Report of the Independent Inquiry into the Care and Treatment of Arshad Mahmood

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Finally, we were all sorry not to have had the opportunity of extending our condolences in person to the family of MA.

INTRODUCTION

On 25 September 1997, Arshad Mahmood fatally stabbed his father, MA. This was his third serious knife attack on his father, the first having occurred in 1987, the second in 1989.

At the time of the 1997 incident, Mr Mahmood was living with his mother, father, brother and sister at the family home in Birmingham. He had been first diagnosed as schizophrenic with paranoid delusions involving his father and other members of his family in 1988, but was not in regular contact with psychiatric services until 1991 following his release from prison after the second attack. With hindsight, in these circumstances, it is all too easy to question why he should ever have been allowed to reside with his family, especially with his father who was the principal focus of his delusions. However, this was a classic case of care in the community and other than permanently detaining him against his will in hospital (which we could not see was warranted), it is difficult to see how unsupervised contact between father and son could have been avoided, or justified. Indeed, at the time of the second incident, Mr Mahmood was living in London and the surprise attack occurred in a mosque in Birmingham where his father was celebrating a religious festival.

The intriguing question is really why MA wanted his son, after the two earlier incidents, to live with him. His decision not only afforded Mr Mahmood easy access to his father, but doubtless also allowed his delusions to feed off their very proximity. The answer is in reality quite straightforward. MA was simply acting in accordance with the traditional values of his community. Mr Mahmood was his first born son for whom he was, by all accounts, very concerned, and for whom he had the normal fatherly expectations. MA had taken the initiative in obtaining psychiatric help for his son and was no doubt hoping that his illness would eventually respond to treatment. Community values and family relationships are perhaps somewhat old-fashioned virtues in today's materialistic society but it was refreshing to find that they are still in evidence.

While we heard ample evidence of this from Mr Mahmood's professional carers, we were unable to speak to his brother and sisters who twice declined to see us. Regrettably, Mr Mahmood's mother was too ill for us even to consider seeing her. It would have been enormously helpful to hear the family's account of living with Mr Mahmood, but it is understandable that, given the lapse of time since their father's tragic death, they prefer to move on rather than relive those distressing times of the past.

Nevertheless, we have been fortunate enough to obtain evidence of all relevant stages of Mr Mahmood's history and our narrative of events is woven around all three of the incidents which have led to this inquiry.

CHAPTER 1

SOCIAL CIRCUMSTANCES AND CONTACT WITH MENTAL HEALTH SERVICES PRIOR TO SEPTEMBER 1997

THE EARLY YEARS

Arshad Mahmood is the first born son of MA and MB. He was born in Pakistan on 7 March 1968. The family moved to England in 1975. There are three younger children, a brother and two sisters. The family had lived together in Birmingham since approximately 1985.

Mr Mahmood, appeared to have been something of a loner. He had no close friends of either sex, no interests or hobbies. He is a Muslim, a vegetarian, a non-smoker and teetotal. There is no history of substance abuse. He has described his childhood as unhappy, saying that he was beaten and neglected in favour of his younger siblings. Medical reports we have read indicate that his parents and brother and sisters denied this, saying that he was treated no differently from the others and that he was a difficult, solitary and discontented child.

He attended schools in Birmingham but left at 16 without any qualifications. He did, however, go on to Garrett's Green College where he gained 'O' levels in Applied Physics and Mathematics. He then joined Bournville College to study for 'A' levels in Applied and Pure Mathematics and Physics, but left during his third term saying that he was unable to concentrate sufficiently to work.

By this time Mr Mahmood's father had become concerned about his son's mental state. Mr Mahmood appeared withdrawn, had a number of somatic complaints and believed that his father had cast a spell on him. However, shortly after leaving Bournville College, he left the family home and lived in hostels, first in Birmingham and then in London. Whilst in London he maintained contact with the family by telephoning them for money. After six weeks in London, he returned to the family home in December 1987 although he

refused to sleep in his own bedroom, preferring instead to sleep on a sofa in the living room.

THE FIRST STABBING INCIDENT - 1987

On one occasion following his return, Mr Mahmood is reported to have become particularly disturbed and argumentative with his father whom he blamed for stopping his social security benefit. He said he would break his father's magic. Mr Mahmood told us that his father had not wanted him to be independent, that he did not want him to complete his education and wanted him to have an arranged marriage.

On 12 December 1987 Mr Mahmood entered his father's room and stabbed him in the neck with a kitchen knife causing a wound that required five stitches. Although this incident came to the notice of the police, no charge was preferred against Mr Mahmood because his father did not wish action to be taken. With the help of their general practitioner, GP A, the family reported the incident to the City of Birmingham Social Services Department on 11 January 1988. The social worker, SW A, asked Dr C of the Queen Elizabeth Hospital, Birmingham, who was then the Consultant Psychiatrist for the area covered by the Main Street Mental Health Resource Centre, to undertake a domiciliary visit to examine Mr Mahmood.

By this time Mr Mahmood had returned to London, and it was not until the end of February 1988 when he returned home that one of Dr C's team, Dr D, was able to see him.

Dr D formed the view that Mr Mahmood had a schizoid pre-morbid personality and had been deteriorating for approximately one year. He clearly expressed paranoid delusions involving his father and other members of his family as well as delusions of thought control and bodily interference. In the absence of cognitive impairment, mood disturbance and any history of alcohol or drug abuse, Dr D thought that schizophrenia was the most appropriate diagnosis.

Mr Mahmood, however, declined to take medication and said that he intended to return to London. Dr D asked GP A for his help in persuading Mr Mahmood to accept treatment should he come into contact with him. He felt that the early and insidious onset of the illness, lack of affective component and pre-morbid adjustment suggested that the prognosis was poor and their involvement with him was likely to be on a long term basis.

THE SECOND STABBING INCIDENT - 1989

Mr Mahmood returned to London where for a time he worked in a bakery. He was dismissed from this job because, he told us, his employer was an Indian who did not like him. He became sick and thought that his father had cast a magic spell on him. He then returned to Birmingham where he waited in the Grand Mosque for his father. When his father appeared and bent down to pray, Mr Mahmood stabbed him twice in the neck with a six-inch bladed knife inflicting four-inch wounds. He also sprayed him with flea spray "to give him spots". He was restrained and the police were called. This time he was prosecuted and in March 1990, he was sentenced at Birmingham Crown Court to four years' imprisonment. He declined to be represented at those proceedings. The Court had two medical reports before it, both from medical officers at HM Prison Birmingham. They were not made aware of the previous psychiatric history nor did they make any enquiries, and both concluded that Mr Mahmood was not suffering from any mental illness.

Comment

The Inquiry Team is concerned that it appears no effort was made to obtain any background information on his medical history at the time of the preparation of these reports. It is of note that his father stated that his son was suffering from mental illness and needed treatment.

During his period of imprisonment, Mr Mahmood wrote a number of letters home containing paranoid ideas. These included complaints that Sikhs and Indians were going to kill him and that someone was travelling from India to murder him. This led to a psychiatric assessment resulting in a diagnosis of agitated depression and treatment with drugs. This had little improvement on his condition.

Comment

It is surprising that he was, at this stage, not referred to his local mental health services for an opinion on his future management, considering his background history, particularly his non-compliance with treatment, and the likelihood that he would probably be non-compliant on release from prison. This was clearly the case following release on parole in 1991 as described below.

Mr Mahmood was released from prison in February 1991, on parole under the supervision of his probation officer, PO A. In September 1991, PO A was so concerned about Mr Mahmood's behaviour that he suggested to his then GP, GP B, that a psychological or psychiatric assessment was needed in order to find out the causes of his problems. PO A had noticed that he was in a very agitated and disturbed state, had become secretive and expressed fears of being persecuted. He had been told that Mr Mahmood had lost his appetite, found it difficult to sleep and that his physical health was deteriorating.

GP B referred Mr Mahmood to Dr E, a Consultant Psychiatrist then at Hollymoor Hospital, Birmingham. Dr E saw Mr Mahmood on 20 September 1991 and had a lengthy discussion with both his parents. Dr E found Mr Mahmood initially to be somewhat defensive, although he opened up as the interview progressed. He talked openly about his paranoid beliefs against his father whom he accused of having a magic spell on him, and preventing him from studying as well as developing his own life. He admitted stabbing his father although he could give no clear reason why he should do so other than his anger against and hatred for him. He described his mood as depressed and how isolated he felt.

He had taken to carrying with him wherever he went a bag full of rubbish paper, empty tins and some Urdu objects. He admitted to auditory hallucinations, hearing the voices of two people who spoke about him and said that he was not a good child and there was something mentally wrong with him. He also spoke about being controlled by an outside force and, at times, he lost control of his mind. Dr E had difficulty in eliciting formal thought disorder but found some evidence of thought broadcasting when he felt that people could read his thoughts and believed that they talked about him. At times he felt suicidal. He did not feel he was mentally ill and continued to hold ideas of persecution against both his parents but particularly his father.

Dr E was satisfied that Mr Mahmood had a psychotic illness which, since its onset, had led to a gradual deterioration in his personality and ability to achieve. His auditory hallucinations and persecutory ideas were severe enough for him to attack his father. He considered evidence of thought disorder, together with the letters from prison, supported a diagnosis of a schizophrenic illness. Dr E recommended regular treatment for the illness, if necessary under a section of the Mental Health Act 1983.

THE FIRST HOSPITAL ADMISSION - 1991

Dr E referred Mr Mahmood to Dr F, the Consultant Psychiatrist for the catchment area covering Mr Mahmood's home. On 3 October 1991, Dr F was asked to attend the home by the family and Mr Mahmood was admitted under Section 2 of the Mental Health Act 1983 to the Midland Nerve Hospital. He was admitted "for the purposes of assessment, in particular his dangerousness".

On admission he was seen to be underweight, with gaunt features. Although he was polite and co-operative, his speech was hesitant, he evaded questions and his attention span was poor. He complained of insomnia and poor concentration. His affect was euthymic. He said that he thought someone could be putting thoughts into his brain though he was unsure how or why. He thought that his father had plotted against him to

make him leave college in revenge for his rejection of an arranged marriage. He said that he felt well and could see no reason for hospital admission.

He was initially admitted to the High Dependency Unit where he was noted to be suspicious and hostile. He made frequent demands for medication saying that he was worried that he might go crazy and complained of feeling low and weak with persistent headaches. He made no attempt to abscond and within a few days was transferred to an open ward. There was a gradual improvement in his condition and at one stage he was able to say that his problems with his father were over, that he had no intention of harming him and that their relationship was good. Once his detention under Section 2 expired, he agreed to stay on in hospital voluntarily. Prior to discharge, he had a number of home visits including overnight leave. In view of a likelihood of poor compliance with medication he was commenced on a depot injection. The importance of medication compliance, his diagnosis and potential for future dangerousness were all discussed with his family who were willing to have him return to live with them. On 26 November 1991, he was discharged from hospital to be followed up by the Home Treatment Team at Main Street under the care of Dr F and her team.

LATE 1991 - 1995

In the early days following his discharge from hospital, Mr Mahmood displayed a lack of motivation and mild suspiciousness. His father doubted that he was complying with his oral medication treatment and as a result, his depot medication was increased. In early 1992 he had ongoing symptoms of thought interference, but these were resolved without any change in his treatment although his negative symptoms continued to dominate his condition. He was reluctant to become involved in any activity at the Day Centre or to consider a rehabilitation placement.

On 17 September 1992, Mr Mahmood presented himself at the Main Street clinic without an appointment. He complained of depressive symptoms and lack of sleep. He was prescribed additional medication for these symptoms.

In the first half of 1993 Mr Mahmood went to Pakistan. In August 1993 he was reviewed at Main Street when he was found to be well. In January 1994, he complained of feeling sedated and over-medicated and asked to have all his medication stopped. As he was at that time not displaying any psychotic symptoms his depot injection was reduced. By April 1994, he ceased taking any medication. However GP B, his GP, persuaded him to start taking Stelazine tablets and he remained well until November 1994. On 17 November 1994, he complained of poor sleep and disturbing thoughts. His Stelazine dosage was increased temporarily but by January 1995, his next review, he appeared rather agitated and was jumpy in his movements. There was no evidence of psychotic symptoms and he was advised to continue his current medication. He was slightly improved by the time of his next review on 14 March 1995, but on 8 May 1995 he was admitted to All Saints' Hospital, Birmingham.

THE SECOND HOSPITAL ADMISSION - 1995

At this time Mr Mahmood was living on his own in a flat in Handsworth, Birmingham. He appears to have ceased taking medication some time before and had, for four days beforehand, been talking "gibberish" and had been physically aggressive towards his mother and brother. The incident that led to his hospital admission occurred at the home of his uncle in Stourbridge where he broke a window. He was arrested by the police and subsequently assessed for admission to hospital under Section 2 of the Mental Health Act 1983. He was confused as to his identity, calling himself Abdulla Gazi. He had delusions that his father and uncle had plotted against him for his friends to beat him up and steal his money some years before and was found to have an incongruous affect, vague speech and thought.

On 19 May 1995, he was transferred to the Queen Elizabeth Psychiatric Hospital, Birmingham in the mistaken belief that he resided with his family in that hospital's catchment area, and on 2 June 1995, he was further detained under Section 3 of the Mental Health Act 1983. He continued to be psychotic throughout his admission, confused as to his own identify and that of the family members. He said that his father was not his biological father and that his real father was a saint. During his stay there was no evidence of any harm or violence towards himself or others. He was visited frequently by his father and other family members. At first, his father said that he did not want Mr Mahmood to return to the family home because of the previous stabbing incidents. But by July 1995, when a Mental Health Review Tribunal hearing was imminent, his father then said that Mr Mahmood could live wherever he wanted to do so.

Two reports were presented to the Tribunal which sat on 4 August 1995. SW B, a senior social worker, Birmingham Social Services Department, said in her report dated 28 June 1995, that Mr Mahmood had virtually no insight into the events which had brought him into hospital or into his mental state at the time. He denied any knowledge of being ill and was inconsistent in his conversations. Whilst his family were willing to have him home, they were unable to cope if he was not fully well. Her opinion was that he required a further period in hospital. Dr G, acting Consultant Psychiatrist, in his report, confirmed Mr Mahmood's lack of insight into his illness and was of the opinion that if he was not formally detained, he would leave the hospital and not take his medication. He said that he needed to remain in hospital for a gradual increase of his medication to adequate doses. He concluded his opinion by saying that when Mr Mahmood was ill his delusional ideas about his family surfaced and that he might act on those ideas as he had done in the past.

The Tribunal, having heard evidence from Mr Mahmood, his brother, SW B and Dr G, decided to release Mr Mahmood from detention under the Mental Health Act. The reasons given were:-

(1) Mr Mahmood was in a much improved state mentally, having gained partial insight and understanding of the need for taking medication;

(2) Dr G gave oral evidence that Mr Mahmood was no longer suffering from mental illness of a nature or degree that warranted his continued detention in hospital under section;

(3) Mr Mahmood gave assurances that he would for the immediate future stay in hospital on a voluntary basis until such time as his future accommodation and social work follow-up had been organised and would continue to take his medication.

Dr G told us that he was surprised by the decision of the Tribunal and felt that the evidence he had given was inaccurately represented. Despite their reasons, he felt that even though Mr Mahmood had improved by the time of the hearing, the symptoms of his illness had not totally resolved and it was incorrect to say that he was not ill. He also did not consider that it was appropriate for him to return to the family home.

SW B also told us that she was surprised at the decision but felt that releasing him to his flat in Handsworth was preferable to his returning to the family home. She said that she had told his father that it was a better idea for him to try to live independently of the family, not only for his own benefit but for that of the family members who had problems coping when he was delusional.

Following the Tribunal decision, Mr Mahmood remained in the Queen Elizabeth Psychiatric Hospital while arrangements were made for the transfer of his after care to the Handsworth Community Mental Health Team. He left hospital on 17 August 1995 and took up residence at his flat in Handsworth. He remained under their care until March 1996, although it appears that during this time he had a great deal of contact with his family and may have spent some of the time in Pakistan. When Dr H, Consultant

Psychiatrist, saw him in Handsworth on 19 March 1996 he reported that he was not then displaying any psychotic symptoms.

MARCH 1996 – 25 SEPTEMBER 1997

1996

Sometime towards the end of March 1996 Mr Mahmood moved back to the family home and came back under the care of the Main Street team. They were alerted to his return by the GP, GP B, who faxed the Resource Centre on 29 April 1996. As a result Dr I, Consultant Psychiatrist and CPN A, Community Psychiatric Nurse, visited him at his home that same day. He told them that he was happy, had no problems, was getting on well with his family and was free of symptoms. He was given his depot injection which was then due.

Dr I and CPN A saw him again on 10 May 1996 when they described him as being reasonably well settled, although he had some slightly odd religious views about Abraham. He had slight Parkinsonian symptoms, thought to be from the anti-psychotic drug (Modecate) which he was receiving. They noted that he was not hostile, aggressive or homicidal. Dr I arranged for him to be reviewed by the Home Treatment Service.

During May, community psychiatric nurses visited the home four times and considered him to be stable. There were three additional visits when he was not seen.

Early in June 1996, Dr I and CPN A visited Mr Mahmood again and reported that the depot injection was taking effect. The plan was for CPN A to monitor his mental state. During the visit on 7 June, Mr Mahmood started refusing his depot medication. The plan, when visited on 20 June, was for him to be reviewed by a doctor. When seen on 22 June, he said that he would accept the medication if Dr I asked him to do so. There were two subsequent visits when he was not seen although it was not clear from the nursing notes

what the purpose of such visits was. There were no recorded community psychiatric nurse visits in July, except for 13 July, when CPN B spoke to Mr Mahmood's father who said that Arshad was asleep. He stated that his son was in a reasonable state, but that he would be happier if Arshad would accept depot medication which he was refusing at the time.

There were no recorded CPN visits in August 1996.

On 13 September 1996, Dr J, a clinical assistant to Dr I, together with CPN C, saw Mr Mahmood at his home following a request from GP B. His mother had been saying that Mr Mahmood was getting aggressive and argumentative with the family and was claiming that someone had put a spell on him. Dr J found him to be quite calm, relaxed and co-operative. He told her that his family kept asking him for money and that they had taken his money and passport away from him. He was given his maintenance dose of medication and a follow-up appointment was made for 30 October 1996. Although the plan was for him to be seen again on 14 September by CPN C and CPN A, there is no record of the visit having taken place. There were two visits by a CPN in September when he was seen and appeared stable and one when he was not at home.

He visited GP B on 30 September 1996 and told him of his intention to travel to Pakistan and obtained from him a prescription for his medication. He told the doctor that he would be away for three months. Neither he nor GP B told anyone at Main Street about this visit and the CPNs visited the family home three times during October 1996. On the third occasion they were told he had gone to Pakistan. He had returned by 25 November 1996 on which date he consulted GP B with a complaint of laryngitis. In early December 1996, after Mr Mahmood's father had telephoned Dr H at Handsworth, Dr I arranged for his depot medication to be recommenced and arrangements were made for him to be seen again in the outpatient clinic at Main Street for regular reviews.

On 17 December 1996 Dr I saw him at Main Street. He found his mental state to be fairly favourable and his symptoms at a low ebb. However, he did commence him on olanzapine, a newly developed anti-psychotic drug, 10mg daily. Dr I's reasons for this change in medication were his negative symptoms, the chronicity of the illness and his previous history of violence.

1997

Dr I saw him again on 7 January 1997 when he found him to be making good progress. There were no side effects from the olanzapine and Mr Mahmood said that he was beginning to feel a little better and at that time he was free of active psychotic symptoms, although he said that his "strange ideas wax and wane". Dr I increased the dose of olanzapine to 10 mg twice per day in view of the absence of side effects.

On 24 January 1997, Mr Mahmood's family reported to the Main Street team that he was behaving in an odd way such as demanding large quantities of cola and eating raw fish fingers. Dr I visited him with CPN D. The reported symptoms were found to be somewhat less dramatic than at first thought in that Mr Mahmood was cooking the fish fingers prior to eating them in his room so as to avoid eating with the rest of the family. Dr I established from him that he was taking his medication and could find no evidence of psychosis, although he did find his mood high. He could find no indication that he was becoming aggressive or dangerous.

This visit was followed up by Dr I and CPN C on 7 February 1997, but Mr Mahmood was not at home. His mother, however, told them that he was very much back to normal.

The last time that Dr I, or indeed any psychiatrist, saw Mr Mahmood prior to the fatal stabbing was on 18 February 1997. Dr I could find no evidence of psychosis and thought that he was much improved, quite calm and with no sign of aggression. He reduced his dosage of olanzapine to 10mg daily because he appeared sedated and arranged to see him

again in two months' time. Dr I informed the GP that the Home Treatment nurses would continue to visit.

In fact, Mr Mahmood was asked to see Dr J on 18 March 1997, but failed to appear. He also failed to appear at Dr I's clinic towards the end of April.

There had been no specific CPN visits in November and December 1996 and January and February 1997, but between March and September 1997 there were, according to the nursing notes held at Main Street Resource Centre 34 home visits (apart from those visits by Dr I). These were relatively brief calls and in the main established that he was well, taking his medication, sleeping and eating satisfactorily. Of those 34 visits the team was able to see Mr Mahmood on only 12 occasions, though on others they spoke to members of his family and ascertained that there were no problems. On 16 occasions no one at all was at home. However, the Client Information System (CIS), the computer record maintained by the Trust, shows that 77 such visits were made, on 20 of which Mr Mahmood was not in. In addition to these visits, CPN A would occasionally see Mr Mahmood's father at the mosque where they worshipped and check with him that Mr Mahmood was progressing satisfactorily. It was also open to the family to contact the Main Street team at any time of the day or night if there was anything in Mr Mahmood's behaviour to cause them concern.

On 12 July 1997, Mr Mahmood was discharged from the Home Treatment Team. This was a decision taken by Dr I with the nurses who, over the previous six months, had been responsible for visiting Mr Mahmood. They had visited him frequently and he had not shown any aggression or homicidal tendencies towards his father. There were no indications that he was breaking down. He was thought to be stable, well, improved, free of psychotic symptoms, and the high risk that he was once perceived to have posed did not appear to be anything like as bad. Dr I asked CPN A to continue monitoring him, leaving it to his judgment as to how often he should visit.

CPN A thereafter made six visits on none of which did he find Mr Mahmood at home. The last visit was on 9 September 1997 when CPN A saw Mr Mahmood's brother who told him that Mr Mahmood was well and taking his medication. This was the last contact the Main Street team had with the family before the police informed them of the fatal stabbing on 25 September 1997.

CHAPTER 2
EVENTS SURROUNDING 25 SEPTEMBER 1997

At the time of the offence Mr Mahmood was living in the family home with his father, his sister and his brother.

At about 9.00am on 25 September, his sister awoke to hear Arshad Mahmood going downstairs and leaving the house. Some time later she heard her father go downstairs. About 15 minutes later she heard Arshad re-enter the house and return to his bedroom. Two minutes later he went back downstairs and she then heard him quarrelling with her father. She could not make out what they were saying, but she next heard a loud groan and then the sound of something falling to the floor. She went on to the landing in time to make out the figure of Arshad leaving the home by the front door. He came back in only some twenty seconds later. She then found her father lying on the floor in the dining room. He was covered in blood and appeared to her to be dead.

The police were called and MA was certified dead by a police surgeon. A post-mortem examination revealed that he had sustained multiple penetrating wounds to the chest.

Mr Mahmood was arrested at the scene, declared fit to be detained but not fit for interview. He had however, just before his arrest, denied to his brother that he was responsible saying that it was "someone from outside". He was charged with the murder on 26 September 1997 and was bailed with a condition of residence at Reaside Clinic, Birmingham.

On 5 November 1997, at his solicitor's request, Mr Mahmood was interviewed by the police at Reaside Clinic. He said that he had not stabbed his father but that he had returned home that morning to find another, unknown man in the house, arguing with his father over drugs and money. He then saw this man produce a knife from a bag and stab

his father. Mr Mahmood panicked and ran upstairs while the man must have left through the front door.

Mr Mahmood told the police that his father practised black magic and that he had used it on him in the past. He also said that he had put demons into his brother and sister to cause them to give evidence against him.

On 6 February 1998 Mr Mahmood appeared at Birmingham Crown Court when he pleaded guilty to manslaughter on the grounds of diminished responsibility. This plea was accepted by the prosecution and he was made the subject of a Hospital Order under Section 37 of the Mental Health Act 1983 with a restriction order under Section 41.

CHAPTER 3
INQUIRY FINDINGS

DIAGNOSTIC CONSIDERATIONS

Arshad Mahmood had been diagnosed as suffering with paranoid schizophrenia and the Inquiry Team is satisfied that there are clear clinical features reported in his notes over the years, which are consistent with this diagnosis as defined in the 10th Edition of the *International Classification of Mental and Behavioural Disorders* by the World Health Organisation. The evidence also suggests that the symptoms of his illness were most probably present at the time of the first stabbing in December 1987.

Comment

It is rather unfortunate that efforts were not made by his family for him to have contact with mental health services, or at least his General Practitioner, when the change in his behaviour was initially noted and he was expressing some odd beliefs about his father.

It was also unfortunate that Dr D's efforts to persuade Mr Mahmood to accept medication were unsuccessful.

RECORDS AND RECORD-KEEPING

The UKCC document, *Standards for Records and Record-keeping* 1993 (updated in 1998 '*Guidelines for Records and Record-keeping*') sets out the profession's expectations of how nurses should document their interaction with clients and patients. The guidelines published in 1993 state that "the important activity of making and keeping records is an essential and integral part of care and not a distraction from its provision". Record-keeping is an essential tool in promoting high quality care and should

i) provide accurate, current, comprehensive and concise information;

ii) provide a record of any problems;

iii) provide evidence of care;

iv) include a record of any factors that appear to affect the patient;

v) record the chronology of events and the reasons for decisions made;

vi) support standard setting, quality assessment and audit;

vii) provide a baseline against which improvement or deterioration may be judged.

Managers should expect records to be factual, consistent and to accurately reflect the intervention carried out by the individual writing the notes. In present day services there is an understanding that care plans are written with the involvement of the patient. Therefore records should be constructive and provide clear evidence of planned care and its delivery whilst including any decisions made and a note of all professionals involved in the process. Any member of the multi-disciplinary team who has contact with clients has a responsibility to document that contact in the notes.

Whilst the ideal cannot always be achieved, the community psychiatric nursing notes in this case fell short of what would have been considered an average standard by many other community nursing services. This was borne out by the internal clinical review which was conducted by Professor F Oyebode, Medical Director. He was sufficiently concerned about the quality of the records, that following discussion with Ms S Turner, Chief Executive, she requested a further investigation to be carried out. This was conducted by Mr B Toner, Service Director, Psychiatry of Old Age. He had recently joined the Trust, and was not in direct line management of the adult mental health directorate.

He concluded that some of the notes were neither contemporaneous nor in keeping with the quality expected from the nursing staff. The notes did not reflect the contact and

intervention there may have been with Mr Mahmood, nor did the notes demonstrate any ongoing care plan.

Comment

We would agree with Professor Oyebode's conclusion that the nursing records between July and September 1997 were probably unreliable and did not reflect a true picture of the community nursing input, thus compromising Mr Mahmood's care and any support to the family. We were pleased to hear that the nursing records are now audited on a regular basis.

CLINICAL SUPERVISION

The notion of clinical supervision, in addition to managerial supervision, has been gradually introduced into the nursing profession since the early 1990's. A working definition of clinical supervision can simply be described as 'an exchange between practising professionals to enable the development of professional skills' (Butterworth, 1992). It gives an opportunity to look at all aspects of care given in individual cases which takes account of personal professional development and changing needs in service delivery. Clinical supervision is perceived by nurses to be a 'sounding board' which gives practitioners the opportunity to clarify thinking, question established practice and seek new approaches to care.

We were told that the community nursing staff at Main Street had no formal clinical supervision but that they had initiated peer group supervision through their own monthly meetings. This was quite surprising as Professor Oyebode sent us a copy of a Trust-wide document titled, '*Nurse Supervision within South Birmingham Mental Health NHS Trust*' dated 1996. This document clearly sets out the Trust's expectations from formal clinical supervision, these being:

- Development of professional competence.
- Improvement in the quality of service delivery.
- To benefit the organisation by providing a skilled and supported workforce.

At the time of the incident, CPN A, who was an 'H' grade nurse, was the team leader of the CPNs at Main Street. Management expected that, in order to maintain this grade, he was available to offer a district-wide service because of his diverse language skills and ability to work alongside the Asian community, although he spent the larger part of his time working at Main Street. He was struggling with a caseload, arguably higher than those in the team because of his perceived role across the whole Trust area. In addition, CPN A was expected to be involved in meetings to develop services with Social Services, and assist in the day-to-day management of Main Street, as well as provide managerial and clinical supervision for the remaining CPNs at Main Street. CPN A told us that he had had no management training.

Comment

It was not surprising that CPN A felt unable to fulfil this dual role of fellow colleague and supervisor as he told us that he rarely saw his manager. He had no model to follow and felt unable to put into place a formal system of clinical supervision. It was said that he was carrying a caseload of approximately 80 cases when the national norm is considered to be between 30 and 40.

MANAGEMENT RESPONSIBILITIES AT MAIN STREET

Main Street Resource Centre, we were told, was by far the most demanding patch in South Birmingham. The catchment area for the centre was 35,000. It was supported by a day centre and had access to a limited number of inpatient beds. However, this figure did not include the university students living in the area (approximately 3000) who did not go on the electoral roll. We were also told that that there was considerable under-reporting of actual residents because of multi-occupancy occurring within some Asian families.

The service had reached its peak when Dr C created a Home Treatment service which was seen as an alternative to hospital admission. Nursing and medical staff identified patients who would benefit from intensive visiting programmes. This meant that patients

received visits out of the usual working hours of 9am to 5pm. Some staff felt it was very difficult to continue to aspire to what she had achieved and to deliver a comprehensive package of care enabling patients to remain at home.

When Dr C left, Dr F took over but unfortunately, after a short time, she too left. It became apparent that not everyone was committed to this new concept of working, that is, looking after people at home who were seriously ill. We were told that Main Street gained the reputation of being a difficult place to work. The constant changes in doctors had been very disruptive and very confusing, particularly for patients when attending for out-patient appointments. It was difficult to appoint a consultant psychiatrist and this led to there being 12 different locum consultants in a period of 18 months until Dr I took responsibility for the catchment area in 1996. The CPN Team had more knowledge of the patients than the majority of the doctors who were in post and they were carrying high caseloads of 60/70 at that time.

Comment

Although the Inquiry Team appreciates the difficulties encountered by the Trust in employing a substantive Consultant to provide sustained clinical leadership to the team under whose care Arshad Mahmood was for a considerable period, we feel it is pertinent to mention that this, to us, had some effect on the lack of stability and continuity of care provided to Mr Mahmood. The CPNs acknowledged in evidence to us that the quality of care they provided to the patients on their lists was at times adversely affected because of a lack of clinical leadership and appropriate professional supervision.

Professor Oyebode was the Clinical Director at this time and, with the appointment of a centre manager, Mr A, had set about trying to achieve some stability at consultant level, as well as trying to bring a formal system of management and clinical processes together. However, Mr A left some five months after he commenced his appointment. We were told that he had met considerable opposition to anything that he had tried to implement.

For example, he attempted to introduce such administrative systems as were necessary for the running of the centre including a duty clinician rota. The reason we were given for his departure was that the nursing team was so strong that he was unable to break through their resistance to change.

Shortly after this time, Mrs B, Community Support Manager, was asked to move to Main Street to manage directly the administrative aspects of the Centre as well as her other duties in respect of the other mental health teams' administration. She had five staff members, a medical secretary, receptionist, typist, data entry clerk and a centre secretary. CPN A was already the team leader for the CPNs and, with the appointment of Dr I, the management team was complete. As a consequence, there were three systems within a system – administrative, medical and nursing with no overall manager to take control and manage.

We were told that the CPNs were a very close-knit team; they were used to each other and newcomers were not always easily welcomed. Social workers were based in the centre but the two staff groups were not integrated into a multi-disciplinary team. Team dynamics had to be taken seriously and dealt with carefully. In addition to these internal difficulties at Main Street, relationships between Social Services and the Trust deteriorated resulting in an exchange of solicitors' letters associated with the implementation of the Care Programme Approach.

Main Street Resource Centre had gained a reputation in the Trust for 'not being a very friendly place and any newcomer considered an outsider'. Mrs B knew this, but in her words 'she liked a challenge'. It took some time for her to be accepted. Gradually she began to implement systems and tried, but not always successfully, to improve the relationship between the nurses and social workers and the local general practitioners.

There were few policies and procedures in place and Mrs B set about introducing systems for referrals, management of case files and the general administration of the service.

There were no recognised systems in place for dealing with records. Often they would go missing and no one would know where they were. A 'tracer' system was introduced. Mrs B told us that she was also concerned about the quality of record-keeping in as much as entries were not being given to the data entry clerks to keep the computer records up to date. In her role as Community Support Manager she had knowledge of the workload of other mental health teams. All the nurses and doctors used a computerised system (CIS) for recording contact with patients. It was usually the function of the administrative staff to input the information on to the system at regular intervals.

Mrs B also told us that Main Street was a very busy centre and that the CPNs had excessive caseloads. However, after she had implemented administrative systems to manage the records, it became evident that the CPNs were keeping cases open which they had not visited for 12 months or more. It therefore looked as if the caseloads were higher than they might have actually been.

In view of her concerns, Mrs B arranged a meeting with the Corporate Affairs Manager to discuss the importance of good record-keeping which focussed on the need to enter all the information about professional contact with patients into the case notes. Even following this session there was little improvement and staff were still not passing on information to the data entry clerk for entering on to the computer. Although she was also concerned about the quality of the content, she was not responsible for monitoring this aspect of record-keeping as that was a professional matter and therefore the responsibility of CPN A, the senior nurse.

She brought her concerns about records and record-keeping to the attention of her line manager, Mrs C, Service Director. CPN A was also line managed by Mrs C and so Mrs B assumed that her concerns about record-keeping would have been raised with him.

She went on to say *" I became increasingly frustrated with the attitude of staff towards any changes that were made. Staff would agree to do something and then change their minds because of the influence of certain individuals. They didn't really like change."*

Professor Oyebode asked Mrs B about the case notes during the internal review of the incident, and again she voiced her concerns about the standard of record-keeping. He wanted to know if she knew whether the nursing notes had been completed after the incident and she told him they had. The notes had been left in the Centre and not removed for safe keeping at the time of Mr Mahmood's arrest until he was transferred to Reaside Clinic.

Mrs B left Main Street in June 1998. She told us that she was 'sent to Coventry' following Professor Oyebode's internal audit of the incident and CPN A's suspension.

Comment

We were unable to interview the Service Manager, Mrs C, as she had retired from the Trust, but we were told that she too had had a large span of control. We heard that staff did not see her often. She met Professor Oyebode weekly and had the opportunity to discuss any management issues. It was just possible that she, too, was unaware of the problems of caseload management, record-keeping and Mrs B's frustration at being unable to address these.

Until the appointment of Mr D as the current Centre Manager, there was clearly a period of time when the management of Main Street Resource Centre was less than satisfactory. The nursing staff were described to us as 'elite' and did not like newcomers joining the group. An internal audit had been conducted which scrutinised the nurses' visiting patterns and their consequent payments for out of hours visits. This had led to some mistrust on both sides. We found it difficult to understand why so many visits were conducted in the final months before the tragic death of MA if, as the CPNs recorded, everything was 'alright'.

COMMUNITY CARE ARRANGEMENTS

We examined the extent of aftercare arrangements on each occasion when Mr Mahmood was discharged from hospital. We also investigated the extent to which a care planning approach was used in the Home Treatment Team in relation to his treatment and care in 1996 and 1997.

Although the concept of focussed, planned aftercare was introduced by Government circular in 1991, it was not until 1995 that Birmingham Health Authority, North Birmingham Mental Health Trust, South Birmingham Mental Health Trust and Birmingham Social Services were able to reach consensual agreement on the approach to planned aftercare.

Interim procedures were established in July 1996, but not consolidated until mid 1997. By no means alone in experiencing difficulties with the interpretation of the government directive, it is perhaps indicative of the quality of the relationship between the various agencies that five years would elapse before procedures could be laid down and implemented in Birmingham.

It might be said that Mr Mahmood was a casualty of this delay, whilst at the same time accepting that he was subject to considerable input from the community teams at various times.

We noted that in the period 1991--1993, after discharge from the Midland Nerve Hospital, where he had been detained under the Mental Health Act 1983, home visits and hospital appointments were fairly regular, although there was a six-week period of no contact when Mr Mahmood made an unplanned visit to Pakistan in 1993. Despite the fact that Mr Mahmood had home visits by the community nursing service and was given out patient appointments, there was no apparent evidence of effort on the part of the professionals involved to agree a co-ordinated care and treatment plan.

In early 1995, he moved to independent living in the north Birmingham area, a fact that was not noted in the South Birmingham Mental Health Trust records. Because of the lack of oversight at this time, and because he had apparently stopped taking his medication, he again became ill and this resulted in a further in-patient admission. This time he was admitted to the catchment area hospital, All Saints' Hospital, although he was later transferred to the Queen Elizabeth Psychiatric Hospital in the belief that he was still living in the family home. On this occasion, he was detained under Section 3 of the Mental Health Act 1983, and under Section 117 of the Mental Health Act 1983 he should have been subject to a structured after care plan and programme. In this instance, there is no evidence of such planning being carried out as required by guidelines laid down by the Mental Health Act Commission in their Code of Practice.

The social worker who was attached to the team at the hospital could not recollect planning meetings being held. She was required to prepare a report for the Mental Health Review Tribunal hearing which took place on 4 August 1995 and, much to the surprise of the staff involved in his care, Mr Mahmood was released from detention. He agreed to remain in hospital until plans could be made for his aftercare. The social worker, with the knowledge that Mr Mahmood had attempted to kill his father on two previous occasions, felt that he should be supported to return to his own accommodation in north Birmingham, and this he did, having been discharged from hospital on 17 August 1995.

Comment

We are concerned that insufficient support was given either by the North or South Birmingham Mental Health Trust multi-disciplinary teams to the social worker who assessed the risk of Mr Mahmood returning to live in the family home.

There was no indication in the notes of any anxiety on the part of those responsible for his care regarding the possible threat to his father or any other family member.

The social worker referred Mr Mahmood to another social worker in the area where he was then living. There is evidence of this social worker's attempts to make contact with him without success.

Comment

We are concerned that a more rigorous attempt was not made to engage Mr Mahmood at this point. We regard this as a missed opportunity.

He was next known to have moved back into the family home. Upon his return to the south Birmingham area, the Main Street community psychiatric service became responsible for his care and he was allocated to the Home Treatment Team. They visited the family home with considerable intensity, but they were not always successful in finding Mr Mahmood at home.

Having accepted the quantity and regularity of visits to the home, we examined the quality, the purpose and outcome of these visits. We were told that because of the dangerousness of the area, CPNs always visited in pairs, despite the lack of evidence, at least on paper in Mr Mahmood's case, of any risk to those visiting nurses. However, since nurses were not then issued with mobile telephones, this was perhaps a precautionary measure, if not a good one in terms of scarce resources.

We had difficulty assessing the quality of this input and how this matched a structured care and treatment plan, since apart from a skeletal and somewhat crude CPA and risk assessment form dated 18 June 1997, there was no evidence of the focus of intervention. The CPA status on this form was designated 'simple' despite Mr Mahmood's attempts on his father's life.

As previously mentioned, there is no evidence in the notes of a structured multi-disciplinary plan for aftercare apart from an out-patient appointment, and therefore no attempt to structure the purpose of intervention. Likewise, the case notes which record the visits shed little light on the nature of the interaction at the time of the visits. This is a

particularly unfortunate omission given that any one of the team of CPNs may have undertaken visits and comprehensive recording would have facilitated continuity of care.

Our concern is that, although discharged by the Mental Health Tribunal, a Section 117 aftercare plan should, nevertheless, have been drawn up prior to the Tribunal and put into effect as soon as discharge was agreed. To his credit, Mr Mahmood agreed to remain as an in-patient for another two weeks after the Mental Health Act Tribunal discharged him from Section, but this did not seem to affect the outcome which was a lack of appropriate aftercare support for this patient.

Comment

It is generally accepted that the measurement of risk continues to be an inexact science, but nevertheless advances have been made and there is now a better understanding of the factors to be taken into account when considering risk management. It is no longer acceptable to ignore this aspect of the approach to care and treatment. Risk assessment and management has to be seen as an integral aspect of the care plan. Despite previous attempts on his father's life, there is little evidence of an acknowledgement of the risk which Mr Mahmood posed. We know that Mr Mahmood's mental state and his compliance with medication fluctuated and these factors, combined with his expressed emotions about his perception of his father's powers, could have been important indicators of risk.

It is also noted that, despite the fact that the CPNs were linked to general practice, no-one seemed to be aware that Mr Mahmood was not collecting his prescriptions. We note that he collected only four prescriptions in 1997.

In view of these indicators we were surprised to learn that Mr Mahmood's CPA designation was 'simple.'

We were told that Mr Mahmood would have been discussed each week at handover meetings, but when we examined the minutes of such meetings, they gave no indication of the purpose, nature or intensity of visits. Indeed, they merely served to reinforce our views that there was no progressive course towards any stated goals of a care plan.

Comment

We found it difficult to understand the thinking behind the care and management plan that existed between March and September 1997 at a time when the frequency of visits increased despite records that Mr Mahmood's mental state was stable and that he was taking his medication. The lack of a written, structured and comprehensive care and treatment plan would not have been so worrying if one could follow the progress of the record of visits and discern a pattern, but the paucity of the records made this impossible. It is accepted that the community psychiatric nurses were under considerable pressure and recording may not have been a priority. Nevertheless, it would not be possible to measure the effectiveness of intervention with the level of recording as it was, and with the absence of a care plan updated at regular intervals. In such circumstances, it is difficult to see how community nurses could be supervised effectively.

We learned that Mr Mahmood was discharged from the Home Treatment Team on 12 July 1997. We do not know how this decision was reached nor whether Mr Mahmood was party to the decision.

Comment

Again, there is no evidence of structured thinking in terms of follow up.

MULTI-DISCIPLINARY TEAMS

We heard that one of the reasons for the difficulties in establishing the CPA process in Birmingham was the lack of cohesion amongst the agencies involved. Thus, in the Sparkbrook area there was no sense of multi-disciplinary co-operation. Indeed, although

the Social Services Department owned the Main Street building, there was little or no interaction between social workers and CPNs. We were told of a physical barrier being erected at one time in the office between the two disciplines.

CHAPTER 4
RECOMMENDATIONS

We make these recommendations with some caution in the light of the management changes which have taken place within South Birmingham Mental Health NHS Trust in the almost three years since the fatal incident. We are satisfied that the new management is aware of many of the deficiencies contained in this report. Action may have already been taken to put matters right, but nevertheless we feel it necessary to highlight the problems.

The Inquiry Team recommends that:

1. The Health Authority, in conjunction with the prison service, should ensure that there is greater liaison between prison medical staff and the local mental health services in relation to prisoners who have had psychiatric care, particularly in cases where they have committed serious offences, and due consideration is to be taken of their mental state at the material time, when preparing a court report.

2. The Trust ensures there is a regular training programme which includes the UKCC *Guidelines for Records and Record-keeping 1998*, which all staff should attend. The focus of the training should be an accurate account of care planning and delivery of care, continuity of and standard of clinical care, dissemination of information and communication between members of inter-professional and intra-agency teams and the ability to detect problems at an early stage.

3. The Trust introduces a training and development programme to ensure that all staff are aware of their responsibilities in clinical supervision, which ensures that there is an ongoing commitment to this taking into account the resource implications.

4. The Trust ensures that clinical teams have a forum for multi-disciplinary discussion of cases under their care, both inpatient and outpatient, and that care and management plans are clearly documented in order that each member of the

multi-disciplinary team is clear about his/her role in providing care for the patient. The role of the clinical team leader in this respect also needs to be given some thought.

5. The Trust carries out an audit of the case mix throughout the Trust so that appropriate resources can be allocated to the CPN team at Main Street Resource Centre.

6. The Trust ensures that Main Street Resource Centre Mental Health Team has a management structure in place which clearly defines professional and managerial accountability.

7. The Trust ensures that all staff are familiar with guidelines laid down by the Mental Health Act Commission in the Code of Practice relating to the requirements of Section 117 of the Mental Health Act 1983, as well as aftercare as described in the Department of Health Guidance 1999 for the Care Programme Approach.

8. The Trust ensures that multi-disciplinary teams reach agreement on the focus of interventions and that this is recorded and monitored formally.

9. The Trust and Social Services Department should strengthen lines of communication and collaboration at all levels of the organisations.

10. The Trust and Social Services Department must ensure that all members of the Community Mental Health Teams are given appropriate training and kept up to date in all aspects of risk assessment and management.

11. The Trust and Primary Care Groups should agree a protocol for establishing ongoing liaison amongst the referring clinician, community mental health teams and the general practitioner to ensure adequate monitoring of the prescribing and dispensing and the taking of medication by patients with mental health problems.

Appendix 1

TERMS OF REFERENCE

1. To examine all the circumstances surrounding the treatment and care of Mr Arshad Mahmood 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.

   c) the extent to which Mr Mahmood's 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 and any local operational policies for the provision and support of mental health services.

   d) 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 the patient's family;
      iv) delivered;
      v) complied with by the patient.

2. To examine the adequacy of the collaboration and communication between the South Birmingham Mental Health Trust, Birmingham Social Services Department, Mr Mahmood'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 Mahmood

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

Appendix 2

LIST OF WITNESSES

Dr SK Ahmad	General Practitioner
Dr M Anwar	Associate Specialist in Psychiatry
Ms M Band	Named Nurse, Reaside Clinic
Mr M Fox	Community Psychiatric Nurse
Mr R Graham	Community Psychiatric Nurse
Dr J Kenny-Herbert	Consultant Psychiatrist
Dr ML Kayente	Associate Specialist in Psychiatry
Mr A Mahmood	Subject of Inquiry
Professor F Oyebode	Medical Director, South Birmingham Mental Health NHS Trust
Dr M Radford	Clinical Director, Adult Mental Health Services, South Birmingham Mental Health NHS Trust
Ms M Reader	Social Worker
Mr S Singh	Community Psychiatric Nurse
Mr J Stow	Social Worker
Mr B Toner	Director Mental Health Services, Old Age Psychiatry, Birmingham Mental Health NHS Trust
Ms S Turner	Chief Executive, South Birmingham Mental Health NHS Trust
Mr C White	Social Worker
Dr EA van Woerkom	Consultant Psychiatrist
Mrs C Wotherspoon	Manager

Appendix 3

WRITTEN DOCUMENTATION

Arshad Mahmood - Case Notes

General Practitioner case notes

South Birmingham Mental Health NHS Trust case notes

All Saints' Hospital Inpatient records

The Central Nerve Hospital case notes

Birmingham Social Services records

South Birmingham Mental Health NHS Trust

Serious Incident Reporting Policy January 1997

Clinical Review Following an Untoward Incident on 15 September 1997

Investigation into Nursing Records pertaining to Mr A Mahmood, March 1998

Nurse Supervision within South Birmingham Mental Health NHS Trust, January 1996

Administration Service Guidelines, Main Street Resource Centre,1997

Home Treatment Policy 1997

Home Treatment Policy 2000

Mental Health Act Commission

Reports of Visits 8 May 1997, 13 November 1997, 21 May 1998 and 18, 19 November 1998

Birmingham Health Authority

Birmingham Adult Mental Health Services Consultation Document 1999

Towards a Pan-Birmingham Mental Health Strategy, A Discussion Document 1996

Birmingham City Council Social Services and Birmingham Health Authority, South Birmingham Mental Health Trust, Northern Birmingham Mental Health Trust

The Care Programme Approach Manual for Professionals, March 1997

Appendix 4

BACKGROUND READING

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