the tendency had been to pass everybody to you, and it is quite overwhelming because you get a very big caseload. The idea is for people like me in that particular catchment area to support the team but also work very closely with the GPs and give them a very good assessment with the supervision of the psychiatrist.'

7 — LEARNING DISABILITY ISSUES

Approximately 2% of the overall UK population have a learning disability and some four people per thousand have a severe form. Twenty five percent of people with severe learning disabilities have profound/multiple disabilities. This means that in Birmingham one would expect around 20,000 people to have a learning disability, with 4000 having a severe form.

Private Finance Initiative funding has enabled the NHS to redevelop the respite care, assessment, treatment and community health services previously provided at the old Monyhull Hospital.

PEOPLE WITH MENTAL HEALTH PROBLEMS AND LEARNING DISABILITIES

Most people with learning disabilities are not mentally ill. However, schizophrenia is six times more common in people with learning disabilities, and affective disorders such as depression are four or five times more common. Alcohol problems, eating disorders , suicide and parasuicide all appear to be less common.

In 1996, 2,651 adults in Birmingham were registered as having a learning disability, and 2,922 children and young adults were on the register of children with a statement of special educational need.

Although Mr Rehman was in contact with local mental health services for many years, whether he has a learning disability remains unclear:

> *'His father once expressed the view that he was mentally retarded.'*
>
> *'He had some learning disability. His academic record was very poor … His intelligence was lower than average [but] I would not class him as mentally handicapped.'*
>
> *'I didn't come away with the impression that he had a significant learning disability.'*
>
> *'I don't know whether he had this particular problem.'*
>
> *'As far as the learning disability is concerned, I wondered whether he had a learning disability because he had very poor literacy. My judgment during that week when I saw him and subsequently … is that he does have a borderline learning disability but not something that would put him in contact with learning disability services.'*
>
> *'If you pushed me to answer it, I would say that there could be a possibility.'*
>
> *'During my interviews with Mr Rehman, I did not feel that he had any severe learning disability, but felt that he is on the lower side of the average … I did not request to have a formal assessment on this issue … I would put his IQ at about 70.'*
>
> *'What is interesting is that there was no formal assessment of his intellectual capacity, although the question was raised …'*

The possibility that Mr Rehman is mildly autistic or has Asperger's Syndrome was also canvassed, but as with the possible existence of a learning disability, never comprehensively investigated.

On the one occasion that Mr Rehman was referred to a consultant in learning disability psychiatry, the interview was conducted through an interpreter and the assessment was not completed. The provisional 'impression' reached on that occasion, that he may have a generalised mild learning disability, is of little assistance.

Although we received no evidence that Mr Rehman has a learning disability or other ancillary condition which impinged on the care and treatment of his mental illness, or the management of his domestic violence, this lack of evidence may be nothing more than evidence of lack of investigation.

LOCAL LEARNING DISABILITY SERVICES

Between 1994 and April 2000, the Northern Birmingham Community Trust provided a learning disability psychiatry service, as well as various community and child health services. The trust's learning disability service had three centres, to each of which was attached one consultant and one community team. Access to the community teams was by open referral, and that remains the case. Access to the psychiatrists was almost always through a medical source.

It should be emphasised that the people referred to the psychiatrists do not have a learning disability alone. They must also have a mental health problem, such as a psychosis, autism, depression, or a neurotic disorder. Whether a mentally ill person is referred to a specialist learning disability psychiatrist therefore turns on the extent of their learning disability:

> *'The common belief is that if you have a mental health problem, you go off to mental health, and if you do not have that you go to learning disability, but that is not true for us. We are there to provide the service for people with learning disability with mental health problems.'*

During the period to April 2000, learning disability services in the south of the city were provided by three community teams, supported by psychiatrists from the South Birmingham Mental Health NHS Trust.

The Birmingham Specialist Community Trust was then established in April 2000, and it comprised the psychiatrists previously employed by the South Birmingham Mental Health NHS Trust, the south Birmingham community teams, and the north Birmingham learning disability services. For the first time, services for people with learning disabilities, services for children with special needs and rehabilitation services were all provided within one organisation, alongside the more traditional community health services.

Subsequently, this trust has been disestablished, and the provision of these services has been transferred to the South Birmingham Primary Care Trust.

Most of the learning disability psychiatrists have approximately 300 clients at any one time, of whom around 40 may be entitled to enhanced CPA. Each receives about 60 new referrals every year. Thus, between them, the six consultants are responsible for around 1,500–2,000 clients (adults and children).

Many clients have significant physical, communication or sensory problems. There is one Registered Nurse for Learning Disabilities (RNLD) and one RMN within each of the six community teams. These teams are multi-disciplinary, with support being

provided by community nurses, psychologists, communication therapists, occupational therapists and physiotherapists.

There are no culturally-specific services: 'The services shape themselves, to some extent, around their needs. Some account is taken of their cultural needs but it is not massively developed as such.'

The standard IQ test is is administered only in English, although in India modified tests in some local languages are available. The local services do not have access to an Urdu-speaking specialist in intelligence testing:

> *'We do not have access to anybody like that. Our psychologists keep reminding us not to rely on tests but we sometimes have to do so in the absence of anything else. You can see there are many weaknesses in the validity of the results even if you do a test.'*

LIAISON WITH MENTAL HEALTH SERVICES

The possibility that Mr Rehman has a learning disability or a developmental disorder ought to have been comprehensively assessed at some stage during his lengthy involvement with the Northern Birmingham Trust.

The fact that this did not happen was not not unusual. It is relatively uncommon for mental health services to obtain an opinion from a learning disability psychiatrist, and the interface between the two services is 'worse than average in Birmingham':

> *'In my view, there is not a good interface between learning disability and mental health services, let us not make any bones about it. It was poor and it remains poor to this day. We have not met and really formed a single service between the two areas through the IQ cut-off. Therefore, it was really a matter of us or them, and it is still like that.'*

> *'I go around a lot and when this topic of joint interface working comes up, I just look away and hide because it is awful here, and it has remained awful in spite of everything. Perhaps we are too big, I do not know. We seem like two giant ships sailing parallel and do not seem to meet.'*

> *'It is very difficult for us to get any support from adult mental health services for a lot of people who fall into the very mild borderline services.'*

> *'It is everything. It is joint working, it is collaboration. It starts from the beginning, treatment and even discharge planning and then funding.'*

> *'If you have a service which splits into two at the point of referral, either you go East to learning disability or you go West to mental health, unless you start from somewhere else you cannot bring those two together. Unless you change it around and say let us make it patient-centered and start from there, and at the initial assessment let there be input from both sides. At the moment, we have a menu of two items and you can pick one but you cannot pick both. However, if you have a menu that is broken down into treatment components or service components like psychotherapy, drugs, rehab, employment and so on, the people from both services can say how is this person best served by taking bits from each service, instead of saying, "I want your bed", "you can't have my bed". That is a very bad starting point with the most precious resource but there are other things we could do, such*

as working jointly across teams. Therefore, the reason why these things have failed is because they have not started from somewhere else, from a patient-centred and needs-led point of view. The responsibility has to lie here between us. There is no third party that will come in and add a bridging service.'

It seems that each service feels under-funded and tends to protect its own beds and resources. This is unfortunate because people on or near the borderline of the two services would benefit from more sharing of services. For example, they may benefit from some sheltered work, a training scheme, or a service culture where there is more supervision.

It is apparently not only NHS mental illness and learning disability services that are not well co-ordinated. An additional problem is that health and social services are not well integrated:

'Integration here is very behind compared with neighbouring areas like Sandwell and Walsall who have integrated teams with nurses and social workers sitting alongside one another. We are 20 years behind. We had interviewed the teams until 1996 and then a new Director of Social Services came and spent a year or two systematically removing the social workers from the teams under the misguided notion that they have to be generic and to see everybody – old people, children, those with learning disability, everybody. Therefore, we lost all the skills and now, six years down the line, we are trying to bring them back together again. So we have difficulties on the ground as well as at the top but the idea is to try to appoint a new Director jointly between Health and Social Services to start trying to sew it back together again.'

We are told that the situation is unlikely to improve without some fresh thinking:

'We have just had Birmingham LIT that has been broken into four and that is going to be coterminus with PCTs. That in itself paralyses everything for six to nine months because everything has been taken apart to start again. So you have four sets of commissioners which will be okay for mental health, but do not forget that learning disabilities is sitting in one PCT for the whole service. The worst thing is that the commissioner for learning disability services is sitting at another PCT all on his own. So with the provider in the South PCT, the commissioner for learning disability in the East PCT and four LITs across the city it does not look that promising.'

8 — DOMESTIC VIOLENCE

We heard from several people that it is not uncommon for domestic violence within the local Muslim community to be quasi-legitimised in terms of the man 'being harsh to his wife', rather than as criminal assault; and that there is 'quite a lot of work to do in terms of protecting women in the Alum Rock and Washwood Heath area.' This last observation can only be understood as an example of dramatic understatement:

'Domestic violence is happening, but it is more cyclical now. It is difficult for us unless the person himself comes in and lets us know what is

happening. The wife tries to protect her husband even if he is harming her.' (General practitioner)

'The problem we have with domestic violence is becoming worse and worse, so much so that every time I present a teaching programme … we end up discussing cases of domestic violence as it is such a big problem.' (Alum Rock mental health professional)

'There have been some situations recently and one in particular, where a guy was brought into hospital. He had been assaulting his wife and his mother. Even though he was actually in hospital, because we had had quite a lot of involvement, his wife phoned us – she had a good relationship with our support worker – to say that he had phoned her from the ward saying that when he came out of hospital, she had better be gone because if not he will kill her and if he kills her he will say he is mentally ill and just get a couple of years in a psychiatric hospital. We took this very seriously and involved the police and the domestic violence people. We met the wife and the Asian services in the trust were involved. We informed the consultant of this and took it almost to the highest level and it was totally ignored. It was almost as if people regarded it as a cultural issue. I have heard one doctor say, "It is their culture. She should expect it." I am sure that, like our team, all professionals feel strongly about it, because we witness it and we are the ones who are told more often than anyone else when we go into the homes and see the effects of domestic violence, not only in Asian families.' (Home treatment team)

'It would be fair to say that the problem of domestic violence is more pronounced in the local Asian community.'

'We have close links with GPs but there are other GPs that are not that sympathetic to women, especially Asian GPs for some reason. If an Asian woman goes to an Asian GP he most often than not says, 'I don't want to get involved.'

'Q. We heard last week …. about the father or the husband being harsh with the women, which was a euphemistic reference to domestic violence. Is that the attitude of some GPs? A. Yes. I would say the majority. It's a hurdle to get over to get the doctor to be able to talk to the women and be able to believe them that something is going on …. They don't want to get involved because more often than not they know the family as well: the father, the son, the husband. They don't want to get involved because if it ever gets back that the doctor helped her there will be implications for the doctor, fears for his own safety as well. That is probably a part of it but a lot of the time it is just the attitude of being male Asian.'

'Q. Is the shame that a man's wife is not putting up with it ? A. She should shut up and take it, she shouldn't stand up to him. Q. The man has lost control of his household is the shame, rather than that he is behaving in that way? A. Yes. The blame is more for the woman: how dare she report him, how dare she let other people know. Should she not think of her children? What is the community going to think of their family … Most of the blame goes to the woman, they won't think the male hasn't any control over his wife. That will be a little part of it but it will be more for the woman: why is she reporting, why isn't she just taking it, or she might be exaggerating. It will also have implications for her and her family if she has sisters. If she divorces or leaves him it will have implications for them:

who will marry the sisters. That woman's mother said, 'You have to go back to him because you have younger sisters to consider. Who is going to marry them when they know there is a divorce?' And the children. How are they going to find their partners and how are people going to be able to respect the children knowing that you've left their father. It's really silly.'

'The Asian doctors don't like it when we tell them how your women should be supported.'

'There has to be a clear stance. There is thing called cultural sensitivity and there is also something called human rights and you cannot have one without the other … As professionals we fail individuals if we sit back and say within the culture it is okay, so we had better not interfere because it would be inappropriate. I would not condone that approach at all and I had a parallel experience of working in child protection with a lot of Asian families. As professionals, we have a responsibility to say to individuals this behaviour is not on regardless of what the cultural context is, regardless of anything else…' (Asian Services Directorate)

'The families are saying 'please can you do something', the wife rings up and says 'can you do something, he might kill me', but it is not because of mental illness. When you tell the police, most of the time they will not go. If they do go, they will not do anything about it. Even if they take the person into police custody, they will release him the next day.'

'Many of the men won't stop if there is an injunction or an occupation order. I have had women saying to me, 'He told me that he doesn't mind going to prison; even if he kills me he doesn't mind going to prison and that's what he will do. He doesn't care about all these orders, he doesn't care about the courts, he doesn't care what people do to him, he wants me killed.' It's difficult to advise them in that situation, other than saying, 'You have to get away, you can't live in that house; you have to get out and move to another area, maybe another city.'

'I had one case where I had a phone call and I was told, 'There is a lady here and she is going to be discharged soon. She's just told us she's been suffering domestic violence, can you please come down here and see her.' I went to see her and her story was very sad. She'd been stuck up in an attic for four years, was hardly allowed to come downstairs. She had a shower once every three months, other than that they wouldn't let her use that much water. She had two children up in the attic with her, it was dark, she wasn't allowed to wash her clothes regularly and she had bin liners with all her children's clothes in. She said that she wasn't allowed out of the house. Her youngest child had something wrong with them and they had lots of hospital appointments coming through but the mother-in-law would rip them up and not let the mother know and the child continued to be in this very ill state.'

'Usually the threat is, 'I will kill your family back home; we'll get someone to do something.''

'It's because there is absolutely no family support, they are isolated. In many cases they suffer from depression and anxiety themselves and it's very difficult to get the whole case through the courts.'

'There was a Muslim women's domestic violence project and one of the workers told me that she constantly gets men saying to her that she is a housebreaker. She has had them spitting on her, sitting on her car when she is driving off and banging on the windows: 'You're a trouble causer, you're a busybody, you're trying to break up our family. The reason our wives have the courage to stand up to us is because you're putting ideas into their heads and they weren't like this before.'

Between January and November 2002, 171 incidents of domestic violence against Asian women in Washwood Heath, Alum Rock, Nechells, Erdington, Aston and Witton were reported to the police.

In our opinion, such violence is wholly unacceptable. It cannot be condoned on any grounds, and we are sure that most local people will be appalled by the behaviour towards local women described in this report:

'There has to be a distinction between religion and culture. Some people use religion as an excuse to be able to beat their wife but there is no way it says that in Islam or any other religion that you are allowed to hit your wife in any way. They use that, they twist the words and make it into what they want to believe. Unfortunately a lot of the Pakistanis go more towards the culture than religion.'

'In my own family it is unheard of to hit a woman. I have never experienced it in my own family; it wasn't accepted and never will be.'

'It depends on the family you come from. In our family we take religion seriously. I am married and I know that my husband respects me as a woman. I'm earning and I have my own money but he will not expect me to spend on the family; he will give me a separate budget for myself.'

REDUCING DOMESTIC VIOLENCE

The Reducing Domestic Violence Project was established in November 2000. It was set up with Home Office funding, following research in Sparkhill and Sparkbrook which showed that Asian women were least likely to report domestic violence to the police. The evidence that received from the project was to the effect that:

- ☐ Domestic violence within the local Muslim community remains a taboo subject.

- ☐ Many local women who suffer from domestic violence are concerned about bringing shame on their families. They are afraid of being stigmatised, and of being branded as loose women. They are also fearful of the repercussions for them and their children:

  'Once the police have arrived that's it, it will never go back to being the same; the family, their in-laws or their husband will always hold that against them: 'You called the police and this is what happened.' They probably don't trust you and it will make their situation worse in some cases.'

- ☐ Many local women who suffer from domestic violence and wish to take action lack family support.

- There is immense pressure on woman who are suffering violence to remain within their family.

- Language barriers mean that the police may not be able to understand 'what is going on in the house' when they are called to deal with a report of domestic violence.

We were impressed by the Reducing Domestic Violence Project. It is well organised and it offers a range of important, well-thought out, services to local women. It has raised local awareness of domestic violence; provides one-to-one outreach support to Asian women, mainly in Sparkhill and Sparkbrook; has produced a personal safety training pack; advises women on their safety within and outside the home; furnishes them with alarms and mobile phones; assists women to pursue civil remedies; helps those who have to move with associated difficulties (housing needs, benefits, schooling); records and photographs women's injuries; provides emotional support; is able to access an Asian women's refuge that is managed by its parent housing association; and provides advocacy, support and counselling:

> *'We work with a trained counsellor now [who gives her services free of charge]. We hold weekly outreach surgeries within the area in the local schools and doctors' surgeries to make it accessible for women. A lot of them are confined to the home and aren't allowed out but they can use the doctor's appointment or picking up the children from school as an excuse to come and access our service. On one of the surgeries we have a Birmingham City Council homeless officer who facilitates the surgery with us and she takes any homeless applications or any advice regarding re-housing.'*

In our opinion, it is essential that the work of the Reducing Domestic Violence Project is expanded so that it can provide a city-wide service, that public authorities are guided by them as to what further services would be useful, and that additional funding is made available as a matter of urgency.

We fully acknowledge that the Mosque and local religious leaders have an important role in condemning domestic violence, and we would like the evidence summarised in this section of our report to be widely distributed to local religious leaders.

9 — THE TRUST'S OWN REVIEW

A preliminary report concerning Mr Rehman's treatment and the events surrounding his wife's death was completed by the local trust on 1 March 2000. The trust then established a review panel which inquired into Mr Rehman's care and management.

CONDUCT OF THE REVIEW

The conduct of the trust's own panel review was criticized by many of those who attended it. Some of them felt intimidated and left with the impression that the panel were seeking to apportion blame for what had occurred. It was also felt that the internal review report focused on individual or team failures, even though many of these were 'track-backable' to weaknesses within the trust:

> *'People came out quite threatened by the last investigation; it wasn't a positive experience at all.'*

'I didn't have much faith in the way that inquiry was conducted, so I wasn't at all surprised by the report although I was disappointed.'

'It had already been made quite clear that they were going to be apportioning blame to somebody and that was the tone. When I was questioned at the inquiry that was the impression I had, that they were trying to apportion blame or put words into your mouth that would potentially make somebody else that was involved in the care of that person look in a less favourable light, and I didn't think that was appropriate or necessary … It was made quite clear to me that the purpose of the inquiry was to apportion blame.'

'The internal inquiry that was done by the trust was absolutely appalling and … it upset a lot of … staff.'

'I agree that some of the questioning was quite attacking. A couple of the members of the panel were really trying to find a scapegoat …. One I found quite insulting. I felt that he wanted to bring in personal issues to a forum that was totally unrelated.'

'There was absolutely no consultation of any sort by the inquiry committee as to whom they were going to call. So I had no input to that other.'

'I was totally disgusted by the whole process and the way it was done. Before I went to the internal inquiry, a lot of the nurses had gone and they were all coming back very upset. I thought how can you hold any inquiry where the people who attend all come back upset, that should never happen.'

'Most of the staff who came out of there were very upset … They said it was too critical, very aggressive and out to find fault with everyone.'

'We have had suicide audits; I was at one a few weeks ago when the doctor was very repentant and almost in tears, but he wasn't in tears at the time it all happened. He was in tears because he was being carpeted, but I know the staff involved in this case — the ward staff and others involved — were devastated.'

DISCLOSURE OF THE REPORT

We think that it was an unfortunate omission that the internal review report was shared with Mr Rehman's consultant psychiatrist but not with the other mental health professionals who were involved in his care and interviewed by the panel. The effect was that the findings and recommendations were not disseminated to those whose practices were under review, and they were not asked to address the issues identified by the panel, or to contribute to the formulation of an action plan. Nor were they in a position to comment on the accuracy of the panel's findings:

'I have not received any feedback regarding the extent to which Mr Rehman's care complied with statutory obligations, procedures or guidance.'

'I can't explain why people didn't receive the report because the report was made available after it went to the trust board.'

'I acknowledge there has been a problem in not having a focus on an action plan … It was the responsibility of the effectiveness manager to work up an action plan.'

7 — SUMMARY, RECOMMENDATIONS, ACTION PLANS

ABOUT THIS CHAPTER

This chapter summarises our findings, and sets out our recommendations and the action plans formulated by local mental health services in response to our recommendations.

National Health Service Guidelines issued in May 1994 require that an independent inquiry is held when a person who has been in contact with mental health services takes another individual's life. In this instance, the independent panel were asked to review the care and treatment of two patients who resided in north Birmingham:

> **Mr Ogilpis Hamilton** killed his neighbour, Mr Lewis Hodge, on 5 July 1999. He later pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to life imprisonment. This sentence was mandatory because the offence was not his first serious offence. The homicide

took place at Mr Hamilton's flat in Erdington, Birmingham. He was residing there informally, having been discharged from liability to detention in hospital fourteen years before. His medical diagnosis on discharge had been 'paranoid schizophrenia possibly complicated by a mild learning disability.' Mr Hodge had also received in-patient treatment from the same NHS trust, and his name was on its supervision register. He too had a formal diagnosis of paranoid schizophrenia superimposed on a mild learning disability.

Mr Abdul Rehman was admitted to Highcroft Hospital on 22 January 2000, under section 2 of the Mental Health Act 1983. After nine days, he was transferred to Newbridge House. His wife obtained an anti-molestation order against him early in February, which was served on him on 8 February 2000. On 10 February, he was granted three periods of half-an-hour's unescorted community leave per day, in order to go to the local shops. Having been allowed half an hour's leave at around 7pm on 11 February, he On 11 February 2000, Mr Rehman returned to the family home in Alum Rock, Birmingham, and stabbed and killed his wife, Mrs Shamim Akhtar, in front of their children. He later pleaded guilty at Birmingham Crown Court to manslaughter on the grounds of diminished responsibility. The court imposed hospital and restriction orders, under the Mental Health Act 1983, and ordered his admission to a medium secure unit.

Both patients lived within the area served by the area then served by BIRMINGHAM HEALTH AUTHORITY, BIRMINGHAM CITY COUNCIL SOCIAL SERVICES and the NORTHERN BIRMINGHAM MENTAL HEALTH NHS TRUST, and had received in-patient treatment in Birmingham. They were not, however, cared for by the same mental health team.

WHO CONDUCTED THE REVIEW

The review was undertaken by a panel of professionals from outside Birmingham:

Anselm Eldergill (Chairperson)	Solicitor. Visiting Professor in Mental Health Law, Northumbria University. Former Chairman of the Mental Health Act Commission's Legal & Ethics Committee. Author of *Mental Health Review Tribunals, Law and Practice*.
Ian Blackie (Social work member)	Manager, Emergency Duty Team, London Borough of Greenwich Social Services; Chairman, National Appropriate Adult Network; Social services consultant and trainer.
Claire Murdoch (Nursing member)	Executive Director of Nursing, Brent, Kensington, Chelsea & Westminster NHS Trust; Director of Operations, Kensington & Chelsea. Co-author of *Psychopathy, the law and individual rights*.
Stephen Wood (Medical member)	Consultant psychiatrist. Medical Director, East Kent Community NHS Trust.

PURPOSE SERVED BY THE REVIEW

The function of an independent inquiry is thoroughly and objectively to review the patient's care and treatment, in order to ensure that the services provided to persons with such needs are safe, effective and responsive. The purpose is to learn any lessons which may minimise the possibility of further tragedies. This is why the report is made to the bodies that have power to change the way the service is provided. The outcome should be that any feasible improvements are made, for the future good of everyone.

Such inquiries serve important private and public needs. At a private level, individual tragedy requires a response, ideally determined by the individual circumstances: inquiries enable the bereaved to know that what happened is being fully and impartially investigated, and to be a party to that process. Equally, local people need to be reassured that the service is operating effectively. In such circumstances, it is wholly understandable, and wholly reasonable, that local people wish to be reassured that when family members come home, or friends or strangers return to their community, the risk of being seriously harmed is minimal.

Although agencies outside the locality may draw useful lessons from an inquiry report, the cost and usefulness of the exercise does not require national justification. The value of the process lies in systematically examining the way in which a particular service, and group of professionals, operate and co-ordinate *their* efforts.

PROCEDURAL SAFEGUARDS

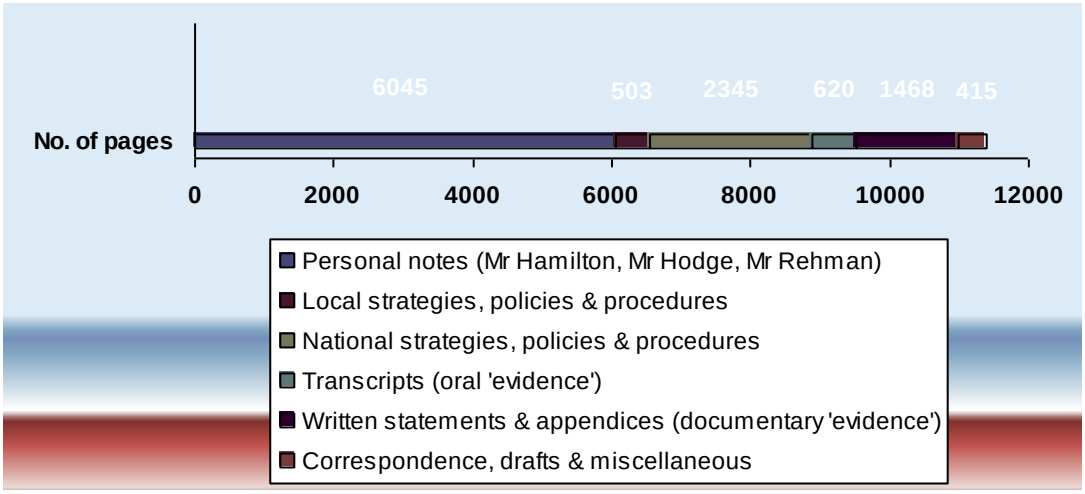
Although not part of the terms of reference, the review panel chose to adopt a set of procedures designed to ensure that those persons assisting them were treated fairly.

TIMETABLE

The panel members met with the professionals involved in Mr Hamilton's case in July 2002 and those who cared for Mr Rehman in November and December 2002. Once underway, each review took approximately seven months.

INFORMATION REVIEWED BY THE PANEL

The following chart summarises the information received by the panel, amounting to almost 12,000 pages, upon which the findings are based.



COMMENDATIONS

Our review was a further source of distress for the bereaved, and for the patients and their families. We particularly wish to acknowledge the way in which they helped us.

We also wish to acknowledge the candour and commitment of the professionals who cared for the patients. A constructive process is impossible without openness, but being open, when so many inquiries have been critical of individuals, took courage.

Such openness is to be encouraged, and is the ultimate test of professionalism. The mature professional who accepts that their practice, or local practice, can always be improved thereby ensures that the future direction of the service is based on a true understanding of its present state.

1 — FINDINGS CONCERNING MR OGILPIS HAMILTON

There were striking parallels between Mr Hodge's situation and that of Mr Hamilton. Both of them were diagnosed as having paranoid schizophrenia with a mild learning disability; both of them tended to see their neighbours as the main source of their problems; both of them had attributed the obscene and accusatory voices they heard to their neighbours; and both of them were now neighbours living in close proximity.

Mr Hamilton was frightened that racists intended to burn down his flat and he thought that some black people locally were colluding with his main persecutor, his 'white racist neighbour'. As a result, he connected up a hose in his flat every night . When Mr Hodge started burning rubbish next to the flats where they lived, Mr Hamilton was extremely anxious and confronted him about this. Mr Hodge became upset and animated when he was approached and he probably followed Mr Hamilton back to his flat.

Mr Hamilton responded to this perceived intrusion and threat by launching a ferocious attack on Mr Hodge. His attack probably contained a great deal of displaced aggression that had been building up over many years.

MR HAMILTON'S MEDICAL & FORENSIC HISTORY

1. Mr Hamilton had two convictions for wounding with intent, dating back to 1975 and 1980.

2. In January 1975, Mr Hamilton attacked a workmate with a penknife, causing injuries to his shoulder and ribs. Following his arrest, he said that that his victim and other people had been continually provoking him at work, and that he had been accused of stealing £10 from his victim's wages. In retrospect, he was probably mentally ill but he received 30 months imprisonment.

3. In 1980, Mr Hamilton attacked a workmate with such ferocity that his victim required 90 stitches and was disfigured for life. He believed that his victim had said that 'he was a police informer, that he was no good and should be killed', and that he had been subjected to the very same abuse on the bus and in local pubs. He had previously got on with his victim, attacked him without provocation, and his eyes were glazed and trance-like at the time. Having been taken into custody, he believed that prison officers might incite other prisoners to attack him. He was clearly mentally ill at the time of the offence but received six years imprisonment.

4. In 1983, while in prison, Mr Hamilton showed unequivocal signs of a psychotic illness. He was transferred to hospital and responded very well to treatment with depot neuroleptics. In March 1985, he was released from liability to detention in hospital by a Mental Health Review Tribunal.

5. In 1991, he complained of verbal abuse from his neighbours 'that was also coming from the church and the bus'. A contemporaneous note records that he 'told the doctors that some neighbours were shouting abuse at him, but it was not racial abuse. The voices said, "They'll find out where I live and they shout abusive words at me, saying '£40,000 — you won't get away with it"'. These auditory hallucinations consisted of male and female voices, and they had started three months previously.

6. From 1991 onwards, Mr Hamilton made numerous complaints about many of his neighbours, most of which involved allegations of racist abuse. In all, he complained about the occupants of eight addresses nearby, including all three of his neighbours in the small block of flats where he lived. He also complained about the behaviour of visitors and passers-by.

7. By the beginning of 1996, local police officers were expressing concerns about his mental state. His demeanour was sufficiently unsettling that they would not visit alone. A police inspector reported that he was 'not a well man' and that 'a lot of the things that he's saying don't make sense'.

8. On 6 July 1999, he demonstrated fixed delusional beliefs regarding racist threats and taunts from neighbours, the radio and television. While in prison he continued to experience 'racist taunts', both from prison officers and inmates acting at their behest. His persecutors said that 'they will cut up my skin, and bad language.'

9. The overriding likelihood is that he continued to hold the beliefs that he expressed both in 1991 and at the time of Mr Hodge's death in 1999 during the intervening years.

MENTAL HEALTH ACT ISSUES

10. The key Mental Health Act issue is whether Mr Hamilton satisfied the legal criteria for detention in hospital between 1985 and 1999, and whether he ought to have been detained for his own health or safety or to protect others.

11. The answer to this question turns partly on legal considerations — the threshold for detention and treatment without consent under the 1983 Act — and partly on professional judgements about how best to manage identified risks, the advantages of community-based care, and the practical benefits of establishing or maintaining some voluntary contact and therapeutic rapport with clients.

12. We believe that Mr Hamilton's admission and detention under section 2 would have been lawful and justifiable during most of the period between 1991 and 1999. There were clear signs that his health had deteriorated and that he was again mentally ill; his unfounded allegations caused many of his neighbours great distress; he did not believe that the voices he heard or the messages he received from the television were unreal; there was no real prospect that he would see a psychiatrist voluntarily, or that informal assessment and treatment was feasible; he had two previous convictions for wounding, which was proof that he could be dangerous when unwell; he was unwilling to talk about his experiences or to disclose information about himself, which meant that the risks were difficult to gauge; his previous offences had been totally unexpected by those with whom he was in close daily contact, and he had remained generally affable before his offence in 1980; he was known to respond to medication but had not received regular medication since 1985; medication could only be administered under section because of his objections; a more intrusive approach was justified by personal and public safety considerations. In short, it was documented that he was mentally ill and distressed; that without medication he was capable of serious violence; that he was unwilling to take medication voluntarily; and that he had responded to medication in the past.

13. The arguments were, however, not all one way. Mr Hamilton's last offence had been in 1980, nineteen years before Mr Hodge's death; he had always tried to resolve his complaints about his neighbours by lawful means, without resort to violence; Mr Hodge was black and the professional view that Mr Hamilton was unlikely to use violence as a way of settling his complaints of harassment and racism was to this extent borne out; a mental health review tribunal had found that his two previous offences were not associated with mental illness; it was not unreasonable to believe that his only psychiatric admission in 57 years constituted a psychotic reaction to incarceration in prison conditions; he presented quite well in many respects; he had been seen and assessed by his general practitioner and a number of consultants since 1985, none of whom believed that he required compulsory admission and treatment; compulsory admission might be counter-productive and result in him refusing all contact with services; the possible benefits of antipsychotic medication needed to be balanced against the physical discomfort it was likely to cause him.

14. Having weighed this evidence, we believe that there was a strong case in favour of compulsory admission in 1991. However, by the time he attacked Mr Hodge nineteen years had elapsed since his last offence of violence. The likelihood of him seriously harming someone else if he was not detained and treated against his will was by then not so apparent as to obviously necessitate compulsory admission. In other words, it was not unreasonable to decide that any risk to others did not justify detention, particularly given the pressure on local hospital beds and the more immediate and obvious risks

presented by other patients. Having said that, we also think that Mr Hamilton's experiences caused him prolonged suffering over many years and his quality of life was poor. This suffering was likely to persist indefinitely unless he received antipsychotic medication, and he would have benefited from a defined period of treatment in hospital.

15. In our analysis, we have tried to be fair and to define the case against compulsion. It must be acknowledged, however, that Mr Hamilton's professional carers did not assess and balance the competing risks in similar terms. Nor did they have or agree a plan for assessing and managing obvious risks, whether in hospital or in the community.

RISK MANAGEMENT

16. The key risk management issues were whether compulsory admission was necessary and, if it was not, how any identifiable risks should be managed while he resided at home informally.

17. Once compulsory admission had been ruled out, the only defensible approach was to provide some element of supervision and support, so as to be better placed to intervene if it became apparent that his mental state, behaviour or social circumstances were deteriorating.

18. The consequence should have been that Mr Hamilton was supervised, and where necessary supported and treated, systematically. The benefit of being systematic is to ensure that clients do not 'slip through the net' because of competing demands on professional time. A simple system, such as the CPA, helps to ensure that changes of circumstances, and individual professional judgements or omissions, are noticed and discussed before they have unfortunate or tragic consequences. Mr Hamilton required an agreed, recorded, care plan that was periodically reviewed and, as part of this, periodic risk assessment. That this was happening should have been verified through supervision and CPA audits.

19. Medical involvement in a CPA and risk assessment process of this kind was possible. Even if Mr Hamilton could not be persuaded to meet his new consultant, his consultant could have reviewed the psychiatric and forensic history; been kept informed of developments and asked to advise on their significance; have given advice about his support and supervision; participated in care programme meetings and risk assessments, and in decisions about the need to conduct a further statutory assessment. Furthermore, Mr Hamilton had an excellent relationship with his general practitioner, who he saw quite often. This doctor could have been asked to examine him and to report periodically on his mental state. Given the history, at some stage it may also have been beneficial to have sought an opinion from a forensic psychiatrist.

20. In the event, there was no simple risk management system in place, and Mr Hamilton's last consultant accepted that no care plan was agreed and no risk assessment process was undertaken.

21. There were many deficits: there was no clearly identified keyworker or proper CPA process in place; no one was responsible for collecting information about his mental health and forensic history; although some contact was maintained with his social worker, the approach was unduly hands-off and low-key; no multi-disciplinary meetings were convened, and no one questioned his social worker's assumptions and judgements about his health and the significance of his forensic history and complaints; apart from his

consultant in 1985 and his CPN in 1996, no one assessed or sought to explain the significance of the seeming discrepancy between his 'gentle giant' status and his forensic history; the professionals kept separate files, and communication was poor; because the information about his mental state and the risks was mostly not shared, each professional had a partial understanding of his mental state and history; files containing important information about his history went missing; and some files were disorganised and lacked detailed, easily digestible, summaries.

CARE PROGRAMME APPROACH & AFTER-CARE

22. Because Mr Hamilton had been detained in hospital for treatment, he was entitled to after-care services, under section 117 of the 1983 Act, until the relevant authorities were satisfied that he no longer required such services.

23. In terms of the care programme approach, he required a care plan, regular psychiatric advice and review; general practitioner involvement; a sharing of relevant information; systematic risk assessment; and keyworker support and co-ordination.

24. No CPA arrangements were made. There was no care plan, no keyworker was appointed, his after-care needs were not periodically reviewed and revised, and the supervision register guidelines were not implemented. His case drifted, in keeping with its status as a low-profile, low priority, case. It was neither closed nor actively worked upon.

25. Mr Hamilton received only social support from 1996 onwards. His last consultant accepted that he had no contact with his general practitioner, and no meaningful contact with his keyworker. This consultant was committed to the care programme approach and was praised by many former colleagues, but he had a heavy workload and lacked systematic support.

26. Mr Hodge had no permanent consultant from the beginning of 1999 until the time of his death. Because of this, a CPA review scheduled for 10 May 1999 did not take place. The psychiatric support provided for him after he was discharged from hospital in November 1998 comprised two short out-patient appointments with a locum consultant.

27. The fact that the same social services team was working with Mr Hamilton and Mr Hodge was not picked up, even though the same two managers supervised both of their social workers. The workers were unaware that two men with histories of serious mental illness and a fear of their neighbours had been placed as neighbours in the same small housing complex, and they did not have the opportunity to consult each other, or to undertake any joint working.

28. Mr Hamilton's situation was not atypical, and there were several reasons for the very patchy implementation locally of the care programme approach: there were no single CPA procedures to which both health and social services professionals worked; the appointment of keyworkers could be very informal, so much so that it was not always clear to the relevant professional that s/he was being appointed; the turnover of consultants resulted in a lack of continuity of medical care, and difficulties in co-ordinating different aspects of care; the conduct of CPA reviews tended to be *ad hoc*; there was no system that flagged up people who had not had a CPA, or had not seen a psychiatrist, for some time; the services were not well-integrated and they used different sets of documentation; CPA forms were partially completed; managerial fighting was rife and responsible for much of this inconsistency and the limited implementation of CPA procedures.

MULTI-DISCIPLINARY TEAM WORKING

29. Practitioners from all disciplines experienced significant problems with joint working.

30. In Mr Hamilton's case, some of the most worrying consequences of this fragmentation were a lack of shared information about his previous offences; the lack of a proper CPA process; the lack of a system within which individual workers could practice as a team, maximizing and co-ordinating their inputs, sharing their skills, views and expertise, and minimizing the professional risks to themselves; and a lack of coterminosity between the social services and health teams.

31. Many factors contributed to the difficulties that practitioners experienced when they tried to work in a multidisciplinary way:

(a) Organisational suspicion and hostility

The evidence of suspicion, and at times hostility, between health and social services managers was incontrovertible. Sutton and Erdington was the area worst affected. The local social services team did not engage in multi-disciplinary working, the implementation of the care programme approach, and the functionalisation of services. The Council's Social Services Committee was aware of this situation, and may even have considered it advantageous to delay the integration of mental health teams. The faults and weaknesses were from the top-down, rather than from the bottom-up. The lack of NHS and social services co-operation at senior levels permeated down to the ground, had a demoralising effect on front-line staff, and hampered their attempts to provide a modern, client-focused, service. Where individuals worked in a multi-disciplinary way, they did so despite the system, not because of it.

(b) High staff turnover

There was evidence of high turnover and instability in key management posts, both within the trust and social services. This seems to have undermined the capacity and ability of managers to lead major service changes in a thoughtful and measured way. Social services in particular had an enormous number of managers acting up in different posts throughout the period reviewed by us. Those in senior positions often lacked knowledge and experience of mental health services.

(c) Different models and professional perspectives

Ideological battles were fought within the organisations about the direction of local mental health services. In some quarters, there was resistance to the relocation of hospital-based services; unease about attempts to move from a medical model of psychiatry to a more social model; and discomfort about the merits of functionalising services. It is possible that some practitioners found it difficult to balance the local user empowerment agenda with the national drive for safer services. Although such debates are common across the country, locally there seems to have been an excess of ideology. Battles within and between teams could be fought with considerable venom, which added to the prevailing dysharmony. This further limited the contribution that individuals could make to the common goal of patient-focused care.

The implementation of functionalised services was not without its difficulties. The need to prioritise scarce resources led to Highcroft Hospital becoming extremely dilapidated; the community teams in Sutton & Erdington were relatively unsupported until it was their turn to functionalise; the City Council

seems not to have felt a full partner in decisions to remodel mental health services and to have withheld some goodwill; and both organisations failed to take proper account of the capacity, experience and ability of local managers to uphold procedures basic to good practice while organisational structures were changing.

(d) Resource problems

For most of the period, the conditions at Highcroft Hospital were extremely poor but there were few local alternatives to in-patient admission. The trust was unwilling to shut the hospital until it had developed suitable community alternatives but developing them sector by sector was impossible if the available money was chanelled into the in-patient service.

(e) The management of the Sutton Mental Health Team

The management of social services' Sutton Mental Health Team was unsatisfactory. Because the team manager lacked experience and expertise in mental health, she interpreted her role as chairing team meetings and fulfilling a 'strategic position in the team', with all operational matters being delegated to the assistant team manager. She justified this by saying that he 'was good at dealing with the crisis stuff and bits of paper.' A system of self-allocation generally operated 'which meant that the two baskets — one for Erdington, one for Sutton — were piled high … A social worker would come in, say that he was ready to take a case, and look through the basket. We were getting incoming calls constantly asking when cases were going to be referred … Some of the cases had been in the basket for months.' At a later stage, the the team did hold their own social services allocation meetings, but without health service personnel. Throughout the period reviewed by us, therefore, social services had its own duty and allocation system and accepted referrals from any source, and this bypassed the trust's CPA procedures.

SUPERVISION ARRANGEMENTS

32. The absence of a care programme and risk assessment in Mr Hamilton's case should have been noticed and remedied during his social worker's supervision.

33. At the time the social services team had no clear supervision procedures in place, although it was universally understood by team members that social workers should receive monthly supervision.

34. Monthly supervision often did not take place because of workload pressures. There could be lengthy intervals between supervision sessions, so that it was not unusual for six or seven months to pass without a supervision meeting being held.

35. The supervision that did take place was ineffective in terms of identifiying non-compliance with the care programme approach and the lack of any systematic risk assessment.

36. The managers who supervised Mr Hamilton's social worker did not query the lack of a care plan, risk assessment or CPA procedures. He received only passive supervision.

37. Supervision notes were often not shared with the caseworker, who was not required to sign and confirm the accuracy of the record.

SUPPORT FOR THE BEREAVED

38. After Mr Hodge's death, his family were supported by the police and victim support services. They did not receive any organised support from the NHS trust or social services.

SUPPORT FOR MR HAMILTON

39. Mr Hamilton was remanded in custody following Mr Hodge's death. On 22 July 1999, his behaviour in prison was described as being as 'very bizarre', and he needed to be urgently reviewed by a psychiatrist. This did not take place for seven months, and Mr Hamilton remained 'on normal [prison] location' for the whole of this time.

SUBSEQUENT PROGRESS

40. A CPA co-ordinator has been appointed across north and south Birmingham. He has brought about noticeable improvements, although work remains to be done.

41. There has been a considerable improvement in multi-disciplinary working in Sutton and Erdington. This improvement was universally acknowledged across organisational boundaries and by professionals at all levels. The City Council's Senior Service Manager for Mental Health (who was variously referred to as the 'specialist mental health lead officer' and as the 'mental health director') started work in August 2000. She has made an extremely positive contribution in this respect, and comes away with much credit.

42. There is now more multi-disciplinary working; better integration of health and social services teams (although there are still no integrated management structures, and separate case notes and forms are still kept); greater functionalisation of services (although some are not yet wholly effective); clearer CPA processes (although they are still not integrated with care management); and coterminous health and social services boundaries.

43. We were assured that the supervision format is much tighter in terms of case management. It involves discussing each case and any problems with them. Social work standards have also been developed that involve examining files, the quality of the file, and factual information that has been collected.

2 — FINDINGS CONCERNING MR ABDUL REHMAN

We accept that Mr Rehman's personality and behaviour, and the unhappy state of the marriage, cannot be understood only in terms of severe and enduring mental illness.

We do not believe, however, that Mr Rehman would have killed his wife had he not had a serious and enduring mental illness.

In the first place, his mental illness was a significant factor in the breakdown of his relationship with his wife, and in his treatment of her.

In the second place, it seems that his illness caused him to have quite explicit paranoid thoughts concerning his wife.

In the third place, he 'had a serious medical illness to the point that he had lost touch with reality'.

In the fourth place, it is likely that his severe and enduring mental illness contributed to his affect, and undermined the degree of self-control that he was able to exert in relation to his thoughts and actions.

MENTAL HEALTH ACT ISSUES

44. Mr Rehman's conveyance to Highcroft Hospital on 22 January 2000, and his admission and detention there, were unlawful. This is because an application made under section 2 confers authority only for the patient's conveyance and admission to the hospital named in the application (in this case, Newbridge House).

45. Because the section 2 papers were sent ahead to the hospital, the approved social worker who conveyed him to Highcroft Hospital was not in a position to verify that the application was properly made out and that the conveyance was lawful.

46. After the section 2 application had been made, at around 7.30pm on 21 January, it took 27 hours to take Mr Rehman into custody and to convey him to hospital. The evidence indicates that Mrs Akhtar, and possibly other members of her family, were at significant risk of violence during this period.

47. The period of delay had four distinct stages: between 7.00pm on Friday 21 January 2000 and the early hours of Saturday 22 January 2000, the police were unable to assist with Mr Rehman's detention and conveyance; from the early hours of Saturday 22 January until noon that day, a bed was not available; between noon and 6pm, Mr Rehman was absent from the family home; between 6pm and 9pm, arrangements were being made for the police to attend the premises.

48. Admission would have taken place safely and promptly had the police been available to attend the statutory assessment which took place at 7.00pm on 21 January, at which time there was a bed available for Mr Rehman at Newbridge House.

49. The fact that the police were unable to provide any support for several hours during the evening of 21 January placed Mrs Akhtar, the duty approved social worker and the on-call psychiatrist in a difficult and dangerous situation. The predicament that faced the two professionals is one with which they and their colleagues are familiar.

50. It was known that Mr Rehman had been violent to his wife and that the situation was urgent for Mrs Akhtar. That the two professionals decided to try to deal with the situation without police assistance was understandable, selfless and courageous.

51. Whether in retrospect this was wise, as well as courageous and selfless, is a difficult question. On balance, our view is that it would have been better to have waited until the police were able to attend. Because the need to withdraw was anticipated, and there was no real prospect of Mr Rehman being removed from the home without police assistance, there was no clear advantage to assessing him before they were present. Bringing forward the assessment would not bring forward his removal from the premises, which was the event that would reduce the identified risk to Mrs Akhtar, and it might increase the risk by angering Mr Rehman, in addition to carrying a risk

for the two professionals themselves. Having given our view, with future practice in mind, we would emphasise that it is unfair to expect professionals to have to grapple with such a situation, and therefore also unfair to criticise them for grappling with it.

52. The approved social worker and the duty psychiatrist who assessed Mr Rehman did not have access to his previous hospital and social services notes. It is probable that they would not have visited Mr Rehman without police assistance had they been fully aware of his record of violence, which is another way of saying that they were unaware of the risks they were taking.

53. Similarly, the approved social worker who conveyed Mr Rehman to hospital had no background information other than that his admission had not taken place the previous evening. She was not told of the previous incidents of violence, and she did not have the admission papers with her, which summarised some of the known risks.

54. The section 3 assessment undertaken after Mrs Akhtar's death was not arranged until the 28th day of the section 2 period. As a result, it was impracticable for the approved social worker to consult the nearest relative before making the application.

NEWBRIDGE HOUSE

55. The building of Newbridge House and the establishment of a local home treatment team resulted in a reduction in the number of beds available to local residents from 44 to 20.

(a) Home Treatment Team

56. The home treatment team has an establishment of 13 staff, although 4.5 of these posts, that is 35%, were vacant at the end of November 2002.

57. Trust policy now is that there can be no admission to hospital without the home treatment team being involved. The current policy was criticised as being unnecessarily rigid.

58. Although general practitioners may still refer patients to the home treatment team out of hours, there is now a single point of entry to the service between 9am and 5pm. This is through the duty system operated by the local primary care mental health team. The primary care team performs a basic telephone screening and decides whether to refer the patient to the home treatment team. The new arrangements are not universally popular with GPs.

59. Some practitioners believe that community resources are not distributed equitably across the trust, partly because of a failure to appreciate the geographical demands and resources necessary to operate a home treatment service outside small inner city areas such as Ladywood.

60. The home treatment team often do not know whether Children & Family Services are involved with a household, and communication can be quite poor in this respect.

(b) Pressure on beds

61. The hospital bed pressures in north Birmingham are intolerable, because they compromise care and require staff to make decisions and compromises which they ought not to have to make.

62. It would appear that the in-patient units in south Birmingham experience similar pressures.

63. The pressure on beds has had significant consequences for patient care. There is evidence that the mental state and behaviour of the in-patient population has become more disturbed, so that for all or some patients the environment is less conducive to recovery; the bed pressures have led to some in-patients being discharged before this is therapeutically appropriate; graduated discharge, commencing with periods of weekend leave, is difficult or impossible; patients may be discharged before their section 117 after-care needs, and the risks involved in discharge, have been fully assessed and managed; a systematic, well thought through, care programme approach to patient assessment and discharge is at times impossible; transfers between hospital units for bed management reasons are a regular occurrence; patients may be transferred between hospital sites at short notice, including at night, without a full multi-disciplinary discussion and assessment of the risks; patients and their families are understandably upset by sudden transfers between hospital sites; there is a danger that the perception of what is an acceptable risk may become skewed over time

64. Some of the main causes of the bed pressures at Newbridge House are a lack of intermediate residential facilities that can provide fairly intensive care for people with longer-term mental illnesses; inadequate crisis facilities; inadequate bed numbers; and, underlying all these service gaps, likely under-funding and the commissioning arrangements.

(c) Other in-patient pressures

65. The in-patient staff at Newbridge House are also affected by a number of other pressures: in-patient units lack an adequate skill mix; the nursing establishment has five E grade staff vacancies, and has been operating with between three and five qualified nursing vacancies for some time; and the nursing team lack adequate opportunities to receive refresher training in important areas such as risk management (a problem that is, to some extent, also experienced by local assertive outreach and home treatment team members).

(d) Security arrangements

66. The security arrangements at Newbridge House are seriously inadequate.

MR REHMAN'S TREATMENT OUTSIDE HOSPITAL

67. After being prescribed antipsychotic medication on 3 March 1998, Mr Rehman refused to attend his follow-up appointment and it was decided not to follow him up.

68. Although he remained in regular contact with his general practitioner, he had no further contact with psychiatric services until 21 January 2000. There does not appear to have been any formal section 117 process during the period between March 1998 and January 2000, or any formal decision by the trust and the local authority that they were satisfied that he no longer required after-care services. Indeed, social services do not appear to have been involved in his care at all.

69. Nor is there any evidence that the care programme approach was implemented during this period, or that Mr Rehman had a keyworker.

70. We accept that Mr Rehman's delusional disorder did not respond to medication and that there was no effective treatment for it. Nevertheless, the fact that his condition was essentially untreatable also means that the risk of harm to his wife could not be managed or reduced medically.

71. The need for a more assertive approach should have been reviewed periodically during this period, and attempts ought to have been made by a keyworker — perhaps with or through the general practitioner — to assess the risks to his wife and the support that she, and their children, needed in order to cope with his behaviour. As it was, the onus was left on Mrs Akhtar to deal with or report problems that arose. This was unsupportive, and probably unrealistic, because she was at times effectively imprisoned in her own house, and there were social pressures on her not to report any deterioration in his mental state or behaviour.

72. Local general practitioners are invited to CPA meetings but do not always receive copies of their patients' care plans.

73. There continues to be local resistance to the care programme approach, in particular from psychiatrists, even though it was introduced as long ago as 1990.

MR REHMAN'S TREATMENT IN HOSPITAL

74. Mr Rehman's catchment area consultant at Newbridge House was on leave from 22 January 2000 until 31 January 2000, during which period Mr Rehman was in any case receiving his in-patient treatment at Highcroft Hospital.

(a) Medical assessment and treatment

75. No risk assessment was carried out, or risk management plan formulated, during Mr Rehman's stay at Highcroft Hospital. This is of concern because the admitting nurse recorded on the CPA admission form that there was a significant but stable risk of significant harm or violence to other people.

76. According to the Code of Practice, on admission all patients should be assessed for immediate and potential risks of going missing, suicide, self harm and self neglect, taking into account their social and clinical history. Individual care plans should include the measures required to manage the risk safely.

77. There seems to be a reluctance on the part of local psychiatrists to complete risk histories and assessments.

78. During the time that Mr Rehman's catchment-area consultant was on leave, another consultant was responsible for Mr Rehman under the holiday cover arrangements that had been agreed. This consultant cannot remember seeing Mr Rehman, which is not ideal but not unusual when the catchment area consultant is on holiday.

79. The consultant granted Mr Rehman escorted section 17 leave on 25 January. We do not think that this was appropriate given the history, and the fact that he had not examined Mr Rehman or assessed the risks involved in granting him leave.

80. Following his transfer to Newbridge House, Mr Rehman was comprehensively assessed by his catchment-area consultant, who had a background in forensic psychiatry. His consultant received a verbal report on him at the ward round on 3 February 2000; delayed granting leave, or any consideration of discharge, until the notes were available, and he had interviewed Mr Rehman and Mrs Akhtar; contacted Mr Rehman's wife and her solicitor, discussing

with them the court proceedings for a non-molestation order; having received the medical notes on 9 February, spent a great deal of time studying them, and much of the next two days on his case; interviewed Mr Rehman on 10 February, and spent an hour and a half on his case, even though he had more than ten other cases; interviewed Mrs Akhtar for an hour without her husband's knowledge, and obtained her consent to the grant of short periods of leave; and recorded the grant of section 17 leave and the conditions to which it was subject.

81. The completion of this assessment was severely delayed by the fact that Mr Rehman's medical notes were not available until Wednesday 9 February. This was some three weeks after his admission to hospital under section 2, during which period Mr Rehman was only seen once by a senior clinician, and then only briefly.

82. The prompt retrieval of in-patients' previous medical notes remains an on-going problem, although the situation has improved.

(b) The nursing assessment

83. Mr Rehman had two named nurses on the ward, neither of whom spoke his first language. Neither nurse made contact with Mrs Akhtar, who would have required an interpreter, despite the rift in the marriage. It was accepted that this was an omission.

84. The short, basic, nursing plan in Mr Rehman's hospital notes was not sufficiently developed. His first language was recorded on the Minimum Data Set for Acute Services form (MIDAS) as Urdu. The way in which his cultural and language needs were assessed by nursing staff was not recorded. The sections on the MIDAS form which are to be used to record any dangerous behaviour to others were left blank.

85. No discharge care planning was undertaken prior to 10 February, and there was no contact with social services, the local home treatment team or Mr Rehman's general practitioner.

86. Mr Rehman appears not to have benefited from a programme of recreational or therapeutic activities.

87. Despite the service of a non-molestation order, it is not clear that the relevant nurses on the in-patient unit were fully appreciative of the on-going risk of violence to Mrs Akhtar. They lacked an understanding of the history of domestic violence, in particular whether the recent violence was a single incident or part of a pattern of violence over many years.

88. The fact that the injunction had a power of arrest attached to it, and was therefore the most serious form of injunction, meant nothing to the named nurse. He read what it said 'from a nursing perspective'.

89. Mr Rehman's mild and deferential manner, and the fact that he kept to himself and was not a management problem, may have partially obscured the fact that his mental condition, which had not been treated, was essentially unchanged since the time of his admission. He was courteous and deferential to professionals, quiet and unaggressive in his manner. However, he was a quiet man with a long history of domestic violence and, based on the history, any violence he committed was likely to be against his wife.

(c) The decision to authorise section 17 leave

90. We believe that the decision to grant Mr Rehman section 17 leave was justifiable. Leave was only granted after a careful consideration of the patient's file, after a mental state examination, and after discussion with the person who both knew him best and was most at risk.

91. The risk of violence to Mrs Akhtar was managed in the same way it was when Mr Rehman had last been in hospital: by his compulsory admission and detention; the use of antipsychotic medication; the grant of short periods of leave before giving any consideration to extended leave or discharge; and court proceedings involving the use of a non-molestation order. It would not be just or appropriate to criticise the consultant for adopting the same strategy. Any criticism of him would be tantamount to berating him for the outcome, rather than the strategy.

(d) The decision to allow Mr Rehman section 17 leave

92. Once Mr Rehman's consultant had authorised short periods of unescorted leave, it was for the named nurse to decide whether leave should be allowed on any particular occasion, in accordance with the authorisation.

93. On this occasion, one of the named nurses says that he allowed Mr Rehman half-an-hour's unescorted community leave at around 7pm on 11 February 2000. However, the fact that a 999 call was made to the police by Mrs Akhtar's neighbour at 7.11pm, and that Mr Rehman must therefore have arrived home some minutes before then, suggests that he left the ward before 7.00pm. That this was so is borne out by one of the cleaners at Newbridge House, who says in her police statement that she saw him leaving the unit at about 6.45pm.

94. Mr Rehman's mental state was not assessed by a nurse before he was allowed leave shortly before 7.00pm on Friday 11 February. Whilst this is the norm in practice, we think that more care is required where an injunction is in force, there is a history of recent domestic violence, the patient has been in contact with his partner by telephone (in breach of the injunction), and the family home is nearby.

95. Two knives similar to that used to kill Mrs Akhtar were purchased from a shop situated close to the gate of Newbridge House, one on Thursday 10 February, and one on Friday 11 February.

96. The security guards remember Mr Rehman leaving Newbridge House on several occasions.

97. The prosecutor at Mr Rehman's sentencing hearing summarised the relevant facts on the basis that he had been absent from Newbridge House without leave when he killed his wife. This is said to have been simply an error on the lawyer's part. However, it adds to the general impression that the security at Newbridge House, and the management and recording of section 17 leave, need to be tightened.

LOCAL COMMUNITY ISSUES

98. Alum Rock is economically deprived area situated in the heart of Birmingham. The families of many of the people who live there originally came to England from the Indian sub-continent. Historically, a considerable proportion of its citizens seem to have found it difficult to access local health services.

99. Urdu and Punjabi are the two languages spoken by the majority of people in the local community. Mr Rehman's first language is Mirpuri. This is distinct from, but related to, the Western Punjabi dialect. Although Mr Rehman can communicate at a basic level in English he is far from fluent.

100. Mr Rehman and Mrs Akhtar spoke with his consultant in a language familiar to them, and they benefited from that. However, one disadvantage was that other members of the ward team were not parties to the interviews, so that his treatment plan, and the decision to grant leave, were not the result of a full multi-disciplinary discussion.

101. Mr Rehman was a very isolated figure within his own community and his mental illness was the most significant factor in his isolation, and sense of isolation, from other people. His isolation and loneliness extended beyond not communicating with nursing staff.

102. We accept that when a mentally ill person is very preoccupied with and troubled by his own thoughts, experiences and distress, and consequently is isolated, it is especially important that professional carers are able to discuss, sympathise with and assess those feelings in the patient's own language. This is commonsense — For it can hardly be claimed that an English-speaking person's sense of isolation would not be exacerbated by being detained in the company of Mirpuri-speaking patients; or that their experiences could be adequately understood and assessed by means of a conversation circumscribed by their understanding of Mirpuri. Nor could the significance of their experiences easily be understood by someone without a sympathetic understanding of the values and experiences which have shaped their personality development and goals in life.

103. It was suggested to us that trying to conduct a mental state examination or to nurse a patient in a language foreign to them is 'like operating blind'. The truth of this observation is, we think, inescapable.

104. The significance of what the patient is saying can sometimes only be appreciated if one is familiar with the social context within which their experiences have developed. Similarly, whether a service is relevant partly depends on the extent to which it is accessible to individuals, acceptable to them, and tailored to their needs. Again, this is virtually axiomatic.

105. Most professionals said that that they would welcome more help from support workers and healthcare assistants who can speak a range of local languages, so that patients are always assessed in their first language. At present, there is also an urgent need also for psychologists and specialist nurses who are proficient in the languages spoken locally.

106. There is a general acknowledgement that the trust's services ought to be able to meet the cultural and linguistic needs of the local population but it lacks the resources and personnel within its teams to meet the need, and there is a lack of commitment in some quarters.

107. The trust audited the competency of the services which it provided to South Asian people and the results were 'very depressing'. The recommendations of the audit panel have mostly not been implemented, mainly because of issues relating to resources and selective recruitment.

108. Recruiting qualified nurses with Asian language skills has been very difficult.

109. Recruiting qualified nurses from abroad is seen as objectionable on ethical grounds; and, in any case, there are major cultural differences between the South Asian people living here and in South Asia.

110. The trust and University of Central England have developed a scheme which enables nursing assistants to move on to nurse training, and a number of people will qualify this year as a result of that initiative.

111. Interpreting services have improved. However, obtaining an interpreter is often very difficult when a person has to be assessed at short notice, particularly out of hours.

LEARNING DISABILITY ISSUES

112. Although Mr Rehman was in contact with local mental health services for many years, whether he has a learning disability remains unclear.

113. The possibility that he is mildly autistic or has Asperger's Syndrome was also canvassed, but as with the possible existence of a learning disability, never comprehensively investigated.

114. On the one occasion that Mr Rehman was referred to a consultant in learning disability psychiatry, the interview was conducted through an interpreter and the assessment was not completed. The provisional 'impression' reached on that occasion is of little assistance.

115. Although there is no evidence that Mr Rehman has a learning disability or other ancillary condition which impinged on the treatment and management of his mental illness, or the management of his domestic violence, this lack of evidence may be nothing more than evidence of lack of investigation.

116. The possibility that Mr Rehman has a learning disability or a developmental disorder ought to have been comprehensively assessed at some stage during his lengthy involvement with the Northern Birmingham Trust. The fact that it did not happen was not unusual. It is relatively uncommon for mental health services to obtain an opinion from a learning disability psychiatrist, and the interface between the two services is 'worse than average in Birmingham':

117. There are no culturally-specific services: 'some account is taken of their cultural needs but it is not massively developed as such.' The standard IQ test is is administered only in English, although in India modified tests in some local languages are available. The local services do not have access to an Urdu-speaking specialist in intelligence testing.

118. We were informed that each service feels under-funded and tends to protect its own beds and resources. This is unfortunate because people on or near the borderline of the two services would benefit from more sharing of services.

119. It is not only NHS mental illness and learning disability services that are not well co-ordinated. Health and social services are not well integrated.

DOMESTIC VIOLENCE

120. Mrs Akhtar's husband made her life a misery, and it was to her great credit that she was unwilling to endure his violence and took court proceedings.

121. Violence within the family is wholly unacceptable. It cannot be condoned on any grounds, and we are sure that most local people local will be appalled by the behaviour towards local women described in this report.

122. We were told that it is not uncommon for domestic violence within the local Muslim community to be conceptualised in terms of the man 'being harsh to his wife', rather than as criminal assault; and that there is 'quite a lot of work to do in terms of protecting women in the Alum Rock and Washwood Heath area.'

123. Having regard to the evidence received by us, this last observation can only be understood as an example of dramatic understatement. The present situation ought not to be tolerated.

124. The Reducing Domestic Violence Project was established in November 2000. It was set up with Home Office funding, following research in Sparkhill and Sparkbrook which showed that Asian women were least likely to report domestic violence to the police. The evidence that received from the project was to the effect that: domestic violence within the local Muslim community remains a taboo subject; many local women who suffer from domestic violence are concerned about bringing shame on their families. They are afraid of being stigmatised, and of being branded as loose women. They are also fearful of the repercussions for them and their children; many local women who suffer from domestic violence and wish to take action lack family support; there is immense pressure on woman who are suffering violence to remain within their family; and language barriers mean that the police may not be able to understand 'what is going on in the house' when they are called to deal with a report of domestic violence.

125. We were greatly impressed by the Reducing Domestic Violence Project. It is well organised and it offers a range of important, well-thought out, services to local women.

THE TRUST'S OWN REVIEW

126. The conduct of the trust's own panel review was criticized by many of those who attended it. Some of them felt intimidated and left with the impression that the panel were seeking to apportion blame for what had occurred. It was also felt that the internal review report focused on individual or team failures, even though many of these were 'track-backable' to weaknesses within the trust

127. It was unfortunate that the trust's own review report was shared with Mr Rehman's consultant psychiatrist but not with the other professionals who were involved in his care and interviewed by the panel.

128. The effect of this omission was that the findings and recommendations were not disseminated to the professionals whose practices were under review, and they were not asked to address the issues identified by the panel, or to contribute to the formulation of an action plan. Nor were they in a position to comment on the accuracy of the panel's findings.

3 — RECOMMENDATIONS

Front-line practitioners have been through a difficult time and morale is quite fragile. Consistent with the national picture, there is a weariness about the constant reorganisation of service structures and the proliferation of guidance issued to staff.

There is now a risk that the development of primary care trusts, the creation of a single mental health trust across Birmingham, and the introduction of a new Mental Health Act, may lead to a further loss of focus on those professional practices that are basic to providing safe and effective services on a day-to-day basis.

A period of consolidation is desirable and it would not help for us to devise a raft of recommendations. The most useful contribution that we can make is to try to help staff ensure that common professional standards and skills are preserved.

We believe that the basic professional standards, tools and skills include those set out in the following table:

CORE STANDARDS AND SKILLS

Resources	It is obvious that resources must match expectations and planning. In a well-managed service, the injection of additional resources will improve the service that is provided. In an inadequately resourced service, much of what follows will not be practicable because of the limitations on practitioner time.
Assessment	Assessment is the process of collecting information relevant to the diagnosis, management or treatment of an individual's condition. A lack of thorough assessment, resulting in an inadequate care plan, reduces the chances of a satisfactory outcome for the patient and their family. Here, it seems obvious that a patient can only be adequately assessed, and family members can only provide information valuable to the assessment, if they are fluent in the language used for the purpose.
CPA and care plans	The benefit of being systematic is to ensure that clients do not 'slip through the net' because of competing demands on professional time. A simple system, such as the care programme approach, is a good method for ensuring that community patients have a care plan, that they are supported, and that any risks associated with their illness are assessed and managed in a planned way. It also helps to ensure that changes of circumstances, and individual professional judgements or omissions, are noticed and discussed before they have unfortunate or tragic consequences.
Admission processes	Everyone would, we think, agree that it is desirable that mental health professionals undertaking Mental Health Act assessments can rely on police attendance and support, and that in-patient services should be able to admit patients who require admission without significant delay.

Risk management	Where the known risks are serious enough to justify depriving an individual of their liberty, it is prudent to assess their mental state and the likelihood of harm occuring before allowing them to leave the place at which they are being detained.
Domestic violence	Violence within the family is unacceptable and is not to be condoned on any grounds. Most local people will be appalled by the behaviour described in our report.
Security	It is more difficult to provide good quality care in an insecure or unsafe environment, and more difficult to retain nurses.
Learning disabilities	Mr Hamilton, Mr Hodge and Mr Rehman were all thought to have both a mental illness and a learning disability, yet none of them was assessed by learning disability services. That this should be typical locally is, fairly evidently, undesirable.
Training	If the key to improving services lies in recruiting and training good staff, and then utilising and developing their professional expertise and judgement, training is extremely important. In particular, training that improves practitioners' assessment skills (whether that is nursing assessment, risk assessment, learning disability assessments or CPA assessments).
Team/Joint working	Patient outcomes and staff recruitment and retention are likely to be better if the different professions and services work together, and rivalry and conflict are kept to a minimum.
Good management	The primary function of NHS and social services bodies is to provide a service to members of the public. Therefore, the primary function of NHS and social services managers is to ascertain from the staff what facilities and support they require to deliver the service and then to seek to provide it for them. To this extent, management practice should be facilitative and 'bottom-up'.

RESOURCES

We understand that the newly-established Birmingham and Solihull Mental Health NHS Trust is required to 'save' £8 million over the next three years. If this is so then it is a matter of some concern given the service deficits noted in our report.

We were told by many people that NHS mental health services in north Birmingham have been under-funded for many years in comparison with demographically similar areas, possibly by as much as £8 million per annum.

The Health Authority's mental health expenditure as a percentage of secondary care expenditure was said to be only half that in Lambeth, Southwark and Lewisham, and about 3% less than the London average. A significant proportion of it has been invested in local forensic services.

A recent survey found that the proportion of Birmingham City Council's total budget allocated to social services was the second lowest in comparison with other 'core cities'. The council spent just over 5% above its Standard Spending Assessment, which was at the lower end of the scale (some core cities spent over 20% more). It also spent proportionately more of its budget on older people and physical disabilities and less on mental health and learning disabilities.

On the evidence, it seems that it must be true that either there are insufficient beds to meet local needs or insufficient community resources. The insufficiency is clear, and the only point of doubt is whether it is the in-patient service, community resources or both that are inadequately resourced.

If it is true that local services are under-resourced, this can be rectified or the standards and targets expected of front-line staff reduced in line with investment. In the latter case, front-line staff will at least have the benefit of knowing that the PCTs and the City Council accept that the service deficits are funding-related.

If the perception that local mental health services are under-funded turns out to be misguided then discussion can focus on how the monies are spent, how resources are distributed, and why the pressures we have noted exist despite adequate funding.

Recommendations

a. **That the Strategic Health Authority, the trust, the PCTs and Birmingham City Council forthwith jointly instruct an independent organisation such as the Audit Commission to examine the level of expenditure on mental health services in Birmingham, both at present and in the recent past. This financial review should involve comparing NHS and social services expenditure on mental health services with that expended by a selection of authorities in other urban areas with a similar demographic profile. The organisation instructed should have free access to all relevant financial information possessed by the instructing bodies. No pressure should be brought on the organisation to reach a particular view. Only factual inaccuracies in the draft report should be corrected or amended. Such inaccuracies aside, the instructing bodies should commit themselves in advance to accepting the findings set out in the report, and any conclusions concerning the level of expenditure that is now necessary to correct and make good any shortfall in current or recent expenditure. The report should be published and made readily available locally.**

b. **Having regard to the pressure on beds in Birmingham, that the Health Authority immediately takes advice from the local trust and from social services mental health team managers as to the number of additional local in-patient beds, crisis house facilities and intermediate residential facilities that are required in order to reduce bed occupancy to an average level of 90% across the trust; and that the Health Authority then attempts to broker an investment agreement between the local PCTs and Birmingham City Council that addresses the realities of the situation. This process should be transparent, and the Health Authority should publish a full and fair summary of the advice tendered by the trust and mental health team managers and of the investment decisions.**

c. **That all local mental health services must have access to crisis teams and crisis residential alternatives to hospital admission, and that additional funding should be made available for this.**

Response of Local Mental Health Services, including any Action Plans

(a)	**A complete review of the financial position of Birmingham & Solihull Mental Health NHS Trust (BSMHT) has been undertaken as part of a Redesign and Recovery Plan commissioned and subsequently accepted by Birmingham and The Black Country Strategic Health Authority (BBCSHA).** **Our Local Delivery Plan demonstrates a £9.5 million under-investment by our five partner Primary Care Trusts (PCT's). This is being addressed. We do not necessarily feel a further comprehensive review would be appropriate at this moment in time, having confidence that we can continue to innovate and improve services within the current overall financial framework.** **However, we welcome the recommendation to ensure that Birmingham is not under-funded in comparison to other similar inner-city areas of the UK and will undertake a piece of work internally, in the first instance, to examine this issue. This will be expedited by our new Financial Director. If we then believe that there is a prima facie case of local comparative under-funding, we will commission an independent examination of the issue of the kind suggested.**	
	Personal Accountability	Finance Director, BSMHT
	Time Line	March-September 2004
(b)	**BSMHT has commissioned the Northern Centre for Mental Health to assist in a complete review of its bed management procedures.** **The strategy for reform is as follows. We have appointed a programme director for in-patient services who will represent the bed management issue to the Clinical Practice Sub-Committee of the Clinical Governance Assembly of the Trust which, in turn, will formulate detailed protocols and policies for the operationalisation of an improved service across the organisation.** **The programme director has begun to convene inpatient forums within each of the Trust's nine directorates, which will ensure local membership and representation, and will also form a competent acute care forum. The inpatient forums will advise on local issues. The acute care forum will have a wider remit, addressing standards of inpatient care across the organisation, most specifically those standards which are manifest in the Trust's CHI action plan, and committing these standards to a process of clinical audit (the strategy for and infrastructure of which has now been established). Service user and nursing representation will be assured at both inpatient forums and the acute care forum.** **The Medical Director has also commissioned an internal review of catchment area populations by way of which population figures will be subject to adjustment in respect of morbidity and then related to Royal College guidelines for bed availability to assess whether an expansion of the 800 or so beds currently in existence across the organisation is required.**	

	A system for the management of 'outliers' has been formulated by the Medical Director and agreed with consultants. The whole system assessment will also be affected by recommendations which arise out of ongoing clinical reviews of other serious untoward incidents, such recommendations now falling within the remit of a newly appointed Associate Medical Director for Patient and Public Safety. **Conclusions arising from the entire process will be shared with our partner PCT's and BBCSHA to ensure that the expanded and refreshed knowledge base in respect of inpatient care across the organisation is translated into action locally and at the front line.**	
	Personal Accountability	The trust's Programme Director, In-Patient Services, together with its Medical Director and the Director of Operations.
	Time Line	April-September 2004
(c)	**Two crisis teams have been launched since July 2003. In addition, three new crisis houses have opened using monies from the Supporting People Initiative. The Home Treatment Teams, who provide the bulk of crisis interventions, will similarly be represented by a Programme Director (to be appointed) who will also report to the Clinical Practice Committee of the Clinical Governance Assembly of the Trust.** **It is important to note the distinction between inpatient services and crisis residential facilities, however. The latter must be viewed as an adjunct to a community treatment package, and while such facilities may reduce risk (by, for instance, mitigating social anomie or temporarily resolving homelessness) they cannot enhance safety in the same way as observation policy may do on an inpatient ward. Therefore, we do not accept that crisis facilities represent an alternative to hospital admission.**	
	Personal Accountability	Programme Director, Home Treatment Team
	Time Line	February 2004, on-going.

ASSESSMENT

Although Mr Rehman received a nursing assessment and had a nursing plan, they were not individualised. His nursing plan consisted of standard clauses, and it reminded us of a legal document created from a book of precedents, *e.g.* '(1) Nursing staff to build a therapeutic relationship with Abdul based on respect and trust.'

His in-patient notes were full of photocopied forms and checklists, such as the MIDAS form. Since most of these were only partially-completed, their completion can only have been regarded as a chore, and they added nothing to the quality of his care.

In general terms, we think that it suffices that a nurse completes and periodically revises an individualised nursing assessment and nursing plan (which includes

assessing and managing any risks associated with the patient's ill-health), and keeps the nursing notes up-to-date.

Although there was a general acknowledgement that the trust's services ought to be able to meet the cultural and linguistic needs of the local population, it lacks the necessary resources and personnel, and there has also been a lack of commitment in some quarters.

Recommendations

d. **That ward managers meet with the Director of Nursing in order (a) to review the range and quantity of documentation that ward nurses are required to complete, with a view to reducing the volume significantly and simplifying the demands made of nurses; and (b) to devise a simple way of ensuring that nursing care plans are individualised.**

e. **That, in the case of in-patients, each patient's named nurse is formally responsible for obtaining all of the patient's previous hospital notes, and that, in the case of community patients, the keyworker is made responsible.**

f. **That the local PCTs, the Health Authority, the local mental health trust and Birmingham City Council agree an action plan for the delivery of primary and secondary mental health care to South Asian communities that is based not on the notion of 'an average citizen' but on the diversity of the services that are required. And that this action plan fixes dates for achieving the following objectives:**

(i) The assessment of people referred to mental health services

- ☐ **Arrangements must be made *as a matter of urgency* to ensure that all patients presenting with mental health problems are assessed in their preferred language.**
- ☐ **All assessments and care plans must take account of and include the significance of the person's ethnicity, culture, language, and religion.**
- ☐ **All assessments must include the individual, their carer and family members, supported where necessary by an interpreter, translator or advocate.**

(ii) Staffing

- ☐ **In order to improve assessment standards, communication and access to services, mental health services must employ more bilingual staff and interpreters, including Mirpuri-speakers.[24] Front-line staff who speak languages that are necessary to the delivery of local mental health services should be paid a significant increment for this valuable additional skill.**
- ☐ **All in-patient units and community teams must include support workers and healthcare assistants who can speak the range of local**

[24] '… there are many languages that have dialects within them, which are incomprehensible to each other. Catalán is not Castilian. Sylhetti is not Bengali. Mirpuri is not Urdu.' Institute of Linguists, National Register of Public Service Interpreters (NRPSI Ltd), A guide to commissioning excellent interpreting services, NRPSI Newsletter, 2001.

languages, so that patients can always be assessed in their first language. (This should be achieved within two years.)

- ☐ The initiative developed by the trust and University of Central England that enables nursing assistants to move on to nurse training needs to be expanded.

- ☐ An agreed proportion of 'space time and recovery workers' linked to assertive outreach and rehabilitation teams must be recruited from minority ethnic groups.

- ☐ A resident, qualified, interpreter who is fluent in languages relevant to the local community must be employed at Newbridge House. Their induction should include training in mental health, and local teams and wards should be able to access this person.

- ☐ The trust must employ a clinical psychologist who is proficient in the languages spoken locally, and if necessary pay a salary increment in order to achieve this.

- ☐ More minority ethnic staff must be appointed at all levels within all local service organisations, and these people need to be adequately supported and trained in their roles.

- ☐ Local people need to be encouraged to work in mental health services through on-going programmes that promote the opportunities locally, for example in schools and local Asian press and broadcasting outlets. The services must ensure and advertise the fact that facilities such as prayer rooms and menus which suit different religious requirements have been introduced in all professional settings.

- ☐ Employment workshops should be established for professionals from minority ethnic groups, where perceived obstacles to promotion can be discussed, as well as potential strategies to overcome them.

- ☐ The collection and publication of accurate, on-going, information from and about minority ethnic communities is necessary. Monitoring procedures are insufficient to identify unmet need, general patterns of use, and comparative service performance. Variations in consultation rates, referrals to specialist mental health services, and the use of psychotropic drugs for different ethnic groups should be audited every year.

g. That leaders from Birmingham's Muslim community are fully involved in the development of this action plan, and that they are represented on any committees that are established in connection with the development and implementation of the action plan. For example, representatives of the Central Mosque; the Confederation of Sunni Mosques (Midlands); the UK Islamic Mission (Midland Zone); and the Islamic Society of Britain (Birmingham)

h. That Islamic patients are treated in accordance with the Islamic Code of Medical Ethics.

(d)	**This will be undertaken by the trust's Director of Nursing.**	
	Personal Accountability	Director of Nursing.
	Time Line	By September 2004.
(e)	**This will also be undertaken by the Director of Nursing, in conjunction with the trust's Medical Director (in his role as the trust's 'Caldicott Guardian').**	
	Personal Accountability	Director of Nursing.
	Time Line	By June 2004.
(f)-(h)	**The trust has created a Director of Diversity, as one of a number of actions manifesting its commitment to meet the needs of a diverse community.** **We have liaised extensively with local community leaders, users and carers in order to inform the development of the Trust's Race Equality Scheme and Diversity Strategy. The former will enable us to meet our statutory obligations under the Race Relations Amendment Act and will also facilitate the incorporation of the findings of the recent Sainsbury Centre commissioned report "Breaking the Circles of Fear"; the DoH commissioned report "Inside Outside" and the NIMHE commissioned report "Delivering a Framework for Race Equality" into our Race Equality Scheme.** **The Trust has created a diversity strategy which, while recognising race quality as a top priority, also details the work programme to address the other facets of equality work that is gender, disability, sexual orientation, age and religion.** **Specifically, and in the first instance, the Director of Diversity will co-ordinate a meeting between herself, the Diversity Directors or nominal leads of each of the five PCT's, Birmingham City Council (BCC) and BBCSHA. The assembly will include BSMHT's newly appointed Director of Organisational and Workforce Development. BSMHT's Asian Services capability will be involved at the Director of Diversity's discretion.** **Such is the diversity of languages spoken in Birmingham that we cannot realistically undertake to have members of staff such as Clinical Psychologists fluent in all of these languages in a two-year time span. We will, however, review which languages are most commonly spoken in Birmingham and prioritise action in respect of these.** **In respect of assessments in patients' preferred languages, we are ensuring that teams have a resource pack detailing the availability of local interpretation services. We are also developing a training module for mental health staff in respect of working with interpreters. Training on mental health issues will also be offered to interpreters with whom we work. We are in the process of exploring the potential for the Trust to develop its own "in-house" interpreting and translating service.**	

	We are at present developing a tender specification for an external agency to deliver mandatory cultural diversity training for all Trust staff. This training will also encompass issues around culturally appropriate assessments. **We are an active member of the Birmingham and Solihull Diversity Partnership whose main remit is to recruit to the Health and Social Care sector staff from local Black Minority Ethnic (BME) communities.** **We are currently engaged in a programme of community development work in the East locality wherein we meet with the local voluntary sector/community organisations and places of worship in order to raise awareness of mental health services in the locality.** **As part of this initiative we are organising a series of stakeholder events and mental promotion activities designed to identify local people who may be attracted to various posts in the locality. Our previous experience suggests that it is possible to recruit to unqualified posts and then mentor individuals to become seconded to the mental health nursing training programme.** **We are actively working with places of worship (for instance the Central Mosque) to advertise our vacancies through their publications and other networks. We recently held a stakeholder event with the BME community which attracted in excess of 400 people. A steering group has been formed to develop an action plan to develop the implementation of recommendations arising from the day.** **We will submit a bid to the Department of Health to become a national pilot site for the development and delivery of appropriate psychological services for all BME communities.** **With regard to diversity issues in inpatient care, we have commissioned a company to produce a video in Mirpuri Punjabi which will inform individuals about their hospital admission, the services they can expect and availability of advocacy. The transcript of the video will be transferred to cassette medium and made available to patients and their families and carers for their own use.** **PCTs have expressed an interest in replicating this across all localities. Ward environments are currently being refreshed to reflect the diversity of inpatients, including audio-visual resources, newspapers, positive images and provisions for prayer.**	
	Personal Accountability	Director of Diversity
	Time Line	By September 2004.

CARE PROGRAMME APPROACH

The care programme approach was introduced in 1990, and it is therefore hard to defend anything other than compliance with the scheme. All patients subject to the CPA should have an agreed, recorded, care plan that is periodically reviewed and, as

part of this, periodic risk assessment. That this is happening should be verified through supervision and CPA audits.

Because local consultant psychiatrists only act as the care co-ordinator in 2% of cases, we do not accept that the system has overwhelmed them with unnecessary paperwork.

Recommendations

i. **That each mental health team appoints a CPA convenor who, together with the team manager, is responsible for ensuring that all patients in contact with the team are (i) allocated to standard or enhanced CPA in accordance with national and local guidelines; (ii) allocated a care co-ordinator; (iii) receive a periodic review of their care plan and, as part of that, risk assessment; and (iv) have a crisis and contingency plan.**

j. **That it should be a disciplinary matter for a trust or social services employee (including a consultant) to refuse to act as a patient's care co-ordinator when required to do so by the local CPA convenor, or without reasonable excuse to fail to attend a CPA meeting arranged by their local CPA convenor.**

k. **That, provided community mental health staff make an adequate record of client examinations and interviews (in the patient's medical, nursing or social work notes, etc), keep their CPA documentation up-to-date, and complete any audit records required of them, they should not be required to complete any other documentation.**

Response of Local Mental Health Services, including any Action Plans

(i)	**All three partner organisations are committed to the operationalisation and ultimate effectiveness of the Care Programme Approach (CPA). We have recently devised and are currently launching new CPA documentation by way of a training road show and are working towards electronification of CPA by way of a major project which is currently underway with a completion deadline of 1 April.** **All aspects of the delivery of CPA will be subject to intense audit within the terms of reference of the freshly reviewed clinical audit strategy. In particular, the Clinical Practice Sub-Committee of the Clinical Governance Assembly has begun work on those recommendations relating to CPA which are present in the Trust's CHI action plan. For instance, the CPA lead officer has now been charged with the responsibility to ensure that each multidisciplinary team appoints a CPA convenor, as explicitly mentioned in this recommendation.** **The appointment of an Associate Medical Director for CPA reflects the Trust's commitment to the CPA agenda, the AMD and CPA lead officer working together to ensure that team leaders are adequately supported to require members of the multidisciplinary teams to undertake care-coordination roles (including consultants when and as appropriate).**

	Personal Accountability	CPA Lead Officer.
	Time Line	By September 2004.
(j)	**The CPA convenor will be suitably empowered by the structure described above to require the necessary involvement in CPA at all levels.**	
	Personal Accountability	CPA Lead Officer.
	Time Line	By September 2004.
(k)	**Care co-ordinators need to complete all sorts of documentation for their clients. The afore-mentioned improved CPA documentation provides enhanced scope for recording assessments but we will also require super-imposed risk assessment and management protocols and outcome measures (such as Health of the Nation Outcome Scales – HONOS) to be recorded. While we will explore every avenue available to us to reduce bureaucracy, there will inevitable be a number of records and notes, which care co-ordinators will be required to keep.**	
	Personal Accountability	—
	Time Line	—

ADMISSION PROCESSES

It took 27 hours to take Mr Rehman into custody and to convey him to hospital.

Admission would have taken place safely and promptly had the police been available to attend the statutory assessment which took place at 7.00pm on 21 January 2000, at which time there was a bed available for him at Newbridge House.

The predicament that faced the professionals was, and is, one with which they and their colleagues are all too familiar.

Recommendations

l. **That Birmingham City Council considers 'purchasing' a number of police officers for mental health services, who can assist staff in conveying patients to hospital and returning to hospital those absent without leave.**

m. **That Birmingham City Council discusses with the police the need for the police to establish a dedicated mental health team (in the same way that the police have a dedicated domestic violence team and a dedicated child protection team).**

n. **That detailed records, including a careful note of dates and times, are kept whenever an approved social worker makes an application and delegates the power to convey the patient to hospital. A form should be devised for the purpose, and it should be attached to the application and the report left on the ward. This should record the name and details of the patient who is to be conveyed; the person (ASW) delegating the power; the person accepting this delegation; where the patient is to be**

transported; a risk assessment; and that the delegating ASW has been told that the admission has been completed.

o: That the proportion of ASW assessments in each locality that result in an application being made under the 1983 Act, and the reasons for local variations, are examined.

Response of Local Mental Health Services, including any Action Plans

(l)-(m)	**Lead Officers for Mental Health Issues will shortly be appointed by both West Midlands Police (WMP) and BCC. Once these two individuals are in post, the trust's Medical Director and the Clinical Director for Forensic Services will meet with them in order to examine alternatives to current arrangements for conveying patients to hospital and other issues relevant to the joint working policies of all three organisations. This will cross reference to the work of an expert panel, convened by the Medical Director, whose role it is to assess all issues as they relate to out of hours mental services in Birmingham and Solihull including care pathways; on-call arrangements; and relations with police, GPs, A&E, social services and paramedics, and whose membership includes representatives from all of these partners. This will be an agenda item for the series of meetings planned with WM Police.**	
	Personal Accountability	Medical Director.
	Time Line	Dependent on WMP & BCC.
(n)	**A form of the nature suggested has already been devised, forwarded to the inquiry team, and implemented within the organisation.**	
	Personal Accountability	—
	Time Line	—
(o)	**This will be passed by the Medical Director to the Monitoring & Communication Committee of the Clinical Governance Assembly (MCC/CGA) of BSMHT with a view to routine monitoring, collation and interpretation of the data as suggested.**	
	Personal Accountability	Chair, MCC/CGA.
	Time Line	On-going.

RISK MANAGEMENT

Mr Rehman's mental state was not assessed by a nurse before he was allowed leave shortly before 7.00pm on Friday 11 February. Although this is the norm in practice, we think that more care is required where an injunction is in force or there is a history of recent violence (whether self-harm or harm to others).

Recommendations

p. **That where a detained patient has recently harmed themselves or others, or an injunction is in force, their current mental state must always be assessed and recorded by a qualified nurse before they are permitted any leave in accordance with their consultant's general authorisation.**

Response of Local Mental Health Services, including any Action Plans

(p)	**This recommendation will be implemented by the trust's Director of Nursing and monitored by the Clinical Audit Team in each of the Trust's nine Directorates.**	
	Personal Accountability	Director of Nursing.
	Time Line	From April 2004.

SECURITY ARRANGEMENTS

We have noted our concern, and that of staff, about the security arrangements at Newbridge House.

Recommendations

q. **That the security arrangements at Newbridge House, and the arrangements there for protecting the physical safety of staff and patients, are immediately independently reviewed.**

Response of Local Mental Health Services, including any Action Plans

(q)	**An internal review of the safety of all inpatient services (including Newbridge House) is currently underway and will now fall within the portfolio of the Programme Director for inpatient services to ensure that this dovetails appropriately with the complex strategy for review and reform outlined above. However, in view of the particular issues raised by the inquiry team in respect of Newbridge House, the trust's Director of Nursing, Director of Estates and a representative from User Voice will jointly commission an independent review of this facility.**	
	Personal Accountability	Director of Nursing and Programme Director, Inpatient Services.
	Time Line	By September 2004.

DOMESTIC VIOLENCE

Violence within the family cannot be condoned on any grounds, and we are sure that most local people will be appalled by the behaviour described in our report.

Recommendations

r. **That Birmingham City Council, the PCTs and the police should consider the need to establish a local control room staffed by Punjabi and Urdu-speaking operators for the purpose of dealing with police, ambulance and health calls from non-English speaking members of the community. This might involve non-English speakers dialing '888' rather than '999'.**

s. **That Birmingham City Council and the local PCTs provide additional funding to the Reducing Domestic Violence Project, so that it can provide a more extensive, city-wide, service.**

t. **That the section of our report dealing with domestic violence locally is copied to local religious leaders; and that the local authority, the Strategic Health Authority, the NHS trust and the PCTs agree a strategy for reducing domestic violence with local religious leaders that is based on a common understanding that such behaviour can never be condoned.**

u. **That the section of our report dealing with domestic violence locally is copied to the local civil and criminal courts.**

Response of Local Mental Health Services, including any Action Plans

(r)	**This recommendation addresses a somewhat broad (probably national) issue, which, in our opinion, is internal to the governance arrangements of the emergency services. However, BSMHT is now addressing the interface between mental health issues in general and the receipt of "999" calls through appropriate representation of the Trust at local Emergency Care Networks by the recently appointed Programme Director for Liaison Psychiatry in conjunction with the Expert Panel referred to above.**	
	Personal Accountability	Programme Director, Liaison Services.
	Time Line	April-September 2004.
(s)	**The Director of Social Care & Health of BCC is tackling the issue of domestic violence perpetrated against Asian Women through its Joint Crime & Disorder Partnership Board in the context of wider Governmental guidance in respect of the issue. There will also be dialogue between the SHA and the relevant departments of BCC. We collectively believe, for instance, that support for both victims and perpetrators of crimes should be forthcoming from agencies external to the trust as well as from within the trust.**	
	Personal Accountability	Joint.
	Time Line	On-going.
(t)	**A representative from social care, East PCT and the Director of Diversity have met with Central Mosque leaders to discuss issues relating to domestic violence in the Asian community. Further meetings are planned.**	

	Plans are in place to produce a video for Asian women on domestic violence issues and where they can find help. **With regard to the more general issue of domestic violence, the trust's Medical Director will ensure that the issue is placed on the agenda when he discusses various issues with the Mental Health Lead of the West Midlands Police, and he has set in motion the creation of another Expert Panel to address the issue of personality disorder. This panel will need to examine the arrangements for multi-agency public protection and will therefore subsume domestic violence within its remit.**	
	Personal Accountability	Service Director, East Locality, BSMHT
	Time Line	By May 2004.
(u)	**This will be expedited by the Director of Corporate Affairs, BBCSHA.**	
	Personal Accountability	Director of Corporate Affairs, BBCSHA.
	Time Line	By May 2004.

LEARNING DISABILITY SERVICES

The prevalence of learning difficulties in South Asians aged between 5 and 32 is up to three times higher than in other communities,[25] and it is particularly worrying that the possibility that Mr Rehman had a learning disability was not thoroughly investigated over so many years.

Recommendations

v. **That <u>simple</u> arrangements are agreed by the mental health trust and learning disability psychiatry services which ensure that patients are jointly assessed whenever one of them thinks that the patient would benefit from shared services.**

w. **That mental health and learning disability psychiatry services agree a joint clinical appointment at a senior level.**

Response of Local Mental Health Services, including any Action Plans

(v)	**We will form a Project Team to include suitable representation from South Birmingham PCT (providers of Learning Disabilities services across the City), Eastern Birmingham PCT (commissioners of Learning Disabilities Services), the Clinical Director for Learning Disabilities Services and the trust's Medical Director to resolve this issue.**

[25] The higher prevalence of learning difficulties in South Asian communities has been linked to high levels of material and social deprivation. These may combine with other factors such as poor access to maternal health care, misclassification and higher rates of environmental or genetic risk factors. See Ghazala Mir, Andrew Nocon and Waqar Ahmad, Learning Difficulties and Ethnicity, Report to the Department of Health.

	Personal Accountability	Medical Director.
	Time Line	By May 2004.
(w)	**The Project Team will also consider this recommendation, and the Medical Director will particularly ensure that a strategy is formulated which prevents patients with mild/moderate learning difficulties falling 'between two stools' (wherein the unacceptable situation arises that both generic services and learning difficulties services express reticence to take on the management of an individual, leaving that individual without a service).**	
	Personal Accountability	See above.
	Time Line	See above.

TRAINING

We noted that in-patient nurses (and, to a lesser extent, NHS members of community teams) do not have adequate opportunities to receive refresher and update training in important areas such as the care programme approach and risk management.

Recommendations

x. **That all frontline NHS staff, including consultants, are offered and required to attend care programme approach and risk management training during the next 12 months.**

y. **That a basic, rolling, training programme is provided for front-line NHS staff that includes mandatory training on the CPA and risk management, and for nurses training also on nursing assessment skills and care planning and review; and that their attendance is recorded in a register.**

Response of Local Mental Health Services, including any Action Plans

(x)	**Risk management training is already underway within BSMHT. It is co-ordinated by the Risk Management Committee of the Clinical Governance Assembly (chaired by the Director of Nursing and attended, once appointed, by the AMD for Patient & Public Safety). We aim to adhere to Departmental guidance in respect of risk management training (for example, all clinicians should receive refresher courses every three years). Training on CPA is also underway (see above) and will similarly be cyclical.**	
	Personal Accountability	Director of Nursing.
	Time Line	By September 2004.
(y)	**The rolling training will be subject to robust audit.**	
	Personal Accountability	Director of Nursing
	Time Line	On-going.

JOINT WORKING

The standard of joint-working has improved considerably, and we understand that there will be full integration at all levels by April 2004. A Section 31 Partnership Agreement was signed and implemented from October 2003. However, it may still be helpful for the trust and social services to agree a short, one page, concordat that formally commits all of their staff to working together, to seeking to ensure an equitable distribution of managerial posts, to sharing resources wherever possible, and to resolving differences of opinion through discussion.

Recommendations

z. **That the trust and Birmingham City Council agree a single management structure for mental health services, joint care programme approach documentation, and joint record-keeping.**

Response of Local Mental Health Services, including any Action Plans

(z)	**An integrated management system of the nature recommended is being developed and implemented across the organisation. As noted, a Section 31 Partnership Agreement was signed and implemented from October 2003.**	
	Personal Accountability	—
	Time Line	—

MANAGEMENT

We think that public service employees receive are in some respects less appreciated by their employers than persons working in the private sector, and that this has had an adverse effect on morale. There is no good reason why public authorities should not reward good working practices by means such as an 'employee of the month' award.

Recommendations

aa. **That managers of mental health services should seek to ensure that their employees are well treated and within resources that they receive those periodic rewards for good work, perquisites and other gestures of recognition that an employee of a non-public body of equivalent size and resources might reasonably expect to receive.**

bb. **That the trust and the social services authority devise simple procedures which ensure that, when a person in contact with either service commits homicide, the needs of the immediate family of both the deceased and the patient are ascertained, and they are supported.**

Response of Local Mental Health Services, including any Action Plans

(aa)	**A Staff Recognition Strategy and Human Resource Organisation Development Plan will be devised and then implemented by the Director of Organisational and Workforce Development and monitored through routine staff surveys.**	
	Personal Accountability	Director of the Workforce Confederation.
	Time Line	By September 2004.
(bb)	**BSMHT's Serious Untowards Incident (SUI) Policy has now been reviewed by the Medical Director in association with the Risk Management Sub-Committee of the Clinical Governance Assembly. The second draft is more concise, contains clearer protocols for reporting and includes components for identifying and meeting the needs of the immediate families of both the victim and the perpetrator.**	
	Personal Accountability	Medical Director
	Time Line	By October 2004.

4 — CONCLUDING REMARKS

We have reviewed the care and treatment of two people in north Birmingham. In the process, have received a great deal of evidence about the quality of the services they received and whether or not their care was typical.

We have tried to be fair to everyone involved in the review, and to ensure that our findings are based on what we heard. Many of the findings, and the recommend-tions that derive from them, thus represent messages from front-line staff and local people to those who commission and manage their mental health services.

The detail is to be found in our report. However, in general terms, there are five main messages. Firstly, local practitioners can and should be proud of the innovative mental health services they have developed. Secondly, the services available to local citizens whose families came to England from South Asia need to be improved, and this ought to be given high priority. Thirdly, the reorganisation of services, and the development of new services, has resulted in some loss of focus on those professional practices that are basic to providing safe and effective care on a day-to-day basis. Fourthly, great care needs to be taken to ensure that the development of primary care trusts, the creation of a new city-wide mental health trust, and the introduction of a new Mental Health Act, do not lead to a further loss of focus. Fifthly, mental health services in Birmingham appear to have been under-funded, and whether this is so should be examined by a reputable, independent, body.

We believe that the action plans that have been formulated in response to our recommendations are helpful, and that their implementation will benefit local services. We also believe therefore that some general good has come from the particular tragedies that were the cause of our review, and we hope that this fact will be a small comfort for the families of Mr Hodge and Mr Rehman.