The KB Inquiry Report

Report of the independent inquiry team to Kensington & Chelsea and Westminster Health Authority and the Royal Borough of Kensington & Chelsea Social Services.

September 1999

A report commissioned by Kensington and Chelsea Health Authority and the Royal Borough of Kensington and Chelsea Social Services Department.

Contents

	Page
Preface	1
Terms of Reference	2
Panel Membership	3
Introduction	4
The Homicide	6
Treatment and care received by Mr. B from South Kensington and Chelsea Mental Health Centre	8
Conclusions and Recommendations	25

Appendices

A List of Witnesses
B List of documents
C CPA Protocols
D Risk Assessment Procedure
E Chronology of events

Report of the Panel inquiring into the treatment and care of Mr. A. B

Preface

The panel wishes to thank all the people who contributed to the inquiry, in particular, those who attended and gave evidence either verbally or in writing (Appendix)

The panel would also like to thank Dawn Bishop, the Inquiry co-ordinator, for all her work.

We hope that this report will be of some assistance to all those who have been affected by the tragic event of 15th May 1998. We also hope that some lessons can be learnt from this report the recommendations of which will be of particular use to Kensington & Chelsea and Westminster Health Authority, the Royal Borough of Kensington & Chelsea Social Services and BKCW NHS Trust when planning and delivering services to those who are mentally ill.

The panel recognises that a culture of blame has sometimes prevailed in similar inquiries. We would therefore wish to state that we have carried out this inquiry without seeking or intending to attribute blame but rather to learn lessons, which we hope, can be used to improve services.

Terms of Reference

With reference to the incident which took place on 15th May 1998, to examine the circumstances of the treatment and care of Mr. A. B, by Riverside Mental Health Services and RBKC Social Services, in particular

1. The quality of his healthcare.

2. The extent to which Mr. B prescribed treatment was

a) documented
b) communicated appropriately within and between relevant agencies
c) complied with by Mr. B

3. His assessed risk of potential harm to himself or others.

4. The extent to which Statutory obligations and national guidance were complied with.

5. To prepare a report of the inquiry's findings and make recommendations as appropriate.

Panel Membership

Mr. Edgar Moyo
Social Services Team Manager
Non Executive Member of KCW HA
Chairman of the Panel

Dr. Philip Harrison Read
Consultant Psychiatrist
BKCW Mental Health NHS Trust
Medical Adviser to the Panel

Mr. Ken Coleman
Retired Assistant Director of Social Services - Westminster
Social Services Advisor to the Panel

Dawn Bishop
Inquiry Co-ordinator

March 1999

Introduction

Vincenzo Giannì (28)

This report was commissioned by Kensington, Chelsea and Westminster Health Authority and the Royal Borough of Kensington & Chelsea Social Services to investigate the events leading up to the murder of Mr V. G by Mr. A. B on 15th May 1998. The report examines the care of Mr. B prior to this event including, Health and Social Services procedures and policies, needs assessment and care management, Care Programme Approach procedures and implementation and other clinical practices in order to make a judgement whether or not the incident could possibly have been prevented and to learn lessons for the future

Mr. B is a thirty-four year old man who was in contact with Riverside Mental Health Trust Services from mid 1990 up until the time that the offence was committed on 15th May 1998. Mr. B was diagnosed as suffering from drug induced paranoid psychosis following his first admission to St. Mary Abbots Hospital in August 1990, but the diagnosis was changed to paranoid schizophrenia during his second psychiatric admission to St Mary Abbots Hospital the following year.

He has a history of drug and alcohol abuse, mostly cannabis but also other Class A Drugs such as cocaine and Ecstasy.

Background Information

A. B was born on 18th December 1964 in South Thailand. He has one older sister who lives in England and one stepbrother and two stepsisters who remain in Thailand.

Mr. B was brought up in Bangkok and he went to school in Thailand but is unable to give details of his education there. Mr. B's mother divorced his father prior to coming to Great Britain in 1973. Mr. B joined her approximately one year later, when he was nine years old.

Mr. B went to Henry Compton School in West London. He also attended a language centre two or three times a week to improve his English.

Mr. B left school aged sixteen with no qualifications. After leaving school, he went to Hammersmith and West London College for 2 years to study art, however he lost interest and did not complete the course.

Mr. B had a number of unskilled jobs after leaving full time education: - a kitchen porter at Victoria Station, a warehouse photographic assistant and a cleaner in 1996.

Forensic History

Mr. B has convictions for burglary, theft and a number of convictions for possession of cannabis: - 1983, 1986, 1991 and 1996. In 1996 Mr. B pleaded guilty to a charge of possession of cannabis, threatening behaviour and assault on a police officer and was given a one year Probation Order.

Drug and Alcohol History

Mr. B began using cannabis from the age of 14 and continued to use it on a daily basis. He also used a variety of other substances including LSD, amphetamines, Ecstasy and heroin.

Mr B had also used cocaine.

He began drinking alcohol excessively whilst at school and continued to consume alcohol, although not heavily.

Events leading up to Incident

According to accounts given to examining psychiatrists by Mr. B, whilst he was remanded in custody, and by his mother and friends, there is good evidence that he was suffering from a relapse of psychosis at the time of the offence and probably for some weeks before hand.

Mr. B woke early on Friday 15th May 1998. He ate and then went back to bed. He woke again at 11am having had an unsettling dream that caused him some distress. He went out to a pub, "Down the Ifield" where he had one pint of beer. He then went to another pub, "The Water Rat", where he had a second pint of beer. He did not feel

intoxicated, as he had eaten earlier in the day. Mr. B then went to Battersea Park where he met up with some friends. At the park Mr. B smoked some cannabis.

Mr. V. (E) G joined them in the park. Mr. B and Mr. G had been friends for a number of years. The group spent an hour playing football in the park. Mr. B felt that E was saying things that had a particular meaning to him and Mr. B was rather upset at these remarks. However, Mr. B did not mention these comments to any one else. Although he and E had spoken earlier in the day, Mr. B had become more and more concerned over E's remarks as the day went on. At this point he left the group and went back to "The Water Rat" pub. Mr. B felt that he wanted to hurt E because of the remarks. Whilst Mr. B was contemplating what to do, and wondering whether he ought to hit or hurt E, the others came to the pub and E sat directly opposite him. Mr B felt that this was a deliberate provocation and he left the pub almost immediately and went home. He began to look for a weapon with which he could hurt E. He searched for a stick but could not find one, but he did find a kitchen knife, and he went back to the pub. On his return to the pub, Mr. B ignored everyone else and instead made straight for E and stabbed him. His other friends tried to apprehend him but he managed to escape and went home. He was arrested at his home about an hour and a half later.

Psychiatric History and Record of Inpatient Care

Mr. B's mental health began to deteriorate in October 1989 at the age of 25. He had his first hospital admission from 27th June to 22nd August 1990 under a hospital treatment order of the Mental Health Act to St. Mary Abbotts Hospital. He was committed to hospital following his conviction on a charge of burglary. Mr. B responded fully to treatment and was discharged on haloperidol tablets 10mg at night, a neuroleptic antipsychotic medication. A diagnosis of drug induced paranoid psychosis was recorded.

He was admitted informally to hospital on 5th February 1991 following a trip to Thailand. He had ceased to take his medication and was found to be using cannabis heavily. He was brought to the unit by a friend who noticed that he had become increasingly confused and unhappy in the preceding weeks. It was noted that Mr. B's general appearance was dirty. He also appeared to be very tense and tearful and was unable to sustain coherent thought patterns.

Mr. B absconded from the ward on 6th February but returned voluntarily the next day. He was started on haloperidol 20mg twice daily. He later absconded from the ward again and went home and refused to return to the ward. He was eventually persuaded to return voluntarily. He was re-started on haloperidol and gradually responded to this. He agreed to take depot medication and a test dose of Depixol depot was given which did not cause any side effects. He was started on Depixol depot 40mg every 2 weeks.

He again responded fully to the medication and was discharged on 11th March 1991. After one month the haloperidol was phased out and he remained on Depixol injections as an outpatient. The dose was subsequently reduced to 40mg monthly, equivalent to approximately 2mg per day of haloperidol by mouth.

It was recorded by Dr. J. E, Registrar to Dr. R, that -

"It seems that this is most likely to be schizophrenic illness. There are a considerable number of symptoms strongly suggestive of it in the mental state examination. However, his considerable history of drug abuse both of cannabis and ecstasy still leaves the possibility of a drug-induced psychosis. The latter would have a better prognosis if he were to take no further drugs and then should not become ill again. However, in view of the fact that he has such a prolonged illness while in prison last time, it seems that schizophrenic diagnosis is more likely. Even so, the relatively acute onset and the presence of affective features and the preservation of personality suggest a relatively good prognosis. If he were to continue his depot medication, it is likely that he will have only infrequent relapses requiring admission."

In April 1992 he was changed from his Depixol depot medication, at his request, to Depixol tablets, the oral preparation of the same drug.

Mr. B continued to have regular outpatient appointments until his trip to Thailand on 6th May 1992. He did default on a couple of occasions, but on the whole he did attend at regular intervals.

On 17th September 1992 he was seen by Dr. R in the outpatient department. It was noted that he had recently returned from his second trip to Thailand and that he had stopped taking his medication. He was admitted informally and diagnosed with having a relapse of schizophrenia. Mr. B absconded almost immediately after admission but was brought back the next day and started on level 2 observations. Mr. B was given haloperidol 20mg twice daily but refused depot Depixol because of his apprehension about extrapyramidal side effects (tremors, abnormal facial and body movements, restlessness etc). He settled quite rapidly and was

discharged on 5th November 1992. His medication on discharge was haloperidol tablets 20mg twice daily and also procyclidine 5mg twice daily, an anticholinergic drug used to ameliorate neuroleptic induced movement disorders likely to result from this high dose of haloperidol. Haloperidol was later stopped and he went back on Depixol injections 40 mg fortnightly as an outpatient and this was reduced to 20mg fortnightly in March 1993, (equivalent to approximately 2mg per day of haloperidol by mouth).

Mr. B had no further inpatient episodes.

Mr. B continued to be seen in the outpatient department until December 1997. He missed his appointment scheduled for the 30th March 1998 and a routine follow up appointment was made for the 29th June 1998.

During the period that Mr. B received outpatient care, no formal risk assessment was carried out until his consultant prepared a psychiatric report in August 1996 (see below). Following the introduction and formal implementation of the Care Programme Approach (CPA) in South Kensington and Chelsea in about 1995, Mr. B was managed on the lower level (CPA Level 2) which did not require regular frequent contact or monitoring in the community, or multi agency reviews, only outpatient follow-up, in this case by a psychiatrist.

Contact with the RMO, Dr. A. H

Dr. A. H had been Mr. B's consultant from 1st May 1996. She was also Mr. B's key worker under the Care Programme Approach (CPA Level 2). Dr. H took over Mr. B's care from Dr. R who had been Consultant Psychiatrist at South Kensington & Chelsea MHU. Dr. H first came into contact with Mr. B on 29th August 1996 when she was asked to provide a psychiatric report for his court case in September 1996. He was to face charges of possession of cannabis, threatening behaviour and assaulting a police officer. Prior to this request for a court report, Mr. B had failed to turn up for 2 outpatient appointments. On 23rd April 1996 Mr. B did not attend his routine outpatient appointment and another appointment was made for 10th July 1996. However he also failed to attend this appointment and another appointment was made for 10th September 1996.

At this time, Mr. B was taking Depixol injections 40mg monthly and in addition 3mg per day of Depixol tablets which he took at his own discretion if he was late for his injections, which happened occasionally. Depixol injections were equivalent to approximately 2mg per day of haloperidol. The Depixol tablets were equivalent to approximately 3mg per day of haloperidol.

Dr. H was confident that Mr. B was taking the extra oral medication that he was being prescribed on an "as required" basis: he asked for the tablets and she also had the impression that all of the medication was being used because occasionally he did come in and ask for another prescription.

Dr. H saw Mr. B for an outpatient appointment again on 10th September 1996, following his being placed on a one-year probation order. She noted that he remained well and that his medication was not changed.

On 23rd December 1996 Mr. B attended an outpatient appointment with Dr. H. At this meeting he told Dr. H that although he had tried to cut down on his cannabis intake he was still using it at least every two days. He also told Dr. H that he had begun to feel "paranoid" and that people in the street were paying particular interest in him. This happened if he had used cannabis and also towards the end of the month when his Depixol injection was due. In an attempt to counter this Dr. H changed his Depixol medication from a monthly injection to an injection of 20mg fortnightly (equivalent dose of haloperidol unchanged at 2mg per day) and issued another script for 3mg Depixol tablets to be taken once at night, as required.

Dr. H met with Mr. B again on 7th April 1997. He told her that he was having regular meetings with his probation officer and that he was also smoking cannabis on a daily basis. He again mentioned that towards the end of the injection cycle he was feeling more paranoid. Dr H increased his Depixol depot to 40mg every three weeks (equivalent to approximately 3mg haloperidol per day) and told Mr. B to continue to take an additional 3mg per day Depixol tablets if required (also equivalent to approximately 3mg haloperidol per day). Dr. H discussed transferring his care to his local catchment area, however Mr. B informed her that he was considering moving back into Dr. H's catchment area and would prefer to stay with South Kensington & Chelsea MHU. Dr. H therefore did not transfer his care.

At this time Mr. B was living in accommodation in North Kensington having being relocated by Social Services. This meant that had Mr. B transferred his care to North Kensington his psychiatric input would have been provided by Parkside Health Trust and not by Riverside Mental Health Trust. However, it had been noted that Mr. B spent a great deal of time at his mother's flat in the South Kensington area

and so it was felt that as he had a local contact there was less of a priority to move his care from the south to the north of the borough.

Mr. B did not attend his appointment on the 30th June 1997, Dr. H noted that he did not attend for his outpatient appointment and made another appointment for 15th September 1997.

On 15th September 1997, Dr H saw Mr B again. He told her that he had been using cocaine and cannabis and that these were making him feel tense and paranoid. He also admitted to drinking one or two cans of beer a day. Dr. H advised Mr B to cease using these illicit substances. He continued on 40mg Depixol depot injections every three weeks and Dr H also issued him with another script for 3mg per day Depixol tablets for him to take at night, if needed.

Dr. H saw Mr. B in the outpatient clinic on 15th December 1997. He told her that he had been using less cannabis recently and that he felt a little better. He continued on 40mg Depixol every three weeks and also was issued with another script for Depixol tablets 3mg per day. Dr. H issued Mr. B with a sick note for a year and advised him to register with a GP.

Dr. H felt that Mr. B had been successfully maintained in the community for several years on a low dosage of medication with no relapse of psychosis requiring admission to hospital in the past five years. Given the fact that Mr. B was prepared to take additional oral anti psychotic medication as well as his Depixol depot, Dr. H felt that there was no strong clinical reason to increase his dosage of regular depot medication. Dr. H mentioned that in any case Mr. B would not agree to be maintained on higher doses of anti psychotic medication. On one occasion when this was suggested, he complained that the medication was affecting his sexual functioning.

Dr. H stated that she always carried out a full mental state examination whenever she saw Mr. B and always checked for delusional ideas and asked him specifically if he had been experiencing any auditory hallucinations, or other psychotic phenomena. Mr. B always denied having any of these symptoms and Dr. H's clinical impression was consistent with this. Dr. H noted that during his previous inpatient admissions, Mr. B was described as being floridly psychotic and thought disordered and clearly unwell. Dr. H noted that she had never seen him in this condition and stated that if he had been more ill, she would certainly have pressed for him to accept an increase in the dose of regular anti psychotic medication. However Dr. H agreed that the dose of Mr. B's regular maintenance anti psychotic medication was at or close to the minimal effective dose, given his regular use of cannabis and his occasional lateness with injections.

Mr. B did not attend his appointment on 30th March 1998, again Dr. H noted that he did not attend his outpatient appointment and made a follow up appointment for 29th June 1998.

Dr. H was aware that Mr. B had not attended for his Depixol injection on 3rd March 1998 as his name appeared on the list of depot defaulters at the following clinical review meeting. Dr. H only remembered seeing his name appear once on the defaulters' list.

However, Mr. B in fact missed two of his Depixol injections; one on 3rd March, which he later received on 10th March, and the other on 21st April, which was given on 28th April. Therefore Mr. B's name should have appeared twice on the depot defaulters' list in quite quick succession and on each occasion a letter would have been sent out ensuring that he attended for his Depixol the following week. If his name had appeared on the defaulters' list on two successive occasions, then this might have raised further concerns and a

member of staff might have been sent out to assess the situation. However apart from the "routine" assessment carried out at the depot clinic, this did not occur. It is worth noting that Mr. B was not quite up to date with his medication at the time of the murder. He had been late with two of his scheduled injections, and therefore he received only 3 out of 4 injections of Depixol that were planned during the ten week period preceding the offence. Since the effective dose of depot medication is a product of the amount injected and the frequency of injections, the average dose of Depixol delivered to Mr. B over this critical period would have been approximately 25% less than the intended dose which was already likely to be at or close to the minimal dose for an antipsychotic effect (see above).

CPN contacts since December 1997

Mr. B was seen in the depot clinic by Community Psychiatric Nurse (CPN) T. R from 9th December 1997 up until the time of the incident. CPN V. M, who up until this time had been administering Mr. B's depot medication, introduced Ms. R to Mr. B on 9th December 1997. It was noted that Ms. R would be taking over Mr. B's nursing care and would continue to monitor him during his three weekly depot clinic appointments. Ms R. noted that Mr. B appeared well with no abnormal thoughts or perceptions. She administered the depot injection and noted that his next injection was due on 30th December. Mr B attended for his depot on a regular basis until 3rd March 1998 when he missed his appointment. Ms. R sent out a standard letter requesting that Mr. B attend the clinic the following week. Mr. B attended the depot clinic the following week. He stated that he had got his dates mixed up and thought this depot had been due on the 10th and not the 3rd March. Ms R reiterated the importance of his attending the depot clinic on a regular basis and made another appointment for him to attend on 31st March 1998, which he attended. Mr. B did not attend his appointment on 21st April 1998. Again a standard letter was sent out to him and his name was recorded on the depot defaulters list. Mr B attended for his depot on the 28th April. He apologised for not attending his appointment the previous week as he had been held up in another part of London and could not get back in time to attend the clinic. His depot was administered and his next appointment was made for 19th May 1998.

The depot clinic

The depot clinic is split between three consultants' teams and each team has one CPN representative who administers depot medication to the patients under those consultants. The clinic operates in a manner that makes it difficult for a CPN to give the depot injection to their own team's patients. Patients are not issued with a specific appointment time. However, there is a stated time between 2 - 6pm and patients can attend within that time.

If a patient who was being seen by a CPN in the community attended the clinic, whoever administered the depot injection would feedback information to the relevant CPN. If a patient did not attend for their depot injection, their name would be put onto the depot defaulters list and this information would be fedback at the next Community Mental Health Team meeting and a standard letter would be sent out to the patient. If a patient was seen as being particularly at high risk and someone who needed to be followed up straight away, then a home visit would be made within that week. If patients were not seen as particularly high risk, then a standard letter would be sent in the hope that they would attend the following week. If they did not attend, following a letter being sent out to them, then a home visit would need to be done.

If a CPN had any major concerns regarding any of the patients that attended the depot clinic, these would be raised with the consultant the next day or written up in the Community Mental Health Team notes.

Following this serious incident, there has recently been a major review of the depot clinic, which was conducted by the clinical audit department from Riverside Mental Health Trust and also by an independent clinical nurse specialist. All users were interviewed in

order to get accurate user feedback as were various members of the staff, including the psychiatrist and social workers. The recommendations that came out of this review were that: -

- Community Mental Health Teams should be running their own clinics.

- Community Mental Health Teams should begin to look at ways to run the depot clinics from GP surgeries so that there could be more choice for users thereby ensuring that users do not always have to attend the depot clinic to get their medication. It was recommended that the teams begin to look at ways in which to implement this once a move to more permanent accommodation had been completed.

Community Mental Health Team

Prior to May 1998 when Community Mental Health Teams were introduced in South Kensington and Chelsea, the social work team was split into three hospital-based groups working with three different consultant psychiatrists. There were 2 social workers working in each consultant firm, making up a multi-disciplinary team, so there were three multi-disciplinary teams operating across the service. A multi-disciplinary team consisted of: - Social Workers, Community Psychiatric Nurses, a Consultant, Occupational Therapists and Psychologists. These teams would have met on a regular basis to discuss both inpatient and outpatient cases.

There are now three Community Mental Health Teams working across South Kensington and Chelsea. Two of the teams are temporarily based in a former old people's home close to the mental

health centre and the other team, Dr. H's Team, is based in the mental health centre, which again is a temporary measure. Before the Community Mental Health Teams were set up, staff worked as a multi-disciplinary team but they were not based at the same site.

Dr. H's team met twice a week to discuss inpatient and day patient and selected outpatient cases. At these meetings there would be a list of all patients and the team would discuss each patient individually. At the bottom of this list would be the names of patients who had defaulted the depot clinic. It was noted that Dr. H was resolute that everyone attended the team meetings. The meetings would consist of: -

A consultant psychiatrist

CMHT Manager

The CPNs

A social worker

Senior social worker

Senior House Officer

Occupational Therapist

History of contact with Social Services

Mr. B was referred by the Community Drug Team to the Psychiatric services in January 1990. He was allocated to Ms. M. H, Social Worker.

Ms. H was involved in Mr. B's discharge planning and monitored him after his discharge from hospital in August 1990.

It was decided that Mr. B would go and stay with his father in Thailand after he had been discharged. M. H discussed this with Mr. B's mother on 8th September 1990. It was noted that Mr. B was happy to go back to Thailand and on November 20th 1990 Mr. B's case was closed although Section 117 aftercare procedures were not formally lifted.

In February 1991, Mr. B was reallocated to Ms. H following a phone call from his mother. His mother was very anxious and advised that Mr. B would not attend hospital. It was decided that Dr. S would do a home visit on 5th February 1991. When he was readmitted informally to hospital he was assessed by Dr. R on 6th February 1991 and was then seen by both Ms H and another social worker. After contact with Ms H ceased in August 1991, Mr B was being seen in psychiatric outpatient clinic and at the drop-in sessions. Ms H noted that he appeared well. No social work follow up was arranged after Mr. B third hospital admission between September and November 1992.

In February 1995 Mr. B requested help from Ms. H with an application for disability benefits. It was suggested that he look at work opportunities and he was referred to "Meanwhile Gardens" employment scheme.

He made an application for a travel pass in July 1995 and social work contact ceased after this time.

In December 1997, he was contacted as part of a review of his travel pass entitlement and he was asked to attend for a reassessment. Mr. B was sent two appointment letters asking him to reattend for an assessment, however he did not attend on the given times. He did turn up at the office by chance one day, but Ms. H was on annual leave and he did not stay to see the duty social worker.

On 14th May 1998 Mr. B's case was closed for the second time. It was noted that he had not been in contact with the social work department despite letters being sent out regarding his travel permit entitlement. It was also noted that there was no reason to believe him to be unwell as he was regularly attending the depot clinic by bicycle.

Care Programme Approach and Care Management

The Care Programme Approach was launched by the Department of Health in 1991. Riverside Mental Health Trust and the Royal Borough of Kensington and Chelsea introduced their integrated Care Programme Approach and Care Management in 1997. The aim of this integrated policy was to achieve one referral, one summary care plan, one key worker and one review which would simplify the system for clients, carers and staff whilst enhancing the multi-disciplinary and multi agency ethos of the service.

RBKC at that time was working across two Health Trusts, Riverside Mental Health Trust and Parkside Health Trust. Parkside Health Trust at this time had 3 levels in their CPA policy, with level 1 being low level (simple) CPA, level 2 being medium level CPA and level 3 being the highest level. Riverside Mental Health Trust had 2 levels in their CPA policy with level 1 being the higher and level 2 being the lower.

Riverside's CPA policy applied to all patients except those who did not have a primary mental health problem and those who were seen exclusively in primary care.

Mr. B fell into CPA Level 2 (lower level, simple) category. This meant that Mr. B's keyworker was Dr. H, as only one clinician needed to be involved in the patient's care. The care plan would have constituted a letter from the psychiatrist to the GP. Outpatient appointments effectively represented CPA reviews and the maximum period between reviews of his CPA would typically have been six months.

It was suggested by all informants questioned that Mr. B would probably not have been put onto CPA level 2 if he had entered the service after 1997. Given the fact that Mr. B was on section 117

aftercare and that he was on depot medication, and therefore seeing more than one healthcare professional, he would have probably been put on a higher level of CPA under the new CPA Guidelines.

However it was felt that if Mr. B had been placed on a higher level of CPA he still might not have had any more contact with the service, if he had continued to make the same progress in the service, i.e. he continued to be fairly compliant with his medication, to attend his outpatient appointments and had no further incidents of violence. Then it may well have been that he would have been moved back down to a lower level of CPA after 6 months to a year.

Comments from Mrs. K - Mr. B's mother.

The panel member wrote to Mrs. K asking for her views.

Regarding the inquiry that has been issued by the B Inquiry Panel members in the case of Mr. A. B, first of all I did not follow up in the past as my English is very poor. Thus, I will answer the questions that have been translated.

a) Did you have any concerns or worries in the days leading up to the event?

Not much, but after the event I had very much concerns because I did not know what was going to happen next.

b) Did you feel that you were able to approach members of the Health Service to discuss these concerns?

I did not contact the member of the Health Services because I do not understand the English language particularly in listening and speaking.

c) How do you feel that you were treated by the Health Service both before and after the event?

I had a good feeling about treatment by the health service, especially after the event.

d) Is there any specific issue that you might relate to the panel that might help them in this inquiry?

There is no more comment.

Once again, due to my lack of English understanding, may I say sorry to you if I did not catch up with you the first time.

Yours sincerely,

N K

Conclusions and Recommendations

It seems likely that Mr. B's mental state had been deteriorating in the week prior to the incident. His mother had asked him to attend the mental health unit a few days before the incident, but Mr. B, fearing he would be admitted, decided to delay going to the unit.

Various members of the multi-disciplinary team expressed the view that prior to the murder Mr. B did not appear to pose any threats to himself or to others given his good compliance with his medication and his relatively good attendance record at the outpatient clinic. However on examining all the evidence, it is clear that Mr. B was not as compliant with his medication as believed, he did not always attend his outpatient or depot appointments and he did have a history of prolonged and frequent use of cannabis which exacerbated his feelings of paranoia.

The panel acknowledges that given the limitations imposed by the recommended practices, protocols and procedures in place and the resource available during the period leading up to the incident, Mr. B received the best possible standard of care from all concerned. Under these circumstances it does not seem that this incident could reasonably have been prevented.

The panel hopes that the following recommendations will go some way to improving the care of local people who suffer from mental illness and assisting those working with and providing services for people with mental illness to minimise risks of serious untoward incidents occurring.

Recommendations

Having considered all the evidence, both verbal and written the panel members would like to make the following recommendations: -

I. Services for patients with Serious Mental Illness (SMI) and Co-morbid Substance Misuse

In cases where substance misuse is a complicating factor in the management of SMI, the panel recommends that active steps are taken to encourage patients' involvement with drug misuse agencies that have specialist experience in dealing with dual diagnosis.

The panel also recommends that if possible, mainstream mental health services should make in house provision for patients with mental illness who also have drug or alcohol problems.

Patients with SMI and Substance Misuse dual diagnosis should be considered for higher level CPA

II. Patients with SMI and a history of violence

When an SMI patient has a history of violence, regardless of whether or not this is judged to result from their mental illness, the panel recommends that he/she should be out on the higher level of CPA for a period of at least 5 years following the last serious incident. Higher level CPA should involve direct or indirect monitoring of patient's mental state at monthly intervals or less. Placing patients on the Supervision register should be considered in these cases.

III. Section 117 aftercare

Section 117 aftercare should not be discontinued without formal agreement between the RMO and the social work care manager.

IV.Risk Assessment

A standardised, brief risk assessment should be carried out on all patients receiving specialist psychiatric services and should be reviewed periodically (e.g. annually). Patients on higher level CPA and Supervision Register should be subject to a more comprehensive assessment of risks.

V. Training

Staff should have regular training sessions in dealing with patients who present special risks or who have dual diagnosis

VI.Family Access

Better access to services should be made available to relatives of patients, especially to those relatives who speak little or no English, and those who are concerned about a patients risk to themselves and others.

The panel also recommends that relatives of patients should be allocated a link worker, especially in cases of families where English is not a first language. One member of the CMHT who is actively involved in the patient's care and treatment should be allocated to act as a link worker. The panel also recommends that the linguistic and cultural diversity of the family should be taken into account when nominating a link worker and also that the choice of the link worker should be sensitive to the family member's needs. Wherever possible the link worker should be the CPA Keyworker.