Independent Inquiry into the Care and Treatment of David Johnson

Commissioned by

Birmingham Health Authority

Mr T McGowran chairman

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Inquiry Team Members

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We should like to thank everyone who gave evidence and who spoke so freely to us which made our task easier despite the time lapse between the tragic incident and the inquiry.

We were sorry not to be in a position of extending our condolences to the family of Geraldine Simpson.

We are also indebted to Fiona Shipley and her colleagues for the efficient way in which they recorded and transcribed the evidence for us.

We would also like to extend our gratitude to the staff of Birmingham Health Authority for looking after all our needs whilst we took evidence.

Finally, the chairman would also like to extend his gratitude to Jane Mackay who not only served as an Inquiry Team member but also acted as our co-ordinator and whose organisational skills made light of the complex arrangements that are required in the establishment and management of an inquiry such as this.

CHAPTER 1 INTRODUCTION

On 17 August 1997 Geraldine Simpson fell to her death from a window of David Johnson's twelfth floor flat in Aston, Birmingham. On 13 May 1998 Mr Johnson was convicted of her murder by the unanimous verdict of a jury at Birmingham Crown Court. He is now serving a sentence of life imprisonment.

Mr Johnson, then aged 45, had had treatment on many occasions, probably since his early twenties, from a number of different psychiatric services throughout England. In or around July 1996 he took up residence in Birmingham and following a referral from his general practitioner, was accepted as a psychiatric patient by North Birmingham Mental Health Trust at its Small Heath Health Centre on 17 October 1996. However, his contact thereafter with the Small Heath teams was sporadic either because they were unable to contact him or because he chose not to have contact with them. His last contact before 17 August 1997 was with a locum Consultant Psychiatrist, Dr G Sidhu, who examined him for the purposes of a court report at the request of solicitors acting for Mr Johnson who was then facing a charge of theft of a motor car.

During our Inquiry we were faced with two principal problems, neither of which have we been able to resolve as we would have liked to do. Was Mr Johnson actually suffering from any mental illness at the time of the offence? We ask this because of the widely differing opinions of Mr Johnson's condition that we heard in evidence or of which we have read. Then, if the answer to this question was "yes", did that illness in any way contribute to the death of Geraldine Simpson?

His trial did nothing to assist us in either of these two questions. Mr Johnson pleaded not guilty to murder and did not offer to plead guilty to manslaughter. He continued to maintain his innocence when we saw him in Gartree Prison. Any question, therefore, of diminished responsibility within the meaning of Section 2 of the Homicide Act 1957 did not arise.

It is against this background that we have had to examine the care and treatment extended to Mr Johnson, albeit on the basis that it appeared that the staff in the North Birmingham NHS Trust, who were involved with his care, believed that he was suffering from a severe form of

mental illness. We are not, therefore, able to suggest whether or not Geraldine Simpson's death could have been avoided had any different action been taken by employees of the Trust.

Regrettably, we have not heard from any member of Geraldine Simpson's family. We did invite her three daughters, to speak to us about their mother and her relationship with Mr Johnson but they declined to do so. We do of course recognise that for them to have, in effect, to relive the events leading to their mother's death would be distressing and painful for them but we were left in something of a vacuum when we tried to see things from Mrs Simpson's perspective.

We do not know for certain, but the delay in holding this inquiry may have had some effect on the family and their wish not to be involved. We have been inquiring into events which took place some two years ago and it is difficult to escape from a sense of futility, almost, when considering events that occurred so long ago and which do not now appear to attract the level of public interest which they might otherwise have been expected to generate.

We were however, fortunate enough to be able to take evidence from most of those responsible for Mr Johnson's care and treatment in Birmingham except for Dr Sidhu and Dr S Hamid, senior clinical medical officer (SCMO). Both those doctors had left the country to take up posts abroad, but we did have the benefit of seeing copies of the reports they provided at the time of their examinations. Our narrative of events will be in two parts. The first deals with Mr Johnson's movements and psychiatric history up to 1996. The second focusses on the story of his time in Birmingham from 1996.

CHAPTER 2 SOCIAL CIRCUMSTANCES AND CONTACT WITH MENTAL HEALTH SERVICES PRIOR TO 1996

In view of the nature of David Johnson's lifestyle obtaining a reliable history of his early years was not easy. The best evidence was that he was born in High Wycombe, Buckinghamshire on 20 June 1952, the son of an Afro-Caribbean father, who was a member of the United States armed forces, and an Afro-Caribbean mother who came from Trinidad. It was not clear when, but at some stage in his early years he went with his family to live in Trinidad returning to England in his early teens, or possibly slightly earlier. He was then brought up by relatives in England whilst his parents moved around England, the USA and Trinidad. He appears now to have little or no contact with his parents.

He learned to read and write at school but left without any formal qualifications. He appears to have had unskilled employment in the past but during his time in Birmingham from July 1996 onwards he was unemployed, although he claimed to us that he was involved in teaching music to members of steel bands.

Over the years, he has moved about the country and has had liaisons with many women, including three marriages. He has seven children by six of them. He claimed to visit them in their different homes throughout the country.

When we saw him in Gartree Prison he presented as co-operative and very willing to talk to us, though this was probably more to do with what he thought we could do for him (i.e. get him out of prison) than for any other motive. He spoke rapidly in a strong Trinidadian patois and largely answered our questions without descending into what one of the psychiatrists described as "peculiar and often incomprehensible speech and thought patterns".

Although his involvement with psychiatric services began in his twenties, reportedly in 1978 after the break up of his first marriage, the medical records available to us begin substantially in 1984 in Milton Keynes.

1984

In Milton Keynes, Dr J S Price, a Consultant Psychiatrist, examined Mr Johnson on behalf of his solicitors for the purposes of court proceedings against him. Dr Price found that he had a grossly disturbed mental state and immediately admitted him to hospital for observation. He found him to be very talkative and intense. He spoke in a discursive and disconnected manner and was pre-occupied with abstract entities such as God and the Devil, beginnings and endings. Dr Price found no evidence of delusions or hallucinations. During his five days on the ward he was difficult to manage, was aggressive to another patient whom he had accused of having illicit relations with his wife, which in the circumstances, suggested to Dr Price that he was motivated by a delusional belief.

The ward staff found him to be less abnormal than he had been during Dr Price's interview with him. Dr Price did recommend detention under the Mental Health Act 1983 but a social worker declined to make the application. As it was not possible to manage him on the ward as an informal patient he was discharged.

Dr Price's conclusion was that Mr Johnson was suffering from a severe mental illness, either manic-depressive psychosis or schizophrenia. He believed that the grossly abnormal state which he displayed during examination was caused or exacerbated by drugs such as cannabis or amphetamines, though he did not think that drug abuse could explain his whole psychiatric history. Significantly, he did not believe that his abnormal mental state was simulated in order to avoid the consequences of his criminal offences.

Dr Price recommended a Supervision Order with a condition of medical treatment. He felt it would be easier to manage Mr Johnson at home rather than in hospital and he should have treatment with an anti-psychotic drug.

Comment

It was unclear to the Inquiry Team why Dr Price recommended a supervision order and what was meant by this. However the recommendation appears to have been followed by the Court and a letter dated 9 August 1984 from Dr Price to Mr Johnson's General Practitioner in Milton Keynes indicated that he started him on a course of Depixol 20 mgs every two weeks. Dr Price also added that his mental state then appeared much more rational than when he had last seen him.

1985

He was admitted to St Matthew's Hospital, Walsall, sometime in 1985 and a case summary form dated 19 January 1986 stated that a Dr Cook at St Matthew's Hospital, Walsall, described him as a "cheat, fraud and trickster". It was reported that he was in hospital for two to three months.

He was admitted to All Saints Hospital, West Birmingham on 12 October 1985. On mental state examination, it was noted that his hair was unkempt. He denied being a Rastafarian. His clothes were otherwise reported to be clean. He seemed anxious and tended to gesticulate with his hands, with some occasional motor restlessness. He was reported to have had an obvious Trinidadian accent. It was noted that he spoke quickly at times to avoid specific questions by being evasive, becoming confused and muddled. He often said rhymes or quoted from the Bible. He claimed to have been depressed but was reported not to have suicidal thoughts. He was also reported not to have had abnormal perceptual or delusional experiences. He was hoping for help, but denied any specific mental or physical illness. He was reported on 16 October 1985 to have shown no gross psychological abnormalities, but nursing staff stated that he continued to request drugs in order to medicalise his problems. He was reported to have been off the ward on 17 October 1985, and his whereabouts were unknown. He subsequently returned to hospital and was still reported to have shown no evidence of mental illness. There was a query as to whether he was suffering with a personality disorder. A Dr Shapero suggested that he was malingering.

It was reported that a recommendation would be made to the court that he was fit to plead, as he had been charged with theft at the time. It was reported on 5 November 1985 that he was having a memory of convenience. He was allowed weekend leave from the ward from 8 November 1985 and it was during one of these periods of leave that he was arrested for burglary during the course of the weekend. He was discussed in his absence at the ward round of 19 November 1985, and Dr Akhtar, consultant psychiatrist, stated that the nursing staff had not observed any symptoms of schizophrenia or evidence of psychotic illness, and this was David Johnson's way of preventing prosecution for his previous offences.

He appeared at Walsall Magistrates' Court, when he was bailed, and a condition of his bail was for him to return to All Saints Hospital. He was admitted to hospital on 27 November 1985. It was reported that there was no change in his behaviour and he denied the charge of theft. It is reported that Dr Akhtar told him that "*he is a silly burglar who mentally is not suffering from a serious illness*". *Confronted that he is pretending to be mentally ill but basically he is not all*

bad. Somewhat angry when he was told that he was pretending. Rationalised by saying that injections in the past have got him better". He was discharged from hospital on 11 December 1985, and the case summary form on 19 January 1986 raised the question of feigned psychosis as a means of avoiding a custodial sentence. It also described him as "a clever thinker, fast thinker, one who could quickly assess people". He was described as having a "memory of convenience but he was not thought disordered or depressed, talks past the point or wide of it. No frank delusional beliefs. Visually thinks long and hard before answering questions especially in relation to auditory hallucinations". It was suggested that he was malingering.

1992

David Johnson's next recorded contact with psychiatric services was seven years later in May 1992 when he was admitted to the Northern General Hospital, Sheffield under the provisions of Section 2 of the Mental Health Act 1983. He had presented himself at a Police Station asking to be locked up. He told them of previous psychiatric problems, mainly depression, which he ascribed to women. On mental state examination he said that he was "*psychic*" and stated "*if I tried to explain this to people they will think I am mad*". He had grandiose ideas, explaining that he was great and people would pay lots of money to see him. He, however, said that people kept saying he had a mental illness. He was also hearing voices and claimed sometimes to have conversations with these voices. He stated "*I hear people talking but I don't know if it is a noise on the road or a noise in my head*". It was noted that he appeared to have been experiencing visual hallucinations during the interview. He was said to be very philosophical at times.

Comment

Unfortunately the report of this admission was incomplete and there was no further information regarding the outcome.

In July 1992 he moved to Liverpool and records indicate he was made the subject of a Probation Order on 6 October 1992.

1993

In January 1993 his GP Dr Kandasamy referred David Johnson to Dr R Poole, a Consultant Psychiatrist, at Sefton General Hospital, North Mersey Community NHS Trust, after he complained to him of hearing voices. Following this referral Dr Poole obtained verbal information, via one of the community psychiatric nurses, that the team in Sheffield knew him quite well. He was described as a " a *drug dealer, and a psychopath*". Further, " *he was known to feign psychotic symptoms"*. Dr Poole informed David Johnson's GP and said his team would be prepared to see Mr Johnson at his own request but in fact there was no such request.

In April 1993, after pleading guilty to various driving offences and of obstructing a police officer he was remanded to HM Prison, Liverpool. He was examined there by Dr N H Tucker, the Head of Medical Services. In his report for Liverpool Magistrates' Court, Dr Tucker referred to Mr Johnson's many previous convictions which had led to short prison sentences, probation orders and fines. He found Mr Johnson had claimed that the secret of life was to relate closely to nature and to "give to the plants", that cats and dogs had considerable innate intelligence and could probably talk if given the opportunity. Mr Johnson also told him that he enjoyed being in prison because it gave him time to reflect, without pressure from bills or women. Dr Tucker found these concepts formed a group of over-valued ideas but Mr Johnson did not present them with the unshakeable conviction of someone suffering from schizophrenia. Whilst he believed he could on occasions become deluded and hallucinated, he found him not to be frankly mentally ill and harboured a suspicion about the reality of his mental illness. He suggested a referral to a forensic psychiatrist and Dr C Boyd, who then saw Mr Johnson, concluded that he was probably suffering from a schizophrenic illness. He further stated that he had a personality disorder. He opined that under stress, he could become more mentally disordered. Dr Boyd thought that Mr Johnson did not require in-patient treatment and recommended a Probation Order.

On 27 May 1993 the Court made such an order. Although he maintained contact with his Probation Officer, Mr Johnson failed to keep any psychiatric out-patient appointments at Sefton General Hospital.

1994

In January 1994 Mr Johnson was back on remand in HM Prison Liverpool after having been charged with a similar set of motoring offences and again, obstruction of a police officer. The Court requested a psychiatric report, which was prepared by Dr Poole from whom we took

evidence. He had the benefit of seeing Dr Tucker's two reports (one incorporating Dr Boyd's views), discussed Mr Johnson with his Probation Officer, Mr P Wynn, and had the information from Sheffield.

Dr Poole reported that having become accustomed to Mr Johnson's mode of expression it became clear to him that he was not thought disordered. He found that he expressed a number of odd philosophical ideas including the thought that it was very valuable for him to spend time periodically in prison, something that he found relaxing and which, because he was kept away from the pressures of the world, helped him to "keep the instinct". Dr Poole found that he was able to give quite logical answers to direct questions and gave no evidence of paranoid delusions, auditory hallucinations or other psychotic phenomena. His conclusions were that Mr Johnson was fit to plead and that he suffered from a disorder in the development of his personality, but that it was unlikely he suffered from schizophrenia. He found no evidence of mental illness to account for his offences which, he said, fitted with a pattern of impulsive petty offending over many years. He recommended a Probation Order with conditions of residence at a bail hostel and of psychiatric treatment to allow a full community assessment and appropriate treatment.

Mr Wynn also provided a pre-sentence report in which he said that Mr Johnson had consistently made it clear that he would expect and welcome a prison sentence.

A further report at this time was provided by Dr E J Ghadiali, a consultant neuro-psychologist. He measured Mr Johnson's IQ as 76 (in the lower 8% of the general population) and determined that he had a reading age of seven and three-quarter years. He found him to ramble in conversation at times in a disconnected and irrational manner. He had pressure of thought and flight of ideas, some mild paranoid tendencies and grandiose thoughts. These, he concluded, were characteristic of some forms of schizophrenia. He was of the view that Mr Johnson required some form of psychiatric treatment and supervision, to be arranged on an out-patient basis.

It would appear that Liverpool Magistrates Court followed Dr Poole's recommendations and made a Probation Order. Follow-up appointments for Mr Johnson to be seen at Sefton General Hospital were arranged but Mr Johnson failed to attend on two occasions. On 22 July

1994 Dr Poole discharged him, expressing the view that he was likely to come to the attention of mental health services in due course.

Comment

We were impressed by the clarity of Dr Poole's analysis of this difficult case particularly in the way he pulled together various salient factors before arriving at his opinion.

1995

This prescient observation became reality on 16 June 1995 when Mr Johnson attended the Accident and Emergency Department at the Royal Liverpool Hospital, having been sent there by his GP. He complained of hearing voices and saying he was depressed. He was offered admission that day but declined, saying that he would return the following day. He did do so, but by then no bed was available. He was sent home with a plan that he would receive community follow-up. However, he returned to hospital on 19 June 1995, complaining of agitation and hearing voices. There was an account that Mr Johnson had been screaming at home, and was said to be very anxious and panicky with marked agitation. He told the assessing doctor he was scared to leave his house, and a phoney ambulance had been sent to collect him. He gave little information about himself. His presentation was noted to be dominated by his fearfulness and the doctor found him hard to understand. He was admitted following which his psychotic symptoms disappeared. He was prescribed chlorpromazine (anti-psychotic drug) 25mgs. to be taken three times a day. He complained to Dr Poole that he had been thrown out of prison where he had been happy. He appeared worried and unhappy.

On 23 June 1995 Dr Poole recorded that Mr Johnson should have appeared in Court in Sheffield for yet more motoring offences. Still no psychotic symptoms were displayed until Dr Poole mentioned the possibility of discharge. He then complained of voices, a symptom which Dr Poole described as "very clearly feigned".

On 25 June 1995 another patient on the ward complained that on two occasions Mr Johnson had offered to sell her cannabis.

On 27 June 1995 Dr Poole reviewed him and recorded that there had been no evidence of mental illness and that his complaints of hearing voices were manipulative. Dr Poole diagnosed him as a "lonely recidivist offender with personality disorder". He believed that Mr Johnson had

admitted himself to hospital because he found himself in trouble over the motoring offences in Sheffield and this was part of a pattern in his behaviour when he found himself in trouble. During this interview Mr Johnson said he was feeling much better but denied he was facing any charges at all. He agreed to be discharged. The care plan was for him to continue to see his probation officer, see Dr Poole as an out-patient and continue to take chlorpromazine 25mgs three times daily. He did not keep his out-patient appointments with Dr Poole but he did see Mr Wynn.

On 7 August 1995 Mr Johnson was arrested for a further series of motoring offences. A police surgeon then examined him and found him to be agitated, perplexed, complaining of voices and unfit for interview. He was again admitted to hospital. Although he was reasonably well on admission and there was no evidence of psychosis, he was treated with chlorpromazine as he did seem quite anxious. The dose was reduced as he was very drowsy. During this admission, on 10 August 1995 he told Dr D Li, a Consultant Psychiatrist acting in Dr Poole's absence on leave, that voices had told him to steal cars.

Dr Poole saw him on 15 August 1995. Mr Johnson complained to him that he was the victim of organised gangs who "taxed" petty thieves for a proportion of the proceeds of their thefts. The only symptom was that of voices occasionally saying "you're a naughty boy". Dr Poole did not believe that he was psychotic at that time. Mr Johnson on this occasion told Dr Poole that about a year earlier he had been taking anabolic steroids. Dr Poole was of the opinion that it would be difficult to attribute the whole situation to anabolic steroid use which was extremely common in the area, but rarely caused many psychiatric problems. He felt that this also might account for some of the changes that occurred in David Johnson's physique.

On 21 August 1995 Mr Johnson went absent without leave from the ward with a female patient. Up to this time he had appeared entirely well. He returned on 23 August and was discharged with a care plan which indicated that he would be followed up by Mr Wynn and Dr Poole. His medication at this time was chlorpromazine 50mgs three times day although it did not appear that he was compliant.

On 13 September 1995 Mr Johnson did attend Dr Poole's out-patient clinic. He said that he needed a rest in hospital and repeated his complaints about being "taxed" at gun point.

When Dr Poole discussed this with Mr Johnson's probation officer, he was informed that he was facing outstanding charges of stealing motor cars and that Mr Johnson was struggling to cope. He suggested a bail hostel placement but this was not practicable as his previous one had only lasted for three days. It was decided to involve a CPN, Mr L Davies. This was the last time that Mr Johnson attended Dr Poole's out-patient clinic although further appointments were made for him. Mr Davies tried to visit him on at least six occasions over the next two months but managed to see him on only three of these. Mr Johnson complained about being threatened by "the yardies". He said that he was taking his medication. Mr Davies tried to arrange a day centre placement but Mr Johnson failed to co-operate.

On 8 December 1995 Mr Johnson again presented himself at the Accident and Emergency Department of the Royal Liverpool Hospital complaining of hearing voices and agitation. He gave a history of long-standing anabolic steroid abuse. It also emerged that he was due to appear at Warrington Police Station on 12 December 1995 having been arrested yet again for car crimes. He was admitted, yet did not display any psychotic symptoms while he was in hospital. Again, it was believed that the likely court proceedings had provoked his admission.

On 11 December 1995 Mr Johnson spoke, for the first time of 'Mr Brown'. This was a man who came out of him when he reached a weight of 16-17 stones and who 'wants to kill women'. Dr Poole told us that in the light of subsequent events this was a chilling comment but which at the time seemed like a throwaway remark. He also told us that a junior doctor had recorded a comment about David Johnson wanting to kill women. This was the second time that a remark about killing women was made.

Dr Poole decided, however, that he should be discharged on 12 December 1995 to allow him to go to Warrington Police Station. He was given advice to cease taking anabolic steroids and it was planned that he would be followed up by Mr Davies and Dr Poole. On 12 December 1995 Mr Johnson confronted Dr Poole saying that he should not be discharged because "Mr Brown" was going to come and he, Dr Poole, would not like what he would do. Dr Poole described him as being theatrical and threatening but nevertheless felt that his behaviour was manipulative in intent and declined to delay his discharge.

Comment

Despite these remarks made by David Johnson, we believe that as Dr Poole had knowledge regarding his pattern of manipulative behaviour to avoid prosecution, his decision to discharge him on the 12 December 1995 was the right one.

They then lost contact with Mr Johnson who failed to attend an out-patient appointment on 3 January 1996. Enquiries by Mr Davies suggested that he had left his address. Subsequent enquiries showed that he had gone to Manchester. We do not know what happened to him until he surfaced in Birmingham later in 1996.

CHAPTER 3 CONTACT WITH MENTAL HEALTH SERVICES IN BIRMINGHAM IN 1996/1997

26 JULY until 4 NOVEMBER 1996

On 26 July 1996, David Johnson presented himself at Nechells Health Centre, Birmingham and registered as a patient with Dr M V Gaspar.

He told her that he had moved from Liverpool and that he suffered from mental illness for which he had been prescribed chlorpromazine. He said that he had no physical illnesses. Dr Gaspar prescribed chlorpromazine for him, gave him a medical certificate for 26 weeks and referred him, with his consent, to Small Heath Health Centre for assessment.

By a letter dated 22 August 1996, he was given an appointment to see Dr A Owen, Registrar to Dr C Dean, Consultant Psychiatrist, on 24 September 1996. Mr Johnson failed to keep that appointment but he turned up unannounced at Small Heath Health Centre on 17 October 1996 accompanied by a girl, said to be 16 years of age. He was first seen by a social worker, Mrs S Plumb, a member of the Primary Care Liaison Team and he told her that he was hearing voices, he had been in hospital before, and he felt unsafe. She arranged for him to be assessed by Dr S Hamid, the Senior Clinical Medical Officer and Ms M Purvey a Community Psychiatric Nurse.

When we interviewed Ms Purvey, she had no recollection of her dealings with Mr Johnson and relied entirely on the notes she had made on the Action Record. She had recorded that Mr Johnson said that he had been hearing voices which gave him orders which he felt he had to obey, like going to the gymnasium, picking leaves and taking them to the woods where he was experiencing hallucinations. He denied any violent thoughts or having ever been in trouble with the police, though the girl with him, in private, said that he told her that he had stabbed his wife. Dr Hamid, in a letter to Dr Gaspar on 22 October 1996 reported that they asked Mr Johnson about this but they could not substantiate the girl's claim. It was agreed that he would be taken on as a patient by the Home Treatment Team, (then known as the Intensive Treatment Team), and prescribed chlorpromazine 100mg in the morning and 200mg at night. Arrangements were made for two members of the clinical team to visit him twice daily and for Dr Hamid and a nurse to visit him the following morning for a physical examination and reassessment.

No risk assessment was carried out at this stage but Ms Purvey told us that they had a month in which to carry this out.

Comment

We understand that this was in line with their protocol at the time but good practice suggests that risk assessment should be part of the initial and ongoing assessment.

That same evening, as planned, two CPNs, Mr G Thomas and Ms G Seegobin, visited Mr Johnson at his flat. He appeared quite settled and repeated his earlier account of hearing voices. He was given the prescribed medication and a further visit was arranged for the following evening. It was on this occasion that David Johnson's girlfriend told the nurses that she was 15 years old, becoming 16 in November 1996. She said that she had been living with him for 4 weeks following an argument with her mother. Although there was no record that Social Services were contacted about her presence at the flat and her relationship with Mr Johnson, Mr Thomas recalled a discussion about her in one of the clinical reviews. He thought that as far as he was aware, contact was made with the Children and Families Team but we saw no evidence of this.

The next contact was made by Mr K Heffernan , Community Psychiatric Nurse, and Ms E Byrne, Care Assistant, who visited Mr Johnson at his flat the following day, 18 October 1996. He told them that he felt good, the voices had gone, but he felt drowsy because of the medication. He was left with medication for that evening and the following morning. A further visit was arranged for the next day. Their plan was recorded as:

1) Continue to assess mental state
2) Closely monitor for side effects of medication.

On 19 October 1996 he was seen at home by Ms Purvey. She found him to be animated and thought disordered. She recorded "He expressed feelings of anxiety and inadequacy about being black and feeling uneducated. He appeared to be projecting his thoughts on to black women, he could not trust them and felt they "ripped him off". He agreed to take chlorpromazine 100mgs. and procyclidine (anti- Parkinsonian drug) 5mg that evening and the same was left for the morning. An arrangement was made to visit him the following day.

Mr Heffernan and Ms Byrne visited on 20 October 1996. Mr Johnson told them that he felt more settled, the voices had gone as they were controlled by the chlorpromazine. He told them about his past life and passion for music. They found it difficult to keep track of his train of thoughts and felt that further assessment would be required to ascertain whether it was due to his philosophical view of life or disintegrated thought processes. They left medication (chlorpromazine 100mgs. to take in the morning and 200mgs. at night and procyclidine 5mg twice daily) for that night and the following morning. Mr Heffernan also noted that Mr Johnson expected a visit from the team the following day (Monday) and that Dr Hamid was to review the medication on Tuesday (22 October).

There is no evidence of a visit on Monday 21 October 1996. On 22 October Dr Hamid recorded on the Action Record that he saw Mr Johnson and decided to stop the chlorpromazine and start risperidone (anti-psychotic drug).

On 23 October 1996 Ms Byrne telephoned Mr Johnson at approximately 6 pm to try to make an arrangement to see him later that evening. He said that he would be out visiting his girlfriend's mother and therefore a visit for the following morning was arranged.

On 24 October 1996, Dr Dean and Mr Thomas visited and they found Mr Johnson in the flat with his girlfriend, whom Dr Dean thought looked under 16 years of age. She found Mr Johnson to be overactive and over-talkative and was convinced that from the way he went from one topic to another he was not faking his behaviour. She told us "He had tremendous flights of ideas and he was speaking so quickly and so incongruently that he would have had to be a really brilliant actor to be able to do it". He spoke of people interfering with his head and that he heard voices which were worse when there was other noise such as from a television or vacuum cleaner. Dr Dean concluded he did have a mental illness but he used that illness when it was convenient. There were, however, no criminal charges against him at this time. Mr Thomas had recorded that Dr Dean's diagnosis was one of a schizophrenic illness with thought disorder and ideas of passivity phenomena. Dr Dean reviewed his medication and prescribed thioridazine (anti-psychotic drug) 50mg nightly with the risperidone to be increased from 2 to 3mgs.. A further visit was arranged for later that day and the following day.

Before a second visit on 24 October Mr Johnson presented himself at Small Heath Health Centre where he was seen by Ms S Shields CPN. He was extremely drowsy; his speech was

rambling and incoherent and he had difficulty in walking steadily. It was apparent he was too sedated by the increased dose of risperidone which had been adjusted at lunch-time. In view of this, risperidone and thioridazine were discontinued and chlorpromazine 25mg was substituted. He became more animated shortly after this and agreed to have coffee with the staff before he drove home.

Comment

It is not clear from the notes why thioridazine was added to his medication, but it was probably to help him to sleep as the dose was given at night. He had become too sedated whilst taking the two drugs risperidone and thioridazine, and so they were discontinued. He was prescribed chlorpromazine again, presumably because he had responded well to this in the past.

At 7 pm that same day Ms Shields visited him at his home. He was found to be much more alert, his conversation was appropriate and clear. He had not collected his medication because he had been delayed on the way home. He was advised to do so. He said his head felt "less cloudy and heavy".

On 25 October Ms Shields again saw him and recorded that he appeared clear in thought and not sedated. It was noted that Dr Hamid was to review him on Tuesday (29 October).

On 26 October there was an abortive visit by Ms Shields and her colleague Ms S Rajpar CPN. Mr Johnson was not in his flat so a note was left for him to contact them. He did not do so but they returned to the flat in the evening and found him there. They found him to be "over-talkative, loosening of association, excitable, thought-disordered". He said that he was talking a lot because he had no one else to talk to and his girlfriend didn't talk much to him. He told them that he was taking his medication. It was arranged that he would be visited the next day.

This was the last contact anyone from Small Heath Health Centre had with Mr Johnson in this short phase of their dealings with him. The Action Record showed, and staff confirmed in evidence to us, that numerous unsuccessful telephone calls were made to contact him on 27 October. Four more calls were made on 28 October; an abortive visit to the flat was made on 29 October when it was noted that the flat appeared deserted, a further unanswered call was made on 31 October and a letter was sent that day to him inviting him to make contact. He failed to do so.

On 4 November 1996, at a meeting of members of the Home Treatment Team, with Dr Dean, a decision was made to discharge Mr Johnson. The decision was taken because they had been unable to contact him and because he appeared to have left his flat and moved on. They had by this time received previous medical records which indicated that he had engaged with services and then suddenly moved on. Mr Heffernan wrote to Mr Johnson that day asking him to contact his GP or the duty worker at Small Heath Health Centre if he needed help in the future. He undertook to inform Dr Gaspar of the situation.

22 NOVEMBER 1996 until 17 AUGUST 1997

On 22 November 1996 Mr Johnson reappeared. He presented himself at Small Heath Health Centre with his girlfriend, asking to see someone. He was seen by Mr Stephen Day a CPN on the Primary Care Liaison Team and, briefly, by Dr Dean. Mr Day was aware through discussion with other team members and Dr Dean that David Johnson had had some previous contact with the Home Treatment Team.

Mr Johnson explained to Mr Day that he had been away staying with his girlfriend's parents and now wanted to get back in touch with the service. He told him that he was generally feeling better and he did not hear voices except perhaps when he was tired, though this was not a big problem for him. He said he was taking one tablet of chlorpromazine although he could not say what the dosage was. Overall he did not display any symptoms to cause Mr Day concern apart from appearing a little anxious and perhaps frightened.

Mr Day advised Mr Johnson to see Dr Gaspar, his GP, to request a medical certificate because he had complained of a lack of money as he was not signing on regularly for benefit. It was also agreed that there would be further contact and follow-up because he was experiencing mild auditory hallucinations, to get a further assessment of him and to provide him with monitoring and support.

By 25 November Mr Day had completed a risk assessment, having by then had access to previous case notes, and having spoken to Mr Johnson's former Probation Officer, Paul Wynn. He noted that there was a history of serious risk of harm to self, harm to others or self-neglect. He recorded on the Risk Assessment form that there had been past violence/assault/aggravated theft

although none recently and that there had been regular contact with the police, especially for vehicle theft. In early 1996, there had been an allegation of child sexual abuse by his partner but it was later withdrawn. Mr Day concluded that there did not appear to be a current risk to himself or to others. More graphically, he told us that on a scale of 1-10 of people who walked into the clinic for advice and assessment David Johnson would have rated 3 or 4 in terms of level of illness or risk.

Comment

We were unclear when assessing David Johnson's risk, what weight Mr Day gave to the relationship between David Johnson and the apparently vulnerable woman who appeared to be living with him.

A team meeting was held on 29 November 1996 and it was decided that the follow-up would be an out-patient appointment with Dr Dean. This was deemed necessary because of the past history, possible risks (although not evident at that time) and to obtain a diagnosis. At that time the Assertive Outreach Team (a team comprising nurses and social workers targeting people with severe and enduring mental health problems) declined to take on Mr Johnson as a patient until he had had a full psychiatric assessment.

A letter was then sent to Mr Johnson's home asking him to attend the out-patient clinic at Saltley Centre for Health on 4 December 1996. He failed to keep this appointment. A further letter dated 16 December invited him to another appointment on 22 January 1997 (this was later changed to 29 January 1997). Again, Mr Johnson failed to keep this appointment.

In the meanwhile Dr Dean sent a report to Dr Gaspar, based on her two examinations of Mr Johnson on 24 October 1996 and 22 November 1996 and on what she had now learned from previous notes and a conversation with the Probation Officer, Mr Wynn. This was used by Mr Day to ask the Assertive Outreach Team to reconsider their earlier decision not to take Mr Johnson as a patient. This appears to have come to naught.

On 12 February 1997 Mr Day made a visit to Mr Johnson's flat. No one was in and there were no signs of life there. This was despite a preliminary letter dated 6 February notifying him of the visit. He made a second visit on 14 February when again there was no one in, no lights on, and several letters on the doormat.

On 24 February 1997 Mr Day spoke to Dr Gaspar's secretary. It transpired that Mr Johnson had attended the surgery the previous week and had requested an appointment with the team at Small Heath Health Centre. He had told them that he had been staying with his sister but declined to give them the address. He said he had now returned home. That same day, Mr Day wrote to Mr Johnson inviting him to attend Small Heath Health Centre on 5 March 1997. He failed to attend and Mr Day informed the GP of this.

On 15 April 1997 some six weeks later, Mr Day attempted to telephone Mr Johnson but it appeared that the telephone was no longer connected. He wrote to Dr Gaspar, on 8 May 1997, saying that he felt that he should discharge Mr Johnson but invited her to contact the team if she felt that Mr Johnson needed to see her or a team member.

Comment

A period of six weeks elapsed from when David Johnson failed to attend the clinic on 5 March and when Mr Day then attempted to contact him by telephone on 15 April.

On 15 May 1997 Mr Johnson attended Dr Gaspar's surgery. He complained of hearing voices. She advised him to increase his chlorpromazine from 25mgs. to 50mgs. at night and the following day contacted Mr Day who agreed to visit Mr Johnson. He called at the flat that afternoon but Mr Johnson was out. He left a letter asking him to make contact but he did not do so. On 22 May 1997 Mr Day wrote to Mr Johnson saying that he would visit him on 28 May 1997. When Mr Day visited there was no reply, neither did he obtain a reply to a telephone call and therefore left a note asking Mr Johnson to make contact with him.

In the meanwhile, by a letter dated 9 May 1997 addressed to Dr Dean (who by this time had left the Trust and had been replaced by Dr Sidhu) Messrs Penmans, solicitors in Kenilworth had requested a medical report on Mr Johnson who had been charged with the theft of a car and was due to appear at Mid-Warwickshire Magistrates Court. According to the solicitor, Mr Johnson had, on 27 February 1997, visited Hillcrest Motors in Stoneleigh where he arranged to test drive a Toyota car. During the test drive, the salesman got out of the car in order to change seats but Mr Johnson slipped into the driver's seat and drove off before the salesman could get into the passenger seat. Mr Johnson then drove the car to Handsworth, Birmingham where he gave the car to, or alternatively it was taken from him by, some men. Mr Johnson had told the solicitors that

'Mr Brown' had told him to drive the car away. He went on to tell them that he had been threatened by some men in Birmingham who had also told him to take the car.

Without any discussion with any other member of the team, Dr Sidhu arranged to see Mr Johnson on 29 May 1997, though this had to be altered to 12 June 1997. On 11 June 1997 Mr Day wrote to Mr Johnson saying that he had made several attempts to contact him, without success, and invited him, once more, to make contact. On 17 June Mr Day heard that Mr Johnson had telephoned to speak to Dr Sidhu who was not present in the Health Centre. He agreed with Dr Sidhu's secretary that he would telephone back to see if he could help. There was no reply when he rang again.

On 18 June 1997 Dr Sidhu wrote to Messrs. Penmans reporting the results of his examination of Mr Johnson on 12 June. He examined him without having access to any of the previous notes or medical records although he had sight of them prior to preparing the report. In setting out Mr Johnson's psychiatric history, Dr Sidhu had copied word for word from Dr Dean's report of 13 December 1996 to Dr Gaspar, including an erroneous statement to the effect that, when Mr Johnson was a patient in the Broad Oak Unit in Liverpool, he was diagnosed as having schizophrenia.

In this report Dr Sidhu wrote that Mr Johnson presented as an agitated man who had not been able to give a clear account of what had recently happened to him, was thought disordered and that his speech was rambling. Mr Johnson told Dr Sidhu he had forgotten to let the salesman back into the car and the 'voices' told him to keep going. Dr Sidhu questioned him about aspects of the judicial process he was about to face and displayed little comprehension of its nature. For example, he said he did not know the meaning of "guilty" or "not guilty" or what it meant to take an oath. He also gave his date of birth as "15 June or something…1964" (It is, in fact, 20 June 1952).

However, what Dr Sidhu did not know, at that time, was the version of events as told by the car salesman to Mr John Mahoney, Chief Executive of the North Birmingham Mental Health NHS Trust, during the course of his internal investigation into the Trust's care and treatment of Mr Johnson. The salesman described Mr Johnson as "very professional". Mr Johnson arrived at the garage on 26 February 1997, accompanied by a young woman aged about 25 years, showed the salesman an envelope full of money and asked to see a Toyota Celica Supra car. He went through

the car's details, asking what service the car had had and found a number of faults with the car which he asked to be rectified. He declined to close the deal that day, saying he would return the next day. He then left with his woman friend. He returned the following day, accompanied by the same woman. The salesman described Mr Johnson as being perfectly clear and sensible and saying " if the car drives nice I'll leave you a deposit". The salesman had no qualms whatever about taking Mr Johnson on a test drive and did so, leaving the girlfriend behind.

Mr Johnson said to the salesman "if you drive there, I'll drive back". He was happy with this suggestion, but during the changeover, Mr Johnson slid into the driver's seat and drove off. He stopped further down the road to adjust his driving position before carrying on. The salesman then went to a telephone kiosk and spoke to a colleague at the garage, asking for Mr Johnson's girlfriend to be detained. He was too late however, for she had already driven off in Mr Johnson's own car. He understood that when Mr Johnson was arrested for the offence he had previously put false registration plates on his car.

Dr Sidhu's conclusion was that his history and symptoms were in keeping with a diagnosis of schizophrenia. He then added that he thought him not fit to plead and stand trial.

On 4 July 1997 Mr Day wrote to Dr Sidhu stating that given Mr Johnson's history, diagnosis and lack of engagement with services he needed more assertive follow-up than could be offered from Primary Care Team and suggested that Dr Sidhu passed the notes on with a covering letter to either the Assertive Outreach Team or the Continuing Care Team.

Comment

There is no written response to this request in the clinical notes

Meanwhile in a letter dated 7 July 1997, Messrs. Penmans notified Dr Sidhu that they had disclosed his report to the Crown Prosecution Service who had then discontinued the criminal proceedings against Mr Johnson.

Mr Johnson was then invited by letter dated 17 July 1997 to see Dr Sidhu at his out-patient clinic at All Saints Hospital, Birmingham on 5 August 1997. He failed to attend. Dr Sidhu then wrote to Dr Gaspar on 6 August and said "I have not made any further appointments to see him. I am sure he will re-surface at a later date, if and when there is a problem".

Mr Johnson resurfaced on 17 August 1997 when he was arrested for the murder of Geraldine Simpson.

EVENTS SURROUNDING 17 AUGUST 1997

Geraldine Simpson was aged about 45 years, and she lived in Aston, Birmingham. She was divorced and lived in a flat with her 12 year old son. She worked as a cleaner at Villa Park. From witness statements taken by the police it appears that she had met David Johnson a few weeks before her death and had formed a casual relationship with him.

A neighbour of Geraldine Simpson told the police in her statement that she had known her for about a year. She knew, she said, that Mrs Simpson used to drink a lot. At about 1 or 2 o'clock on the morning of Sunday 17 August 1997 she was in her flat when she heard Mrs Simpson shouting through her own letterbox to her son, asking to be let in. She also heard her arguing with a man about where her flat keys were. Mrs Simpson then banged on her neighbour's door and asked for help to get into her flat because she could not find her key. Mrs Simpson was very distressed and asked her friend to make some telephone calls for her. A call was to a man called 'Prenton' (a name by which David Johnson was known). She asked Prenton to come out in his car and collect Mrs Simpson. He was not willing to do that and Mrs Simpson stepped into the lift.

The next sighting of Geraldine Simpson was by another neighbour. She said in her witness statement that she saw Mrs Simpson at 7:15 am with a man she knew by sight and who lived on the 12th floor of Normansell Tower. They were walking towards the local shops. She saw them a second time at about 10:45 am again walking to the local shops. They visited a shop in Aston Hall Road where they were served with cigarettes and a 75 cl size bottle of vodka.

Between 12:30 pm and 1:30 pm yet another neighbour heard shouting and screaming coming from high up in Normansell Tower. The voices were a male and a female and went on for about half an hour. Then a pill bottle was thrown out and when he looked up he saw a black man looking out of a kitchen window towards the top of the block. At the same time a man sitting in his garden had his attention drawn to Normansell Tower because he heard what he thought was an

argument or fight. He saw a woman at a window of what he later identified as David Johnson's flat. She was hanging quite a way out of the window, as if she might fall out. She was, he said, speaking loudly and shouting. He assumed that she was shouting to someone on the ground and paid no further attention to her. Shortly afterwards Geraldine Simpson was found dead at the foot of Normansell Tower. The cause of her death was given as multiple injuries. David Johnson was arrested at 5:40 pm that day.

David Johnson was seen at Queen's Road Police Station by a Police Surgeon, who found him to smell strongly of alcohol, his eyes were bloodshot and his speech was slurred. He thought that David Johnson was fit to be detained but not to be interviewed or charged for 8 – 10 hours.

At 11:30 am the following day David Johnson was seen by Mr Terry Halliwell, an Approved Social Worker (who was later to act as an Appropriate Adult), and by Dr Sidhu. Mr Halliwell was originally called in to carry out an assessment under the Mental Health Act 1983, when he was first accompanied not only by Dr Sidhu but also by a second consultant psychiatrist. It soon became clear that Mr Johnson was fit to be interviewed. He did not show, according to Mr Halliwell, any evidence of mental illness and an admission to hospital was therefore not appropriate. The second consultant was not then called upon to examine him.

Dr Sidhu made a statement to the police, dated 26 March 1998 in which he said that Mr Johnson, when he saw him on 18 August 1997, was in a better mental state than when he had assessed him in June1997. On this occasion Dr Sidhu agreed that David Johnson had been fit to be detained and to be interviewed. He referred to his earlier assessment in which he said Mr Johnson was unfit to stand trial and said that in order to confirm this (in August) he would have to assess him again. However on 19 August 1997, Dr Sidhu reported his assessment of the previous day to Dr Gaspar. In this letter he said that Mr Johnson's mental state was very similar to that in June 1997. He said his thinking was scattered, he was not able to focus and he did not have an appreciation of the circumstances which had brought him into conflict with the law again. He reported that David Johnson was fit to be interviewed but was unfit to plead and stand trial.

Comment

As the Inquiry Team were not able to discuss David Johnson with Dr Sidhu, we were unable to understand why in his statement to the police in March 1998, some seven months after the

incident, Dr Sidhu agreed David Johnson was fit to be detained and interviewed, when at the time of the incident he told Dr Gaspar that David Johnson's mental state was similar to when he had previously seen him in June 1997 when he had advised he was not fit to plead and stand trial.

There were two interviews on the afternoon of 19 August 1997. Mr Halliwell and Mr Johnson's solicitor, a Mr Perks, were present. In the first interview Mr Johnson claimed an alibi from, at the latest, 1:00 pm on the Sunday afternoon. He said that he had visited a friend at her home after which they had both gone to a public house in Newtown, Birmingham. On his return he was arrested. He told the police that Mrs Simpson was a friend who had only once visited his flat some time previously with another woman.

In the second interview that afternoon he denied that he had had a fight with anyone on the Sunday (blood had been found in his flat). He said that he had argued "a little bit" with a girl (not Mrs Simpson) who had spent the Saturday night with him at his flat.

On Tuesday 19 August (with a Mr Price in place of Mr Perks) he was told by the police that they had information at variance with what he had told them the previous day. He then told the police that he had now decided to tell them what really happened. He told them that he and Mrs Simpson had gone to the shop where they bought vodka and cigarettes and they had started arguing over the girl who had stayed with him. They returned to the flat where they argued as they drank the vodka. He had smashed the bottle when it was empty but stepped on some of the glass and cut his foot. Mrs Simpson had then gone into the kitchen, climbed out of the window and started to climb down the outside (of the block of flats). He said she must have grabbed something (a central heating flue) which broke off, causing her to fall.

He was asked whether blood found on his knuckles was the result of his hitting Mrs Simpson and injuring her (the pathologist had found injuries on her which had been caused before her fall). He replied "*I don't think so. I have never. I didn't do nothing to her, she done it herself. She must have committed suicide. I don't know why she done that. That's all I can say."* He told police why he had lied in the first two interviews – because he was shaking and because he did not think anyone would believe him.

Mr Halliwell, an experienced social worker, formerly a probation officer, was satisfied that the interviews were properly conducted, that Mr Johnson was aware of what was happening to him, where he was and that his answers were rational.

At the request of the Crown Prosecution Service Dr Manjit Gahir, acting Consultant Forensic Psychiatrist at Reaside Clinic Birmingham, prepared a psychiatric report on Mr Johnson. Dr Gahir interviewed him on four occasions at HMP Birmingham between October 1997 and April 1998. Dr Gahir obtained the previous psychiatric case notes held by North Birmingham Mental Health Trust, read the court depositions and spoke to Dr Sidhu. Mrs Toni Smith-Carrington, Community Psychiatric Nurse, saw him and felt that he appeared rather grandiose and odd, but denied any mental health problems. He stated that he had previously told a psychiatrist that he was mentally ill and hearing voices in order to obtain disability allowance. He was not co-operative with the assessment when Dr Gahir saw him on 16 January 1998. He told Dr Gahir that because of his loud speech, he was mistakenly thought to be mentally ill or thought to be aggressive by the judicial system. In his report Dr Gahir referred to an assessment by his colleague Dr Ann Stanley, locum Consultant Psychiatrist who saw him on two occasions but made no diagnosis at that stage. He concluded that he did not exhibit any symptoms of mental illness such as schizophrenia or manic depression and there was nothing to suggest that at the time of the offence, he was suffering from a serious mental disorder sufficient to impair his responsibility for his actions within the meaning of Section 2 of the Homicide Act 1957. Dr Gahir declared David Johnson fit to attend court and to stand trial.

A contrary opinion was prepared by Dr Frederick Hickling, a Consultant Psychiatrist who had many years experience of working in Jamaica. He had been invited by the North Birmingham Mental Health Trust to advise them on issues of Afro- Caribbean mental health. He arrived in this country in July 1997 and worked in the Aston and Nechells area within the locality of the Small Heath Health Centre. Dr Hickling saw Mr Johnson on 22 December 1997. Like Dr Gahir, Dr Hickling read the depositions and the case notes. His conclusions were very different from those of Dr Gahir. He said that Mr Johnson was suffering from a severe mental illness, schizophrenia, the symptoms of which were severe thought disorder, (which included thought derailment and verbigeration - word salad), command auditory hallucinations and bizarre grandiose and paranoid delusions. He believed him to have been mentally ill at the time of the offence but did not express

any opinion as to whether Mr Johnson was suffering from diminished responsibility. Dr Hickling later provided a supplementary report after he had seen Mr Johnson on 11 May (during the course of the trial). He confirmed his previous diagnosis and added that Mr Johnson's level of thought disorder would seriously adversely affect his ability to testify at his trial.

During the course of the murder trial held at Birmingham Crown Court between 5- 13 May 1998, the defence attempted to have the evidence of the police interviews with Mr Johnson excluded on the ground that he was not fit to be interviewed. Various witnesses gave evidence about this, in the absence of the jury, including Drs Gahir, Sidhu and Hickling, Mr Halliwell and Mr Thomas. The Judge ruled in favour of the prosecution and the interviews were admitted in evidence. On 13 May 1998 the jury returned a unanimous verdict of guilty and Mr Johnson was sentenced to life imprisonment.

CHAPTER 4 INQUIRY FINDINGS

Diagnostic Considerations

Dr Poole

When Dr Poole met the Inquiry Team and was asked for his overall clinical impression, he told us that David Johnson impressed as "being simple minded, but full of wisdom". He felt that it was a slightly comic performance that Mr Johnson produced for him. Dr Poole, initially, could not really follow what he was talking about because he was talking in Trinidadian "patois". Dr Poole asked him what he meant by these expressions and, following Mr Johnson's explanation, they then made sense. He did not think, therefore, that Mr Johnson was thought disordered. He was of the view that he was certainly not psychotic when he saw him on 26 January 1994. He was uncertain whether he suffered from a schizophrenic illness. He recorded that the symptoms were "very clearly feigned". His diagnosis on discharge on 20 June 1995 was "lonely recidivist offender with personality disorder". Dr Poole believed that the admission had been provoked by the fact that he was facing multiple charges for motoring offences in Sheffield, and he thought that this was part of a pattern of his behaviour when he found himself in trouble.

Dr Poole in discussion with the Inquiry Team was of the view that Mr Johnson was a man who suffered from a personality disorder, who when not able to cope had a number of different ways of dealing with his difficulties. He was of the view that the evidence suggested that he probably did not have an enduring mental illness. When asked for his interpretation of David Johnson's form of speech, which at times was described as a form of thought disorder, he said that if someone is talking in a thick Trinidadian accent with unusual modes of expression, it was very easy to think that they were thought disordered. Dr Poole felt that this was not uncommon particularly when intoxicated with drugs, but he did not feel that this would equate to suffering from a schizophrenic illness.

Dr Dean

In the notes Dr Dean stated that there was a consistent side to David Johnson's diagnosis. When she saw him at home, she wrote he was "quite definitely classically thought disordered and I have no difficulty in making a diagnosis of schizophrenia". She repeated this view to the Inquiry Team, but felt that he used mental illness when it was convenient. She accepted that he may have had a drug induced state but her team did not have the opportunity of testing to see if he had been

taking drugs. When she was asked if she thought his was an episodic illness or an enduring mental illness, she said that on the basis of two examinations, she could not say.

Dr Sidhu

In Dr Sidhu's opinion, David Johnson suffered from mental illness, and was not fit to plead and stand trial. He did not consider it necessary to admit him to hospital for treatment or make such a recommendation in his report to the court. Given the tone of his report for the solicitor we concluded he must have had some concerns. We could not help wondering if Dr Sidhu's decision not to admit him to hospital was in keeping with the philosophy of the Trust's new community based service, which was to provide patients with treatment they required out of hospital as much as possible.

It was unfortunate that the Inquiry Team could not meet with Dr Sidhu as it would have been very helpful to have an understanding of David Johnson's needs and clinical management at that time.

Dr Gahir

When Dr Gahir met the Inquiry Team, he said that he found no evidence that Mr Johnson was suffering from any psychotic illness on each of the four occasions when he interviewed him. Although he was aware Mr Johnson had a previous diagnosis of schizophrenia he was unable to confirm this. He said that he did know that Dr Stanley had found him rather over-familiar and perhaps elated, but again he found no evidence that he was suffering from manic depression. He stated clearly to the Inquiry that in his opinion Mr Johnson did not suffer with an enduring mental illness. In Dr Gahir's opinion the symptoms which Mr Johnson described seemed to appear when it was convenient for him, for example, when he was charged with an offence.

Dr Hickling

The Inquiry Team expressed its concern to Dr Hickling, that in view of his opinion of the nature and severity of David Johnson's illness, he did not recommend a hospital disposal in his report. He stated that he was not requested to address this, and all he was asked to address was Mr Johnson's fitness to give evidence, which is in contrast to the content of a letter to him dated 12 March 98 from Tyndallwood, Solicitors. He stated that he was also not allowed to address

issues related to the Homicide Act 1957. His opinion on the defendant's fitness to plead and stand trial, diminished responsibility and effects of not complying with drug treatment were requested in the letter. When asked, in view of his opinion of his mental state, if he thought that David Johnson had been dealt with appropriately by the court, Dr Hickling told the Inquiry Team, that he did not think it was for him to give a view on this.

Comment

The Inquiry Team had difficulty in accepting that David Johnson suffered with an enduring mental illness, particularly schizophrenia, as there were no clear consistent records of symptoms to support this view in his clinical notes. We consider that an in-patient assessment and/or treatment would probably have enabled the clinical team to reach a clearer view of his diagnosis.

It was evident from his notes that he sometimes reported abnormal perceptual experiences, but we were of the view that the clinical features reported in his notes were more consistent with transient episodic psychosis, as defined in the 10th Edition of the International Classification of Mental Disorders by the World Health Organisation. These were probably associated with his multi-substance abuse and further compounded by his personality difficulties, which had not been formally assessed.

However we accept that it was difficult to be conclusive about the relationship between his illness and drug use, as there were no records of laboratory investigations carried out to support this view.

Community Based Services

From the early 1990's there has been an expectation that mental health services should be provided more locally, and that these should be sufficiently flexible to meet patients' needs. Such needs have changed over the years. Changes in provision have included a move away from hospital based care to "Community Care" as well as the setting up of community based services as an alternative to hospital admission.

Community Mental Health Teams comprised of social workers, mental health nurses, psychiatrists and sometimes psychologists as well as occupational therapists. The aim of the teams was to deliver and co-ordinate a specialist level of care which endeavoured to use the team

members' skills in a flexible way. The introduction of the Care Programme Approach set standards for care. This meant that each person accepted by the specialist mental health services, had one person, a "keyworker" who was responsible for ensuring that health and social care needs were assessed, and, as far as possible, met.

North Birmingham Mental Health Services

We heard from the Chief Executive of the North Birmingham Mental Health NHS Trust that the mental health services provided in that area, six years ago were "*absolutely awful*", and in some parts of the city there were virtually no community based services. *"People with serious mental illness didn't use the service and would never seek help. People wouldn't seek help because the only option was being admitted to All Saints Hospital…..... Putting 200-odd people in the same environment was a recipe for chaos. There were lots of incidents in the community."*

Senior managers in the North Birmingham NHS Trust studied the research carried out in Madison, Wisconsin, where community based services had been in operation for some 20 years. This research showed that people were far more likely to seek help if there were alternatives to hospital admission. Following their visit and a closer look at such community based service, senior managers in north Birmingham introduced specialist teams into the community each with a specific remit. This was a move away from the generic team model to one based on the individual needs of patients. The objective was to provide comprehensive and integrated care and treatment round the clock. Although reflecting the same composition as the original community mental health teams there was a greater emphasis on the role of the community psychiatric nurse.

Primary Care Liaison Teams were set up to respond to the increased demand from general practitioners created by their change in priorities and the advent of GP fundholding,. These teams were the point of referral for each locality mental health team as well as for each defined catchment area. 70% of clients who were in contact with mental health services were seen by the members of Primary Care Liaison Teams which created pressure on the service. All referrals were assessed and where necessary referred on to another team.

At the same time Home Treatment Teams were created for two reasons, 1) because referral rates were increasing and 2) as a consequence of Government policy to close large hospitals, an alternative to hospital admission was required. The criteria for admission to the team

was based on the severity of the illness which might require in-patient admission and in this way the team became the "Gate Keeper" to the in-patient facility. Such people would otherwise be in hospital, most of whom would not be regarded as dangerous but they would need considerable intensive input. The team focussed on people with acute psychotic and depressive conditions but not on people who were thought to have a personality disorder. Each team was linked to a GP practice area and provided a 24hour service. Each consultant had a locality responsibility for Primary Care Liaison and Home Treatment Teams assigned to a geographical area.

In addition to these two teams the Assertive Outreach Team was set up to deal with people with complex needs who had a pattern of frequent admissions referred to as "Revolving Door" patients. According to the Chief Executive of the Trust, in Birmingham it was estimated that there were between 300 and 500 people in this category who were in contact with mental health services. Over 15% of those had been in prison, 50% of those may have been using illicit drugs, 99% were single and all of them had been admitted regularly to hospital, always in a crisis and often through police intervention. They were usually found to be people living in inner city type deprived areas who drifted in and out of services, many being black men. The intention was to provide more intensive support. Teams were set up to manage this particular client group and for every 100 clients there was a team of 10 staff with a specific remit to treat only those 100 clients. Later a dedicated half-time consultant was appointed to each team.

Continuing Care Teams provide support to longstanding chronically mentally ill people living in the community. This aspect of the service did not feature in the care of Mr Johnson and therefore the Inquiry Team had no need to comment on its operational activities.

Discharge arrangements from Home Treatment Team and the Care Programme Approach

The Home Treatment Team did not initiate the Care Programme Approach in the early days of their dealings with David Johnson. Had they done so, this could have given Mr Day (CPN Primary Care Liaison Team) some basic information when he interviewed Mr Johnson on 22 November 1996, following which, contact could have been re-established. As it was, he told us that he only knew about David Johnson through a discussion with other team members rather than having access to the contemporaneous notes made during the previous month

David Johnson was discharged from the Home Treatment Team in early November 1996 when the CPN wrote to him saying that if he required further help he should contact his GP.

Comment

Discharge arrangements from the Home Treatment Team were contrary to the Community Care legislation and the guidance given in the Health of the Nation document, Building Bridges (Department of Health 1995). No consideration seems to have been given as to how David Johnson's after-care was to be managed when he was discharged from active involvement with the community mental health services.

Whilst we accept that this man was elusive, we are of the opinion that when he disappeared, insufficient effort was made, either to trace him or to make provisional plans if he again came to the attention of the team. This seems to be in contrast to the extensive pro-active measures which the Assertive Outreach Team is said to instigate and maintain contact with, or track down clients who, like Mr Johnson move on, or only accept treatment on their own terms.

Inter-Disciplinary and Inter-Agency Communications between the Community based Services in North Birmingham

North Birmingham's organisation of community mental health services differs quite considerably from the generally accepted Community Mental Health Team model. This is not to say that it is less effective. Indeed some of its strongest proponents are those who work in the system and because of its proven success in America, it has generated interest in other parts of this country.

By diversifying and forming four multi-disciplinary teams in an area where only one Community Mental Health Team would be in operation otherwise, the first imperative would be for an effective and efficient communication system to be in place. Although it was not part of our remit to comment on the merits or otherwise, it was felt important to look at the organisation as it offered a service to David Johnson, and, in this respect, communication was evaluated.

In the first instance, when someone such as Mr Johnson presented to the team on a first visit, there would be an expectation that a search would take place prior to the interview to find

out whether this person was known to the service. After interview it would be good practice to contact previous services, if such information was forthcoming from the client/patient. In this case, the CPN contacted a Probation Officer in Liverpool. There were comprehensive case notes to be had from at least three mental health NHS Trusts most notably, perhaps, those in Liverpool where David Johnson had had considerable contact with Dr Poole and his team.

Comment

The Inquiry team was surprised to learn that no formal request was made for the case notes, and that no-one in the clinical team involved in his care contacted Dr Poole.

Record Keeping

On one occasion when David Johnson was interviewed the duty officer went into the interview with only verbal information gleaned from available colleagues. On another occasion the duty officer recorded that, after the interview, she met a CPN who "has notes and wrote to (David Johnson) a couple of months ago".

Comment

We do not consider that risk assessment could be adequately carried out in such circumstances.

Multi-agency and multi-disciplinary team members used the Action Record Sheets, although we were told that some social workers kept their own case notes. Opinions differed as to the criteria adopted for doing so.

Comment

The Inquiry Team was concerned that the standard of record keeping, and that the case-notes generally, gave little support to team members in their work. Some assessment interviews seemed to take place in a vacuum with team members apparently having no access to case notes prior to interview. The referral from the Primary Care Liaison Team to the Assertive Outreach Team seems to have been most casual, having been written on a plain piece of paper with no evidence of discussion having taken place. The response, turning down the request, seemed equally casual.

We were also concerned that there was no evidence of a structured format to pass on vital information either between agencies or within agencies, e.g. from mental health services to Children and Families Teams in the Social Services Department.

Risk Assessment

During the course of our Inquiry we heard on several occasions about a young girl who was said to be Mr Johnson's girlfriend. She was variously described as 15, 16 or 17 years old and therefore some thirty years younger than him. Several professionals said they had concerns about her vulnerability, and apart from one witness, who said she had contacted the Children and Families Team in Birmingham Social Services Department to get confirmation about her age, nothing was done, despite that by then the Home Treatment Team knew that this girl was known to the Children and Families Team. During one assessment by both a doctor and CPN, this young woman mentioned that Mr Johnson had told her that he stabbed his wife. Although she was not yet sixteen years old, no one was sufficiently concerned to act in her interest nor to acknowledge that a crime was likely to be occurring, despite the team being aware that Mr Johnson had a forensic history which included allegations of child abuse. Mr Johnson was later seen by a team member when he was accompanied by this young woman who was seen to be heavily pregnant. She gave birth to his child in June 1997.

This same young woman was called to give evidence during the Court hearing when Mr Johnson was facing a charge of murdering Mrs Simpson. She gave evidence to the effect that on one occasion Mr Johnson had lifted her up, took her to the window of the flat they were sharing and talked about throwing her out of the window.

Comment

The Inquiry Team was deeply concerned that a more rigorous risk assessment was never undertaken on the various occasions when Mr Johnson was in contact with the services, and that a more active approach was not taken to seek professional help for this young woman who could be said to have been at grave risk. Moreover, the Inquiry Team was particularly concerned at the non-response by the social worker, who interviewed Mr Johnson in the company of the young woman who was living with him, when he presented himself on the 17 October to the Primary Care Liaison Team. In relation to this young woman, the social

worker recorded "says she is sixteen but I doubt it". The social worker told the Inquiry Team that on that occasion she was acting as duty officer, not specifically as a social worker. The Inquiry Team believes that this person, acting in a professional capacity, was first and foremost a social worker and secondly a member of the multi-disciplinary team. In fairness she was not supported by the organisations which she represented since there appeared to be no well-defined protocols for cross-referring people who may be at risk either between specialist services in an organisation, or between the different agencies already referred to above.

This practice has been recommended by the National Institute of Social Work and is now in place in many other parts of the country where the procedures are said to be satisfactory.

Use of Locum Psychiatrists

The Inquiry Team was unable to interview two of the psychiatrists who were employed as locum doctors because they had left the country. We were therefore not in a position to obtain a view as to their understanding of mental health legislation in this country, or the procedure in the Trust to facilitate satisfactory handover between doctors.

Comment

While we have accepted that there will always be instances when it is necessary to appoint locum doctors, the Inquiry Team felt that it should be the responsibility of the Medical Director to ensure that the handover of patients is made as smoothly and as comprehensively as possible and that locum doctors have a working knowledge of mental health legislation.

Medical Certification by General Practitioners

When Dr Gaspar saw Mr Johnson for the first time on 27 July 1996, she issued him with a medical certificate for six months on the basis of his assertion that he suffered from schizophrenia. She told us that she found him to be physically well but could not herself confirm whether or not he had a psychiatric illness. Although she did see him on two occasions during the following six months, this was at his instigation rather than hers. In other words, he attended when it suited him rather than from any desire to conform to the system.

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Comment

It seems to us to be undesirable to provide such an extensive certificate without knowledge of a patient's illness. With hindsight, given Mr Johnson's erratic response to services, short-term certificates issued until such time as his psychiatric assessment was completed may well have helped in keeping in touch with him.

Access to Patient Information and Previous Records

It seemed to us that a considerable a degree of investigative skills is required to obtain the complete record to enable services to assess and treat their patient most effectively. Either consciously or subconsciously the patient may obstruct this process. Dr Poole told us of a proposal he put to the Department of Health some years ago. He suggested a register of psychiatric patients who moved around the country. This would not hold clinical information but would indicate where that information could be obtained.

Comment

We were concerned about the difficulty of accessing a patient's previous medical records, particularly in the case of someone who drifts around the country such as Mr Johnson.

CHAPTER 5 CONCLUSIONS

1. The Inquiry Team had difficulty in accepting that David Johnson suffered with an enduring mental illness, particularly schizophrenia, as there were no clear consistent records of symptoms to support this view in his clinical notes. It was evident from his notes that he reported abnormal perceptual experiences but we are of the view that he probably suffered brief psychotic episodes, most probably associated with his multi-substance abuse. However, we accept that it is difficult to be conclusive about the relationship between his illness and drug use, as there were no records of laboratory investigations to support this view.

2. Mr Johnson told us that because of the way he presented with a Trinidadian "patois' it was sometimes difficult for clinicians to understand what he said and meant which may have been interpreted as a symptom of mental illness. We had a similar problem when we met with him but when pressed he was able to articulate his meaning.

3. The Inquiry Team was rather surprised that, if in Dr Sidhu's opinion, David Johnson suffered from a mental illness, and was not fit to plead and stand trial, he did not consider it necessary to admit him to hospital for treatment. Neither did he make such a recommendation in his report to the court, as he must have had some concerns given the tenor of his report for the solicitors. We consider that this was a missed opportunity for inpatient assessment and/or treatment of David Johnson, which would have provided an opportunity for a better understanding of his illness and personality difficulties. Dr Sidhu should at least have considered admitting him to hospital under a civil section, possibly Section 2 of the Mental Health Act 1983.

4. Whilst the Inquiry team endorses the philosophy of community based services, we believe there will be occasions when it would be more appropriate to admit a patient in order to carry out an adequate assessment.

5. The Home Treatment Team did not initiate the Care Programme Approach and risk assessment in the early days of their contact with David Johnson. If nothing else, this could have

given Mr Day some basic information when he interviewed Mr Johnson on 22 November 1996, following which contact could have been re-established. It would also have focussed on Mr Johnson's social circumstances and in particular his relationship with an under-age girl.

6. The referral made to the Assertive Outreach team on the occasion Mr Johnson was seen by Mr Day of the Primary Care Liaison Team, was not accepted by them and there appeared to be no discussion or reasons given for this decision.

7. We heard that there were regular multi-disciplinary meetings when patients were discussed. In David Johnson's case he disappeared from the Home Treatment Team after about 10 days only to be seen a few days later by the Primary Care Liaison Team. It could be argued that an opportunity for continuity of care was missed at this point.

8. When Dr Sidhu, the designated consultant, was contacted by David Johnson's solicitor to prepare a court report, there is no evidence of liaison between him and the Primary Care Liaison Team who had been trying to make contact with him since his re-appearance some six months previously and his subsequent disappearance.

9. We were surprised that the referral to the Assertive Outreach team was not given due consideration since it had become difficult for the Home Treatment Team to keep in contact with Mr Johnson.

10. The Inquiry Team was concerned to learn that when David Johnson registered with a new general practitioner he was given a medical certificate for six months.

11. Mr Johnson told the GP that he suffered from mental illness and he was taking chlorpromazine. She prescribed this without any discussion with his previous GP or RMO. (However we note that Mr Johnson was referred to a psychiatrist the same day).

12. We find it difficult to understand why more effort was not made to liaise with previous services with which he had been in contact. The CPN spoke to a probation officer in Liverpool

and there were case notes with at least three other mental health services in other parts of the country. There appeared to be no discussion made with any previous RMO, particularly Dr Poole in Liverpool, who had considerable knowledge of David Johnson. Accessing information on itinerant patients is essential and general practitioners are central to this as they receive correspondence from secondary and tertiary services.

13. The Inquiry Team noted that there appeared to be no structured format for passing on vital information either between or within agencies, for example, from mental health services to Children and Families Teams.

14. Whilst the Inquiry Team accepts the use of locum doctors, there is a responsibility on the Trust to ensure that they are fully inducted into the operational and legal policies and procedures, for example, use of the mental health legislation, as well local cultural factors. There is a need for a formal handover procedure which should include a detailed review of cases.

15. When David Johnson first presented himself at Small Heath Health Centre, the new services were in the throes of being developed with which staff had to cope as well as seeing patients who previously would have been in hospital. It could be argued that this could have resulted in difficulties in delivering care to patients. We were told that this could have been the case at the time but we were also assured that this is no longer so.

CHAPTER 6 RECOMMENDATIONS

The Inquiry Team recommends that:

1. the Trust ensures that the Primary Care Liaison Team carries out a full multi-disciplinary assessment including consideration of hospital admission before patients are referred to one of the functional teams.

2. the Trust and Social Services Department ensure that if procedures for implementing CPA and risk assessment are not yet in place this should be done as a matter of urgency.

3. the Trust ensures that there is a forum where all the teams can meet to discuss difficult to manage cases and to share ideas and opinions about the management of such cases.

4. the Health Authority and Primary Care Groups should agree a protocol which gives guidance on the issuing of medical certificates by GPs when patients first register with them.

5. the Health Authority and the Primary Care Groups should agree a protocol for the prescribing of anti-psychotic drugs without having a psychiatric assessment or knowledge of the previous medical history.

6. the Health Authority and the Primary Care Groups should discuss the procedures enabling GPs to obtain previous notes so that the patient's previous history is available as a matter of urgency.

7. all borough-focussed agencies should agree a protocol which facilitates communication of vital information relating to individual or community safety across and within agencies as recommended by the National Institute of Social Work.

8. the Trust agrees procedures for ensuring that locum doctors receive the appropriate induction and that there is an effective handover procedure.

Appendix 1

Terms of Reference

1. To examine all the circumstances surrounding the treatment and care of Mr David Johnson by the mental health services, in particular:

(a) the quality and scope of health care, social care and risk assessment

(b) the appropriateness of treatment, care and supervision in respect of:

i. assessed health care and social care needs;
ii. assessed risk of potential harm to himself or others;
iii. any previous psychiatric history including drug and alcohol abuse;
iv. Number and nature of any previous court convictions.

(a) the extent to which Mr Johnson care corresponded to statutory obligations; national guidance (including the Care Programme Approach, HSG(90)23/LASSL(90)11); Supervision Register HSG(94)5; Discharge Guidance HSG(94)27; Mental Health Act 1983 including Sec 136 and any local operational policies for the provision and support of mental health services.

(b) the extent to which his prescribed treatment and care plans were:

i. effectively drawn up;
ii. agreed with patient;
iii. communicated within and between relevant agencies and patients family;
iv. delivered;
v. complied with by patient.

2. To examine the adequacy of the collaboration and communication between the North Birmingham Mental Health Trust, Birmingham Social Services Department, Mr Johnson's General Practitioner and any other agencies who were, or might appropriately, have been involved in his care.

3. To investigate the scope and nature of any other reviews into the care and treatment of Mr Johnson.

4. To prepare a report and make recommendations to Birmingham Health Authority.

Appendix 2
Written Documentation

David Johnson
General Practitioner case notes

North Mersey Community NHS Trust case notes

All Saints Hospital Inpatient records

North Birmingham NHS Trust case notes

HMP Birmingham and Gartree Health Care records

Birmingham Social Services records

North Birmingham Mental Health NHS Trust

David Johnson Internal Inquiry Report

Home Treatment team Operational Policy

Primary Care Liaison Team Operational Policy

Serious Incident Policy

Care Programme Approach Policy and Guidance

Business Plan 1998/9

Birmingham Health Authority

Birmingham Adult Mental Health Services Consultation document 1999

Service and Financial Framework Agreement with North Birmingham Mental Health NHS Trust

Towards a Pan-Birmingham Mental Health Strategy a discussion document 1996

Birmingham City Council Social Services and Birmingham Health Authority

North Birmingham Mental Health NHS Trust and Social Services Department Joint Operational Policy for Adult Mental health Services 1999

Crown Prosecution Service

Summing Up and Verdict Mr Justice Hidden 1998

West Midlands Police Force

Witness Statements

Appendix 3
List of Witnesses

Ms J Beale	Locality Manager Small Heath Health Centre
Ms E Byrne	Healthcare Worker
Dr J Bywaters	Commissioning Manager Mental Health Services
Mr P Craddock	Locality manager Social Services
Mr J Creber	Area Manager Social Services
Mr S Day	Community Psychiatric Nurse
Prof. C Dean	Consultant Psychiatrist
Dr M Gahir	Consultant Psychiatrist
Dr M Gaspar	General Practitioner
Mr K Hefferman	Community Psychiatric Nurse
Mr T Halliwell	Approved Social Worker
Dr F Hickling	Consultant Psychiatrist
David Johnson	Subject of the Inquiry
Mr J Mahoney	Chief Executive North Birmingham Mental Health NHS Trust
Ms S Plumb	Social Worker
Dr R Poole	Consultant Psychiatrist
Ms M Purvey	Community Psychiatric Nurse
Ms S Rajpar	Community Psychiatric Nurse
Mr G Thomas	Community Psychiatric Nurse

Appendix 4

Background Reading

Code of Practice Mental Health Act 1983 1994 and 1999 HMSO

Audit Commission: Making a Reality of Community Care HMSO 1986

The Mental Health Act Commission, Sixth Biennial Report HMSO 1996

Review of Health and Social Services for Mentally Disordered Offenders and others requiring similar services chaired by Dr John Reed Dept of Health and Home Office 1991

Criminal Justice Act 1991 Mentally Disordered Offenders Health Service Guidelines NHSME 1991

The Health of the Nation Key Area Handbook - Mental Illness Dept of Health 1993

The Health of the Nation - Mentally Disordered Offenders Dept of Health 1993

Professional Conduct and Discipline Fitness to Practice. General Medical Council 1993

Caring for People with Severe Mental Illness, Information for Psychiatrists Dept of Health 1993

Forensic Psychiatry ; Clinical, legal and Ethical Issues Ed Gunn J and Taylor P J Butterworth - Heinemann 1993

Introduction of Supervision Registers for Mentally Ill People HSG(94)5 Dept of Health 1994

Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community HSG (94)27 Dept of Health 1994

Audit Commission Finding a Place: a Review of Mental Health Services for Adults HMSO 1994

Report of the Dept of Health and Home Office Working Group on Psychopathic Disorder. Chairman Dr John Reed Dept of Health and Home Office 1994

24 Hour nursed Care for People with Severe and Enduring Mental Illness Dept of Health 1996

The Health of the Nation The Spectrum of Care. Local Services for People with Mental Health Problems Dept of Health 1996

Risk Taking in Mental Disorder Analysis, Policies and Practical Strategies David Carson SLE Publications 1990

Building Bridges A Guide to arrangements for inter agency working for the care and protection of severely mentally ill people Dept of Health 1995

Safer Services National Confidential Inquiry into Homicides and Suicides by People with mentally illness Department of Health 1999

A National Service Framework for Mental Health Department of Health 1999

Report of the Inquiry into the Care and Treatment of Christopher Clunis Jean H Ritchie et al HMSO 1994

Report of the Inquiry into the Circumstances leading to the death of Jonathan Newby Oxfordshire Health Authority 1995

The Falling Shadow Report of the Committee of Inquiry Chaired by Louis Blom-Cooper Duckworth 1995

The Case of Jason Mitchell Chairman Louis Blom-Cooper Duckworth 1996

The Report of the Independent Inquiry into the Circumstances Surrounding the deaths of Robert and Muriel Viner Dorset Health Authority 1996

The Hampshire Report Redbridge and Waltham Forest Health Authority 1996

The Mabota Report Redbridge and Waltham Forest Health Authority 1996

Report of the Inquiry into the Treatment and Care of Raymond Sinclair West Kent Health Authority 1996

Independent External Review into Mental Health Services Bolton Hospital NHS Trust 1996

Report of the Independent Inquiry into the Care and Treatment of NG Ealing Hammersmith & Hounslow Health Authority 1996

Report of the Independent Inquiry into the Treatment and Care of Richard John Burton Leicestershire Health Authority 1996

The Report into the Care and Treatment of Martin Mursell Camden and Islington 1997

Practice, Planning and Partnership The Lessons to be learned from the Case of Susan Patricia Joughin Isle of Man 1997

Report of the Independent Inquiry following a Homicide by a Service User Bromley 1997

Report of Inquiry into the Treatment and Care of Darren Carr Berkshire Health Authority 1997

Report of the Independent Inquiry into the Care and Treatment of Peter Richard Winship Nottingham Health Authority 1997

Report of the Independent Inquiry into the Care of Doris Walsh Coventry Health Authority 1997

The Report of the Independent Inquiry into the Care and Treatment of William Scott Bedfordshire Health Authority 1997

Inquiry into the Treatment and Care of Damian Witts Gloucestershire Health Authority 1997

Inquiry into the Care and Treatment of KK Enfield & Haringey Health Authority 1998

Inquiry into the Care and Treatment of Wayne Licorish Northamptonshire Health Authority & Northamptonshire Social Services Department 1999

Mental Health Act Manual sixth Edition Richard Jones Sweet & Maxwell 1997

Textbook of Psychiatry Gelder et al Open University Press 1996

Learning the Lessons 2nd Edition Mental Health Inquiry Reports published between 1969 1996 and their recommendations The Zito Trust 1996

Inquiries after Homicide edited by Jill Peay, Duckworth 1996