# An independent investigation into the care and treatment of P in the West Midlands.

**June 2017**

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Niche Health & Social Care Consulting (formerly Niche Patient Safety) is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.



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## Foreword by Panel Chair

Although this report focusses heavily on P and the care and treatment he received from the various organisations he came into contact with, we have kept at the forefront of our mind, Christina and her family. She may not feature prominently in the report but she is at the heart of it, having paid with her life for the multi-organisational failures that she could not have thought would involve her, and which her family could never have contemplated would turn their lives upside down in a matter of seconds.

Service provision within Birmingham and Sandwell has changed, and it is hoped with significant new initiatives in the City, that the proactive and responsive service that is so desperately needed by children and young people with mental health issues is available to them at the point in time that they need it.

That said it is disheartening and worrying that our review, as with many reviews and investigations before ours, has found that many of the underlying challenges and problems remain despite the commendable effort made by all organisations involved to change practice and procedure.

In saying this, we do not seek to undermine the work done to date and we are encouraged that action is being taken as it is, with huge strides being made to improve mental health service provision locally and nationally. These changes will need to continue evolving in response to the changing needs of an increasingly diverse group of service users, and to make real impact, endeavor to anticipate needs in order to stay ahead.

Whilst individual organisations can do what they can, the real challenge and issue lies in the fact that to truly learn and provide assurance to service users, their families and the public at large, there needs to be recognition of the need for *actual* partnership and communication between police forces, the criminal justice system, prison, health, social care and housing support services.

The absence of access to partner organisations IT systems, information sharing, joined up thinking and working practice as well as longitudinal assessment, all contributed to the failings identified in this case. None of these will however, come as a surprise to the reader. They have been identified as the root cause of failures in the past and continue to be identified as root causes of failures today.

Jurisdictional, legal and financial constraints prevent and hinder key organisations from integration to the level that is needed for effective change to take place and to the extent needed to prevent, in so far as is possible, the recurrence of tragic incidents such as this one. The jurisdictional issues tied in with the legal challenges and constraints that arise, can only be addressed and eradicated by a change in policy and to some extent legislation. The question is to what extent there is the appetite for that change.

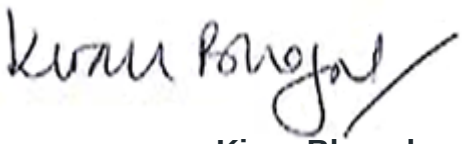
Despite the national focus on the provision of mental health services, the need for the service to, as Lord Bradley said as far back as 2009, “transcend all traditional governmental and organisational boundaries” remains.

The task ahead is not an easy one. The practical challenge in bringing down barriers to effective partnership and provision of a seamless service may never be possible to overcome having regard to the fundamental right to privacy and personal autonomy.

Nonetheless, serious consideration needs to be given to improving the information sharing platform across all agencies for service users. Add to this the need for the adoption of holistic and longitudinal assessments in order to ensure that the needs of those accessing mental health services are understood and met.

Focus on closer working between mental health and criminal justice services is essential to address and ease the pressure on prisons which are not designed to manage complex mental health disorders. The difficulties of robust discharge planning and referral pathways for unplanned or early release prisoners who have little insight into their mental health problems and/or are reluctant to engage with services, needs to be addressed urgently. The fact that there remains a risk that these vulnerable prisoners continue to be released from prison without adequate support and supervision leaving them and the general public at risk is of extreme concern. We can but hope that in addressing these points, the failings identified in this and other homicide investigations are not repeated and that families' do not have to suffer the pain and anguish of losing loved ones.

Finally, we would like to acknowledge the efforts made by all the organisations involved in this incident in addressing and implementing the recommendations made in the initial investigation report.



**Kiran Bhogal**

# 1 Executive Summary

## The incident

1.1 On 7 March 2013 shortly after 5.00am P boarded the number 9 bus (the bus) close to Birmingham city centre and went to the upper deck of the bus. Shortly after 7.25am after a passenger informed the bus driver that P was asleep, the driver went to the upper deck and saw P, but he took no action.

1.2 Christina boarded the bus at approximately 7.30am and sat on her own in a seat on the upper deck of the bus. Within seconds of Christina sitting down P got up and moved forward three seats and sat down. CCTV evidence showed P taking a knife from his bag and then hiding it between his hands and thigh. P then stood up and walked towards Christina, stabbed her and then disembarked from the bus. Emergency services attended the scene but Christina was declared dead at about 8.00am.

1.3 Christina and P were not known to each other.

1.4 Eye witnesses and the bus driver were able to provide police with a detailed description of P. He was subsequently arrested, and a knife belonging to him was found hidden in nearby bushes. P told the police he had bought the knife the previous day, as he feared for his safety.

1.5 P appeared before the Crown Court and was convicted of manslaughter on the grounds of diminished responsibility (2 October 2013).

1.6 P is currently detained under Section 37/41 of the Mental Health Act 1983 (Amended 2007) in a secure psychiatric hospital.

## Christina Edkins

1.7 At the time of her death, Christina was 16 years old. She was the youngest child of the family and was studying for her GCSE exams. On the morning of the incident Christina was on her way to school.

1.8 At the Crown Court Hearing, Christina was described as “a living breathing, caring and exciting young woman. She was taking the world by storm. She was full of care, concern and generosity”. Her head teacher wrote “if a school could choose its pupils it would be full of Christinas”.

## Basis for this investigation

1.9 NHS England have a revised Serious Incident Framework[1], which:

“Aims to facilitate learning by promoting a fair, open, and just culture that abandons blame as a tool and promotes the belief that incidents cannot simply be linked to the actions of the individual healthcare staff involved but rather the system in which the individuals were working. Looking at what was

[1] NHS England; “Serious Incident Framework. Supporting learning to prevent recurrence” 1 April 2015 https://www.england.nhs.uk/patientsafety/serious-incident/

wrong in the system helps organisations to learn lessons that can prevent the incident recurring."

1.10 An independent investigation can be commissioned:

"When a homicide has been committed by a person who is or has been in receipt of care and has been subject to the regular or enhanced care programme approach, or is under the care of specialist mental health services, in the 6 months prior to the event."

1.11 NHS England (Midland and East Region) commissioned Niche Health & Social Care Consulting (previously Niche Patient Safety) to undertake an independent investigation into the care and treatment of P and the events that led up to the homicide of Christina to identify further opportunities for improvement and learning.

1.12 Where reference is made to the Mental Health Act it is a reference to the Mental Health Act 1983 (as amended in 2007) ("MHA").

1.13 In September 2014 Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) had published a report following an investigation into "the circumstances surrounding the death of Christina ….in enabling lessons to be learned."[2] We refer to this report as the 'initial investigation report'.

1.14 Because of the quality and comprehensiveness of the initial investigation, the intention of this report is not to cover the same ground again. Instead the remit was to review the initial investigation to identify if there are any further opportunities for learning and service improvement, and to review progress on the implementation of recommendations.

1.15 Although Christina is not the subject of our investigation her tragic death and the effects that it has had on her family and the community has consistently been at the forefront of our minds throughout this investigation.

## P's Background

1.16 P was born in Swaziland in 1990, and is the eldest of three children. The youngest sibling was born after the family moved to the UK. P's father was an insurance company clerk and his mother was a teacher who worked with children with learning disabilities. P's parents separated when he was about six years old and still in Swaziland, after which he had no further contact with him.

1.17 P's mother told us that he was a "shy but bright child" who was very protective towards his younger sibling. After P's parents separated, his mother came to England. P and his younger sibling remained in Swaziland living with their maternal grandmother.

[2] "Dr Alison Reed (Chair). "Homicide Investigation Report into the death of a child: STEIS Reference: 2013/7122" Final Report– September 2014, http://bhamcrosscityccg.nhs.uk/about-us/publication/safeguarding/674-final-pdf-report-september-2014/file

1.18 When P was 12 years old, in 2002, he and his sibling came to live with their mother in the UK. In 2004, P's mother remarried and when P was 15 years old, she gave birth to another son.

1.19 When P was 13 records indicate that the school had begun to contact P's mother as her P's attendance at school was worsening. P's grandmother, whom he was very close to, had also died, and his mother had to return to Swaziland. From here on P's academic progress and attendance at school declined.

1.20 School records documented P being involved in confrontations with both staff and other pupils. It was believed that P was involved in violent altercations between rival gangs of Somalian, Asian and Afro-Caribbean boys. Following the school's investigations into an incident when P's life was threatened, several pupils were excluded.

## P's care and treatment

1.21 On 17 December 2004 P reported to his mother he had taken an overdose of medication he had found in her bedroom. He was taken to A&E and then admitted to hospital. He said he had taken the overdose following an incident with another pupil and a rival gang had told him that they intended to shoot him. P perceived this threat as very credible.

**2005**

1.22 P was assessed in hospital by a Community Psychiatric Nurse (CPN) from the Black Country Partnership NHS Foundation Trust (BCPFT) Child & Adolescent Mental Health (CAMHS) Team on 20 December 2004. The CPN assessment referred to P's problems at school and the tensions between various groups of boys at school. P was referred to the local CAMHS team in West Bromwich for follow up in a weeks' time.

1.23 In the referring letter the CPN noted that although there were no signs of psychosis or depression, P was "at risk of further deliberate self-harm", although this risk could be minimised if the situation at school resolved. The CPN's overriding concern was to improve the safety of the environment for P.[3]

1.24 P was seen on six occasions in clinic at the CAMHS service in 2005. His mother also reported she had arranged counselling for him from a Youth Pastor at her Church Centre. The CAMHS service did not follow this up although they had intended to.

1.25 The school social worker contacted the CAMHS specialist registrar in February as she was concerned that P was "very depressed and that his attendance at school was from 17 January 2005 progressively declining".[4]

[3] Letter from Specialist Registrar Child and Adolescent Psychiatry to CAMHS Community Psychiatric Nurse, 10 January 2005
[4] Letter from school social worker to CAMHS's specialist registrar, 23 February 2005

1.26 P failed to attend his last two offered appointments in September and December and he was discharged from CAMHS in December 2005.

**2006**

1.27 P's mother attended the school in February because of his lack of attendance. Despite all the effort of the previous year his behaviour and attitude to school had not changed, and he was missing out on important information regarding exams and further support.

1.28 On 3 February 2006 P was found in the early hours by police in a high crime area. He could give no reason for being there at that time, though it was noted that P previously lived in this street.[5]

1.29 P's mother reported that he was not washing or getting out of bed and he complained of being tired all the time. She had arranged for him to see the GP on 10 February 2006 and she attended the GP surgery with him to convey her concerns.

1.30 In June 2006 his end of year school report noted that he had some difficulties with memory and was easily distracted. P had obtained mainly mid-grades in his GCSE results. P arranged to study during the summer to prepare for GCSE exam resits. He did not obtain good exam grades. This was a surprise to his mother as he was always expected to do well.

**2007**

1.31 P left school, and briefly enrolled in college, though this did not last, and he became unemployed.

1.32 He started to have further brushes with the law. On one occasion he and four other young men were stopped by the police. He was found in possession of a lock knife, arrested and cautioned. On another he and another person were detained in a private garden by a member of the public. He was arrested but not charged.

**2008**

1.33 P had left school, and briefly enrolled in college, though this did not last, and he became unemployed.

1.34 His mother reported that early in 2008 P had dropped a cigarette on some clothes in his bedroom, leading to a fire which caused significant damage and the family had to be rehoused.

1.35 His mother remained very concerned about P's mental health. She arranged an appointment for him with his GP, reporting he appeared to be hearing

[5] Dr Alison Reed "Homicide Investigation Report into the death of a child: STEIS Reference: 2013/7122" Final Report– September 2014, p20

voices. P would not attend, and because of the fire and the family being rehoused they registered with a different GP practice.

1.36 P turned 18 in August 2008.

1.37 Between August and December, P's mother contacted the police on three occasions reporting him making verbal threats and causing damage to property.

**2009**

1.38 On 5 March 2009 police were called by P's mother who reported P had pushed his three year old brother into a wall, causing bruising. However P's mother reported to us that this was more of an accidental push than one intended to cause harm. The younger brother was taken to A&E and then admitted to hospital for safety. After a social services assessment, the younger brother returned home, and social services told P's mother that P needed to move out.

1.39 After the incident, P was arrested. He was assessed in custody by the police Forensic Medical Examiner (FME) who noted some scars on his lower arms. Though P denied self-harm the FME was concerned and advised the custody officer to place P on Level 4 Observations. P accepted a police caution for the offence.

1.40 On 10 March 2009 P attended his GP and was prescribed Zopiclone. Although there is a note in his GP records from social services discussing the incident on 5 March, there is no record that the GP and P discussed the incident.

1.41 P's mother called the police on 19 March at 2.45am, reporting that P was verbally abusive. She wanted him removed as she felt unsafe. P was arrested for breach of the peace. He was seen by the Black Country Partnership NHS Foundation Trust (BCPFT) mental health Criminal Justice Team after concerns were raised by custody staff about his mental health.

1.42 P was offered an 'opt in' letter for an assessment appointment by the BCPFT Primary Care Liaison Team (PCLT). He did not attend the appointment and his GP was informed that he had therefore been discharged by the team.

1.43 P's mother remained concerned about his mental health, and tried to get help for P from the GP. The GP referred him again to the PCLT. Two further letters of appointment were sent but again he did not attend, and again was discharged from the service due to his not engaging. His GP was informed.

**2009 - 2011**

1.44 Between October 2009 and early 2011 P's mother reported to us that she saw a significant improvement in her son after P's step-father left and the tensions in the family home reduced.

1.45 The only incident of note occurred in July 2010 when a police officer stopped P and undertook a PACE search. P was not arrested.

**2012**

1.46 Several events occurred in early 2012 in P's family that appear to have had a negative effect on P's mental health.

1.47 The first of these was the death of his grandmother, who had been an important figure for P. He was unable to go to her funeral.

1.48 His mother was also hospitalised for several weeks and then had to return to Swaziland for her mother's funeral. P's mother reported to us that during this time her son became increasingly withdrawn and paranoid. When she returned from Swaziland he also became confrontational and violent towards her.

**10 May – 17 July 2012**

1.49 On 10 May 2012 the police were called because P had come to the house demanding money from their mother. P was also threatening to stab his mother and had thrown an electric fire striking her on the head. Police attended, and arrested and charged P with criminal damage.

1.50 The following day P's mother telephoned the police reporting that P had broken a window. P was again charged with criminal damage. On 12 May 2012, he pleaded guilty at a magistrate's court and was given a six month conditional discharge sentence.

1.51 Police completed a Domestic Abuse, Stalking and Honour Based Violence (DASH)[6] assessment. This noted six calls had been logged from P's mother in the past two days. She reported she was afraid of being killed by her son but she did not consider her other children to be at risk. She also reported verbal abuse from P was occurring daily. The assessment assessed P's mother at "medium risk"[7]. A referral was made to the Independent Domestic Violence Advisor (IDVA).

1.52 A Multi-Agency Risk Assessment Conference (MARAC)[8] was convened on 14 May 2012 and reviewed on 23 May 2012. A Street Index Gazetteer (SIG) marker[9] was placed on P's mother's address. Police were to discuss with the

[6] The DASH risk assessment measures 'serious harm' defined as death or injury (either physical or psychological) which is life-threatening and/or traumatic and from which recovery is expected to be difficult, incomplete or impossible. It is used by professionals who work with victims of domestic abuse and their children, stalking and harassment and honour based violence.http://www.dashriskchecklist.co.uk/index.php?page=dash-2009-model-for-practitioners

[7] DASH medium risk: there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, e.g. failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse'. The initial DASH completed by police assessed risk as medium this was downgraded by PPU and then at initial MARAC to re-graded to medium again

[8] A Multi-Agency Risk Assessment Conference (MARAC) is a local, multi-agency victim-focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies.http://www.caada.org.uk/practice-support/resources-marac-meetings and https://www.app.college.police.uk/app-content/major.../victim-safety-and-support/

[9] The National Street Gazetteer is the definitive reference dataset of streets within England and Wales used for street works, highways maintenance and traffic management. It is also used by the police and other public bodies.

P's mother safety planning, neighbours were informed regarding 'cocoon watch'[10] and an alarm was provided to P's mother.

1.53 On 20 May 2012, P's mother again called the police. On arrival she told them that P was inside the house in possession of a knife. She reported P had held the knife to her stomach and threatened to kill her, in front of his younger brother. P had also phoned the police stating he was going to kill his mother. The police entered the house, and P was searched but the knife was not found. P was placed in the police vehicle, to return him to his home address. P then assaulted one of the police officers and he was charged with a Common Assault (Section 39)[11] on his mother and assaulting a police officer.

1.54 On 21 May 2012 P pleaded guilty to the assault on the police officer. He was sentenced to four weeks imprisonment. He pleaded not guilty to the assault on his mother and the trial hearing was adjourned until 11 July. He was remanded in custody at HMP Hewell.

1.55 On 30 May 2012 P was granted bail. He was to be bailed to a bail hostel in Walsall arranged by the Bail Accommodation and Support Service (BASS), with the condition that he did not have contact with his mother or be in the locality where she lived. He was released from HMP Hewell on 1 June 2012

1.56 P did not arrive at his bail address until 2 June. He attended court on 11 July for the trial of his assault on his mother.

1.57 During the trial there was concern about P's behaviour and demeanour. P had stated he would stab and kill his mother under oath. The Court requested an assessment of his mental health by the BCPFT CJT. Due to P's presentation, the CJT practitioner concluded that P needed a MHA assessment, which was arranged for 16 July.

1.58 The CJT's TAG Risk Assessment documented that they considered that P's level of risk to others was "severe". The CJT practitioner asked for P to be remanded overnight but the prisoner escort staff had left so P was conditionally bailed to the bail hostel address. He failed to return to court the next day so a warrant was issued for his arrest. P was arrested the following day (13 July) at the accommodation his mother had previously secured for him. P's case was then adjourned to 16 July 2012 and he was remanded to HMP Hewell.

1.59 P was initially assessed in reception at HMP Hewell on 13 July 2012. It was noted he appeared shy and vulnerable, but had mental health issues.

[10] "Cocoon Watch" scheme, in which friends and neighbours were asked to keep an eye and call police if their attackers appeared. https://www.app.college.police.uk/app-content/major.../victim-safety-and-support/

[11] Common Assault, contrary to section 39 Criminal Justice Act 1988. An offence of Common Assault is committed when a person either assaults another person or commits a battery. An assault is committed when a person intentionally or recklessly causes another to apprehend the immediate infliction of unlawful force. A battery is committed when a person intentionally and recklessly applies unlawful force to another. It is a summary offence, which carries a maximum penalty of six months' imprisonment and/or a fine not exceeding the statutory maximum.
http://www.cps.gov.uk/legal/l_to_O/offences_against_the_person/#a07

1.60 A more comprehensive mental health assessment was attempted twice on 14 July 2012. He appeared distracted, responding to unwanted stimuli, and was thought to be psychotic.

1.61 P was assessed by the in-reach forensic specialist registrar[12] on 14 July who found him guarded, paranoid and suspicious. He was tentatively diagnosed with an acute paranoid psychotic disorder and prescribed Olanzapine.

1.62 Arrangements were made for an MHA assessment on 16 July 2012 in Court. However P had not been transferred from prison as following assessment by the forensic specialist registrar at HMP Hewell he was not considered to be fit to appear in Court. The hearing was adjourned until 17 July 2012.

1.63 On 17 July the Court requested that a MHA assessment be undertaken at Court. A mental health nurse from HMP Hewell (Healthcare) gave an update on P's presentation. A member of the assessment team contacted P's mother who provided extensive details of her son's symptoms and that he had a conviction for carrying a knife. The CJT's records were not reviewed by the assessment team. The assessment found that P did not meet the criteria for admission to hospital under the MHA, but concluded he may have a personality disorder with depressive traits requiring the future involvement of mental health services.

1.64 P was assessed in Court as having capacity and well enough to answer the charges against him. He pleaded guilty and received a 26 week sentence of imprisonment for the assault on his mother. The Court made a restraining order in respect of his mother for a period of two years.

1.65 He was transferred back to HMP Hewell and remained in the healthcare unit for the remainder of his sentence.

**18 July – 15 October 2012**

1.66 P was reviewed (4 August 2012) by the forensic specialist registrar working with the in-reach team. He documented he did not agree with the outcome of the MHA assessment of 17 July 2012. He concluded P had a mental disorder which required detention for assessment in hospital in the interests of his protection and for the protection of others. The forensic specialist registrar referred P to the clinical director /consultant psychiatrist with responsibility for Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) forensic service, based at Meadowcroft Psychiatric Intensive Care Unit (PICU).

1.67 The referral stated P had been assessed twice by local mental health services in court, and both had concluded he was not detainable or suffering from a mental health disorder. But, the referral states that 'our longitudinal assessment is the reverse' and that 'the mental health team at HMP Hewell

[12] Specialist registrar (now Specialty Registrar or SpR) is a doctor who is working as part of a specialty training with a minimum of six years' experience (previously 4-6 years' experience).

are of the view he suffers from a schizophreniform psychosis which is of a degree that warrants detention in hospital'.

1.68 The initial referral was made to PICU on 4 September 2012 and in the absence of a response, the referral was resent on 12 September 2012.

1.69 The PICU specialist registrar with the PICU's deputy and ward manager assessed P on 20 September. Only the ward manager had previously undertaken such an assessment.

1.70 The assessment reported that P had symptoms in keeping with the criteria for 'at risk mental state for psychosis of early psychosis, but concluded they did not feel that a PICU admission was appropriate.

1.71 The HMP Hewell forensic specialist registrar disagreed with the PICU assessment. In his opinion P needed to be referred to the local CMHT prior to his release.

1.72 At the MDT meeting on 4 October 2012, it was agreed that P would be referred for a further PICU assessment.

1.73 It was also agreed that if the PICU assessment decided P did not require a hospital admission, the MDT would request that the PICU assessor refer him to the Home Treatment Team. This letter was sent to the PICU unit on 8 October 2012 but PICU was unable to locate the letter. No agency therefore referred P to community mental health services, either prior to or after his release from HMP Hewell.

1.74 P was released from HMP Hewell on 15 October 2012. He was provided with three days' supply of his medication (Olanzapine).

**20 October – 13 December 2012**

1.75 On 20 October 2012 P was arrested in a car park on suspicion of possession of cocaine and vehicle interference. In custody P was assessed twice by the FME and assessed as fit to be interviewed and detained.

1.76 P appeared at a magistrates court (22 October 2012) and pleaded guilty to interfering with a motor vehicle. He was remanded and transferred to HMP Birmingham to serve an additional 28 day custodial sentence for the offence and an 11 week sentence for re-offending whilst on license.

1.77 P was initially screened at reception in HMP Birmingham by a nurse. P denied having any mental health problems but the nurse was concerned about his presentation and referred him for a first night mental health assessment. A Cell Sharing Risk Assessment (CSRA) was completed. This assessed he was at high risk for cell sharing. He was placed in a single cell on the prison's general population wing. P was discussed at the mental health in-reach[13] MDT meeting (22 October 2012) and referred to the mental

[13] Prison mental health in-reach services are mental health teams that work within prisons to provide a community type service to prisoners with mental health problems. For more detail see: A National Evaluation of Prison Mental Health In- Reach Services December 2009 http://www.ohrn.nhs.uk/resource/Research/Inreach.pdf

health in-reach team and allocated a nurse key worker. P was scheduled to be assessed by the consultant psychiatrist (7 November 2012) but he did not attend.

1.78 A further appointment was made for P to see the Consultant Psychiatrist on 21 November 2012 but P did not attend this appointment either. P continued to deny to the nurses that he was experiencing any symptoms of mental illness. He could not recall why he was assessed by the BSMHFT's PICU Team whilst he was in HMP Hewell.

1.79 P was seen jointly by the Consultant Psychiatrist and his nurse key worker on 12 December 2012. P denied hearing voices but was difficult to engage. He was not presenting with any active or acute mental health problems nor any immediate risk of self-harm or suicide. The plan was to refer P to BSMHFT's Homeless Team on his release. It was the consultant psychiatrist's intention to review P's notes from HMP Hewell but this did not happen before he was released.

1.80 P was released from HMP Birmingham custody the next day (13 December 2012). The healthcare team were not informed that P was being released.

1.81 It is not known where P lived from December 2012 up to the incident. It is thought he was homeless.

## Findings

1.82 Because of the quality and comprehensiveness of the initial investigation, the focus of our investigation was to review the progress made with the implementation of recommendations amongst the partner organisations, and to identify any further opportunities for learning to improve services.

1.83 We were pleased to note that in the main, those organisations involved had worked diligently and nearly all recommendations from the initial investigation had been implemented.

### General Practice

1.84 We found that the GP practice involved had implemented the recommendations. In summary there was an improved screening approach for new registrants, monitoring and documenting concerns and contacts with children and young people with mental health problems and their parents. Key changes included new patients on the practice list having their medical history reviewed by a senior partner and careful documentation of histories on patients there were concerns about.

1.85 However, there are further opportunities for services to improve and we have made recommendations for the CCGs and GP members to share good practice and learning arising from this investigation, and also for other GP practices to review the systems and practices they have in place to support the parents of young people with mental health problems.

**Risk and domestic violence**

1.86 We noted that there had been a Multi-Agency Risk Assessment Conference (MARAC) in May 2012 and plans were put in place to protect the risks posed by P to his mother.

1.87 However, we identified that adolescent to parent violence and abuse was a remaining concern and a hidden problem, and that more could be done to detect it and support families.

1.88 Alongside this many of the risk assessments completed did not seek or correctly identify other sources of historical information or communicate with other agencies involved. This could have altered the risk assessment outcomes. This extended to the prison healthcare centres and the use of the Care Programme Approach for people with mental health problems.

**Black Country Partnership NHS Foundation Trust – CAMHS**

1.89 We found that much had changed in the intervening period within Child and Adolescent Mental Health Services (CAMHS) in Sandwell. The Trust has developed new operational policies, including guidance on clear communications with third party organisations involved in patients care.

1.90 There is a new policy for managing 'did not attend' appointments for young people and a much greater focus on record keeping.

1.91 There are now weekly audits to review compliance with policy and practice.

1.92 There are several new services, which if available for P when he was younger could have made a difference.

1.93 There are new Crisis Assessment and Intervention Teams for young people and families in mental health crisis, available 8am to 8pm, seven days a week.

1.94 Alongside this there is a new Early Intervention Service for young people with emerging psychosis or other serious mental health problems. The CAMHS team are now closely linked with the local Multi Agency Safeguarding Hub (MASH) for children and young people, which is intended to promote closer working between agencies where children are at risk of harm.

1.95 We asked all of the CAMHS practitioners who we interviewed to reflect on which care pathways would be available to P and his family, if he presented now. They unanimously said that P would still not be assessed as "high-risk" as he was not presenting with any major symptoms of anxiety or depression. The problems he was presenting with would still be seen as a school-based problem.

**Schools**

1.96 The school which P attended is now an academy. If a school now requires additional support services to tackle issues such as gangs or increased self-harming, they have the funding to bring in additional support services, such as counsellors and behavioural therapists. We were told that local BCPFT CAMHS mental health workers now provide training in the local schools.

1.97 Additionally Sandwell Children's Services now convene co-production meetings, which include health and local authority commissioners, to review local children's service strategies and services.

**Black Country Partnership NHS Foundation Trust – criminal justice and mental health services**

1.98 P was in contact with both the Crisis and Home Treatment Team and the Criminal Justice Mental Health Liaison Team. These teams have new Operational Policies, which promote closer working together.

1.99 There is a new Black Country Liaison & Diversion (L&D) Service, whose remit is to work much more closely with people in custody, whilst the CJT had a closer focus on people in contact with the courts.

1.100 Following the initial investigation recommendations, the Trust has changed the "Did Not Attend" (DNA) policies for its adult and children's services.

1.101 The Trust is also piloting a new 'Street Triage' scheme, which works much more closely with local police, supporting them when dealing with people with mental health problems and hopefully diverting them away from criminal justice services into more appropriate mental health care.

**HMP Hewell (Healthcare)**

1.102 The healthcare team in HMP Hewell has addressed the recommendations for its services:

- GP information is now inputted onto SystmOne
- Administration staff phone the GP if a fax is to be sent.
- Discharge summaries are given to the prisoners at the point of release and if a prisoner is registered, a copy is sent to their GP surgery.
- The service has a new CPA process and has reviewed and changed how the service undertakes liaison with community services, including GPs and primary care.
- There is a new provider (Care UK) of healthcare services within HMP Hewell.

1.103 The Discharge summaries are given to the prisoners at the point of release and if a prisoner is registered, a copy is sent to their GP surgery. This

remains a challenge for the approximately 20% of prisoners who are not registered with a GP.

1.104 However, we found that the service had identified problems with arranging care for prisoners released earlier than planned. There also remained a problem of logging correspondence from relatives into the prison.

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

1.105 The Trust has implemented the actions required of it. These include:

- Revised guidelines for PICU staff undertaking assessments in prison
- Improved guidance for escalation, when there is disagreement about the outcome of an assessment of a referral
- A new single point of entry for mental health services
- Improved audit and clinical supervision processes

It is also significant that this tragic incident permeates everything the Trust now does. The incident is used in induction for new staff. Few staff have not heard of Christina and her sad death. The senior management team continue to use the care of P as a benchmark against which it judges progress in improving services.

**HMP Birmingham (Healthcare)**

1.106 Since the incident HMP Birmingham (Healthcare) have worked hard to address the findings of the initial investigation.

1.107 There is a new screening pathway for new prisoners, with an improved 'first night' screening process, and also improved discharge planning for planned release prisoners.

1.108 It is possible to undertake more checks on SystmOne, though they are still not able to access all information on previous prison spells.

1.109 HMP Birmingham (Healthcare) also identified a problem with arranging aftercare for prisoners released early, and the problems of high churn of high volumes of prisoners.

1.110 Other inspections of the prison have found problems with increased waiting times for prisoners requiring transfer to mental health care.

**West Midlands Police**

1.111 Prisoners in custody are now asked routinely for details of GPs, but again this remains a problem for the 20% who are not registered with GPs.

1.112 The police have not been able to engage with primary care services to roll out their information sharing protocol.

1.113 Prisoners who opt out of information sharing on the 'Spine'[14] information system present continued problems for the custody nursing staff and street triage.

### Housing and aftercare

1.114 We noted the much improved pathway for those with planned release from prison. We were pleased to see the increased range of services, through partnership with the third sector, focussed on providing more accessible support and housing for people with mental health problems in Birmingham.

### Offender Rehabilitation Act (ORA) 2014[15]

1.115 Since 2015, if a person receives a prison sentence of less than 12-months, the prisoner will be released on an ORA licence,[16] after serving one half of their sentence. The remainder of the sentence being served in the community. They, and those who have been sentenced to less than 2 years in prison, will be monitored for up to 12 months by a named probation officer.

1.116 In P's case, if an ORA licence had been available it would have been helpful as it would have provided him with one named person who would have been overseeing his release. This could have enabled the opportunity for an assessment of P's presentation to have taken place and a referral made to both adult mental health and homelessness services. As it was there was no supervision or support for P when he was released from both HMP Hewell and HMP Birmingham.

### Forward Thinking Birmingham

1.117 Since this incident the Clinical Commissioning Groups (CCGs) of NHS Birmingham South Central, NHS Birmingham Cross City, and NHS Sandwell and West Birmingham have commissioned a new service for children and young people under 25 with mental health problems. In April 2016 the Forward Thinking Birmingham (FTB) service was launched. It is a consortium of providers of mental health services for children and young people from age 0 to 25 years. One of its core visions is that "Care will be delivered in a more joined-up manner across all services in the city to the benefit of patients and families."[17]

1.118 The commissioners have informed us of their intention to develop a more open, inclusive and accessible service for young people with mental health problems.

1.119 We discussed with the Birmingham Cross City CCG commissioners and FTB managers how this new service and pathways might have identified P's risks

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[14] The **Spine** is a set of national services used by the **NHS** Care Record Service. These include: The Personal Demographics Service (PDS), which stores demographic information about each patient and their **NHS** Number, http://systems.hscic.gov.uk/ddc/spine

[15] Offender Rehabilitation Act (2014) http://www.legislation.gov.uk/ukpga/2014/11/contents/enacted

[16] Under the ORA, adults serving prison sentences of less than 12 months, for an offence committed after 1 February 2015, will be released on licence after serving one half of their sentence in prison and will serve the remaining period in the community.

[17] https://forwardthinkingbirmingham.org.uk

and support needs. We also discussed how accessible such services are to people from different cultural backgrounds, such as P and his family. We noted the following FTB services which may have provided the opportunity for P to receive the care and treatment he needed:

- 24/7 telephone help line offers “immediate access to mental health crisis support for all 0-25s, families, friends, health professionals, schools and anyone else with a concern”.
- Access Centre, acts as “the front door for all patients and referrers.”[18]
- FTB provides support and therapy for not only the child or young person but for the whole family.
- PAUSE city centre hub: operates seven days a week and offers a drop in for anyone under the age of 25 years old and includes open access for parents and carers, young people and young adults. Pause have access to sign-post anyone on to psychological and primary care services where indicated
- FTB have links with both the court diversion service as well as the street triage service.
- Pattigift provides psychotherapy and counselling and Start again services provide emotional, housing, practical support to vulnerable young people.

1.120 If P had presented himself to such services when he was released from both HMP Hewell and HMP Birmingham, it could have been the pathway to an initial mental health assessment and access to secondary community mental health services.

1.121 We also noted Anawin Rehabilitation service which provides support for young women who attend voluntarily after a custodial sentence or as part of their community sentence. The focus on the service is rehabilitation after a custodial sentence and also prevention of re offending.

1.122 We were informed by West Midlands Police Detective Chief Inspector and Force Lead for Mental Health that he is currently involved in developing a service for young men of African and Caribbean heritage, who are over represented within their prisoner groups and who are most at risk of reoffending. Progress of this development is being monitored by their Mental Steering Group.

[18] The service is open from Monday to Friday (8am-8pm) and Saturday and Sunday (10am-3pm). Outside of these hours there is a direct emergency out-of-hours crisis service https://forwardthinkingbirmingham.org.uk

### National Recommendations

1.123 We noted that one of the overarching problems still outstanding with this incident was that there was no single body to bring together the completion of recommendations, and to oversee completion.

1.124 There remains a conflict with an individual's right to privacy versus the need for enhanced management of risk for vulnerable people with mental health problems and increased information sharing. This is best addressed at a national level between NHS England and the Ministry of Justice.

### Initial investigation and oversight

1.125 The initial investigation was extensive and comprehensive, with a wide ranging panel of expertise. We felt the constitution of the panel could have been improved by additional expertise from Sandwell or Black Country Services.

1.126 We noted that NHS Birmingham Cross City CCG had worked hard to try and pull together oversight of the extent of completion of individual organisation action plans. But because of the complicated nature of the commissioning of this initial investigation, it has never been clear if it was an internal investigation 'owned' by BSMHFT or a multi-agency investigation overseen by the CCG.

1.127 It was initially thought that the Birmingham Safeguarding Children's Board could have provided oversight, but this did not happen. We heard that the Safeguarding Adults Board retained an interest and regularly asked the CCG for updates on progress of completion of action plans.

1.128 The tragic death of Christina occurred at a time of organisational change within the NHS. Because of this, it seems there was a lack of commissioner oversight. We believe that were such an incident to happen now, a regional arm of NHS England would take charge of commissioning the investigation and the Birmingham Safeguarding Adults Board would provide oversight across the different agencies and organisations for completion of action plans.

1.129 We found that although the organisations involved had worked diligently to complete and implement the actions, and that an update of the state of implementation had been requested by the CCG, there had been no opportunity for all the services involved to share the learning and work collectively to develop new pathways and solve problems.

## Predictability and preventability

1.130 We agreed with the initial investigation that the death of Christina was not predictable.

1.131 However, we found that it was predictable that P's mental health would continue to deteriorate. He had multiple risk factors including: previous history of violence, threats to kill, being released into the community without

access to mental health service or supervision and was in a state of denial about his problems.

1.132 Based on these, and the escalation of his problems and offences, in our view it was predictable that P was at significant risk of reoffending, and that this would involve an act of violence. We believe that this would have been directed at a family member, most probably his mother. That he would attack a stranger was not predictable.

1.133 During our investigation it was evident that over time there had been a systemic failure within multiple organisations and by some professionals to correctly assess and identify P's increasing risk of dangerousness. This was linked to his social isolation on release, homelessness, history of escalating erratic and violent behaviour, substance misuse and mental health needs.

1.134 This was compounded by other factors. Alongside a quiet and shy demeanour, it seems that P could manage to conceal his mental health problems when assessed for a time. Many of the services in contact with P failed to triangulate historical information from other services in order to build up a more comprehensive picture of P and his problems. This led to what appears to be an exponential failure in service provision, in particular the lack of support upon his release from HMP Hewell or HMP Birmingham.

1.135 We therefore fully endorse the initial investigation findings that the homicide of Christina by P was directly related to his mental illness and in our view, it is likely that the homicide might have been prevented, if his mental health needs had been identified and met.

1.136 We believe that if all the measures and new services that are now in place were in place, it is more likely that P's mental health would have been better monitored and more likely also that he might have had access to a more supportive and caring environment, instead of being homeless and left untreated in the community.

## Overall analysis and recommendations

1.137 During the course of this investigation we have identified many of the profound difficulties that faced both P and his family in his route through health and criminal justice services which led up to Christina's tragic death.

1.138 We fully concur with the findings of the initial investigation report that there were a number of missed opportunities to initiate a more appropriate response for Ps mental health care, starting with his initial contact with BCPFT's CAMHS, then from primary care services, and his later contact with prison health and the criminal justice services.

1.139 Since then it is clear the services involved have taken the findings of the initial investigation report seriously and have largely addressed and responded to all of the recommendations.

1.140 However it is of continued concern to us that despite the high number of reports and inquiries into high profile homicides, many of the same issues

that arose in those investigations are identified in this report. Many of the underlying systemic changes needed to provide integrated mental health services still remain, despite the steady progress over recent years with new services such as In-Reach, Liaison & Diversion and Street Triage.

1.141 The largest concern shared by all on the investigation panel and many of the people we interviewed was that despite these efforts, the challenges to ensure appropriate after care on release for prisoners with mental health problems remain. If we were able to make just one recommendation to improve services and reduce the likelihood of such a tragic case happening again, it would be that the national services concerned (Department of Health, NHS England and Ministry of Justice) strenuously work together to improve the care and aftercare of prisoners with mental health problems.

1.142 Despite this we also want to recognise, not just the individual service efforts made to address the findings of the initial investigation report, but also the other wider changes made to services across the West Midlands that we hope will lead to earlier detection and access to more appropriate and timely intervention for offenders with mental health problems.

## Recommendations

Where appropriate throughout the report we have made 25 recommendations to improve practice. These have been given one of three levels of importance:

- Priority 1: the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems/process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.
- Priority 2: the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems/process objectives. The area of concern does not compromise the safety of patients, but identifies important improvements in the delivery of care required.
- Priority 3: the recommendation addresses areas that are not considered important to the achievement of systems/process objectives. The area of concern relates to minor improvements in relation to the quality of service provision.

The following list shows the recommendations in priority order. Throughout the text of the rest of this report they are presented in numerical order, as they refer to aspects of our findings and investigation.

**PRIORITY 1**

**HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)**

Recommendation 8: Staff undertaking the initial Care Programme Approach Plan must ensure that they liaise with all agencies who have been involved with the prisoner, in the community and/or during the court process, in order to obtain an accurate profile of their needs and risks to themselves and others.

Priority 1

**Department of Health, NHS England, CCGs and local Police and Crime Commissioners**

Recommendation 11: To work in partnership to roll out and further develop the street triage service to reduce the impact of mental health crises on local police and emergency services.

**Priority 1**

**NHS England Specialised Commissioning Health & Justice commissioners, prison health care providers and Ministry of Justice**

Recommendation 15 : The specialist health and justice commissioners, prison healthcare providers and the Ministry of Justice should work together to improve discharge planning of vulnerable prisoners with mental health problems who are released earlier than planned, and produce clear guidelines for all healthcare staff to refer to other mental health services.

**Priority 1**

**NHS England and Ministry of Justice**

Recommendation 18: To consider what protocols if any, within the current legislative framework can be developed and implemented to share relevant healthcare information about prisoners at risk of mental health problems who refuse consent to share information with GPs.

**Priority 1**

**HMP Hewell and HMP Birmingham, BCPFT, BSMHFT, NHS Birmingham South Central CCG, NHS Birmingham Crosscity CCG, NHS Sandwell and West Birmingham CCG, West Midlands Councils, West Midlands Ambulance Service, the Crown Prosecution Service.**

Recommendation 19: The named partner agencies should work collectively to 'sign off' the information sharing protocol as soon as possible, ensuring wider membership as much as practicable across the West Midlands public sector so long as this does not delay completion.

**Priority 1**

**NHS England Specialised Commissioning Health & Justice commissioners, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare).**

Recommendation 21: The above to seek assurance that the current pathway for released prisoners with mental health problems ensures that those in need have access to appropriate mental health care after release

**Priority 1**

**Forward Thinking Birmingham and HMP Birmingham (Healthcare) and HMP Hewell (Healthcare)**

Recommendation 22: Forward Thinking Birmingham, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare) should review the new service provision, to ensure that the referral and homeless pathways are effectively utilised to identify and support young offenders being released into the community.

**Priority 1**

**Forward Thinking Birmingham and NHS Birmingham CrossCity CCG**

Recommendation 23: To ensure that the recommendations and lessons learnt from this incident continue to inform the development of services for vulnerable young people in contact with mental health and criminal justice services.

**Priority 1**

**All local and national organisations involved in this case and the implications of the recommendations (BCPFT, Care UK/ HMP Hewell (Healthcare), BSMHFT (PICU and HMP Birmingham (Healthcare), Forward Thinking Birmingham, West Midlands Police, NHS Birmingham South Central CCG, NHS Birmingham Crosscity CCG, NHS Sandwell and West Birmingham CCG Sandwell Social Services, Birmingham Safeguarding Adults Board, NHS England and HMPs Hewell and Birmingham.**

Recommendation 24: There should be a local 'lessons learned' day, as soon as practicable, for each organisation to share with others an update on the progress made on the implementation of their action plans, seek clarification and share experiences. We also recommend that the outcome of the 'lessons learned day' is a shared understanding and agreement of how oversight of the recommendations made in this independent investigation will be taken forward, and which body is best placed with the appropriate authority to do this.

**Priority 1**

**NHS England**

Recommendation 25: Should provide clear guidance for the 'ownership', commissioning and oversight of future very serious incident investigations that cross organisational and agency boundaries, so that local responsibilities are very clear.

**Priority 1**

**PRIORITY 2**

**Black Country Partnership NHS Foundation Trust**

Recommendation 1: The Child and Family Service Operational Policy must provide clear guidance on how CAMHS clinicians are to work with other partner agencies and the young person's family in the assessment and support planning processes.

**Priority 2**

**Black Country Partnership NHS Foundation Trust**

Recommendation 2: The Trust's revised Record Keeping Policy must include reference to the importance of documenting the details and the involvement of other involved agencies.

**Priority 2**

**Black Country Partnership NHS Foundation Trust**

Recommendation 3: Black County Partnership NHS Foundation Trust should ensure that the CAMH services are culturally sensitive to the needs of a patient and their families, and that they recognise and understand the potential impact of immigration on the family.

**Priority 2**

**NHS Sandwell and West Birmingham CCG and NHS Birmingham CrossCity CCG and their GP practices.**

Recommendation 4: NHS Sandwell and West Birmingham CCG and NHS Birmingham CrossCity CCG and their GP practice members should share the learning from the initial investigation and roll out the enhanced safeguarding practices now implemented in Ps final GP practice.

**Priority 2**

**NHS Sandwell and West Birmingham CCG and their member GP practices,**

Recommendation 5: NHS Sandwell and West Birmingham CCG and its member GP practices should review the systems they have in place to identify and support parents of children who have mental health problems to ensure that they are providing them with appropriate levels of support, including referral for a carer's assessment.

**Priority 2.**

**West Midlands Police**

Recommendation 6: Before the decision is made by the police to remove safety and alert equipment from a victim of domestic violence West Midlands Police should ensure that a full risk assessment is undertaken to inform this decision. All relevant agencies and the victim should be involved in this assessment and decision.

**Priority 2**

**HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)**

Recommendation 7: Healthcare staff at both HMP Hewell and HMP Birmingham who are undertaking CPA and risk assessments should familiarise themselves with the Home Office 'Adolescent to Parent Violence and Abuse Guidance for Practitioners' (2015) and be categorising incidents of violence by children on a parent and/or carer as incidents of domestic abuse.

**Priority 2**

**Black Country Partnership NHS Foundation Trust**

Recommendation 9: The new EHR must facilitate the recording of other agencies involvement and contact details.

**Priority 2**

**Black Country Partnership NHS Foundation Trust**

Recommendation 10: The Trust should assure itself that the new DNA/ No Access Visit policies are complied with.

**Priority 2**

**HMP Hewell (Healthcare) and NHS England's Health and Justice Commissioning Team (North Midlands).**

Recommendation 12: NHS England's Health and Justice Commissioning Team (North Midlands) should discuss the findings of the original Trust report with the new provider of healthcare at HMP Hewell to ensure that implementation is still progressing and that lessons learnt are continuing to inform practices and policies.

**Priority 2**

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

Recommendation 14: The Trust should discuss their PICU guidance with all the prison health care services who refer to their PICU units.

**Priority 2**

**HMP Birmingham (Healthcare) and Birmingham and Solihull Mental Health NHS Foundation Trust**

Recommendation 16: HMP Birmingham (Healthcare) should provide assurance to the Trust and their commissioners that the issues with SystmOne (accessing prisoner's full medical notes from the point of admission) have been resolved.

**Priority 2**

**West Midlands Police**

Recommendation 20: West Midland's Police should formalise the involvement of family and carers within their policies and protocols, relating to information sharing.

**Priority 2**

**PRIORITY 3**

**HMP Hewell and HMP Birmingham**

Recommendation 13: Both HMP Hewell and HMP Birmingham introduce a requirement, supported by guidance, that all prison staff, including the governor's office and pastoral care services, should document any contact, either written or verbal, with prisoners' families in a prisoner's P-NOMIS record.

**Priority 3**

**NHS England Specialised Commissioning Health & Justice commissioners, prison health care providers, G4S and Ministry of Justice**

Recommendation 17: to consider what action can be taken to allow healthcare teams in prisons to have access to the prison records P-NOMIS.

**Priority 3**

The investigation team would like to offer their deepest sympathies to the family of Christina Edkins. It is our sincere wish that this report does not contribute further to their pain and distress.

It is at the request of both families, and to minimise any distress, that Christina is referred to by her full name, and the perpetrator as P, throughout this report.

We would also like to thank P's mother for her valuable contribution to this investigation. It is equally our sincere wish that this report does not contribute further to her pain and distress.

The investigation team would like to acknowledge the contribution and support of staff from:

- Birmingham Safeguarding Adults Board
- Birmingham and Solihull Mental Health NHS Foundation Trust
- Black County Partnership NHS Foundation Trust
- Care UK
- Forward Thinking Birmingham
- HMP Birmingham (Healthcare)
- HMP Hewell (Healthcare)
- NHS Birmingham CrossCity CCG
- NHS Birmingham South Central CCG
- NHS Sandwell and West Birmingham CCG
- NHS England
- NHS England Health and Justice Commissioning Team (West and North Midlands)
- Partnerships in Care
- University Hospitals Birmingham NHS Foundation Trust
- West Midlands Police

# 2 The events that led to the death of Christina Edkins

2.1 The following information was taken from the Court transcript, 2 October 2013.

2.2 CCTV and eye witnesses' evidence indicated that on 7 March 2013 shortly after 5.00am, P aged 23, boarded the number 9 bus (the bus) close to Birmingham city centre. P presented a travel card, which was later found not to belong to him and he went to the upper deck of the bus. At about 5.25am after he had eaten some food, he took an item out of the bag which was "estimated to be about 10 to 12 inches in length and had a reflection on it". CCTV also showed that P then changed seats and appeared to go to sleep. Shortly after 7.25am after a passenger informed the bus driver that P was asleep, the driver went to the upper deck and saw P, but he took no action.

2.3 At the subsequent Crown Court hearing the prosecution reported that "at one point (P) went to walk downstairs carrying the white plastic bag but thought better of it and went back to sit at the back of the bus where he started to drink from a bottle". CCTV evidence showed that at 7.30am, immediately prior to Christina Edkins boarding the bus, P had withdrawn an item from his coat, which was described by the prosecution as being "light coloured or reflective" which he then placed into the white plastic bag. Christina boarded the bus at approximately 7.30am and sat on her own in a seat on the upper deck of the bus. Within seconds of Christina sitting down, P got up and moved forward three seats and sat down. CCTV evidence showed P taking the knife from his bag and then hiding it between his hands and thigh. P then stood up and walked towards Christina, stabbed her and then disembarked from the bus. Emergency services attended the scene but Christina was declared dead at about 8.00am.

2.4 The post mortem report concluded that Christina died from a single stab wound.

2.5 Christina and P were not known to each other.

2.6 A number of eye witnesses and the bus driver were able to provide police with a detailed description of P. P was subsequently arrested, a bag, containing a mobile phone, a "smoked spliff" (a hand rolled cannabis cigarette) and a knife was found hidden in nearby bushes belonging to P. Subsequent forensic tests proved that this was the knife P had used to stab Christina. During police questioning P reported that he had bought the knife the previous day, as he feared for his safety.

2.7 P appeared before the Crown Court and was convicted of manslaughter on the grounds of diminished responsibility (2 October 2013).

2.8 P is currently detained under Section 37/41 of the Mental Health Act 1983 (amended 2007) in a secure psychiatric hospital.[19]

[19] This is a court order, which can only be made by the Crown Court, which imposes a s37 hospital order together with a s41 restriction order. A s37 is a court order imposed instead of a prison sentence, if the offender is sufficiently mentally unwell at the

## Christina Edkins

2.9 At the time of her death, Christina was 16 years old. She was the youngest child of the family and was studying for her GCSE exams.

2.10 On the morning of the incident Christina was on her way to school.

2.11 At the Crown Court Hearing, Christina was described as “a living breathing, caring and exciting young woman. She was taking the world by storm. She was full of care, concern and generosity”. Her head teacher wrote “if a school could chose its pupils it would be full of Christina’s”.

# 3 Independent investigation into the care and treatment of P

## Basis for this investigation

3.1 On 1 April 2015 NHS England introduced the revised Serious Incident Framework[20], which:

> “Aims to facilitate learning by promoting a fair, open, and just culture that abandons blame as a tool and promotes the belief that incidents cannot simply be linked to the actions of the individual healthcare staff involved but rather the system in which the individuals were working. Looking at what was wrong in the system helps organisations to learn lessons that can prevent the incident recurring.”

3.2 Identified within the Serious Incident Framework are the following criteria for the commissioning of an independent investigation:

> “When a homicide has been committed by a person who is or has been in receipt of care and has been subject to the regular or enhanced care programme approach, or is under the care of specialist mental health services, in the 6 months prior to the event.”

3.3 Article 2 of the European Convention on Human Rights[21] provides a legal basis to the investigation of serious incidents in mental health services. This imposes a procedural obligation on the State to conduct an investigation in circumstances where the State owed a duty to take reasonable steps to protect a person’s life, because a person was under the State’s control or care and the State knew (or ought to have known) there was a real and immediate risk to the person’s life.

time of sentencing to require hospitalisation The s41 restriction order is imposed to protect the public from serious harm. The restrictions affect leave of absence, transfer between hospitals, and discharge, all of which require Ministry of Justice permission

[20] NHS England; “Serious Incident Framework. Supporting learning to prevent recurrence” 1 April 2015 https://www.england.nhs.uk/patientsafety/serious-incident/

[21] Department of Health; “Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services” November 2015 https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

3.4 In September 2015 NHS England (Midland and East Region) commissioned Niche Health & Social Care Consulting (previously Niche Patient Safety) to undertake an independent investigation into the care and treatment of P and the events that led up to the homicide of Christina to identify further opportunities for improvement and learning.

3.5 Because of the quality and comprehensiveness of the initial investigation, the intention of this report is not to cover the same ground again. Instead the remit was to review the initial investigation to identify if there are any further opportunities for learning and service improvement, and to review progress on the implementation of recommendations.

3.6 Although Christina is not the subject of our investigation her tragic death and the effects that it has had on her family and the community has consistently been at the forefront of our minds throughout this investigation.

## Structure of the report

3.7 In September 2014 Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) published a report following an investigation into "the circumstances surrounding the death of Christina ….in enabling lessons to be learned."[22] We refer to this report as the 'initial investigation report'.

3.8 This report made an extensive number of recommendations to local, regional and national bodies. It is not our intention to duplicate this comprehensive report but simply to highlight aspects that we considered and identified as requiring further investigation and comment.

3.9 In addition, we have reviewed the progress the various agencies, services and Trusts have made on the action plans and recommendations made in this report.

3.10 We have also been asked to consider whether the incident on 7 March 2013, which led to the death of Christina, was either predictable or preventable.

3.11 The terms of reference (ToR) for this investigation can be found in Appendix B. In developing the ToR, the Head of Independent Investigations at NHS England (Midlands and East Region), who commissioned this report, met with both Christina and P's family.

3.12 The investigation team Chair and author also met with both families and discussed with them the areas they wished us to revisit and consider during the course of our investigation. They raised particular concerns in relation to the:

- lack of interagency communication;
- significant deficits in multiagency services;

[22] "Dr Alison Reed (Chair). "Homicide Investigation Report into the death of a child: STEIS Reference: 2013/7122" Final Report– September 2014, http://bhamcrosscityccg.nhs.uk/about-us/publication/safeguarding/674-final-pdf-report-september-2014/file

- individuals' accountability for the decisions that were made;
- lack of liaison with families; and
- preventability of the incident.

3.13 These have been reflected in the ToR, and we have addressed these so far as we have been able to throughout this report.

3.14 As this investigation was commissioned by NHS England, the focus of our investigation has been on NHS services. We had limited jurisdiction with partner organisations which sit outside the NHS structure but which play an important and parallel part in the delivery of mental health services. All NHS organisations we contacted cooperated fully with this investigation as did the West Midlands Police and Birmingham Safeguarding Adults Board.

3.15 This report has been divided into the following sections:

- P's childhood up to 2007
- 2007 to 2009
- 2009 to December 2011
- 18 July 2012 to 15 October 2012 (HMP Hewell)
- 20 October 2012 to 13 December 2012 (HMP Birmingham)

3.16 We then review in more depth other key aspects including:

- Risk and discharge planning
- West Midlands Police
- Ethnicity
- Housing
- Forward Thinking Birmingham
- National recommendations
- The initial investigation and action plan
- Predictability and preventability

3.17 Where it is required, some sections have arising issues and commentary in a subsection. These provide either:

- additional information that we have obtained;
- further commentary; and,
- analysis of the issues that have been identified in that section.

3.18 Where appropriate throughout the report we have made recommendations. These have been given one of three levels of importance:

- Priority 1: the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems/process objectives and without which the delivery of safe and effective clinical care would, in our view, be compromised.
- Priority 2: the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems/process objectives. The area of concern does not compromise the safety of patients, but identifies important improvements in the delivery of care required.
- Priority 3: the recommendation addresses areas that are not considered important to the achievement of systems/process objectives. The area of concern relates to minor improvements in relation to the quality of service provision.

3.19 At the end of each section there are associated recommendations. A full list of all the recommendations is in Appendix A.

3.20 We have provided a full chronology from February 2012. This can be found in Appendix C.

## Niche Health & Social Care Consulting investigation team

3.21 This investigation was chaired by Kiran Bhogal who is a partner and Head of Healthcare (London) at Hill Dickinson LLP. She has extensive experience of advising the health and public sector on medico-legal issues including mental health law, the law relating to children, child protection, complaints handling, complex and sensitive inquests, clinical and corporate governance, serious untoward incidents (including homicide inquiries) and human rights.

3.22 Grania Jenkins was the senior investigator and report author. Grania is a senior mental health care, performance and quality professional who has worked in primary, secondary and third sector organisations. She has extensive experience of undertaking investigations into critical incidents, unexpected deaths and suicides.

3.23 Dr David Ndegwa was the clinical advisor in forensic psychiatry. Dr Ndegwa is a consultant forensic psychiatrist in the NHS with considerable experience of all aspects of psychiatric services. He has been a clinical director for more than 16 years and has led and developed services in a part of London which is culturally diverse with high psychiatric morbidity and rates of violent crime.

3.24 Bill Abbott, OBE, provided advice on criminal justice and secure mental health services policy issues. He has been a prison governor, and advised on criminal justice and security with the North West Secure Commissioning Team. He later became the senior policy adviser to Department of Health Secure Services Policy Team.

3.25 Dr Jane Winstone provided the expertise in management of adult offenders with mental health needs within a multi-agency environment. She has extensive experience in the interface between these services, and has

worked as a youth and adult probation officer in community and secure settings, before moving to the University of Portsmouth to develop and lead the qualification in probation training and more recently the Professional Doctorate in Criminal Justice.

3.26 Nick Moor, director of Niche Health & Social Care Consulting was co-chair and focused on reviewing governance arrangements for the initial investigation report and testing the evidence supplied by organisations as assurance for the implementation of their action plans developed in response to the recommendations. He provided additional project management support and editing of the final report.

3.27 For the purpose of this report, the investigation team will be referred to in the first person plural.

3.28 Where appropriate we have referred to the relevant Black Country Partnership NHS Foundation Trust (BCPFT) and Birmingham and Solihull Mental Health NHS Foundation Trusts' (BSMHFT) policies that were in place at the time of the incident as well as those that have been revised in response to the recommendations from the initial investigation report. We have also referred to relevant NHS England, Department of Health (DH) and National Institute for Health and Care Excellence (NICE) guidance and best practice guidelines.

3.29 As far as possible we have tried to eliminate or minimise hindsight or outcome bias[23] in both our investigation and our analysis of the information available to primary and secondary care services at the time of the incident. However, where hindsight informed our judgement, we have identified this.

3.30 The list of people interviewed during the course of this investigation can be found in appendix D. Interviews were managed by reference to the National Patient Safety Agency's (NPSA) investigation interview guidance.[24]

3.31 Where there has been the potential for perceived criticism of individuals or their actions we have adhered to the Salmon/Scott principles.[25]

3.32 Where reference is made to the Mental Health Act it is a reference to the Mental Health Act 1983 (as amended in 2007) ("MHA").

[23] Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgement and assumptions around the staff closest to the incident. Outcome bias is when the outcome of the incident influences the way it is analysed. For example, when an incident leads to a death, it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair. (National Patient Safety Agency. "Independent investigation of serious patient safety incidents in mental health services. Good practice guidance: February 2008". 2008)

[24] National Patient Safety Agency (2008) "Root Cause Analysis Investigation Tools: investigation interview guidance" http://www.nrls.npsa.nhs.uk

[25] The 'Salmon process' is used by a public inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1996 Royal Commission on Tribunals of Inquiry, whose report, among other things, set out principles of fairness to which public inquiries should seek to adhere

## Anonymity and people's names

3.33 For the purposes of this report:

- The identities of all those who were interviewed have been anonymised and they have been identified by their professional titles.
- The perpetrator is referred to as P.
- At the request of her family, the victim is referred to as Christina.

## Involvement of Christina and Ps' families

3.34 The NHS Serious Incident Framework directs that all investigations should:

"Ensure that families (to include friends, next of kin and extended families) of both the deceased and the perpetrator are fully involved. Families should be at the centre of the process and have appropriate input into investigations."[26]

3.35 Niche Health & Social Care Consulting always try to seek the views of the families of both the victim and the perpetrator, not only in relation to the incident itself, but also their wider thoughts regarding where improvements to services they consider could be made in order to prevent similar incidents from occurring.

3.36 P was invited to be interviewed as part of this investigation but chose not to participate. However his care team have been provided with a copy of this report to share with him.

3.37 The Chair of the panel and the lead investigator met with members of Christina's family on one occasion.

3.38 The Chair of the panel and the lead investigator met with P's mother on two occasions.

3.39 Throughout the course of the investigation, the Chair of the panel, Kiran Bhogal, and the lead investigator, Grania Jenkins, have remained in contact with both families to provide updates on the progress of this report.

3.40 We are extremely grateful for the information that both families have provided, as this has been essential in assisting us to have an accurate chronology of events that led up to the incident itself. Both families also provided valuable background information on the lives of both P and Christina.

3.41 We have provided both families with a copy of our report, and have met with P's mother. We invited Christina's family to meet with us prior to the report

[26] NHS England, Serious Incident Framework. Supporting learning to prevent recurrence, https://www.england.nhs.uk/patientsafety/serious-incident

being published but they declined. However, Christina's family have asked that the following statement from them be included in this report:

*"It is depressing for us to read that 'despite the high number of reports and inquiries into high profile homicides, many of the same issues that arose in those investigations are identified in this report'.*

*Christina's parents and two family members met with the Niche team once, on 4 December 2015, prior to the commencement of their investigation (3.12). We had previously written to Niche on 9 November 2015, detailing our concerns.*

*We challenge strongly the statements (1.130 and 16.4) that the homicide of Christina was not predictable. For the assessment to have any practical sense, the test should not be whether or not it was predictable that the specific set of facts which did occur would do so in that way and that Christina specifically would be the victim of P's act. Rather the proper test is whether or not it was reasonably foreseeable that P would cause serious harm or death to another person. The simplistic test of predictability used in the report is misleading. Similarly, the conclusion drawn that although it was predictable that P may kill a member of his family, but not a third party is not, in our view, credibly supported by the facts. That P increasingly presented a danger to the public and would eventually commit serious harm or even murder was clearly apparent.*

*It was clear that P's mental state was further deteriorating. He had twice threatened to commit murder (1.53 and 1.57) and was left unsupervised and without medication. He had a conviction for carrying a knife (1.63). He was considered as a severe risk to others (1.58). He was found guilty of common assault and assaulting a police officer.*

*There are numerous reported instances of failures to deal effectively with Ps poor mental condition: the most egregious of which was the failure to act on recommendations from the forensic specialist registrar at HMP Hewell that P be detained in hospital (1.66 to 1.74). This was highlighted by the prosecution in the Crown Court as a fundamental mistake leading to the death of Christina. The Judge instructed that the record of the trial be provided to those reviewing the crime. We do not accept the statement that there was a communication failure and misunderstanding between the in-reach psychiatrist and the PICU unit (16.11); that facts are that PICU failed to take appropriate action and P was not treated as was clearly and repeatedly recommended by staff at HMP Hewell.*

*Christina's parents, brother and sister and wider family continue to believe that failings within the NHS and Prison Service led directly to her death, which was both predictable and preventable."*

# 4 P's childhood up to 2007

## Childhood and family background

4.1 P was born in Swaziland in 1990. P is the eldest child. He has two siblings; the youngest was born after the family moved to the UK. P's father was an insurance company clerk and his mother was a teacher who worked with children with learning disabilities. P's parents separated when he was about six years old. When he was first assessed by Black Country Partnership NHS Foundation Trust's (BCPFT) Child and Adolescent Mental Health Service (CAMHS) in 2004 he described having a difficult relationship with his father. After his parents separated, he had no further contact with him.

4.2 P's mother reported that he had had a normal delivery and that he reached all his early developmental milestones. She told us that when the family was living in Swaziland he was a "shy but bright child"[27] who was very protective towards his younger sibling. Also that until they came to the UK, P did not present with any behavioural difficulties.

4.3 After P's parents separated, his mother came to England whilst P and his younger sibling remained in Swaziland living with their maternal grandmother. Initially P's mother came to the UK on a study and then work visa. In 2012 she was granted right to remain indefinitely in the UK.

4.4 When P was 12 years old, in 2002, he and his sibling came to live with their mother in the UK. In 2004, P's mother remarried and when P was 15 years old, she gave birth to another son. This marriage has subsequently ended.

4.5 On P's arrival in the UK in 2002 he registered with a GP. P was seen occasionally by his GP for normal childhood illnesses and sporting injuries.

4.6 In December 2003 he was referred to a paediatric consultant as he was experiencing persistent vomiting that was documented to have commenced before he returned to Swaziland for a holiday. On his return to the UK, P's symptoms continued for four months, with no identified cause. P's symptoms subsequently resolved themselves.

4.7 However on 19 September 2004, the GP documented for the first time that P was being bullied at school and that he was experiencing cluster migraines. P was seen in a paediatric clinic where it was documented that P's migraines were not affecting his school. As tests could not identify any underlying cause, he was discharged from the clinic.

### Early Education

4.8 P's mother reported that whist in Swaziland her son had excelled academically, especially in mathematics. When P arrived in the UK, he was placed initially in year 7 at a local secondary school but after his academic abilities were assessed, he was moved to Year 8.

[27] Noted in various psychiatric reports, post incident.

**2004**

4.9 By March 2004, when P was 13, his school records indicate that the school had begun to contact P's mother to inform her that her son's attendance at school was worsening. This was at the time when P's grandmother, whom he was very close to, had died, and his mother had to return to Swaziland. From this point there was a significant decline in P's academic progress.

4.10 There were numerous incidents documented in his school records of P being involved in confrontations with both staff and other pupils. There were also a number of incidents where it was believed that P was involved in violent altercations between rival gangs of Somalian, Asian and Afro-Caribbean boys. At first the school attributed these incidents to P's increasing behavioural difficulties but on further investigation, the gang issues were also acknowledged. Following one of the school's investigations into an incident where P's life was threatened, several pupils were excluded.

4.11 There was regular communication and liaison between the school and P's mother. She reported to the school that her son was frequently coming home with bruises and cuts which he had said were the result of being attacked either at school or on the way home. She also reported to the school that P was becoming increasingly withdrawn and refusing to leave the house or attend school. This was because he feared for his safety as he believed that the gangs knew where he lived.

4.12 On 17 December 2004 P reported to his mother that he had taken an overdose of medication he had found in her bedroom. He was taken to an A & E Department and then admitted to hospital.[28] The overdose was not of an amount to cause serious harm and paracetamol levels were noted to be below treatment level.

4.13 He disclosed that he had taken the overdose following an incident with another pupil and an escalation of intimidation where a rival gang had told him that they intended to shoot him at the end of the week. P reported that he had felt that this was a credible threat as he was aware that guns and knives were on the school premises. P reported that he had not had previous thoughts of self-harm but that leading up to the overdose, he had "felt that he wanted to die".[29]

4.14 On 20 December 2004 P was assessed in hospital by a Community Psychiatric Nurse (CPN) from the BCPFT CAMHS Team. The CPN assessment referred to P's problems with other boys at school and the tensions between various groups of boys at school. The CPN was reassured by P that he discussed his worries and concerns with his mother, who would also liaise with the school. The CPN also referred P to his local CAMHS team in West Bromwich for follow up in a weeks' time.

[28] Noted that he had taken approximately 10 cold relief tablets (each containing 300mg paracetamol, 5 mg phenylephrine) 2 paramax tablets (each containing paracetamol 500mg and 1 ibuprofen. Information taken from discharge summary from Birmingham Children's Hospital NHS Trust, 21 December 2004

[29] Discharge summary Birmingham Children's Hospital NHS Trust, 21 December 2004 , p1

4.15 Following P's overdose P was assessed by the Specialist Registrar, Child and Adolescent Psychiatry, in the CAMHS clinic in West Bromwich on 31 December 2004. In the referring letter to the CPN it was noted that although there were no signs of psychosis or depression, P was "at risk of further deliberate self-harm, although this risk can be minimised if the situation at school resolves to his satisfaction. I believe that the overriding concern is to improve the safety of the environment for this young man".[30] At this assessment P had disclosed that leading up to the overdose he had "carried a knife". However this was not mentioned in any subsequent assessment and was not reported in the letter to the GP, P's mother or the school social worker.

## Contact with Black Country Partnership NHS Foundation Trust's (BCPFT) Children and Adolescent Mental Health Service (CAMHS)

**2005**

4.16 Throughout 2005 P was seen by the BCPFT CAMHS specialist registrar on two further occasions.[31] After each appointment a letter was sent to P's mother, his GP and the school's social worker.

4.17 As part of the CAMHS initial assessment process P's head of year was asked to complete an assessment. This recorded that P had "a few close friends at school and that he was withdrawn, anxious and lacking self-confidence".[32]

4.18 It was documented that P's mother had advised that, following her son's overdose, she had arranged counselling for him from a Youth Pastor at her Church Centre. The CAMHS records note that it was the specialist registrar's intention to liaise with the Youth Pastor. We have been unable to find evidence that this happened.

4.19 There was one occasion when the school social worker contacted the CAMHS specialist registrar reporting that she was concerned that P was "very depressed and that his attendance at school was from 17 January 2005 progressively declining".[33] This alert did not trigger any further response from CAMHS, for example offering P an additional appointment.

4.20 P was seen at his next scheduled appointment (8 March 2005). No reference was made to the concerns of the social worker at this appointment and it was again assessed by the specialist registrar[34] that P was not displaying any symptoms of a depressive disorder. It was noted that P was denying any self-harm ideation. The assessment concluded that the situation between P and his peers "remained volatile".[35] It was documented that there had been a recent incident where one of P's friends had been hospitalised, following a

[30] Letter from Specialist Registrar Child and Adolescent Psychiatry to CAMHS Community Psychiatric Nurse, 10 January 2005
[31] 31 January 2005, 8 March 2005, 26 April 2005 19 July 2005
[32] Head of Year report, 6 February 2005
[33] Letter from school social worker to CAMHS's specialist registrar, 23 February 2005
[34] This is the same Specialist Registrar that saw him previously
[35] Letter to P's GP from CAMHS's specialist registrar 8 March 2005

fight in the school playground, and that “given these circumstances” P’s “reluctance about going to school [was] understandable”.

4.21 P attended two more appointments with CAMHS in April and September, seeing a new Senior House Officer. After failing to attend a further two successive appointments (13 September and 12 December 2005), he was discharged from the service. The discharge letter was sent to P’s GP, but was not copied to the school’s social worker.

4.22 After his overdose considerable efforts were made by the school and P’s mother to improve P’s attendance and engagement with his studies. Despite these efforts, including ‘daily reports’, involvement of the school social worker and on-going contact with his mother, P’s attendance did not improve.[36] On a number of occasions P had to be restrained by teachers and removed from the premises either for his own protection or the protection of others. On one of these occasions, when P had been verbally abusive towards staff,[37] P disclosed to the teacher escorting him home that he had smoked cannabis but that he had now stopped. Following this incident, the head of year reported that he “felt that [P] was now a danger to both staff and students”.[38]

4.23 P’s mother reported to the investigation panel that although she had considered moving her son from the school, she had not known how to negotiate this with the relevant education authorities. She also reported that when she discussed this option with the school, she was informed that if she moved her son to another school he would not be able continue with certain areas of his studies. She therefore decided that he should remain at that school.

**2006**

4.24 On 2 February 2006 P’s mother attended the school because of his lack of attendance.

4.25 It was noted that despite all the effort of the previous year, his behaviour and attitude to school had not changed, and he was missing out on important information regarding exams and further support.

4.26 On 3 February 2006 P was encountered in the early hours by Police, on foot in a high crime area. He could give no reason for being there at that time, though it was noted that P previously lived in this street.[39]

4.27 P’s mother reported that he was not washing or getting out of bed and he complained of being tired all the time. She had arranged for him to see the GP on 10 February 2006 and she attended the GP surgery with him to convey her concerns.

[36] P’s attendance was 79%, 6 February 2005
[37] School Records, 22 June 2005
[38] Head of year report, 22 June 2005
[39] Dr Alison Reed “Homicide Investigation Report into the death of a child: STEIS Reference: 2013/7122” Final Report– September 2014, p20

4.28 In June 2006 P obtained mainly mid-grades in achievement. His end of year school report noted that he had some difficulties with memory and was easily distracted. P arranged to study during the summer to prepare for GCSE exam resits. He did not obtain good exam grades. This was a surprise to his mother as he was always believed to be clever and it was expected that he would do well.

## Black Country Partnership NHS Foundation Trust's progress in implementing recommendations in relation to CAMHS

4.29 Following the publication of the initial investigation report, BCPFT developed an action plan to address the report's findings and recommendations. We have been provided with a copy of this.

4.30 The initial investigation made one recommendation for BCPFT directly concerning CAMHS:

- **BCPFT Recommendation 2:** BCPFT should ensure robust processes are in place when a patient is receiving counselling or any other form of mental health support from another service (private, charity or voluntary) that efforts are made to establish clear communications whenever possible with this service to monitor progress and that a written record is maintained to this effect.

4.31 This recommendation addressed the point that no member of the CAMHS team had made efforts to liaise with the Church Centre where P was receiving counselling.[40]

4.32 In response to this recommendation, the action plan states that "new operations policies will outline the process for clear communication with 3rd party organisations involved in a patient's care… Evidence of implementation and compliance will be weekly case note audits… addressed in the MDT meetings. Third party information can be captured within assessment documents (CAT, SAP, Needs assessment). This will be monitored through weekly records audits."[41]

4.33 This action has been signed off as completed by the Trust.

4.34 We have reviewed the Trust internal audit report into the action plan dated 22 June 2015.[42] This audit identified a need for the new proposed electronic record to provide space to record 3rd party involvement, and for the Trust to develop information sharing protocols to share information with 3rd parties.

4.35 In September 2015, BCPFT introduced a "Child and Family Service" Operational Policy.[43] On reviewing this policy we noted that the policy states "the service promotes an evidence based approach to assessment …and follows the principles of partnership working….the team will undertake an

[40] Initial Investigation report: Executive Summary, p29
[41] BCPFT initial action plan, date not documented
[42] Black Country Partnership NHS Foundation Trust "Access Arrangements: Internal Audit Assurance Report" BCP 15-034 22 June 2015.
[43] BCPFT's Child and Family Services Operational Policy,p10

assessment in partnership with service users, families and if appropriate other professionals". It would be helpful if further guidance is provided as to how this should be done.

4.36 We have also reviewed the revised CAMHS referral, risk assessment and care plan forms that have been introduced since the incident. The referral form now includes a section for details of "other specialists involved". The risk assessment also directs the assessor to include "other sources" of information and to identify if the assessment and subsequent care plan should be forwarded to "any others i.e. professional and/carer." However the care plan review does not have a section for comments from other agencies who are involved with the patient.

4.37 The initial investigation also made one wider recommendation for all services:

- **BCPFT Recommendation 5:** BCPFT should review, as a matter of urgency, their current arrangements and policy guidance within the service, across all teams, for the management of cases where a patient 'did not attend', paying particular attention to:
  - the use of 'opt in' letters
  - engagement with carers prior to the patient's discharge
  - communication with the patient's GP

4.38 This recommendation was made because at the time of the incident BCPFT's CAMHS and Adult Community Mental Health Teams (CMHTs) did not have a specific "Did Not Attend" Policy, and P was sent appointments on several occasions. As he did not respond or attend two consecutive appointments he was discharged from services.

4.39 In response to this recommendation, BCPFT introduced a "Did Not Attend/No Visit Access" Policy [44] for its children and young peoples' (CYP) services in August 2015.

4.40 We have reviewed this policy. The policy states that "serious case reviews both locally and nationally, have repeatedly identified parental non-engagement or disengagement with professionals as a factor which places CYP at increased risk. Therefore, any failure of planned contact should be regarded as a potentially serious matter and should lead to an assessment of potential risk."

4.41 The policy directs practitioners to utilise the following escalation processes when there is an unplanned disengagement:

- If services would normally be accessed in a clinic, primary care surgery or school setting, consideration should be given to a home visit to access the CYP.

[44] BCPFT's Did Not Attend/No Access Policy definition of 'Did not Attend' (DNA) is "any scheduled appointment missed without prior arrangement by the service user. Types of defaulted appointments are any pre-arranged contact with a service user whether that is at their home, community clinic, at a community team building, within a hospital setting or any other type of contact arranged relating to the provision of service".

- Liaise with the referrer and other professionals e.g. health visitor and school health advisor who have knowledge of the family. In this way more information can be obtained to make an informed estimation/risk assessment of the possible impact to the CYP's non-attendance/ access.
- In order to safeguard and protect the welfare of the CYP, practitioners should be aware of the risks and damaging impact disengagement from health care services can pose.
- Practitioners must analyse/risk assess situations where disengagement is a feature. The Trust NHS governance and Children Safeguarding Team will assist in decision making about the level of intervention required and whether a referral to Children Safeguarding is needed.
- Clinicians must record discussions of particular cases that take place in their supervision within the child's case notes.

4.42 If such a policy had been in place, and followed at the time of P's unplanned disengagement with CAMHS in late 2005, it is much more likely in our opinion that there would have been more effective liaison between services, such as between CAMHS and the school social worker. This could have identified more up to date information for an informed decision to be made prior to P being discharged from the service.

**Record Keeping and information sharing**

4.43 At the time of the incident BCPFT's "Care Record Keeping Standards and Practice" Policy clearly emphasised "the importance of good record keeping (as) a key aspect of good clinical care….it assists all those associated in the delivery of care to the patient/service user, now and in the future…. Reduces the chance of errors and mistakes."[45] However, the policy does not direct staff in the 'Records must document' section (7.2.1.) of the need to record the details of other agencies involved. Nor has this policy been reviewed following the incident despite being due for revision in November 2015. We were informed that that this policy is currently at consultation stage. We recommend that the revised policy include reference to the importance of documenting the details and the involvement of other agencies. It should also provide greater clarification on what the consequences are for failures to adhere to the policy.

4.44 During our interviews with CAMHS practitioners, it was reported to us that at the time of the incident, record keeping within CAMHS had not been of a consistently good standard. It was suggested that this may have been the reason P's notes did not record what efforts had been made to contact the church where P was receiving counselling. We were also told that since the incident the assessment form requires the assessor to document what other agencies are involved. Further, that the CAMHS team are now 'religiously' documenting all actions taken because they see the advantage in doing so.

[45] BCPFT Care Record Keeping - Standards and Practice, November 2012

If something like this were ever to happen again, we were told that the service would know that CAMHS had contacted the other services.

**Black Country Partnership NHS Foundation Trust**
Recommendation 1: The Child and Family Service Operational Policy to provide clear guidance on how CAMHS clinicians are to work with other partner agencies and the young person's family in the assessment and support planning processes.
**Priority 2**

**Black Country Partnership NHS Foundation Trust**
Recommendation 2: The Trust's revised Record Keeping Policy must include reference to the importance of documenting the details and the involvement of other involved agencies.
**Priority 2**

## Changes to local services in Sandwell for young people with mental health problems

4.45 None of the CAMHS clinicians we interviewed had direct knowledge of P, as at the time of the incident they were either not in post or had been working within other area CAMHS teams. However all reported they were familiar with this case and the findings of the initial investigation. Our interviews therefore focussed on discussions about developments and changes that have taken place since the incident to the BCPFT CAMHS services. We were informed and saw evidence that there has been a significant restructuring of the provision of services for young people and their families within BCPFT. The following section outlines the services and changes that have been made. We have also identified, where relevant, how we consider P's care pathway would have been different had these changes been in place at the time of the incident.

### Sandwell CAMHS Crisis Assessment and Intervention Team (CAIT)[46]

4.46 The Sandwell CAMHS Crisis Assessment and Intervention Team (CAIT) operates 7 days a week (8 am to 8pm) 365 days a year. The CAIT Team responds to referrals received from Sandwell General Hospital and Birmingham City hospital offering CAMHS assessments to those children and young people who have been admitted following an act of self-harm, or who are presenting with significant mental health concerns. The service provides home visits, fast track gateway assessments, referrals to other CAMHS and manages the step down programme to less intensive support. There is a CAMHS consultant psychiatrist on call 24/7.

4.47 We were told that if a child now presents having taken an overdose, the child would be assessed as very high risk and would be admitted to an inpatient

[46] Sandwell CAMHS CAIT (Crisis Assessment and Intervention Team)
http://www.bcpft.nhs.uk/services/children-young-people-and-families/84-camhs/248-deliberate-self-harm-service

unit for further assessment. The CAIT now supports the child and family until CAMHS or other service become involved.

4.48 If these services had been in place in 2013, there was the opportunity for a more proactive and comprehensive response when P and his family first came to the attention of mental health services. If this service had been in place when P first came to the attention of services in A&E following his overdose in December 2004, the expectation is that a referral would have been made to the CAIT for an initial assessment to be undertaken, for it to have made the relevant referral and provide a 7 day follow-up visit to P and his family.

**Early intervention service**

4.49 The Early Intervention Service (EIS)[47] provides treatment and support for young people who are experiencing symptoms of psychosis for the first time, and during the first three years following a first episode of psychosis.

4.50 If CAMHS assess that a child is presenting with psychosocial problems, for example due to difficulties at school rather than having a mental illness, CAMHS would now refer the child and their family to the Early Help Service. This service is run by the local authority, in partnership with social care, education and third sector organisations, such as Barnardo's. This service is known as the 'team-around-the-family' (TAF) service. It utilises the Common Assessment Framework (eCAF) to identify the problems and support required for the whole family, and all involved agencies use a centralised electronic notes system to enable them to maintain a comprehensive knowledge of all cases. A care coordinator is allocated either from the school or social care agencies. The aim of the service is to provide the support necessary in order to resolve the problems that the child is experiencing, prevent their emotional difficulties developing into either a major mental illness or an escalation of their risk factors.

4.51 In P's case this service intervention would have been most helpful at the times when P was truanting from school and exhibiting aggressive behavioural difficulties. It would have provided not only support to P but also to his mother and family and have provided the opportunity to discuss the effects P's difficulties were having on them to allow for the provision of appropriate support.

**Specialist CAMHS**

4.52 CAMHS professionals are now co-located within the Sandwell Multi- Agency Safeguarding Hub (MASH).[48]

[47] Early intervention services. http://www.bcpft.nhs.uk/services/children-young-people-and-families/84-camhs/473-early-intervention

[48] Multi-Agency Safeguarding Hubs, or MASH, bring together key professionals from services that have contact with children, young people and families, making the best possible use of their combined knowledge and information to keep children and young people safe. Sandwell Multi-Agency Safeguarding Hub (MASH) is a centre which co-locates safeguarding agencies (and

4.53 Evidence was provided of the new CAMHS care and review plans which are now used when a child or young person is initially assessed and then throughout their involvement. The initial care plan documents the aspirations of both the child/young person and their parents and identifies how these can be achieved. The service also uses a 'letting go' plan which is completed during the discharge planning stage. It reviews the initial goals to assess in conjunction with the child and their families whether the goals have been achieved, and what support the child/young person and family can access post discharge. It also notes how the family can re-access CAMHS.

4.54 CAMHS have also introduced a 4 page risk assessment form that documents both past and current risk factors; indicators of risk, and also directs that the assessment must be reviewed six-monthly or if there is a crisis.

4.55 Again if this more comprehensive risk assessment had been in place at the time P and his family were involved with CAMHS, it would have provided clinicians with the opportunity for both a more comprehensive profile of P's risk and contributory factors as well as assisting in the monitoring of his on-going risk factors.

4.56 Because the service is co-located within Sandwell MASH, any referral from a health, social care or educational professional or the family would be much more likely to be shared with other relevant agencies and services, and a holistic care plan drawn up to help support P and his family.

4.57 However, when tested, many of the links on websites to download multi-agency referral forms (MARF) which would be used to inform Sandwell MASH of interagency working on both NHS Sandwell and West Birmingham CCG, Sandwell Safeguarding Children's Board and Sandwell Metropolitan Borough Council, did not work.

**Schools**

4.58 It was also reported to us that since this incident there has been a change in funding for schools. The school which P attended is now an academy. If a school now requires additional support services to tackle issues such as gangs or increased self-harming, they have the funding to bring in additional support services, such as counsellors and behavioural therapists. We were told that local BCPFT CAMHS mental health workers now provide training in the local schools.

4.59 Additionally Sandwell Children's Services now convene co-production meetings, which include health and local authority commissioners, to review local children's service strategies and services. We were informed that these meetings also review the government's Five Year Forward View plan for

their data) with a view to identifying risks to children at the earliest possible point and responding with the most effective interventions.
http://sandwellandwestbhamccg.nhs.uk/safeguarding/safeguarding-children/information-for-gps-and-health-professionals/key-contacts

CAMH services[49] as the principal guide for the development of the local CAMH services.

4.60 We asked all of the CAMHS practitioners who we interviewed to reflect on which care pathways would be available to P and his family if he presented now. They unanimously said that P would still not be assessed as "high-risk" as he was not presenting with any major symptoms of anxiety or depression. The problems he was presenting with would still be seen as a school-based problem.

**Social Services**

4.61 The initial investigation makes two recommendations for Social Services.

- Children and Adult Social Services should arrange a review of their involvement in the life of P and his family. This should include the social work contribution to the MHA assessment completed on 17 July 2012 to consider whether relevant issues were adequately addressed, particularly safeguarding.

- Social Services should ensure that when there are safeguarding concerns regarding a child there is a clear written plan of action which wherever possible is shared with parents and relevant agencies.

4.62 The initial investigation did not identify which Social Service this recommendation was directed to and we assumed that because the recommendations discuss the care of children, the recommendations were directed to Sandwell Social Services within whose catchment P fell as a child. We contacted the Service Director at Sandwell Social Services to discuss action planning and implementation of recommendations.

4.63 Unfortunately, despite several attempts, we did not receive a reply and so are not able to say if Sandwell Social Services have implemented their recommendations.

## P's cultural background:

4.64 Later in this report, we address the role P's ethnicity may have played in regard to his presentation, communication, experiences and outcomes of mental health and prison services (Section 10). We also address both his and his family's experience of having to negotiate the complexities of what were unfamiliar health care, judicial, educational and housing systems.

4.65 We wanted, however, to note the fact that all the agencies involved with P, including his school and CAMHS, documented that they were aware that he and his sibling had moved from Swaziland in 2002. They were also aware that P's mother repeatedly reported that her son's escalating behavioural and psychological difficulties had begun after his arrival in the UK. It appears

[49] https://www.england.nhs.uk/wp-content/.../Mental-Health-Taskforce-FYFV-final.pdf

that no agency considered what the impact of P and his family's recent migration may have had on both his psychological and developmental well-being. There was no documented evidence in the various assessments and support offered to P, that his recent move was identified or considered as a contributory factor. His problems were seen as anger and behavioural related to the school situation and his peers.

4.66 We note the initial investigation report comments on P's school, the diversity of pupils and extent of local socio -economic deprivation. The Ofsted report of 2010[50] notes that a very large majority of students were from minority ethnic groups. Three quarters of students spoke English as an additional language, with 40 other languages spoken in the school. Student turnover was high, with almost 25% of students leaving or joining the school during the year. Many of the new students had little or no English, and around 20% were asylum seekers.

4.67 However the potential impact of P's culture on his presentation and engagement with services was not considered or addressed within the initial investigation report.

4.68 Research suggests that "migration has an impact on the family and can have a significant interference in the child's psychological development and mental health … Older children and adolescents, may present increased externalised aggressive behaviour and/or internalised anxiety and depressive behaviour." [51] Migration can also cause "ruptures in the external cultural framework which, as consequence, can also cause ruptures in the internal psychological cultural framework of the person affecting his or her psychological and cultural identity." For some children this can mean that they are first experiencing a sense of loss, dislocation, alienation and isolation, a loss in their confidence in "the external social and cultural framework, and [they] may feel that the outside world is no longer safe… generating anguish and insecurity."

4.69 For certain children and young adults the acculturation process can be relatively seamless, whereas for others it can take a long time "and imply struggling with stress, eventually even leading to the development of a health problem". They can experience a sense of marginalisation and failure to integrate into the cultural identity of the host culture, being drawn to certain minority groups, increased levels of risk of harm to themselves e.g. through truancy, association with negative peer groups, breakdown in family communication, substance misuse, retaliation or self-harm, in order to cope with the stressors in the new environment. Having reviewed P's history from his arrival in the UK, we note that he was exhibiting most, if not, all of these symptoms and behaviours.

4.70 It is also suggested that some children/young people who are unable to manage this transitional process can exhibit symptoms of post-traumatic stress disorder (PTSD). PTSD symptoms may present as concentration

[50] http://www.reports.ofsted.gov.uk/provider/files/947979/urn/103559.pdf
[51] Culture and Migration: Psychological Trauma in Children and Adolescents. Elizabeth Batista-Pinto Wiese, http://www.brown.uk.com/teaching/intercultural/wiese.pdf

difficulties, irritability, hyper vigilance and affective disorders, withdrawal behaviours, isolation which can be manifested by avoiding contacts with the peer group and not wanting to attend school.[52] These emotional and behavioural difficulties can also present themselves as psychosomatic illness, such as headaches, stomach aches.

4.71 It is of note that within a year of P coming to the UK, he began to present to his GP with persistent headaches and vomiting which had no apparent cause. Additionally after his overdose in 2004, he began also to exhibit many of the psychological difficulties and symptoms which can be associated with PTSD.

4.72 During our interviews with CAMHS clinicians we asked them how they and their service address the cultural needs of their patients and families. They said that the workforce was culturally diverse and that diversity was part of the mandatory training for all staff. They also reported that diversity was a standard item on their operational agenda. However, they acknowledged that when it came to assessing and identifying a particular patient's cultural and ethnic needs there were some deficits. There was also an acknowledgement from those interviewed that the CAMHS service were not sighted on potential PTSD as a diagnosis for P as there was a perception that P's problems were related to his cannabis use.

4.73 The NICE guidelines relating to the management of PTSD in adults and children in primary and secondary care state:

"where a PTSD sufferer has a different cultural or ethnic background from that of the healthcare professionals who are providing care, the healthcare professionals should familiarise themselves with the cultural background of the PTSD sufferer*".*[53]

4.74 The guideline goes on to advise that:

"…healthcare professionals should be aware that many PTSD sufferers are anxious about and can avoid engaging in treatment… Healthcare professionals should also recognise the challenges that this presents and respond appropriately, for example, by following up PTSD sufferers who miss scheduled appointments. For PTSD sufferers whose assessment identifies a high risk of suicide or harm to others, healthcare professionals should first concentrate on management of this risk. Healthcare professionals should pay particular attention to the identification of individuals with PTSD where the culture of the working or living environment is resistant to recognition of the psychological consequences of trauma".

4.75 When treating a child with a history such as P's, clinicians should, in our view, be familiar and pay attention to the cultural background of the patient and their family. They should ensure that any difference in language or in cultural background between them, their patient and their families is not an

[52] As above.
[53] NICE guidelines CG26 (March 2005), Post-Traumatic Stress Disorder http://pathways.nice.org.uk/pathways/post-traumatic-stressdisorder

obstacle to the effectiveness of treatment. Consideration should be given to the patient's psychological development and presentation with reference to their original culture, its societal belief systems, the cultural meanings of symptoms and disorders.[54]

4.76 We could find no documented evidence to indicate that any of the practitioners were either asking or considering the impact and possible effect that his families' migration may have had on P's functioning and developmental progress. This was despite P's mother continually reporting that her son's behaviour and educational progress had significantly deteriorated since his arrival in the UK.

4.77 It is the view of the investigation panel that this was a significant deficit in the assessment and treatment of P, not only by BCPFT services but also his subsequent involvement with mental health and judicial services.

4.78 The revised BCPFT's Child and Family Service's "Operational Policy"[55] identifies that the service should 'consider the context and the influences that affects their whole environment including their family friends, schools and local communities'. There is further reference to the Trust's 'Equality and Diversity' team, policy guidance and training to support equality and diversity within the CAMHS service'. However, since 35% of the population of Sandwell come from non-white ethnic backgrounds[56] this could be strengthened by identifying the expectation that its services and clinicians provide sensitive and appropriate services to meet the diverse cultural and ethnic needs of its patient population.

4.79 In view of the conclusions we have reached regarding the importance of practitioners taking into account an individual's cultural heritage, the psychological impact of migration to the UK and how these may affect the individual's engagement with services, we recommend that BCPFT's Child and Family Service's Operational Policy be revised to include this.

**Black Country Partnership NHS Foundation Trust**
Recommendation 3: Black County Partnership NHS Foundation Trust should ensure that the CAMH services are culturally sensitive to the needs of a patient and their families, and that they recognise and understand the potential impact of immigration on the family.
**Priority 2**

[54] Culture and Migration: Psychological Trauma in Children and Adolescents. Elizabeth Batista-Pinto Wiesehttp://www.brown.uk.com/teaching/intercultural/wiese.pdf
[55] BCPFT (December 2015). "Operational Policy: Child and Adolescent Mental Health Services Children, Young People and Families Division"
[56] Sandwell trends. http://www.sandwelltrends.info/lisv2/navigation/home.asp

# 5 Events from 2007 to 2009

**2007**

5.1 When he was 17, P initially enrolled at a local college but after a few weeks he reported that he had been threatened by a man with a gun. Police found no evidence to support his claim but P refused to go back to the college.

5.2 From this point P was unemployed. It is not certain if P was claiming benefits but his mother reported to us that there had been several verbal altercations with him about money. She said that later, when she secured his private rental accommodation, he was not able to complete the housing benefit forms as he was so mentally unwell.[57]

5.3 During 2007, P had the following two contacts with the police:

- On 22 April 2007, when P was 17 years old, a uniformed police unit stopped him and four other males. It was reported that P was acting suspiciously and the police carried out a Section1 PACE search.[58] A handled lock knife was found on P. He was arrested and was subsequently cautioned. During his arrest it was documented that P disclosed that he had been smoking cannabis.

- On 8 May 2007, a member of the public detained P and another male in their garden, police attended and arrested P on suspicion of being found on enclosed premises. No charges were brought.

**2008**

5.4 In early 2008, there was a fire in P's bedroom. His mother reported to the investigation panel that it was accidentally caused by P dropping a cigarette onto some clothes. The fire caused significant smoke damage. This resulted in the family having to move out and the children being placed with various family friends until P's parents could find alternative rented accommodation. There is no indication that the police were involved.

5.5 On 30 May 2008, P's mother reported to the family's GP that she was becoming increasingly worried about her son's mental health, reporting that he appeared to be responding to voices and was increasingly isolated and would only leave the house at night. His mother had previously made him an appointment with the GP for 28 April, but P had refused to go. Because the family had to relocate to another area after the fire they had had to register with a new GP practice.

[57] In or around 2009. Also see later section on Housing.
[58] Section 1 of the Police and Criminal Evidence Act (PACE 1984) authorises that a police constable can stop and search any person or vehicle, providing that reasonable suspicion exists. The constable can detain the person for the purpose of the search but only for the minimum amount of time necessary to conduct the search.
http://www.legislation.gov.uk/ukpga/1984/60/section/1

5.6 P turned 18 in August 2008.

5.7 On 19 August, 12 October and 19 December 2008, police records show that P's mother contacted them reporting incidents where P was verbally threatening her and had damaged property. Police attended but no action was taken. The police's Family Protection Report noted P's vulnerability.

**2009**

5.8 On 5 March 2009, P's mother called the police reporting that P had pushed his three year old brother into a wall at home and who had then sustained minor bruising to his face. P's mother reported to us that this was more of an accidental push than one intended to cause harm. His younger brother was admitted to hospital, as a place of safety. After a social services assessment (Emergency Duty Team), P's brother was discharged back to the family home. P's mother reported that social services visited the family after the incident and they told her that P needed to be moved out of the family home. P's mother informed us that she had feared she would lose custody of her younger son at this time, so she had secured alternative accommodation for P (see section on housing later in this report). She also reported that she had no further contact with or from social services after this.

5.9 During her police interview P's mother reported that she had found containers of household chemicals, such as bleach and vinegar, under her son's bed and that she "was concerned that he [was] trying to poison himself." It is not evident if the police questioned P about this but it was documented that there was "no evidence that he [was] involved in extremism or terrorism of any kind, the presence of various chemicals hidden in his room is a cause for concern given his mental state." It was also documented that social services "have indicated that they will support mom with [P's] possible mental health problems and assist in referring him via his GP to obtain help". There is no evidence that this was done.

5.10 P was arrested after this incident, and assessed twice by the police forensic medical examiner (FME), who noted that P had scars on both arms but P denied having self-harmed or having suicidal thoughts. The FME advised the custody officer that P needed to be kept on level 4 observations.[59] P accepted a Police Caution[60] for the offence and was released to his home address. The social worker contacted P's GP (6 March 2009) to report the incident and also confirm that she had advised P's mother to arrange for P to see his GP.

5.11 P attended an appointment with his GP (10 March 2009) and was prescribed a short course of Zopiclone.[61] The GP notes indicate that a social worker had a telephone discussion with a GP about the incident, but there is no

[59] Those at the highest risk of self-harm are observed at this level - constant observation
[60] A police caution (since 2005 more properly known as a simple caution) is a formal warning given by the police to an adult offender aged 18 years or over and who has admitted that they are guilty of an offence.
[61] Zopiclone is a non-benzodiazepine hypnotic agent used in the treatment of insomnia.

evidence that the GP discussed with P the incident and P's subsequent arrest at this appointment. This was the last time that P was seen by a GP.

5.12 On 19 March 2009 at 2.45am P's mother called the Police reporting that her son was being verbally abusive and that she wanted him removed from the premises as she felt unsafe in his presence. On his arrest for breach of the peace, P was uncooperative, aggressive and appeared to be in a state of intoxication. P appeared at a Magistrates Court on 20 March 2009 and was seen by the Criminal Justice Team (CJT),[62] after concerns were raised by custody staff about his mental health. Following discussion with the CJT's CPN it was agreed that P would be offered an 'opt in' letter by the BCPFT Primary Care Liaison Team. P did not attend his assessment appointment and his GP was notified that he had been discharged from the service (20 April 2009).

5.13 On the 20 March 2009, P's mother saw the family GP reporting that her son was becoming increasingly aggressive, exhibiting paranoid thoughts, responding to imaginary voices and that he had lacerations on his forearm. She was unsure if he was taking illegal drugs but confirmed that he had previously admitted to taking cannabis and was using alcohol. The GP advised P's mother that her son needed to come to the surgery to be seen.

5.14 On 26 March 2009 following a telephone call from P's mother, the GP referred him to the Oldbury/ Smethwick Primary Care Liaison Team.[63]

5.15 Two letters were sent by Oldbury/ Smethwick Primary Care Liaison Team to P inviting him to an assessment appointment but he failed to attend. On 22 May 2009 the home treatment team notified the GP that they were discharging P as he had not engaged with the service. No further action was taken by the GP.

5.16 On 5 October 2009 P's mother again attended the GP surgery without P, reporting that her son was becoming increasingly withdrawn and isolated, only leaving the house at night. The GP gave P's mother a letter inviting P to make an appointment at the surgery with a view to assessing him. The clinical entry ended by saying, 'We need to see him and assess'. P's mother stated that she gave her son the letter but P did not make an appointment. No other action was taken by the GP surgery. This was the last entry made by the GP.

## Arising issues, comment and analysis

5.17 On 12 August 2008, P turned 18 years old. His mother reported to us that after this point she found it increasingly difficult to discuss her son's problems with mental health and criminal justice services because he was classed as an adult. She was informed that P's permission was required before information could be disclosed to her and it is documented that on

[62] Now known as Criminal Justice Mental Health Liaison Team, the team works with all people with mental health problems in touch with the criminal justice system (magistrate's courts, probation services and prisons).
[63] The Primary Care Liaison Teams, offers non-urgent mental health care to people with common mental health problems, such as depression, anxiety and stress.

several occasions P refused to allow agencies to disclose his whereabouts to his mother.

5.18 It is evident from our review of the information we have obtained that from 2007, when P was 17 years old, he was beginning to exhibit symptoms of a more serious mental illness.

5.19 The Joint Commissioning Panel for Mental Health (2012)[64] reported that "most mental illnesses have their origins in the teenage years. The years 16–18 are a particularly critical period of vulnerability to mental illness, as well as a period of major physiological, emotional and social change in the young person's life. It is particularly important that care remains consistent and uninterrupted throughout this time of heightened vulnerability". They also advised that consideration should be given to the commissioning of "transitional services" not only for young people who are patients of CAMHS, but also for the following cohort of individuals who are not in receipt of such services:

- "young people with risk factors for multiple poor outcomes (including mental illness) as adults
- young people whose symptoms are insufficient to meet the diagnostic criteria for mental disorder (i.e. sub-threshold) but have a considerable impact on their lives and who are at risk of developing mental disorder that meets diagnostic thresholds
- young people who have previously undiagnosed and unmet needs, particularly those whose needs become more acute as adolescence progresses and family/educational/ other supports diminish. These needs may include: emerging personality disorder and early stage psychosis."

5.20 The report also identified the following key components of such transitional services situated within adult mental health services (AMHS):

- "access to a multidisciplinary team with expertise from both CAMHS and AMHS providing individual and family psychosocial and psychological interventions alongside medication
- a youth-centred and flexible approach with an emphasis on effective engagement of young people through outreach and joint working with other agencies
- expertise to treat the range of mental disorders presenting in this age group
- flexibility around age boundaries
- access to a range of services to help young people achieve independence, including education, employment and housing

[64] The Joint Commissioning Panel for Mental Health (JCP-MH) collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists, "Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services. Volume Two: Practical mental health commissioning", March 2012 http://www.rcpsych.ac.uk/pdf/JCP-MH%20CAMHS%20transitions%20(March%202012).pdf

- in-reach to primary care, which offers holistic health care, family practice and early detection of problems".

5.21 To these we would also add that services and practitioners need to take into account and develop an understanding of how best to meet the needs of young patients' cultural backgrounds, including the particular needs of migrant and refugee children who may be experiencing particular difficulties and trauma.

## General Practice

5.22 P had been under the care of three GP practices. The initial investigation report made the following recommendations for General Practice.

- **GP Recommendation 1:** The General Practitioner should review their local processes for responding to concerns raised by relatives/significant others, that an individual may be experiencing mental health issues.
- **GP Recommendation 2:** The General Practitioner should ensure that in cases where relatives/significant others have been unable to persuade an individual, who may be experiencing mental health issues, to attend the GP surgery for assessment, that alternative arrangements for assessment are made.

5.23 We received evidence that the GP practices reported to the initial investigation panel (July 2014) that the following actions had been fully implemented:

- When a new patient registers at the practice the senior partner reviews their medical history notes.

- The GPs have been informed that they must "keep careful and full record of when a family member /carer reports their concerns"[65] about a patient.

- The GP now undertakes a risk assessment with the person (s) who has reported a concern about another patient: for example "harming behaviour, involvement of police/prison/mental health services/substances."

- The GP should arrange to see the patient at the surgery (either by letter or telephone) and "consider the option of home visiting/referral to CMHT/Home Visiting Team."

- The GP to "tell the informant and record in notes to let the practice know if the patient refuses to attend appointment and/or secondary referral."

[65] GP action plan July 2014,p1

- "The clinician who deals with the first time [appointment] assumes responsibility for follow up and passes on information to colleagues if he/she is going away."

5.24 The third recommendation for General Practice included the following:

- **GP Recommendation 3:** If a secondary referral for mental health assessment is not completed due to non-attendance, there needs to be a General Practitioner review of the case and an action plan formed.

5.25 In implementing this recommendation, we were provided with the guidance which GPs should follow.

In such cases the responsible GP for the case should:

- Telephone the informant or patient;
- Carry out a risk assessment; and
- Discuss the case with the secondary care [service] who discharged the patient without seeing [them].

## Arising issues, comment and analysis

5.26 The three General Practices involved in P's care promptly addressed the issues that the initial investigation report identified in regards to their management of P. In our interview with the last practice P was registered with, we were shown evidence of the implementation of the recommendations and we also discussed the effect of the changes that had been made.

5.27 If these processes had been in place in 2013, there would perhaps have been the opportunity for the GPs involved with P's care to have responded more proactively to P's mother's concerns. There may also have been the opportunity for them to have taken more action when they were notified (22 May 2009) that had P failed to engage with the Primary Care Liaison team.

5.28 We were also told that since the initial investigation report and our subsequent interview for this report P's last GP practice has started reviewing its procedures and an audit (of patients with a similar profile as P), to assess the compliance with their guidelines regarding the responsibility of the GP in the referrals process, risk assessment and overall management of the cases. However we have not seen the output of this review or audit.

5.29 We also understand that the learning from this tragic incident has not been shared with other GP practices in the CCG catchment area. Since this would benefit all GP practices in the area, we recommend that the CCGs share the learning from the initial investigation recommendations and so that the

enhanced safeguarding practices introduced by P's practice can be rolled out across the member GP practices within the CCGs.

**NHS Sandwell and West Birmingham CCG and NHS Birmingham CrossCity CCG and their GP practices.**
**Recommendation 4:** NHS Sandwell and West Birmingham CCG and NHS Birmingham CrossCity CCG and their GP practice members should share the learning from the initial investigation and roll out the enhanced safeguarding practices now implemented in Ps final GP practice.
**Priority 2**

5.30 Having reviewed both P's GP notes and the initial investigation report, the lack of support given to P's mother features prominently. P's mother was not only trying to manage the situation with P, but also find the appropriate help and treatment for her son in what she reported to us was an unfamiliar healthcare system to her at the same time as caring for her young family and maintaining their economic viability. She told us that as so many services failed to acknowledge the difficulties she believed her son was experiencing, she eventually began to doubt herself and the concerns she had. She reported to us that she eventually stopped asking for help and advice. The initial investigation report made reference to the fact that "it must have been distressing [for P's mother] to experience the hostility and threats [P] was making and frustrating not being able to find or be offered a solution to his needs."[66] The report also goes onto reflect that P's mother also "was a victim in this tragic case…and that it had had a major impact on her and her family's life." However, no direct recommendations were made to address the identification of and the need for support to individuals who have assumed a carer role or who, like P's mother, may be experiencing significant difficulties managing a member of their family who is presenting with difficult behaviours and also refusing to engage with services.

5.31 We referred to the Government's Carers Strategy,[67] which was published in 2010 which we would have expected to have been embedded into the practice of all services at the time that P's mother was expressing her concerns and difficulties. The Strategy's vision is that:

"Carers [should] be universally recognised and valued as being fundamental to strong families and stable communities… Carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role."

5.32 We have been told that the last practice P was registered with now has a Carers Strategy.

5.33 Since the initial incident and report and subsequent interview for this investigation, this practice has also started reviewing its procedures and has already started an audit (of patients with a similar profile as P), to assess the

[66] Initial investigation report, p 69
[67] HM Government (2010) "Recognised, valued and supported: Next steps for the Carers Strategy" https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213804/dh_122393.pdf

compliance with their guidelines regarding the responsibility of the GP in the referrals process, risk assessment and overall management of the cases.

5.34 The strategy also recognised that :

"carers need better and timely access to information – on the illness or condition of the person they are caring for; on appropriate caring; on accessing benefits and other support; and on financial and employment issues; carers can often feel excluded by clinicians – both health and social care professionals should respect, inform and involve carers more as expert partners in care.

They may also find it hard to know how to access information and advice on how to balance a caring role with other responsibilities and opportunities in their lives. The concept of caring is assumed but not recognised in some families in ethnic minority communities."

5.35 It states that:

"There is a clear relationship between poor health and caring that increases with the duration and intensity of the caring role. Those providing high levels of care are twice as likely to have poor health compared with those without caring responsibilities… supporting carers to remain physically and mentally well is therefore a key part of the prevention and public health agenda."

5.36 In our review of all services involvement it was very evident that there was a general lack of recognition of the support needs of P's mother. She was not identified as needing referral for a carer's assessment or provided with information about services that she and her family could access for support and advice.

5.37 The failure of services to recognise the needs of P's mother and her family was, in our view, a significant deficit. The GP practice had the greatest opportunity to maintain ongoing and direct contact with P's mother. We consider their role was pivotal in the identification of the support she and her family needed. In order to share the learning we therefore recommend that the Birmingham and Sandwell GP practices review the systems they have in place to assist with the identification and provision of support to carers and parents who are supporting a child or young person with emerging mental health difficulties. In particular, awareness should be raised of families of different cultural backgrounds where the role of caring is perhaps not overtly recognised and where there is a risk that they may not be able to communicate the difficulties they are experiencing in this role. These principles also apply to the other services involved in this case who failed to recognise the needs of P's mother.

**NHS Sandwell and West Birmingham CCG and their member GP practices.**

Recommendation 5: NHS Sandwell and West Birmingham CCG and its member GP practices should review the systems they have in place to identify and support parents of children who have mental health problems to

ensure that they are providing them with appropriate levels of support, including referral for a carer's assessment.
**Priority 2.**

5.38 P was assessed on his admission to HMP Hewell's heath care unit as significantly underweight and malnourished.[68] After P's release from HMP Birmingham (December 2012) he was homeless and living on the streets during the winter months. All these factors are recognised as significant risk indicators[69] to a person's physical health. Yet from March 2009, four years prior to the incident that led to the death of Christina, P was not seen by any GP service.

5.39 The senior partner at the last GP surgery that P was registered with reported that his practice still do not receive medical information directly from the prison health care unit when one of their patients is released from prison. He acknowledged that unless the patient themselves brings their medical summary from prison to the GP practice, there is often a significant gap in the medical history of what are at times very vulnerable and complex patients. This leaves the GP totally reliant on the patient presenting themselves, disclosing that they have been in prison and sharing the details of the medical care they had been receiving. It was acknowledged that some patients can be unreliable historians. It was agreed that this lack of information can significantly affect the GP's ability to provide the appropriate seamless level of care that is needed. We address this further in this report

5.40 We were also informed by the senior partner that since this incident the practice has installed an IT system that enables patient records to be electronically transferred from GP practice to GP practice. This allows for new patient notes to be accessed as soon as they are registered at a new practice. We were also informed that the senior partners now review all new patients' records in order to highlight any particular risks that may require immediate attention.

[68] When P was admitted to HMP Hewell his BMI was below 55 kgs. HMP Hewell (healthcare) medical notes 9 July 2012, p9
[69] http://www.crisis.org.uk/pages/health-and-dependancies.html

# 6 Events from 2009 to 17 July 2012

6.1 Between October 2009 and early 2011 P's mother reported to us that she saw a significant improvement in her son after P's step-father left and the tensions within the family home reduced.

6.2 The only incident of note that occurred was in July 2010 when a police officer stopped P and undertook a PACE search but no arrest was made.

**January 2012 to 20 May 2012**

6.3 In early 2012 several significant events occurred within P's family that appear to have precipitated a noticeable decline in P's mental health.

6.4 The first of these was the death of his grandmother, who had been a significant and important figure for P and he was unable to go to her funeral.

6.5 His mother was also hospitalised for several weeks and then had to return to Swaziland for her mother's funeral. P's mother reported to us that during this time her son became increasingly withdrawn and paranoid. When she returned from Swaziland he also became confrontational and violent towards her.

6.6 On 10 May 2012 P's younger brother, who was aged six, called the police reporting that P had come to the house demanding money from their mother. P's brother reported to the police that P was threatening to stab his mother and had thrown an electric fire which had struck her on the head. Police attended and arrested and charged P with criminal damage and then released him. The following day, (11 May 2012), P's mother telephoned the police reporting that her son had broken a window. When police arrived, P was hiding in the garden shed and had tied himself to a garden bench. P was subsequently uncooperative whilst in custody and was charged with criminal damage. On 12 May 2012, P pleaded guilty at a magistrates court's hearing to criminal damage and he was given a six month conditional discharge sentence.

6.7 Police completed a Domestic Abuse, Stalking and Honour Based Violence (DASH)[70] assessment which noted that 6 calls had been logged from P's mother in the previous two days. She had reported that she was afraid of being killed by her son but she did not consider her other children to be at risk. She also reported that the verbal abuse from P was happening on a daily basis. DASH assessed that P's mother being at "medium risk".[71] A referral was made to the Independent Domestic Violence Advisor (IDVA).

[70] The DASH risk assessment measures 'serious harm' defined as death or injury (either physical or psychological) which is life-threatening and/or traumatic and from which recovery is expected to be difficult, incomplete or impossible. It is used by professionals who work with victims of domestic abuse and their children, stalking and harassment and honour based violence.http://www.dashriskchecklist.co.uk/index.php?page=dash-2009-model-for-practitioners

[71] DASH medium risk: there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, e.g. failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse'. The initial DASH completed by police assessed risk as medium this was downgraded by PPU and then at initial MARAC to re-graded to medium again

6.8 An initial Multi-Agency Risk Assessment Conference (MARAC)[72] was convened on 14 May 2012 and reviewed on 23 May 2012. The following actions were agreed and subsequently monitored at the review meeting: to ensure that a Street Index Gazetteer (SIG) marker[73] on P's mother's address was active; to discuss with the victim (P's mother) safety planning, cocoon watch[74] and placement of an alarm or mobile phone.

6.9 On 20 May 2012, P's mother again telephoned the police. On their arrival she told them that P was inside the house and was in possession of a knife. She reported that P had held the knife to her stomach and was threatening to kill her. This occurred in front of his younger sibling. P had also phoned the police stating that he was going to kill his mother. When the attending police officers entered the house, P was searched and no knife was found. P was placed in the police vehicle with the intention of removing him to his home address. P then assaulted one of the police officers and he was charged with a Common Assault (Section 39) on his mother and assaulting a police officer.

## Arising issues, comment and analysis

6.10 Before considering the period when P was in HMP Hewell and HMP Birmingham and the events that led up to the incident on 7 March 2013, we discuss the issue of Adolescent to Parent Violence and Abuse (APVA). There is currently no legal definition of adolescent to parent violence and abuse; however, this is increasingly being recognised as a form of domestic violence and abuse. In 2015 the Home office issued the 'Information guide: adolescent to parent violence and abuse (APVA)',[75] which defines APVA as:

"any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to psychological, physical, sexual, financial and emotional abuse. While this definition applies to those aged 16 or above, APVA can equally involve children under 16."

6.11 The Home Office guidance notes that as incidents of APVA have not been universally flagged on police or health and social care databases, accurate information about the number of cases of APVA is not currently available. That said, the guidance does cite that over a one year period (April 2009 to March 2010) in the Metropolitan Police Service there were 1,892 incidents of violence, threats of violence, or criminal damage in the home, perpetrated by a 13-19 year old towards their parent(s)/carer(s). Data that is available

[72] A Multi-Agency Risk Assessment Conference (MARAC) is a local, multi-agency victim-focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies.http://www.caada.org.uk/practice-support/resources-marac-meetings and https://www.app.college.police.uk/app-content/major.../victim-safety-and-support/

[73] The National Street Gazetteer is the definitive reference dataset of streets within England and Wales used for street works, highways maintenance and traffic management. It is also used by the police and other public bodies.

[74] "Cocoon Watch" scheme, in which friends and neighbours were asked to keep an eye and call police if their attackers appeared. https://www.app.college.police.uk/app-content/major.../victim-safety-and-support/

[75] Home Office "Information guide: adolescent to parent violence and abuse (APVA)" https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/420963/APVA.pdf

indicates that victims of APVA are overwhelmingly female (77.5%) and 66.7% involved a son mother relationship.[76]

6.12 There is currently no single explanation for the cause of APVA but in one research report[77] this is described as "the most hidden, misunderstood and stigmatised form of family violence" and is a signal of a possible break down in the parent child relationship. A range of reasons have been cited as causal factors which include substance abuse and mental health problems.

6.13 The guidance identified a number of factors and circumstances which may predispose a child or young person to APVA. We noted that the majority of these were present for P from the age of thirteen, when he began to experience emotional and behavioural difficulties as follows:

- "Is the young person associating with peer groups who are involved in offending or older peers?"

P was involved in gangs and had a history of offences which included carrying a weapon.

- "Is there a risk that the young person is being bullied?"

It is thought that P experienced considerable bullying and intimidation whilst at school. He also reported several incidents, after he left school, when he had been threatened.

- "Are Children's Services currently involved with the family?"

Children's services had been involved in the family after P pushed his younger brother.

- Is the young person isolated from people and services that could support them?"

P repeatedly refused to engage with services at school and primary and secondary mental health services. He became increasingly withdrawn and isolated from both his peers and his family.

6.14 The Home Office guidance identifies that APVA is a complex problem which can cause family breakdown, serious injury, damage to property, poor mental health for all concerned, and long term risk to the safety and wellbeing of the young person, who may become excluded from the family and be homeless or may go on to perpetuate further abuse and violence. It directs that the incidents of APVA should be considered as a possible risk indicator in assessing the child's or young persons' current and potential future risk of harm to others.

[76] Jo Sharpen "Child to Parent Abuse and the Care Act", 2015 http://avaproject.org.uk/wp-content/uploads/2016/03/Joanna-Sharpen-Oct-2015.pdf

[77] Paula Wilcox (University of Brighton) and Michelle Pooley (Brighton & Hove City Council), "The Responding to Child to Parent Violence (RCPV) Project, European perspective" , March 2015

6.15 The police were correctly and appropriately considering the incidents reported to them involving P and his mother, as incidents of domestic violence. They were also assessing the risks to P's mother via their DASH assessment, placed SIG markers on the address and initiated the MARAC processes. However, it was concerning to note that the panic alarm was not installed in P's mother's home until 12 July 2012[78] which was two months after the initial MARAC meeting recommended this to be installed, especially as P was released on bail from HMP Hewell on the 1 June 2012 and remained in the community until the 12 July 2012. P's mother was contacted by the IDVA who advised to be vigilant regarding security at her home, and to call the police in an emergency. Police were also advised that P had been released on bail and that his mother may be at risk but this did not appear to expedite the installation of the panic alarm.

6.16 Additionally a Threshold Assessment Grid (TAG) risk assessment,[79] completed by BCPFT CJT on 12 July 2012 in response to concerns by the magistrates regarding P's mental health, concluded that P was "a severe risk to others" and that he had told the court that "he would kill his mom."

6.17 We were therefore concerned that the panic alarm was removed from P's mother's address by the police on the 9 October 2012, six days prior to P's release from HMP Hewell. There is no indication that either the police or any other agency that had been aware of the previous incidents of domestic violence, undertook a review of the potential risks that faced P's mother and his siblings when P was released, before removing the alarm. This decision is difficult to reconcile when such was the concern for the safety of P's mother that the magistrates' court had imposed a 2 year restraining order banning P either going to the family home or his mother's work address.

**West Midlands Police**
Recommendation 6: Before the decision is made by the police to remove safety and alert equipment from a victim of domestic violence West Midlands Police should ensure that a full risk assessment is undertaken to inform this decision. All relevant agencies and the victim should be involved in this assessment and decision.
**Priority 2**

6.18 On P's detention in HMP Hewell (11 July 2012) a Care Programme Approach (CPA) Assessment tool was completed. There was no evidence that the assessor actively questioned other agencies who had been involved with P and the court assessment, such as the CJT, to inform the assessment. If this had been done the assessor would have had the opportunity to make further enquiries as to the concerns regarding P's risks to others, in particular his mother.

6.19 The CPA assessment failed to document that P had a younger brother with whom he had contact. The CPA form directs that if a prisoner has, or is likely to have, contact with a child then a risk assessment must be completed and

[78] 12 July 2012 was when P failed to attend court
[79] Threshold Assessment Grid assesses the severity of intentional self-harm' and risk to others
bjp.rcpsych.org/content/186/2/146

the assessor should consider liaising with other agencies, for example the children's safeguarding nurse. The opportunity to identify the incident with P's younger sibling on 10 May 2012 which had led to a child protection investigation was missed.

6.20 We also noted that when P was detained in HMP Birmingham (22 October 2012) there was no reference of any previous risk to others except for the altercation with the police officer. There were other instances where no reference was made to the fact that his victim had been his mother. If both HMP Hewell (Healthcare) and HMP Birmingham (Healthcare) had been aware that P was a perpetrator of domestic violence and that the victim was his mother, the relevant agencies, for example the police could have been notified of his impending release dates. This would have enabled an assessment to have taken place with regard to P's mother and adequate protection and support provided. As it was, when P was released from prison, his mother's panic alarm had been removed and she was not receiving any on-going support.

6.21 In our view, if both the domestic violence and the potential child protection issues had been documented accurately, these were likely to have been noted as significant risk factors when it came to P's discharge planning from HMP Hewell (Healthcare) and then subsequently HMP Birmingham (Healthcare) who had access to the CPA documentation.

6.22 We noted that the CPA concluded that there were no concerns regarding P's mental capacity. Two days later (14 July 2012), when P would not sign the consent form to enable the health care team to access his medical records such were the concerns of the forensic specialist registrar regarding P's presentation, that it was decided that he "did not have capacity in this regard so a decision was made to seek records in [P's] best interest." At no point was P's CPA again reviewed when he was at HMP Hewell (Healthcare) despite the change in the assessment of P's capacity and the increasing concerns about his mental health during his time at HMP Hewell (Healthcare).

**HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)**
Recommendation 7: Healthcare staff at both HMP Hewell and HMP Birmingham who are undertaking CPA and risk assessments should familiarise themselves with the Home Office 'Adolescent to Parent Violence and Abuse Guidance for Practitioners' (2015) and be categorising incidents of violence by children on a parent and/or carer as incidents of domestic abuse.
**Priority 2**

**HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)**
Recommendation 8: Staff undertaking the initial Care Programme Approach Plan must ensure that they liaise with all agencies who have been involved with the prisoner, in the community and/or during the court process, in order to obtain an accurate profile of their needs and risks to themselves and others.
**Priority 1**

**21 May to 17 July 2012**

6.23 On 21 May 2012 P pleaded guilty to the assault on the police officer. He was sentenced to four weeks imprisonment. He pleaded not guilty to the assault on his mother and the trial hearing was adjourned until 11 July. He was remanded in custody at HMP Hewell.[80] At P's initial health screen the specialist nurse practitioner was concerned that P had mental health problems and referred him to the prison's GP who prescribed olanzapine.[81] P also disclosed that he had been using khat.[82]

6.24 On 30 May 2012 P was granted bail. He was to be bailed to a bail hostel in Walsall arranged by the Bail Accommodation and Support Service (BASS), with the condition that he did not have contact with his mother or be in the locality where she lived. He was released from HMP Hewell on 1 June 2012.

6.25 P did not arrive at his bail address until 2 June, which was a breach of his bail conditions, by which time the BASS had contacted the police who had undertaken a 'safe and well check on his mother'.

6.26 P attended court on 11 July for the trial of his assault on his mother.

6.27 During the trial there was concern about P's behaviour and demeanour. Whilst under oath P had stated that he would stab and kill his mother. The Court requested an assessment of his mental health by the BCPFT CJT. Due to P's presentation, the CJT practitioner concluded that P needed to be assessed by the BCPFT Crisis Team and that a MHA assessment was required. This was arranged for 16 July.

6.28 The CJT's TAG Risk Assessment documented that they considered that P's level of risk to others was "severe". The CJT practitioner asked for P to be remanded overnight but the prisoner escort staff had left so P was conditionally bailed to the bail hostel address. He failed to return to court the next day so a warrant was issued for his arrest. P was arrested the following day (13 July) at the accommodation his mother had previously secured for him. P's case was then adjourned to 16 July 2012 and he was remanded to HMP Hewell.

6.29 P was initially assessed in reception at HMP Hewell on 13 July 2012. He was identified as uncooperative and uncommunicative, and thought to have "possible mental health issues". It was noted he appeared shy and vulnerable.

6.30 A more comprehensive mental health assessment was attempted twice on 14 July 2012. It is noted he appeared distracted, responding to unwanted stimuli, and was thought to be psychotic. A psychiatrist assessment was arranged.

[80] HMP Hewell (Healthcare) was at the time provided by Worcestershire Health and Care NHS Trust.
[81] Olanzapine is an antipsychotic medication used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic depression) in adults. http://www.drugs.com/mtm/olanzapine.html
[82] Khat is a flowering plant native to the Horn of Africa and the Arabian Peninsula. When chewed it acts as a stimulant. In the UK khat has been classed as a C drug under the Misuse of Drugs Act. http://www.drugwise.org.uk/khat/

6.31 P was assessed by the in-reach forensic specialist registrar[83] on 14 July who found him to appear guarded, paranoid and suspicious. He was given a tentative diagnosis of an acute paranoid psychotic disorder and prescribed olanzapine.

6.32 The CJT attended Court on 16 July 2012 and contacted the Sandwell Crisis and Home Treatment Team (the Crisis Team) to undertake a MHA assessment, but P had not been transferred from HMP Hewell as he was not considered to be fit to appear in Court following assessment by the forensic specialist registrar at HMP Hewell.

6.33 The court adjourned the hearing until 17 July 2012. The Crisis Team made three attempts to speak with the forensic specialist registrar at HMP Hewell on 16 July.

6.34 The following morning (17 July 2012) at 8.55am another message was left for the forensic specialist registrar at HMP Hewell. A telephone conversation with a secretary recorded an apology that the forensic specialist registrar had not returned their calls, stating that he was in court that morning and would not be available until the afternoon.

6.35 A mental health nurse from HMP Hewell (Healthcare) gave the Crisis Team an update on P's presentation and the court requested that a MHA assessment be undertaken at court. A member of the assessment team contacted P's mother who provided extensive details of her son's symptoms and also disclosed that he had a conviction for carrying a knife. The CJT also informed the assessment team of the concern expressed by the forensic specialist registrar that P did not have capacity. The assessment team made several failed attempts to speak to the forensic specialist registrar. Also the CJT's records were not reviewed by the assessment team. The assessment found that P did not meet the criteria for admission to hospital under the Mental Health Act. It concluded that P may have a personality disorder with depressive traits which would require the future involvement of mental health services.

6.36 The Crisis Team opinion was relayed to the Court. P was assessed as having capacity and deemed well enough to answer the charges against him. He pleaded guilty and received a 26 week sentence of imprisonment for the assault on his mother and the Court made a restraining order in respect of his mother for a period of two years.

6.37 He was transferred back to HMP Hewell. He then remained in the healthcare unit for the remainder of his sentence.

[83] Specialist registrar (now Specialty Registrar or SpR) is a doctor who is working as part of a specialty training with a minimum of six years' experience (previously 4-6 years' experience).

## Black Country Partnership NHS Foundation Trust's progress on implementing recommendations in relation to their Criminal Justice Team.

6.38 We have discussed earlier the implementation of the recommendations relating to CAMHS, and the changes to local services for children and young people in Sandwell.

6.39 The initial investigation made four recommendations for improvement in the Criminal Justice Team (now the Criminal Justice and Mental Health Liaison Team, or CJMHLT):

- **BCPFT Recommendation 1:** BCPFT should ensure that there is a clear operational policy in place for the Criminal Justice Team. This document should outline:
  - roles, responsibilities and accountabilities within the team
  - guidance on undertaking risk and mental health assessments
  - agreed standards of record keeping and documenting outcomes of assessments
  - processes for information sharing with the wider MDT, GP and other internal and external services/agencies

- **BCPFT Recommendation 3:** BCPFT should ensure that the current arrangements for clinical record keeping within the Criminal Justice Team are reviewed as a matter of urgency considering the availability of records and Information Governance.

- **BCPFT Recommendation 4:** BCPFT should review the issue of availability and accuracy of Criminal Justice Team records on OASIS[84] as a means of supporting effective communication and clinical risk management.

- **BCPFT Recommendation 6:** BCPFT should review how the Criminal Justice Team and the Crisis Team work together, and with partners, to share information and ensure effective recognition of severe mental illness including psychosis. Such co-working should support:
  - recognition of psychotic features (across all age groups)
  - the use of longitudinal risk assessment
  - hearing the voice of the Carer
  - implementation of the Mental Health Act

### Operational Policy

6.40 In August 2015 BCPFT ratified and introduced its Criminal Justice Mental Health Liaison Team (CJMHLT) Operational Policy.[85] The policy outlines the

[84] BCPFT electronic information system
[85] BCPFT's Criminal Justice Mental Health Liaison Team's Operational Policy , April 2015

operational framework for the service with regard to the assessment of both urgent (from Sandwell Magistrate's Court) and routine referrals (from other agencies such as police or probation). It also states that the service will provide short term limited interventions "to promote an engagement of services users into services." It identifies the responsibilities of the team in regard to risk assessments and reporting of "urgent risk information and/or dangerousness to the police care coordinators, key workers and other appropriate agencies". It also outlines its expectation that all staff will work collaboratively with other services both in regard to information sharing and supporting service users.

6.41 The CJMHLT operational policy also confirms that it had referred to and had regard to the findings and recommendations and values of the Bradley Report,[86] the Bradley Report: Five Years On[87] and the Francis Report[88] to underpin the policy.

6.42 The initial investigation report recommendations were discussed at interview with BCPFT's General Managers of Urgent and Planned Care and the Mental Health Group Director. Of these, only the General Manager of Planned Care had been in post at the time of publication of the initial investigation report. They reported that, as far as they were aware, there had not been any recent cause for concern about the CJMHLT, and in fact they had been awarded the Butler Award.[89]

6.43 Assessment of risk, robust record keeping and ensuring information sharing between agencies are core themes and recur throughout the policy. Appendix one of the policy contains detailed guidance on use of the Clinical Risk Tool with guidance for completion. The Trust has also developed a comprehensive clinical risk assessment guidance.

**Access to records**

6.44 At all of our interviews with staff from BCPFT it was unanimously accepted that the recommendations in the initial investigation report concerning the lack of consistency with regard to clinical record keeping, risk management and availability of records still remains an issue throughout the Trust. Clinical record systems within the Trust remain entirely paper based. We were told that there is a considerable amount of duplication of information from the point that a service user is initially referred.

6.45 It was also reported to us by several BCPFT practitioners that one of the challenges they face is the absence within the Trust of an electronic patient records system. This can cause problems as not only is it time consuming to

[86] Dept. of Health "The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system"; 2009 now archived: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf

[87] Durcan G, Saunders A, Gadsby B & Hazard A "The Bradley Report five years on: An independent review of progress to date and priorities for further development" Centre for Mental Health; 2014 ttps://www.centreformentalhealth.org.uk/the-bradley-report-five-years-on

[88] Francis, R. "Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry" The Stationery Office; 2013 http://www.midstaffspublicinquiry.com/report

[89] Butler Award celebrates outstanding dedication, skill and creativity by those working in correctional settings across the UK. http://www.butlertrust.org.uk/

handwrite notes but the patient's file can also be at another site, leading to delays in obtaining the file.

6.46 This finding was echoed in the recent CQC inspection reports of January and November 2015, published in June 2015 and April 2016.[90,91]

6.47 We were informed that the expectation is that these issues will be addressed by the introduction of a Trust wide electronic patient records system. There has been a pilot of the new IT system, with CJMHLT being one of the services involved in the pilot. The project team for the development of the new IT system has included ward managers and service managers. However there continue to be delays in the roll out across the Trust due to capacity issues and on-going technical difficulties. We were informed that at the time of the interviews[92] a date for the roll out of the electronic records system had yet to be finalised.

6.48 We have also seen a copy of the internal audit report issued 22 June 2015 which reviewed the reasonableness and effectiveness of arrangements for accessing Trust services based on the revised policy for the CJT. This audit report also identified that the new electronic health record (EHR) required appropriate space in the record to document the involvement and contact details of other agencies involved.

6.49 We note a further recommendation in this audit report of the need for information sharing protocols across agencies. We have seen a copy of an information sharing protocol for health and justice agencies in the Black Country, but draw attention to it being draft at the time of review, and the absence of other key local health organisations as signatories. We make a recommendation regarding this protocol later in the report at section 9

**Black Country Partnership NHS Foundation Trust**
Recommendation 9: The new EHR must facilitate the recording of other agencies involvement and contact details.
**Priority 2**

### Did not Attend/ No Access Visit

6.50 We were informed that following the incident BCPFT has introduced a "Did Not Attend / No Access Visit Adult Safeguarding" Policy (July 2014). We reviewed this policy.

6.51 The policy states that its purpose is to "provide a clear process for all staff working within the Black Country Partnership NHS Foundation Trust on how to apply safeguarding procedures to the following situations:

[90] CQC. Mental Health Crisis Care: Sandwell Summary Report Date of local area inspection: 13, 14 & 15 January 2015 https://www.cqc.org.uk/sites/default/files/20150414%20Sandwell%20Crisis%20Review%20-%20Local%20Area%20Report%20FINAL%20for%20publication.pdf
[91] CQC. Black Country Partnership NHS Foundation Trust Quality Report. Date of inspection visit:16th – 20th November 2015 http://www.cqc.org.uk/sites/default/files/new_reports/AAAE6508.pdf
[92] March 2016

- non-attendance at pre-arranged appointments;
- no access visits where community staff are unable to make contact or gain access to a person's place of residence;
- appointments cancelled in advance by people; and
- those occasions when appointments need to be cancelled by the Trust.

6.52 It provides clear protocols for both new referrals who do not attend their first appointment and also for known service users who do not attend.

6.53 Guidance on what action should be taken and the potential risks for service user who disengage from services in order to safeguard and protect their welfare is outlined within the policy. This includes the advice that "the referral should be discussed with the GP and referrer to agree on what further action needs to be taken or whether discharge is appropriate".

6.54 This policy identifies clear responsibilities and actions to take where there may be safeguarding concerns for an individual that 'did not attend' or had a 'no access visit'. The policy clearly states that where there are no safeguarding concerns the service operation policy for DNA applies.

6.55 Both the CJMHLT and the Crisis & Home Treatment team have sections within their operational policies which clearly identify the steps to take in the event of a DNA/ No Access Visit or when there is no response from the service user on a home visit.

6.56 We were informed that this year BCPFT's adult mental health services are re-introducing an annual cycle of service development planning which includes: identifying particular areas where there are issues or concerns for that service, for example the number of DNA appointments. We were also informed that the BCPFT's carers group have been asked to be involved in the planning of this development. It was reported to us that the aspiration of such a cyclical planning cycle process will facilitate a structure for continuous monitoring and evaluating quality and performance within the Trust.

6.57 We concluded that the revised policy was robust and clearly provided both guidance and the escalation processes that are required when a service user disengaged with a service. However, we recommend that the Trust assures itself that the policy is effective in practice.

**Black Country Partnership NHS Foundation Trust**
Recommendation 10: The Trust should assure itself that the new DNA/ No Access Visit policies are complied with.
**Priority 2**

**Closer working between CJMLHT and Crisis Team**

6.58 We have reviewed this recommendation with BCPFT and its team managers, practitioners and the quality and governance team. There was unanimous confirmation that following the incident, all the community mental health, criminal justice, forensic and crisis teams as well as the learning

disability teams were relocated within one building. This has made a significant improvement in communication between the teams. It has also, made the convening of multidisciplinary meetings (MDT) easier, which now occur on a weekly basis. These meetings are the forum to discuss referrals, service users and highlight service users where there is a particular concern or whose risks may have significantly increased. The teams also have monthly joint interface meetings to discuss wider issues around care pathways, share learning and good practices.

6.59 We were also informed that on a day to day level, practitioners are now also using emails, rather than faxes, to communicate with other members of their teams and other services. This has resulted in there being a clearer audit trail of communication. We have heard how the 'virtual fax system' now directs emails to the Crisis Team duty worker, and how there is no danger that a printed fax will get lost.

6.60 With regard to how lessons learnt from internal and external investigations are communicated within BCPFT we were informed that:

- BCPFT publishes quarterly bulletins "Assuring Times" and monthly bulletins which include a "lessons to be learnt" section which aims to disseminate throughout the Trust recommendations and any learning from internal and independent investigations. We were provided with copies of this monthly bulletin. Although it is not possible to ascertain how many of BCPFT's employees actually read the bulletin, we found it to be both informative and accessible to readers of all abilities.

- Community mental health service managers reported that at their team's monthly meeting they have "lessons learnt from incidents and investigations" as a standard agenda item. As our investigation was focused on BCPFT's community service, we are unable to say whether there is a similar standard agenda item on inpatient unit/ ward meetings.

- On a Trust wide basis we were informed that recently Birmingham and Solihull, Dudley and Walsall, and Coventry and Warwick NHS Trusts, became one of the first of NHS England's Vanguard' sites.[93] The partnership is called MERIT (Mental Health Alliance for Excellence, Resilience, Innovation and Training) and it aims to share best practice and create replicable models for long-term clinically and financially sustainable specialist mental health services across all the Trusts. The aspiration is that they will work together to solve efficiency, workforce, equality and policy implementation challenges. There are three clinical streams of MERIT, i.e. crisis, seven-day working, and recovery. The Vanguard is also looking at having a West Midlands expertise investigation group, which will provide

[93] For more information on the Spring 2016 Vanguard project see http://www.dwmh.nhs.uk/west-midlands-mental-health-trusts-forge-alliance-to-transform-acute-care/

skilled investigators and processes where lessons learned and action plans can be shared.

## Arising issues, comment and analysis

6.61 We asked those BCPFT practitioners we interviewed what pathways would now be available to P within the Trust, with emphasis on contact with the criminal justice system.

### Offender Rehabilitation Act (ORA) 2014[94]

6.62 Since 2015, if a person receives a prison sentence of less than 12-months, the prisoner will be released on an ORA licence,[95] after serving one half of their sentence. The remainder of the sentence being served in the community. They, and those who have been sentenced to less than 2 years in prison, will be monitored for up to 12 months by a named probation officer.

6.63 Depending on the length of the prison sentence, the length of the supervision period can vary significantly. Anybody who breaches the requirements of the new supervision period will be taken back to court. The court can, in the event of breach of conditions or reoffending, impose the following sanctions: fines, unpaid work, curfew or return to prison. In P's case, if an ORA licence had been available it could, in our opinion, have been helpful as it would have provided him with one named person who would have been overseeing his release. This could have enabled the opportunity for an assessment of P's presentation to have taken place and a referral made to both adult mental health and homelessness services. As it was there was no supervision or support for P when he was released from both HMP Hewell and HMP Birmingham.

### Liaison and diversion

6.64 There is a new Black Country Liaison & Diversion (L&D) Service which is funded by NHS England. This is one of several pilots around the country which are being set up to ensure people who come into the criminal justice system with mental health conditions, learning disabilities and other vulnerabilities are recognised and are promptly referred into health and other services to get the treatment or support they need.

6.65 By identifying someone brought into a police station or involved in court proceedings that may have a mental health problem or other vulnerabilities, L&D schemes can ensure an individual is supported through the criminal justice system and into the right mental health or social care service. It can also help the police and courts to do their jobs by providing up-to-date information on a person's state of mind; as well as benefit the individual's health, contribute to a reduction in re-offending, and reduce the likelihood that the individual will reach crisis-point.

[94] Offender Rehabilitation Act (2014) http://www.legislation.gov.uk/ukpga/2014/11/contents/enacted
[95] Under the ORA, adults serving prison sentences of less than 12 months, for an offence committed after 1 February 2015, will be released on licence after serving one half of their sentence in prison and will serve the remaining period in the community.

6.66 The major difference between this new L&D service and the Criminal Justice Team is that the new service is intended for people at the point of, or shortly after arrest, such as in a police cell, whereas the Criminal Justice Team works with people in the Court.

6.67 In P's case, had this been available, it would have provided the opportunity for him not to be processed via the criminal justice system. The L&D service is located at police stations and includes a community psychiatric nurse. Their role is to support a prisoner through their custody experience and, if assessed as being required, a referral can be made directly to the appropriate services, such as community adult mental health services. They also provide an outreach service. Such a service would, in our view, have been able to support P whilst he was in custody and would not only have been able to signpost him to appropriate services but also monitor P until he had engaged with those services. The service has access to records held by the NHS and custody records on ICIS (Case & Custody management system).

**Street Triage**

6.68 Street Triage (this service model was launched by the Department Of Health in August 2013).[96] This is a joint mental health service and policing approach to crisis care. A police officer and a trained mental health nurse, using a patrol car, respond to all calls with potential mental health involvement. The West Midlands model includes a paramedic. The aim of Street Triage is to enable vulnerable people to receive appropriate mental health services with the hope that this will lead to improved outcomes and a reduction in the police's use of section 136.[97] Mental health professionals are present to provide advice to police officers. This advice can include an opinion on a person's condition, or appropriate medical information sharing about a person's health history. The aim is, where possible, to help police officers make appropriate decisions, based on a clear understanding of the background to these situations. Referrals can be made directly by the police and street triage team to the local L&D services or Crisis and Home Treatment Team who would assess the person's mental health needs and if appropriate, refer them to longer term community or inpatient mental health services. At present, clinicians are able to access the Trust's patient records and the Police National Computer (PNC) records but not primary care notes.

6.69 The DH has provided funding for nine areas to provide pilot schemes for Street Triage in England. Street Triage is managed by local police authorities in partnership with Clinical Commissioning Groups (CCGs), NHS England and Police and Crime Commissioners.

[96] "Street Triage pilots, the Crisis Care Concordat". http://www.crisiscareconcordat.org.uk/inspiration/get-inspired-2/

[97] Section 136, Mental Health Act 1983 (amended 2007). The police can use section 136 of the Mental Health Act to take a person to a place of safety when they are in a public place. They can do this if they think they have a mental illness and are in need of care. A place of safety can be a hospital or a police station for up to 72 hours.

6.70 A recent evaluation of nine pilot schemes in England (2016)[98] reported that "all but two of the nine Street Triage schemes resulted in a reduction in the use of s136 detentions…. The mean reduction was 21.5%". The evaluation report also identified certain functions of the Street Triage model that may be associated with better outcomes and longer-term sustainability. These included:

- Joint ownership of the scheme at a senior management level to support the development of effective partnerships.
- An established and regular process to review joint working arrangements.
- Provision of information on agreed referral pathways to health and community services at the point of crisis or after its resolution.
- Joint training programmes for all staff involved in the Street Triage schemes and enhanced mental health training for all police officers.
- Effective information sharing between services, in particular, access to health information.
- Provision of timely advice to police officers at the point of initial contact and during the assessment process;
- Integration of Street Triage schemes with the health service-based crisis and alcohol pathways.

6.71 The evaluation report recommends that the operational hours for Triage Schemes is extended to 24 hours, stating that the "co-location of health and police staff (e.g. linked to a Control Room) or dedicated phone line(s) [which] appear to be an important component of effective Street Triage schemes and could support a cost-effective roll out of the programme". Current indicators suggest that it is an effective multiagency service for this vulnerable group who, like P, have historically been managed unsuccessfully via the judicial system. With mental health problems being such a significant factor in 999 calls to the police and ambulance service, and the positive impact demonstrated by the pilot studies we would encourage the further rollout of street triage throughout England, and recommend that commissioning bodies work with local police and crime commissioners and the Department of Health to further extend this service.

**Department of Health, NHS England, CCGs and local Police and Crime Commissioners**
Recommendation 11: To work in partnership to roll out and further develop the street triage service to reduce the impact of mental health crises on local police and emergency services.
**Priority 1**

6.72 In response to our request for reflection on the different pathways now in place, the BCPFT and BSMHFT practitioners confirmed that in their view it was not possible to definitively conclude that the systemic changes and

[98] Dr Bianca Reveruzzi and Professor Stephen (2016) "Street Triage Review report on the evaluation of nine pilot schemes in England" Pilling Department of Clinical, Health and Educational Psychology University College London, http://www.crisiscareconcordat.org.uk/wp-content/uploads/2016/03/Street-Triage-Evaluation-Final-Report.pdf

developments outlined above would have prevented the tragic death of Christina. However, in their view the new services now available, such as Street Triage and new court powers such as the ORA licence, would have made it far more likely that P would have avoided a custodial sentence and thus provided the opportunity for community mental health to have engaged with him.

6.73 In our view it is likely that had the above alternative approaches been operational at the time P began to come to the attention of the police there would have been a greater opportunity to both engage and assess P at an earlier stage. It is also more likely that services would have then been able to divert P from a criminal justice pathway into a more appropriate mental health care and treatment response.

6.74 The BCPFT and BSMHFT practitioners and managers also reported that the lack of discharge planning and referral to community mental health services when P was released from HMP Hewell and subsequently HMP Birmingham was a critical factor in the lack of community care for P. We asked if, since this incident BCPFT had discussed the findings of the initial investigation report with the providers of HMP Hewell and HMP Birmingham's health care services. We were told that this had not happened but that BCPFT's forensic team have a good working relationship with local prison healthcare. We consider the findings and recommendations of the Bradley Report later in this report.

# 7 Events of 18 July 2012 to 15 October 2012 (HMP Hewell)

7.1 After sentencing, P was returned to HMP Hewell. He was immediately placed in the prison's health care wing where he remained until his release on 15 October 2012. P continued to present as withdrawn, and it was frequently documented that he was observed responding to unseen stimuli and that his self-care was poor.

7.2 P was reviewed (4 August 2012) by the forensic specialist registrar working with the in-reach team, who documented that he did not agree with the outcome of the MHA assessment undertaken on 17 July 2012. He concluded that P had a mental disorder which required detention for assessment in hospital in the interests of his protection and for the protection of others. Following a further review on 9 August in Upper Medical,[99] the forensic specialist registrar in decided to refer P to the clinical director /consultant psychiatrist with responsibility for BSMHFT's forensic service, based at Meadowcroft Psychiatric Intensive Care Unit (PICU).

7.3 Within the letter of referral it is stated that P had previously been assessed twice by local mental health services in court, and the assessments

[99] Upper Medical of the main healthcare department carries out the majority of primary health functions. Lower Medical houses the inpatient unit. There were also healthcare facilities in reception and house blocks

concluded he was not detainable or suffering from a mental health disorder. Further, the referral states that 'our longitudinal assessment is the reverse' and that 'the mental health team at HMP Hewell are of the view he suffers from a schizophreniform psychosis which is of a degree that warrants detention in hospital'.

7.4 The initial referral was made to PICU on 4 September 2012 and in the absence of a response, the referral was resent on 12 September 2012. P's medication at this time was olanzapine 15mg.

7.5 The PICU specialist registrar undertook an assessment on 20 September 2012, with the PICU's deputy and ward manager. Only the ward manager had previously undertaken such an assessment. At the time, BSMHFT's PICU did not have any guidance or proforma for undertaking a PICU assessment within a prison environment. The assessment team did not open a RiO file[100] to record their assessment and gave a verbal report to one of the nurses on healthcare wing prior to leaving.

7.6 The assessment, dated 24 September 2012, reported that P was "presenting with emotional and behavioural changes [in] keeping with the criteria for 'at risk mental state for psychosis… I believe that when he is in the community he will benefit with support from Early Intervention Services, including psychological therapy to look into aspects of his low self-esteem and social interactions."[101] The report concluded "at present we did not feel that [a] PICU admission was appropriate." It also suggested that P's poor social skills might be an indication that he was exhibiting some form of autistic spectrum disorder.

7.7 After the outcome of the assessment had been relayed verbally to him, the HMP Hewell forensic specialist registrar documented that he did not agree with the PICU assessment and that in his opinion P needed to be referred to the local CMHT prior to his release. On the 20 September (the same day as the PICU assessment), at an MDT meeting, it was documented that P was to be released from prison on 15 October 2012 and that he was to be referred to a local CMHT prior to his release. There is no record that a referral was made.

7.8 At the next MDT meeting (4 October 2012), which was after the formal report from PICU had been received, a discussion took place as to the concerns about P's mental health and it was agreed that P would be referred for a further PICU assessment. It was also agreed that if the PICU assessor remained of the opinion that P did not require a hospital admission, they (the MDT) would request that the PICU assessor refer him to the Home Treatment Team. There is evidence that this letter was sent to the PICU unit on 8 October 2012 but during the course of the initial investigation, PICU was unable to locate the letter. No agency therefore referred P to community mental health services, either prior to or after his release from HMP Hewell.

[100] RiO patient record system http://www.servelec-group.com/health-social-care/healthcare/products/rio/
[101] Letter from speciality registrar forensic psychiatry, 24 September 2012,

7.9 P was released from HMP Hewell on 15 October 2012. He was provided with three days' supply of his medication (Olanzapine). P's GP was not notified of P's release from prison and P declined a copy of his Inmate Medical Record (IMR).

## HMP Hewell (Healthcare) progress on implementing recommendations

7.10 The initial investigation report made 9 recommendations in relation to the provision of healthcare within HMP Hewell. At that time healthcare was provided by Worcestershire Health & Care NHS Trust, and it is now provided by Care UK. For clarity we refer to these recommendations as pertaining to HMP Hewell (Healthcare). We were provided with a copy of the action plan for HMP Hewell (Healthcare) action plan and were informed that an audit had taken place in November 2014 to monitor the effectiveness and staff compliance with the actions in the plan.

- **HMP Hewell (Healthcare) Recommendation 1:** HMP Hewell (Healthcare) should ensure that when the GP is known that the information is recorded appropriately on SystmOne and noted on the IMR main demographic record.

7.11 In addressing this recommendation the following changes have been made:

- A prisoner's GP contact details are now documented in the main demographic records. A consent form to obtain the prisoner's permission to contact their GP to access their medical records is also now in situ in the initial reception assessment forms.
- The consent form is passed to admin who will fax it to the prisoner's GP.
- A GP tracking sheet is in place and all the forms and note templates have been amended to include this information.
- All staff have been briefed of the changes via global email and memorandum and protocols in place.

7.12 This action was completed September 2014.

7.13 Following the audit, a further action was agreed that the administrative staff will also telephone a prisoner's GP surgery by phone to alert them that a fax is being sent.

- **HMP Hewell (Healthcare) Recommendation 2:** HMP Hewell (Healthcare) should ensure a review of the process of healthcare assessment prior to release to ensure relevant healthcare information, which may have been found during detention, is identified.

7.14 A review of pre-release processes has been undertaken, “with particular reference to newly identified healthcare information, how this can be shared and in what circumstances”.[102]

7.15 This action was completed December 2014.

- **HMP Hewell (Healthcare) Recommendation 3:** HMP Hewell (Healthcare) should ensure that whenever possible a summary of the individual’s Prison health records is provided to their GP on release from Prison.

7.16 Action: “a review of community liaison prior to and upon release will be completed. This will include GP liaison but also links with other primary care, mental health and substance misuse providers”.[103]

- Discharge summaries are given to the prisoners at the point of release and if a prisoner is registered, a copy is sent to their GP surgery.

7.17 This action was completed October 2014.

- **HMP Hewell (Healthcare) Recommendation 4**: HMP Hewell (Healthcare and Prison) should ensure that in all cases where there are concerns in respect to a prisoner not having the necessary capacity to make a significant decision that the guidance outlined within the Mental Capacity Act is enacted and that a Best Interest decision is made. This should be recorded, maintained and shared as appropriate to Courts and other services.

7.18 Action: all staff to complete the e-training on mental capacity. All staff to be reminded to record decisions about mental capacity in the patient’s record. Where indicated, liaison with Courts and other services with regard to mental capacity will be facilitated by the appropriate clinical staff. A local protocol will be developed in order to manage this process

7.19 The first part of this action was completed February 2015. It was reported to us that mental capacity training is currently on-going.

- **HMP Hewell (Healthcare) Recommendation 5:** HMP Hewell (Healthcare) should ensure that robust systems are in place for assessing, managing and communicating all known physical and mental health concerns at admission, transfer and release from Prison.

7.20 Action: on transfer, all information will be made available to the receiving prison via SystmOne (patient record system) which is available.

7.21 This action was completed September 2014.

[102] HMP Hewell action plan, p2
[103] HMP Hewell action plan, p3

7.22 Action: assessments undertaken on and subsequent to admission will be reviewed for primary care, mental health and substance misuse services. Any change indicated will be implemented. There is a regional group developing the templates for SystmOne which has representation from the Offender Health Directorate.

7.23 This action was completed January 2015.

7.24 Action: a review of community liaison prior to and upon release will be completed. This will include GP liaison but also links with other primary care, mental health and substance misuse providers.

7.25 CPA process was implemented in October 2014 and audited in February 2015 for compliance.

- **HMP Hewell (Healthcare) Recommendation 6:** HMP Hewell (Healthcare) should review the local arrangements for requesting and managing physical and mental healthcare referrals and clarify: roles and responsibilities: record keeping system for production of correspondence monitoring of timeliness of responses noting and confirming follow-up arrangements processes for escalating concerns.

7.26 Actions: on-going log of all referrals to mental health units will be maintained and routinely reviewed and monitored through MDT meetings and referral mental health act returns.

7.27 Action: local protocol to be developed in order to ensure effective management of mental health and physical health referrals to secondary and tertiary services.

7.28 Action completed: January 2015.

- **HMP Hewell (Healthcare) Recommendation 7:** HMP Hewell (Healthcare) should review the local arrangements for release of Prisoners with physical and/or mental healthcare needs, where there are significant concerns that an individual is likely to deteriorate on release, such as due to non-compliance. In such cases, as good practice, such concerns should be shared with the individual's GP whenever possible.

7.29 Action: release protocol will be developed and implemented which will address the requirement to liaise with patients' GPs wherever appropriate and other services where indicated.

7.30 Action completed: pathway and protocol in place March 2015.

- **HMP Hewell (Healthcare) Recommendation 8:** HMP Hewell (Healthcare) should ensure health screening on discharge includes

reference and cross-checking between health and prison records systems.

7.31 Action: requested health care access to P-NOMIS[104] computers to be located in healthcare locations. Access has been requested by healthcare. Action completed: September 2014.

7.32 Action: staff training to P-NOMIS. Access and training is in place and on-going. Action completed: March 2015.

7.33 Further action: to explore the practice of reviewing prison and healthcare records.

7.34 Discharge summaries given to the prisoners at the point of release and a copy sent to the GP surgery where they are known.

7.35 Action completed: 3 March 2015.

- **HMP Hewell (Healthcare) Recommendation 9:** In all cases where HMP Hewell has significant concerns at the time of release as to an individual's mental health and wellbeing, HMP Hewell (Healthcare) must ensure that appropriate consideration is given to undertaking an urgent assessment under the Mental Health Act 1983 (as amended 2007) and that a written record is maintained to this effect.

7.36 Action: "in cases of known release dates – referral for assessment under the Mental Health Act will be considered by the MDT." This will be recorded in MDTs minutes and on SystmOne entries.

7.37 Action completed: October 2014

7.38 It is evident that HMP Hewell (Healthcare) has implemented this recommendation with regard to MHA assessments and documenting such decisions when it is 'known' a prisoner is to be released. However, we were told that often a prisoner can be released without notice; for example they may not return from a court hearing, be transferred to another prison or released early. We were informed that prisons are fined if they do not release a prisoner at the correct date.[105]

7.39 HMP Birmingham's health care staff also told us that this is a difficulty for them when trying to arrange care for a prisoner when released.

## Arising issues, comment and analysis

7.40 HMP Hewell (Healthcare) responded promptly to all the recommendations made in the initial investigation report with regard to the management of prisoners, such as P, who are presenting with complex needs. HMP Hewell's

[104] P-NOMIS: Prison National Offender Management Information System. Operational database used in prisons for the management of offenders. https://data.gov.uk/.../prison-national-offender-management-information-system-p-no...
[105] Although this was not the case for P as HMP Hewell health care unit had been aware of his release date.

healthcare team were able to demonstrate to us that they had addressed all of their actions.

7.41 However it was acknowledged that despite the changes they have introduced, it still remains a challenge to ensure that prisoners such as P, who have little insight into their mental health problems and who are reluctant to engage with either primary care or secondary mental health services have the appropriate after-care planning on their release. These challenges were also identified within the initial investigation report for HMP Birmingham (Healthcare).

7.42 From 1 April 2016 Care UK became the new provider of healthcare services at HMP Hewell. We recommend that NHS England's Health and Justice Commissioning Team (North Midlands) discuss with Care UK the findings of both this report and the initial investigation to ensure that they are aware of the recommendations and the action plan in place. This will ensure that the lessons learnt continue to inform future practices and policies.

**HMP Hewell (Healthcare) and NHS England's Health and Justice Commissioning Team (North Midlands).**
Recommendation 12: NHS England's Health and Justice Commissioning Team (North Midlands) should discuss the findings of the original Trust report with the new provider of healthcare at HMP Hewell to ensure that implementation is still progressing and that lessons learnt are continuing to inform practices and policies.
**Priority 2**

## HMP Hewell (Healthcare) progress on implementing recommendations

7.43 The initial investigation report made two recommendations for the wider prison:

- **Recommendation 6:** HMP Hewell should ensure that there is a robust system in place for recording letters to the Governor, which relate to the health, clinical risk assessment or wellbeing of a named Prisoner, and that a record of such communication is placed within the relevant SystmOne healthcare records.
- **Recommendation 7:** HMP Hewell should give consideration to the development of a recording or log system for concerns raised by relatives to the Prison Chaplain.

7.44 Unfortunately the prison governors at both HMP Hewell and HMP Birmingham declined to participate in this investigation, perceiving it to be a health service matter.

7.45 However, we have been provided with a copy of the HMP Hewell organisational action plan[106] coordinated via the CCG. This identifies that the two recommendations were signed off and completed in August 2014.

7.46 The action completed for Recommendation 6 is "the existing system will now include ensuring that letters containing such information are passed to Healthcare for them to scan onto SystmOne".

7.47 The action completed for Recommendation 7 notes that "All Chaplains and volunteers in the Chaplaincy have been advised that relevant information should be logged on P-NOMIS and a record book placed in the office for a paper trail".

7.48 The logging of correspondence remains an issue for Ps mother. She told us that P refused to see her whilst he was in HMP Hewell. She told us that she had written a letter to the prison governor in which she set out her concerns about her son's mental health. She also informed them that there was a restraining order in place and her son was not allowed to return to her address on his release. She told us that she did not receive a response to this letter and we could find no record of this letter in P's prison health records. She also told us that she had contacted the prison chaplain at HMP Birmingham to ask for help to visit her son. Neither contact was recorded in P's P-NOMIS records.

7.49 We recommend that both HMP Birmingham and Hewell require all staff, including the governor's office, to document all contact with prisoners' families in a prisoner's P-NOMIS record.

**HMP Hewell and HMP Birmingham**
Recommendation 13: Both HMP Hewell and HMP Birmingham introduce a requirement, supported by guidance, that all prison staff, including the governor's office and pastoral care services, should document any contact, either written or verbal, with prisoners' families in a prisoner's P-NOMIS record.
**Priority 3**

## Birmingham and Solihull Mental Health NHS Foundation Trust's progress on implementing recommendations focussed on PICU assessment

7.50 The initial investigation report made six recommendations that focused on the issues that arose during the PICU assessment and subsequent actions of the assessors. The team that undertook the assessment came from Meadowcroft PICU, provided by BSMHFT. As the first six recommendations relate to the PICU we comment on them together.

[106] Homicide Investigation into the death of a child - STEIS Reference: 2013/7122 Organisational Action Plan: HMP Hewell.

- **BSMHFT Recomendation1:** BSMHFT should ensure that there are guidelines for PICU staff undertaking an assessment at a Prison. This process should include:
    - guidance on access to background information
    - who can/should undertake Prison assessments
    - risk assessment
    - Mental Health Act
    - agreed standards of record keeping and documentation information sharing with the wider MDT
    - supervision arrangements
    - what to do in the event of a re-referral

- **BSMHFT Recommendation 2:** BSMHFT should ensure that PICU induction and training for doctors and nurses includes how to undertake Prison assessments.

- **BSMHFT Recommendation 3:** BSMHFT should ensure that there are appropriate arrangements for clinical supervision for all doctors and nurses undertaking Prison assessments.

- **BSMHFT Recommendation 4:** BSMHFT should ensure that all Prison assessments for admission to the PICU are appropriately discussed and recorded within the PICU MDT meetings.

- **BSMHFT Recommendation 5:** BSMHFT should ensure that all Prison referrals and their outcomes are documented in the clinical records.

- **BSMHFT Recommendation 6**: In all cases where there are disputes or concerns raised in respect to the outcome of a prison assessment BSMHFT must ensure that there is a robust escalation/resolution process in place and should consider the applicability of this recommendation to other assessments.

7.51 At the time of the incident BSMHFT did not have a policy or protocol in place for mental health prison assessments undertaken by its PICU staff. In September 2015 BSMHFT introduced guidance for PICU staff undertaking assessments in a prison setting. The guidance identified:

- Those who are authorised to undertake such assessments[107] in future and what training they required;

- The decision making process so that the assessor must discuss their assessment in a MDT meeting;

[107] Consultant psychiatrist, middle grade doctor or senior trainee (ST-6)

- The assessment process is to include access to and review of the prisoner's Prison health care records and a search of the Trust's RiO notes to see if the prisoner had been a patient of BSMHFT;

- That a police national computer (PNC) check should be requested. This can be done via the prison health care staff or utilising the information sharing protocol that the Trust has in place with West Midland's Police;

- The risk assessment (a RiO standard level 2 risk assessment) which must be completed (guidance refers the assessor to BSMHFT's Care Management and CPA Policy regarding completing risk assessments);

- the escalation process for resolving disputes /concerns airing out of a PICU assessment;[108]

- Record Keeping directions for new patients which state that a RiO record should be opened at referral stage and the assessment should be located on RiO and SystmOne;

- Supervision arrangements for both medics and ward staff to be involved in prison assessments; and,

- Training, support and guidance (initial and annual) for staff who are authorised to undertake prison assessments.

7.52 Since the implementation of the PICU assessment policy, BSMHFT have audited prison assessments undertaken by its PICU. The audit reported that from 1 August 2015 to 17 December 2015 there had been four requests for a PICU assessment by prison healthcare services.[109] The audit also showed that only one prisoner was admitted to PICU within 14 days of the assessment.[110] The auditor found an on-going risk that the Trust "will not be able to comply with the deadline around admitting a prisoner to PICU."

7.53 One of the reasons for this delay is that the Trust has only one female PICU. In this period this resulted in a delay of 37 days before the female patient could be admitted. The audit concluded that there had been significant improvements but identified several aspects that were not robust enough: these related to supervision; the impact of accepting prisoners with impending out of area court cases; and the appropriateness of referrals.

7.54 BSMHFT had discussed their new PICU guidance with HMP Hewell in April 2015. We recommend that BSMHFT discuss the new PICU guidance with all other the prison health care services which refer to the Trust PICU's so that

[108] Initially with Operational Manager, reassessment with a member of forensic team and PICU staff, Second Opinion Doctor (SOD), escalation to Clinical Director level
[109] BSMHFT PICU Prison Assessment Audit, December 2015, p3
[110] DH Guidance on prison transfers under S47/48 identifies a requirement that prison to mental health service transfers be completed within 14 days. The transfer clock starts when the first doctors' assessment identifies that the criteria for detention under the Mental Health Act is met. This assessment will provide one of the medical reports required by the Secretary of State and triggers the formal referral to the responsible mental health provider to undertake the second doctor's assessment.

they are fully aware of the assessment, and escalation process in the event of disagreement on the outcome of assessments.

**Birmingham and Solihull Mental Health NHS Foundation Trust**
Recommendation 14: The Trust should discuss their PICU guidance with all the prison health care services who refer to their PICU units.
**Priority 2**

## BSMHFT's progress on implementing Trust wide recommendations

- **BSMHFT Recommendation 7**: BSMHFT should ensure that all clinical teams have a robust centralised process in place to ensure that all clinical correspondence **(incoming and outgoing) is maintained appropriately and that such clinical** correspondence can be accessed in the clinical records.

7.55 Action taken by BSMHFT:

- In November 2013 the Trust issued the following guidance for staff in a Lessons Learnt Bulletin 'can I also reinforce the requirement (again identified from recent serious incident reviews) to ensure that any assessment undertaken by the Trust is recorded on RiO'.[111]

7.56 This action was given a green status[112] in September 2014. A subsequent audit took place September 2015 reviewing compliance with this requirement.

7.57 The audit reported its finding of "very positive results" in January 2016.

- **BSMHFT Recommendation 8*:*** BSMHFT should ensure that all medical and nursing staff are advised of their individual professional responsibilities and accountability for maintaining contemporaneous records and those records must be made available in accordance with Trust policy.

7.58 Actions taken by BSMHFT :

- Initially this action was rated as amber[113] on the basis that the Medical Director would publish this directive in a Lessons Learnt bulletin by October 2014. The lack of a guideline specifically for PICU staff undertaking prison assessments also contributed to this status.
- March 2015: assessed as green status on the basis of publication of the Lessons Learnt bulletin in November 2014
- October 2015: PICU guideline in place. Alerts were also issued to all nursing staff via the Nursing Advisory Council.

[111] BSMHFT action plan January 2016, p5
[112] Green status: fully completed - full assurance
[113] Amber status: partially completed action – limited assurance

- January 2016: audit has taken place with “full assurance” given. Green status

- **BSMHFT Recommendation *9*:** BSMHFT should ensure that there are appropriate systems of clinical supervision and clinical audit in place to ensure that best practice across all professional groups in respect to clinical record keeping is maintained.

7.59 Actions taken by BSMHFT:

- September 2014: Amber status was awarded on the basis that a review of current policy would be presented to NHS Birmingham CrossCity CCG in October 2014.
- November 2014: BSMHFT undertook engagement of staff groups to further review policy and identify improvement actions.
- September 2015: this was downgraded to amber status as the Clinical Supervision Policy on the intranet was dated October 2010. NHS Birmingham CrossCity CGC requested changes to the Trust’s supervision policy. Not actioned until October 2015 by the Deputy Director of Nursing.
- October 2015: BSMHFT’s Clinical Supervision Policy amended and uploaded on the intranet.
- From December 2015 an annual clinical audit programme in place. Revised to a green status.
- Result of first audit January 2016 noted “demonstrates positive assurance.”[114]

## Arising issues, comment and analysis

7.60 BSMHFT have implemented robust changes and provided clarity in relation to decision making, documentation, escalation processes for PICU assessment in prisons and the skill base required to undertake such assessments, through their new guidance on undertaking assessments in prisons for referrals to PICU.[115]

7.61 As of January 2016, BSMHFT audits have shown that most of the changes have taken place together with an embedded audit process to monitor on-going compliance. We were provided with evidence of all the actions and were satisfied that they had been completed.

7.62 We concluded that even if the above processes had been in place at the time of P’s PICU assessment, the decision that he was not suitable for a PICU placement may still have been reached. Our reasons for this are provided below.

7.63 The initial investigation recommendations focussed on improving PICU assessments and referrals. Whilst these local recommendations have been

[114] BSMHFT action plan January 2016, p9
[115] BSMHFT “Guidance for PICU Staff undertaking assessments in a prison setting” September 2015.

completed, we are left concerned about some of the more systemic issues around transfer from prison to PICU.

7.64 Psychiatric intensive care is intended for people in an acutely disturbed phase of a serious mental disorder. The commissioning guidance for PICU[116] outlines the typical presentation of someone requiring PICU care.

7.65 "There is an associated loss of capacity for self-control, with a corresponding increase in risk, which does not allow their safe, therapeutic management and treatment in a less acute or less secure mental health ward. Care and treatment must be patient-centred, multidisciplinary, and intensive and have an immediacy of response to critical clinical and risk situations. Patients should be detained compulsorily under the appropriate mental health legislative framework, and the clinical and risk profile of the patient usually requires an associated level of security".

The National Minimum Standards for Psychiatric Intensive Care in General Adult Services defines psychiatric intensive care as 'for patients who are in an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self-control, with a corresponding increase in risk, which does not allow their safe, therapeutic management and treatment in a less acute or a less secure mental health ward'.[117]

7.66 Although P was obviously mentally unwell, he had recently been assessed (twice) as not requiring detention under the Mental Health Act. When then assessed by the team from the PICU, it seems his behaviour did not present with the degree of acuity and risk defined above, despite the Specialist Registrar, noting in the referral to the PICU, that he was suffering with an illness 'which is of a degree that warrants detention in hospital'.

7.67 We were able to interview the specialist registrar involved in the referral of P to the PICU. We also spoke to the forensic consultant psychiatrist who also worked in the in-reach service for those higher risk prisoners. The specialist registrar told us that he thought referral to PICU was considered appropriate on the grounds of the 'least restrictive' principle within the Mental Health Act Code of Practice, as P was not appropriate for more secure care, and as a detained prisoner could not have been placed on a more open acute psychiatric unit. This use of PICU as the least restrictive environment for a prisoner needing treatment was confirmed as appropriate by the forensic consultant psychiatrist.

7.68 The Department of Health guidance[118] on the transfer of prisoners makes no direct recommendation on the level of security required for prisoners, instead stating that the medical report to the Mental Health Casework Service (MHCS) at the Ministry of Justice 'should refer to the level of physical,

[116] National Association of Psychiatric Intensive Care Units & NHS Clinical Commissioners "Guidance for Commissioners of Psychiatric Intensive Care Units (PICU) 2016" http://napicu.org.uk/wp-content/uploads/2016/04/Commissioning_Guidance_Apr16.pdf
[117] NAPICU (2014) "National Minimum Standards for Psychiatric Intensive Care in General Adult Services Updated 2014" Glasgow http://napicu.org.uk/wp-content/uploads/2014/12/NMS-2014-final.pdf
[118] Department of Health (2011). "Good Practice Procedure Guide: The transfer and remission of adult prisoners under s47 and s48 of the Mental Health Act".

relational and procedural security appropriate to the clinical needs of the prisoner and include a recommendation for the level of security (PICU, low, medium or high) in which treatment is required'.

7.69 This guidance identifies four levels of security which are deemed suitable for transfer of prisoners to mental health services (high secure, medium secure, low secure and PICU). For PICU it says that 'in some circumstances, MHCS will agree to transfers to psychiatric intensive care wards in general adult mental health services. These services provide a degree of physical security in addition to intensive treatment programmes'.

7.70 Whilst we have heard from other forensic psychiatrists that it is now quite routine practice to refer prisoners for admission to a PICU from prison, there does seem to be some conflict with the definition and guidance for PICU admission detailed earlier, and perhaps explains why P was not deemed suitable for admission to PICU when assessed at that time.

7.71 We have noted earlier the new guidance issued by BSMHFT for PICU staff undertaking assessments in prisons. Unlike the DH guidance, this does not mention the possibility of the use of a low secure facility for transferred prisoners.

7.72 The second letter from the forensic specialist registrar to the PICU service of 8 October also asks the service to re-assess P and if found not to require detention in hospital for treatment asks that they refer him to the relevant home treatment team for appropriate support on release.

7.73 It is clear from our work, and that of the initial investigation, that there was a failure to arrange follow up after care for P when released from prison.

7.74 However we have noted that since 2014 BSMHFT have implemented a Single Point of Access (SPA)[119] which aims to 'improve access to our services by ensuring that people are seen by the right person at the right time'. Whilst this does speed up access to appropriate mental health care for planned releases within Birmingham, we have heard of the considerable difficulties experienced by health care staff when trying to arrange appropriate care/ after care with immediate or earlier than planned release of prisoners.

**NHS England Specialised Commissioning Health & Justice commissioners, prison health care providers and Ministry of Justice**
Recommendation 15 : The specialist health and justice commissioners, prison healthcare providers and the Ministry of Justice should work together to improve discharge planning of vulnerable prisoners with mental health problems who are released earlier than planned, and produce clear guidelines for all healthcare staff to refer to other mental health services.
**Priority 1**

[119] BSMHFT "Operational Framework for Single Point of Access" v2.4 March 2014.

# 8 Events of 20 October 2012 to 13 December 2012 (HMP Birmingham)

8.1 Five days after P was released from HMP Hewell, on 20 October 2012 he was arrested in a car park next to a police station on suspicion of possession cocaine (7 wraps) and vehicle interference. In custody P was assessed twice by the FME and assessed as fit to be interviewed and detained.

8.2 P appeared at a magistrates court (22 October 2012) and pleaded guilty to interfering with a motor vehicle. He was remanded and transferred to HMP Birmingham to serve an additional 28 day custodial sentence for the offence and an 11 week sentence for re-offending whilst on license. The total sentence to be served in Prison was 105 days but he only served 59 days.

8.3 On admission to HMP Birmingham, P was initially screened at reception by a nurse. It was documented that P denied having any mental health issues but the nurse was concerned about his presentation and referred him for a first night mental health assessment. A Cell Sharing Risk Assessment (CSRA) was completed, which assessed that he was at high risk for cell sharing and he was placed in a single cell on the prison's general population wing. P was discussed at the mental health in-reach[120] MDT meeting (22 October 2012) and referred to the mental health in-reach team and allocated a nurse key worker. P was scheduled to be assessed by the consultant psychiatrist (7 November 2012) but he did not attend. The reason he did not attend is not documented but we were told that there are several reasons that this could occur; for example the prisoner is not in their cell when the escorting prison officer arrives to collect them or the due to an incident the prison, guards do not have capacity to escort a prisoner to the health care wing.

8.4 P was discussed in the in-reach team MDT meeting on 13 November 2012 and seen by the in-reach nurse on two occasions (19 November and 5 December). A further appointment was made for P to see the Consultant Psychiatrist on 21 November 2012 but P did not attend this appointment either. P continued to deny to the nurses that he was experiencing any symptoms of mental illness. He also could not recall why he was assessed by the BSMHFT's PICU Team whilst he was in HMP Hewell.

8.5 P was seen jointly by the Consultant Psychiatrist and his nurse key worker on 12 December 2012. P denied hearing voices or having any abnormal experiences. It is documented that it was difficult to engage P in any meaningful conversation and that he was not presenting with any active or acute mental health problems nor was he presenting with any immediate risk of self-harm or suicide. It was noted the plan was to refer P to BSMHFT's Homeless Team on his release and it was the consultant psychiatrist's intention to review P's notes from HMP Hewell. P was released from HMP

[120] Prison mental health in-reach services are mental health teams that work within prisons to provide a community type service to prisoners with mental health problems. For more detail see: A National Evaluation of Prison Mental Health In- Reach Services December 2009 http://www.ohrn.nhs.uk/resource/Research/Inreach.pdf

Birmingham custody the next day (13 December 2012). The healthcare team were not informed that P was being released.

## HMP Birmingham (Healthcare) implementation of recommendations

8.6 The initial investigation report made eight recommendations for HMP Birmingham (Healthcare) and BSMHFT. For clarity we will refer to these recommendations as for HMP Birmingham (Healthcare). The initial investigation report also made one recommendation for HMP Birmingham to action. Where this is discussed we refer to HMP Birmingham alone.

8.7 Then and now, the health care (including in-reach mental healthcare) in HMP Birmingham is provided by BSMHFT. Based on the findings of the initial investigation report HMP Birmingham (Healthcare) developed an eight point action plan.

8.8 We were provided with two action plan reviews dated 3 December 2015 and 27 January 2016.

- **HMP Birmingham (Healthcare) Recommendation 1:** HMP Birmingham (Healthcare) should ensure that prisoner self-disclosure of their past physical and/or mental health history is not the only resource of information utilised upon their reception to the Prison when other records are/could be available

8.9 HMP Birmingham (Healthcare) action plan recognised that at the time P was being processed in at the reception "there [was] limited time available to screen new prisoners in detail as all new receptions need to be screened and the process completed before lockdown. The role of the reception nurse is to identify the risk that the client poses to themselves and others over the following 24 hours. Following an initial screening when patients are referred to mental health a further review of the notes is completed."[121]

8.10 Following the initial action plan that was developed, HMP Birmingham (Healthcare) have introduced a procedure that underlines the importance of reviewing notes to verify patient history and risk has been outlined to staff. At the point of reception the client's paperwork is handed to the nurse in reception, the information within this paperwork contains the charge/crime committed, faxes from court (if they received a review by a GP or any treatment), Person Escort Record (PER)[122] forms or any 'markers'. Markers are an indication of how the client is acting at the time, i.e. if they have tried to self-harm or threatened to self-harm. Where patients are known to BSMHFT, healthcare staff have access to RiO[123] and can review patient records and risk assessments.

[121] HMP Birmingham action plan ,updated 3 December 2015, p 1
[122] Prison Service Order number 1025 "Communicating Information About Risks on Escort or Transfer – The Person Escort Record (PER)"
[123] RiO is the electronic patient record for BSMHFT

8.11 Following an initial screening when patients are referred to mental health a further review of the notes is completed. Evidence that this has been integrated into the first night screening is:

- Healthcare & reception 1st night pathway;
- Communication protocol;
- First night screening template;
- Document detailing information sources for prisoners arriving at HMP Birmingham
- Audit of PER form review on SystmOne and output

8.12 All actions were in place and reviewed in January 2016.

- **HMP Birmingham (Healthcare) Recommendation 2:** HMP Birmingham (Healthcare) should ensure that on reception a full check is made of SystmOne to identify whether a Prisoner has any previous significant physical and/or mental health history: this should include:
  - past identified diagnosis
  - past care and treatment management
  - past prescribed medications
  - past identified risks

8.13 Following this incident, the action plan records HMP Birmingham (Healthcare) put the following procedure in place "When prisoners come to reception an initial screening is completed. If health concerns (mental & physical health) are identified those prisoners are referred on to the appropriate service, this includes immediate referral to 1st night mental health screening by RMN and admission to Ward 2 if appropriate. All prisoners are booked into a follow up secondary care screening clinic (Wellman clinic). This enables a more detailed assessment to take place."

8.14 This includes a review of SystmOne records: it was noted that nursing staff only have access to a summary of the prisoner's medical notes on SystmOne and not their full history.

8.15 If prisoners refuse/ are unable to attend the secondary health screening appointment the reason for non-attendance is documented on SystmOne and the prisoners name added to a follow-up list. A further two opportunities are provided to attend.

8.16 Evidence that this has been fully implemented are: Healthcare & reception 1st night pathway:

- Communication protocol;
- First night screening template;

- Secondary health screen used at well-man clinic;
- Document detailing information sources for prisoners arriving at HMP Birmingham.

8.17 All actions implemented by August 2014.

## Arising issues, comment and analysis

8.18 Although the action plan dated 3 December 2015 documented that this action has been fully actioned it does note that at "the next review of SystmOne this will be looked into to find out why staff cannot access all information from a past prison spell and whether this can be made available in the future." The action plan 27 January 2016 does not identify this as an issue.

8.19 As far as we have been able to ascertain this has not been resolved at HMP Birmingham (Healthcare).

**HMP Birmingham (Healthcare) and Birmingham and Solihull Mental Health NHS Foundation Trust**
Recommendation 16: HMP Birmingham (Healthcare) should provide assurance to the Trust and their commissioners that the issues with SystmOne (accessing prisoner's full medical notes from the point of admission) have been resolved.
**Priority 2**

8.20 The initial investigation noted the need for early assessment of any mental health problems picked up in reception of new prisoners.

- **HMP Birmingham (Healthcare) Recommendation 3:** HMP Birmingham (Healthcare) should ensure that in all cases where concerns are raised in respect to the mental health of a Prisoner at the point of reception that this individual is seen by a Nurse Specialist within 24 hours and if recommended to see a Psychiatrist that this happens within a maximum of five working days:

8.21 The 27 January 2016 action plan notes that "where concerns regarding mental health are raised at reception a TAG referral is made to mental health services who will see the prisoner the following morning. If more urgent concerns are raised a ward nurse can see the prisoner and a decision can be made to admit directly to ward two for further assessment."

8.22 In the action plan dated 3 December 2015 it is noted that a further action has been identified: "to repeat the mental health screening questions asked at reception in the Wellman clinic. This helps to pick up any issues that may have been missed at initial screening and gives those prisoners who answered negatively the chance to reconsider their response (this is especially important as some prisoners arrive at the establishment in an incoherent state due to drugs or alcohol or are tired and want to get through

the reception process as quickly as possible). If at this point significant mental health concerns are raised there is a process in place which enables patients to be admitted directly to the ward.

8.23 The 3 December 2015 action plan documented that an audit of the review of all prisoners received in November 2014 by HMP Birmingham had taken place with the following results :

- 100% of the 38 prisoners referred for first night mental health assessment were seen. Of the 38, 3 were referred for admission to ward 2 and were admitted.
- 47 were referred for 1st night mental health prescribing by prison GPs and 100% were prescribed on the same night.
- 59 prisoners were referred for non-urgent mental health assessment of which 73% were seen in less than 24 hours and the remaining 27% within 24-72 hours
- In 20% of the 24-72 hours cases the prisoners were not in their cells when the nurse went to assess them or refused to engage.
- 14 prisoners were referred for a psychiatrist appointment, of these 29% were seen in less than 5 days, 57% between 6 and 14 days and 14% in 15-28 days. Decisions around psychiatrist appointments are based on clinical urgency as determined by the nursing assessment.[124]

8.24 The 27 January 2016 action plan documented that the mental health questions, which are asked during the initial at reception assessments, are now part of the template on SystmOne that is used by Wellman clinic.

8.25 All actions were reported to have been implemented by January 2016.

- **HMP Birmingham (Healthcare) Recommendation 4:** In-Reach staff and Psychiatrists in HMP Birmingham (Healthcare) who are identified as having responsibility for assessment or management of cases should take the time to read relevant documentation and raise concerns if there is insufficient time for this to be achieved.

8.26 Action taken with regard to this was “Notice to Staff issued reminding them of their responsibility to read relevant documentation.” This was to be evidenced by “Healthcare & reception 1st night pathway document”.

8.27 Action was reported to have been completed August 2014, and further audits support that this is now routine practice.

8.28 We were not provided with any evidence to show that further reminders had been provided to in-reach staff since 2014 or that an audit had taken place to assess current practitioners’ compliance. This was an extremely important issue that was highlighted in the initial investigation report and was noted as

[124] HMP Birmingham action plan ,updated 3 December 2015 , p4

being a significant deficit in the assessment and treatment of P by the in-reach team whilst he was in HMP Birmingham.

- **HMP Birmingham (Healthcare) Recommendation 5:** In-reach staff and Psychiatrists in HMP Birmingham (Healthcare) who are identified as having responsibility for assessment or management of cases should consider discharge planning from an early stage and liaise with relevant providers and agencies, including staff from Birmingham Community Healthcare Trust, which has responsibility for the final assessment prior to release.

8.29 In response to this action "staff have been instructed on the importance of early discharge planning. This is included within nursing care planning, ward rounds and the community team multi-disciplinary meetings. This process is in place for all planned releases and includes a final assessment by Birmingham Community Healthcare Trust prior to release. Documentation sharing is in place whereby a summary of discharge planning and care planning are provided to known GPs together with a copy of the prison care record. For those individuals with no known GP, a copy of the summary care plan is given to the patient directly with a request that they share this with their GP."

8.30 In the action plan dated January 2016 it was noted that:

"a compendium of information for all in-reach and ward 2 patients has been developed. This includes all relevant contact details and relevant risk information. This is available to primary care colleagues including GPs upon the planned release of a prisoner. In the event that a prisoner is released unexpectedly this provides a single point where critical information can be found and relevant services contacted and made aware of the prisoners release. This practice was reviewed in July 2015 at which time 80% of in-reach patients and 90% of patients on Ward 2 had a compendium completed".

8.31 Evidence in place:

- "Immediate and planned releases from prison template.
- Immediate and planned releases from prison report – July 2015.
- Compendium of Information."

8.32 This action was still amber rated within the 27January 2016 action plan.[125]

- **HMP Birmingham (Healthcare) & BSMHFT Recommendation 6:** HMP Birmingham (Healthcare) should consider developing an agreed system for routinely auditing a random sample of healthcare records on SystmOne, of Prisoners who have recently been taken into custody, but who were deemed not to require the input of Prison healthcare. This system of ongoing audit should be utilised to offer

[125] Amber Partially completed action – Limited assurance

additional assurances of the robustness of the screening process at point of reception to the Prison.

8.33 It was noted in the two action plans that it was assumed that this referred to "mental healthcare."

8.34 An audit was undertaken in March 2015 of a random sample of the prisoners, received in November 2014 by HMP Birmingham, where there was no mental health concern raised at the point of reception. The auditors reviewed their records over a 3 month period (Dec 14 to Feb 15) to see whether any mental health needs were identified.

8.35 The audit concluded that "two prisoners were highlighted with concerns around their mental health, however in both cases these were new presentations not issues that had failed to be identified at reception."[126] There was a point of learning in that one of the prisoners had not been seen by mental health staff. Practice has since changed and any prisoners for whom mental health concerns are raised [are] seen by the primary care mental health team."

8.36 The action was completed March 2015.

8.37 It also suggested that the audit should be repeated in April 2016 of the prison intake in November 2015 to provide a direct comparison. The results of this audit were not available at the time of this report.

8.38 The initial investigation report made the following recommendation for HMP Birmingham to action:

- **HMP Birmingham Recommendation 7:** HMP Birmingham should ensure that appropriate and timely communications take place to alert Prison healthcare when an individual is due to be released from detention.

8.39 The action plan identified the following actions that were currently in the process of being actioned.

- "Process needs to be agreed with BSMHFT on what expectations there are from prison healthcare when patients are released without healthcare knowledge.
- A project group led by BSMHFT is meeting to review communication links between BSMHFT community teams and HMP Birmingham – initial meeting was scheduled for 23 July 2015.
- The deputy manager of Ward 2 has contacted several other large prisons across the country to see if they are experiencing the same issue or have a solution. The response has been that this is a national problem and there is no legal framework to enable mental health services in prison to access care and support without the prisoner patients consent.

[126] HMP Birmingham action plans 3 December 2015,p8

- A proposal has been made to formally contact every prison to gain a view of the position nationally. If the issue is as widespread as suspected the intention is to form a working group with support from the trust, other mental health trusts, other prisons, MP's and secretary of state. A possible solution would be an amendment to the Mental Health Act permitting the compulsory transfer of a prisoner from prison to a place of safety where a mental health assessment could take place."

8.40 As this is a national problem, and lies at the heart of this tragic case, we made the earlier recommendation 16 requiring specialist health and justice commissioners, prison healthcare providers and the Ministry of Justice to work together to improve discharge planning of vulnerable prisoners with mental health problems

- **HMP Birmingham (Healthcare) and BSMHFT Recommendation 8:** HMP Birmingham (Healthcare) should ensure health screening on discharge to include reference and cross-checking between health and Prison records systems.

8.41 It was noted in both action plans that "a number of patients do not want to engage and just want to leave the Prison. When patients are released with prior notice a discharge letter is sent to their GP and evidenced on SystmOne. If we subsequently find out that someone has been released this takes place as soon as we are aware. When planned releases take place the prisoner is reviewed by a nurse who completes a release template."

8.42 A audit was requested by the HMP Birmingham Homicide action plan working group for a review of "the last 10 patients who have been discharged from our in-patient settings, ward 1 & ward 2 who have been released into the community or another establishment but not discharged to another setting within HMP Birmingham". The audit concluded that "there was robust evidence of cross checking with prison records and cross reference with external agencies there were some gaps on both wards with regard to secondary health screening."

8.43 It was documented that following on from a discussion regarding "the prison release process, what checks prison staff complete on release and whether this information could be shared" to "stand this action down as the above mentioned review confirmed that communication between healthcare and prison staff was very good".

8.44 At present health screening on discharge does not cross reference between health and prison record systems as healthcare staff do not have access to the prison P-NOMIS[127] (prison records) system which holds information that would be of benefit to healthcare staff. P-NOMIS is available on both healthcare wards and staff can request information via a healthcare office but there is no robust and consistently agreed process in place.

[127] P-NOMIS: Prison - National Offender Management Information System.

8.45 We were concerned that this remains a national problem and there is no indication these issues have been resolved.

**NHS England Specialised Commissioning Health & Justice commissioners, prison health care providers, G4S and Ministry of Justice**
Recommendation 17: to consider what action can be taken to allow healthcare teams in prisons to have access to the prison records P-NOMIS.
**Priority 3**

- **HMP Birmingham (Healthcare) and BSMHFT Recommendation 9:** HMP Birmingham (Healthcare) should ensure, whenever possible, that a summary of the individual's Prison health records is whenever possible provided to their GP routinely on release from Prison.

8.46 Both action plans identified that all prisoners are asked to consent for their information to be shared with their GP on point of admission to prison. Where consent has been given healthcare staff send the information to the GP by fax on the day of release. For both planned releases and for cases when health care staff are not aware that a particular prisoner has been released, the summary is faxed to the GP as soon as they are informed. Where a prisoner's GP is not known, if they are not registered with a primary care service or they refuse permission for the prison to contact their GP the prisoner is provided with a letter to take to a GP when they register. This action was noted as completed in March 2015.

8.47 However, we noted two areas identified in the action plan dated 3 December 2015 that require further action:

- "There is a need to ensure that more information is provided in terms of a summary to assist with continuity of care.
- "At some point in the future the option of using nhs.net accounts to send the information to the GP surgeries nhs.net accounts will be explored."

8.48 We recommend that both these actions are addressed as soon as possible to ensure that GPs receive adequate information. The use of secure email will ensure that GPs receive summaries in a timely fashion. Both will ensure continuity of medical care.

8.49 Although P was given a summary this was not received by his GP. And although the above guidance goes some way to mitigating the risk of prisoners healthcare information not being shared with GPs, it does not clarify what to do about prisoners who are 'at risk' from mental health problems who refuse to share information.

**NHS England and Ministry of Justice**
Recommendation 18: To consider what protocols if any, within the current legislative framework can be developed and implemented to share relevant healthcare information about prisoners at risk of mental health problems who refuse consent to share information with GPs.
**Priority 1**

# 9 Risk and discharge planning

9.1 Despite the obvious progress BCPFT and BSMHFT have made in their implementation of recommendations from the initial investigation report with regard to PICU assessments and robust discharge planning, this is not an issue that exists in the West Midlands area alone. We remain concerned about the robustness of arrangements for assessment of risk, support needs and aftercare referral processes for prisoners such as P across the country.

9.2 When P was admitted to healthcare at HMP Hewell, a CPA assessment was completed.[128] The CPA assessment documented[129] a significant number of life events and difficulties that P had experienced which, when clustered together, are recognised as possible indicators of multiple and complex needs. These events in P's case were:

- P had been bullied, stigmatised at school and had limited peer networks;
- During his formative teenage years, P was socially isolated and had made a suicide attempt;
- There was a breakdown in P's familial relationships, especially with his mother who had been his primary source of support. He was also excluded from the family home and his mother as part of his sentence;
- There had been several incidents where he had been the perpetrator of domestic abuse, against his mother. It was also documented in his CAMHS notes that P reported that he had been physically abused by his father;
- P was isolated and lacked engagement with education, training, employment and his community. He had also failed to attain his expected academic level of attainment;
- P had very low self-esteem, mental health problems and a history of lack of engagement with services and compliance with medication; and,
- There was evidence that he was misusing illegal drugs and alcohol.

9.3 Despite the CPA assessment identifying P's complex needs and potential high risk factors, there is no evidence that the CPA assessment was reviewed at any stage during his time at HMP Hewell or HMP Birmingham. P had been assigned a CPA worker at the initial CPA assessment who we consider would have been ideally placed to coordinate not only the release planning from HMP Hewell but also to advise HMP Birmingham of P's needs when he was admitted.

[128] 17 July 2012
[129] Documented in CPA, Perception of Current Problems , p3

## Arising issues, comment and analysis

9.4 HMP Hewell mental health in-reach team consistently assessed that P had an emerging psychosis. As soon as they learned that the PICU team had declined to accept P to their unit, the in-reach team had, in our view, a duty of care to refer P to the appropriate community mental health team. We consider there was ample opportunity to arrange for P's GP and the social care team in the locality of P's release address to be contacted. Whether the failure to refer P to the community health team was an oversight on the part of the in-reach team or whether this was indicative of a more systemic issue regarding high churn of prisoners, inadequate CPA and after care planning is difficult to draw any conclusion on.

9.5 Additionally in both HMP Hewell (Healthcare) and HMP Birmingham (Healthcare) it was repeatedly being documented that P was in a state of denial about his history, his mental health problems and symptoms.

9.6 The Bradley report,[130] noted that within "mental health in the wider community, the Care Programme Approach has been developed as the fundamental process for ensuring co-ordination and continuity of care for people with mental health problems. As with other elements of mainstream mental health treatment, this should also be integral to the treatment for the offender population, regardless of their location in the criminal justice system."

9.7 The report goes onto recommend that:

"Prison mental health teams must link with liaison and diversion services to ensure that planning for continuity of care is in place prior to a prisoner's release, under the Care Programme Approach Improved continuity of care for prisoners subject to the Care Programme Approach should become a mandatory item in the standard NHS contract for mental health."

9.8 Bradley goes onto state that

"If we are not to repeat the mistakes of the past few years, as exemplified by the rather uncoordinated approach to the implementation of liaison and diversion services, it will be vital to ensure that there is a clear, visible, national focus on this agenda that transcends all the traditional governmental and organisational boundaries."

9.9 It recommends that "national accountability for this agenda will be via a new Programme Board, which will bring together all the relevant government departments, covering health, social care and criminal justice. The National Programme Board will develop a clear, national approach to mental health/learning disability for offenders."

[130] See earlier reference to the "Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system" April 2009

9.10 The Centre for Mental Health Service Development review, "The Bradley Report five years on",[131] noted that "there is, as yet, little evidence of fundamental changes to screening on reception to a prison and by and large the same process takes place."

9.11 Bradley had identified that information sharing between agencies was vital for a coordinated approach and that "if stakeholders are expected to improve the way in which information is shared, they must be supported in this by provision of the necessary IT infrastructure". Lord Bradley made a particular point of addressing the need for improved communication between and access to relevant information systems. He made a recommendation that health service bodies and the then IT Programme for the NHS, Connecting for Health, work together to roll out integrated healthcare information systems.[132]

9.12 This recommendation was also reviewed by the authors of The Bradley Report Five Years On. They concluded that although prison healthcare services now have a standardised electronic clinical information system (SystmOne) there is still the inherent weakness in that it is not linked with other health information systems outside prisons. Therefore detainees are arriving at prison from courts with little or no information about either their physical or mental health.

9.13 The Bradley Report Five Years On concludes that there remains the fundamental issue that "the pathways out of the criminal justice system are the responsibilities of a multitude of agencies and their commission bodies."

9.14 Multi-agency failure, particularly in relation to a failure of information sharing, risk management and inadequate supervision either on release from prison or secure care are features of many highly publicised cases of patients, who were known to both secondary mental health services and the criminal justice services.

9.15 After each incident an investigation or inquiry has occurred and consistently identified the following areas that required remedial action at local and national and commissioners' levels:

- Protocols for information sharing
- Management 'buy in' for multi-agency arrangements
- Case workers to co-ordinate resources
- Professionals identified within a co-ordinated response to undertake specific actions in relation to care and risk management
- Risk management plans where indicated
- Social care plans as indicated
- Substance misuse, accommodation, employment advisors
- Timely intervention

[131] The Bradley Report Five years on , June 2014 https://www.centreformentalhealth.org.uk/the-bradley-report-five-years-on
[132] "Recommendation - Connecting for Health, primary care trusts and strategic health authorities should work together to roll out integrated information systems to health services provided in all criminal justice settings" p148, The Bradley Report.

- Pro-active follow-up (of, for example, non-attendance at agency appointments)
- The need to listen to carers of people with mental health problems

9.16 Nationally, it has been known that effective care coordination of a care plan, based around a comprehensive assessment of needs has been the most effective response to prevent people with mental health problems falling through the net. This is called the Care Programme Approach, and has been mental health policy since 1990.[133] In most care settings for most people around the country, this provides an appropriate and coordinated response. But it was not provided to P in prison.

9.17 Despite the reviews and developments over the years, prisoners with mental health problems continue to be reported as a cause for concern.

9.18 In HM Chief Inspector of Prisons for England and Wales "Annual Report 2013-2014", [134] a number of concerns were raised over the safety and welfare of prisoners. It found that staff had insufficient training to identify prisoners with mental health problems, and the knowledge to refer them for assessment, with primary mental health care services in 25 per cent of prisons identified as being insufficient to meet the demand. A report in 2013 which investigated the variations in prison mental health services in England and Wales concluded that prison in-reach teams are unable to offer prisoners care equivalent to that they would receive in the community, [135] and yet the concept of equivalence of care has been government policy since 1990.[136,137]

9.19 In response to such findings the Royal College of Psychiatrists, introduced Standards for Prison Mental Health Services in 2015 (the Standards).[138] The Standards are for admission and assessment, case management and treatment, referral, discharge and transfer, patient safety, environment; staff capacity and training as well as patient experience and involvement.

9.20 With regard to CPA management the Standards state that "there is a written care plan for every patient, reflecting their individual needs… The team has a policy on inter-agency working across criminal justice, social care, physical healthcare and the third sector within limits of patient consent, confidentiality and risk management…The care plan may vary in complexity depending on issues identified and interventions offered… The care coordinator or equivalent is involved in discharge planning."

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[133] HC (90)23. Department of Health. "Care programme approach for people with a mental illness referred to the specialist psychiatric services" London; DH 1990
[134] HM Chief Inspector of Prisons' for England and Wales (2014) "Annual Report for 2013-2014" London. https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/10/HMIP-AR_2013-141.pdf
[135] Forrester, A., Exworthy, T., Olumoroti, O., Sessay, M., Parrott, J., Spencer, S., and Whyte, S. (2013) "Variations in Prison Mental Health Services in England and Wales", International Journal of Law and Psychiatry, 36: 326-332. published in 2013
[136] Prisoners should receive the same level of health care as they would were they not in prison – equivalent in terms of policy, standards and delivery. Health Advisory Committee for the Prison Service "The Provision of Mental Health Care in Prisons" .London: Prison Service. 1997
[137] Home Office Report of an Efficiency Scrutiny of the Prison Medical Service. London: Home Office. 1990
[138] Royal College of Psychiatrist's Standards for Prison Mental Health Services, 2015 http://www.rcpsych.ac.uk/.../Standards%20for%20Prison%20Mental%20Health%20Services...

9.21 We fully concur with the findings of the initial investigation report which found that there were significant failings in the management of P's ongoing mental health care following his release from both HMP Hewell and HMP Birmingham.

9.22 However we are also mindful of the Standards concluding comments:

"However there are still improvements that need to be made. Too few staffing and resources, a lack of joint working, and the complexity of patient needs have been the key challenges identified preventing services from providing quality services to the prison population … Ultimately, it is evident that further guidance on how prison mental health services should operate is required, ensuring consistency and continuity across the UK."

9.23 In a more recent report, Her Majesty's Chief Inspector of Prisons was "struck by the sheer number of people in various forms of detention who are clearly contending with mental health issues" despite some notable examples of good practice and innovative approaches to dealing with mental health problems in prisons, around the country.[139]He also drew attention to "prisoners with mental health needs" who "waited too long for transfer to hospital".

9.24 These continuing difficulties were reported by many of our interviewees who all described the ongoing difficulty in coordinating discharge planning, especially when a prisoner is released at short notice or directly from court.

9.25 In an unannounced inspection report of HMP Birmingham in 2014,[140] Her Majesty's Chief Inspector of Prisons noted the positive steps taken to improve mental healthcare in HMP Birmingham and that mental health services in HMP Birmingham 'were impressive". The report also noted that routinely there were around 100 prisoners with severe mental health problems in the prison at any one time, and that "communications between the prison and providers in the community were more challenging as the catchment area of the prison had widened". However an area of concern remained the time taken for transfer under the MHA from prison to a mental health unit, which took between two and four weeks to complete, which was beyond the 14-day transfer guideline.

9.26 The recent Independent Monitoring Board report[141] noted the many improvements in HMP Birmingham with respect to mental health care, but also reported that healthcare appointments were often cancelled due to a lack of escort, and that "the extremely high 'Churn Rate' among prisoners in HMP Birmingham and its impact on providing the best health care should not be underestimated".

[139] HM Chief Inspector of Prisons for England and Wales (2016) "Annual Report 2015–16". London
[140] HM Chief Inspector of Prisons (2014) "Report on an unannounced inspection of HMP Birmingham by HM Chief Inspector of Prisons 24 February – 7 March 2014"
[141] Independent Monitoring Board – HMP Birmingham "Annual Report to The Secretary of State for Justice 2016 1st July 2015 to 30th June 2016"

9.27 It also commented that HMP Birmingham was “expected to comply with the needs of the Prison Service by accommodating very disruptive and often mentally disturbed individuals”.

9.28 In our interviews, we were also told that in retrospect, P could have been any one of very many prisoners. We were told by one interviewee that in a large remand prison, eight per cent of prisoners have a psychotic mental illness and another eight per cent, have severe and enduring mental illness. HMP Birmingham Prison has about 1,500 places, “so at any given time you would have over nearly 250 to 300 severely mentally ill individuals in that prison, the average length of stay is about six to eight weeks and so you would have hundreds of individuals with severe mental illness being released on an annual basis, if not thousands”. We also understand that significant numbers of prisoners would not be released to a fixed address.[142]

9.29 They also reported the tension between prison management and health care staff when a decision is made to release a prisoner whom the healthcare staff have assessed as being mentally unwell. Often we were told, there is little opportunity to arrange appropriate after care especially if the prisoner either is not registered with a GP practice or has refused to give permission for medical information to be shared with their GP.

9.30 At times they described that such has been their concern about a prisoner’s mental health that they have arranged a Mental Health Act assessment to take place in the prison car park as the prisoner is being released.

9.31 Whilst there has been significant improvement made in care planning, there is some evidence, both anecdotally and in high profile inquiries that many deficits remain in the provision of mental health services and after care arrangements to prisoners with mental health problems. We have been told that there remains a risk that vulnerable prisoners, like P, are continuing to be released from prison without adequate support and supervision leaving them at risk to both themselves and the general public.

# 10 West Midlands Police

10.1 The Trust’s initial investigation report made 3 recommendations in relation to West Midlands Police. We were provided evidence of the following progress on implementing the recommendations made:

- **West Midlands Police Recommendation 1:** West Midlands Police should review pre-Court disposal arrangements where repeated concerns about mental health have been identified and ensure that longitudinal background information is provided to health professionals undertaking fitness to plead assessments and to the

[142] Ministry of Justice (March 2012) “Accommodation, homelessness and reoffending of prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) survey” - Fifteen per cent of prisoners sampled in a Surveying Prisoner Crime Reduction survey had no accommodation prior to imprisonment
A third of people leaving prison say they have nowhere to go (Centre for Social Justice, 2010)

Crown Prosecution Service where they are providing advice on charging and/or for Court process.

10.2 We were informed that all police custody suites in the Birmingham area now have a mental health nurse in situ. The nurse will undertake the initial assessment when a prisoner is brought into a custody suite. If there are concerns about their presentation and/or their mental health the mental health nurse will undertake a second mental health assessment, obtain further information from other involved agencies, for example secondary mental health service . They also advise the Crown Prosecution Service (CPS)[143] on 'fitness to plead' issues and will contribute to pre-sentencing reports. If they feel that a mental health assessment is required they will contact the Emergency Duty Team.

- **West Midlands Police Recommendation 2:** West Midlands Police should review the current information sharing protocol with BSMHFT to consider how to share information where concerns exist prior to a formal recorded diagnosis of psychosis. The Police had information which could have been of assistance to healthcare professionals beyond the recorded convictions and/or cautions.

10.3 We were also told that the West Midlands Police has, since this incident, reviewed their Information Sharing Protocol (June 2015). The partner organisations are Birmingham and Solihull Mental Health NHS Foundation Trust and West Midlands Police. We have reviewed this protocol.

10.4 We were informed that since the incident, the Street Triage service has been introduced and that its practitioners have access to not only the PNC records but also secondary heath care records. Further, if the police have a concern about an individual who they suspect may have mental health problems they will contact the Trust's bed manager to seek information about the patient within the restrictions of the Data Protection Act 1998.

- **West Midlands Police Recommendation 3:** Assessments undertaken in Police cells by Forensic Physicians for fitness to process should be routinely considered for sharing with the offender's GP by the healthcare professional undertaking the assessment. Contracting arrangements with healthcare providers should reflect this.

10.5 We were informed that this recommendation has presented some challenges on account of data protection requirements. Prisoners are now asked to give their permission for this information to be shared with primary care services but they can refuse and we were informed that over 20% of prisoners in custody are not registered with a GP.

[143] CPS crown prosecution service http://www.cps.gov.uk/

## Arising issues, comment and analysis

10.6 In our telephone interview with the Detective Chief Inspector and Force Lead for Mental Health we were told that the West Midlands Police are currently in discussion with Forward Thinking Birmingham[144] regarding the Information Sharing Protocol to resolve some initial difficulties that have occurred during the transition process. We would expect Forward Thinking Birmingham to become one of the protocol partners in the near future.

10.7 We were also informed that the West Midlands Police has consistently been unable to engage primary care services in their Information Sharing Protocol. In P's case it would, in our view, have been helpful to his GP if there had been a protocol in place for the police to have been able to share information regarding P and the fact that P's mother was a victim of domestic abuse to the family GP. It would have alerted the GP to both the concerns about P but also to the escalation of violence within the family.

10.8 We were also told that the current lack of primary care information being available will be resolved with the introduction of Spine. Patient's medical records will be on a central electronic system which will be accessible to multiple services, such as the Street Triage and custody nurses. However patients can opt-out of this in which case their records will not be available.

10.9 Given that many of the issues identified within the initial investigation report also underpin many of our findings in relation to the lack of information sharing between agencies about P and his family, we recommend that strenuous efforts be made to engage the key health, social service, police prison and probation services and 'sign off' the West Midlands Information Sharing Protocol as soon as possible. We have seen the excellent progress made in developing this protocol and recommend that it extend across the whole of the West Midlands.

**HMP Hewell and HMP Birmingham, BCPFT, BSMHFT, NHS Birmingham South Central CCG, NHS Birmingham Crosscity CCG, NHS Sandwell and West Birmingham CCG, West Midlands Councils, West Midlands Ambulance Service, the Crown Prosecution Service.**
Recommendation 19: The named partner agencies should work collectively to 'sign off' the information sharing protocol as soon as possible, ensuring wider membership as much as practicable across the West Midlands public sector so long as this does not delay completion.
**Priority 1**

10.10 The Detective Chief Inspector and Force Lead for Mental Health who has been advising the panel on the progress of the recommendations and action plan, reported that the Force have been implementing the initial investigation recommendations, alongside recommendations made in other serious case investigations, within their developmental planning. He has also reported to, on one occasion, the Deputy Chief Nurse and Quality Officer at Birmingham

[144] Forward Thinking Birmingham are the new providers of mental health services for young people up to the age of 25 in Birmingham. Discussed in Section 13.

CrossCity CCG on the progress and implementation of their actions in response to the recommendations in the initial investigation report.

10.11 West Midlands police have taken extensive and prompt action to address the concerns and recommendations from the initial investigation report which mainly focused on the need for information sharing from the point of an arrest by the police to the point of court involvement. However given P's presentation and his on-going reluctance to engage with primary and secondary health care there was little information available about him and his mental health problems. In such cases agencies would still have to be relying on self-reporting and in P's case he was clearly an unreliable self-historian. The only person who was in a position to provide valuable information was P's mother and after the age of eighteen no agency were proactively involving her. Although we do appreciate the constrictions of data protection we would like to see the involvement of family members and carers embedded within all of West Midlands police authorities' policies and protocols relating to information sharing.

**West Midlands Police**
Recommendation 20: West Midland's Police should formalise the involvement of family and carers within their policies and protocols, relating to information sharing.
**Priority 2**

# 11 Ethnicity

11.1 We believe there was a lack of consideration by BCPFT's CAMHS of P and his family's ethnicity and the possible connection between his arrival in the UK and his mental health problems. We have noted that although it was documented in assessments undertaken in HMP Hewell and HMP Birmingham that P and his family had migrated from Swaziland there appears to have been little consideration of his cultural background in the context of both his mental health and lack of engagement with services.

## Arising issues, comment and analysis

11.2 The challenges faced by people from black and minority ethnic (BME) groups when they come into contact with psychiatric services are well documented. It is commonly accepted that mental health problems can result from the range of adverse socio-economic factors associated with disadvantage and discrimination and these can also be a cause of social exclusion. "Nowhere is this more evident than amongst black and minority ethnic groups. The extent of social exclusion among these communities, the levels of racism and racial discrimination experienced by them in public life and, more pertinently, when they come into contact with institutional

agencies are key determinants of psychiatric morbidity within black and minority ethnic groups."[145]

11.3 Research reviews and evidence-based policies highlight inequalities in both experiences and outcomes. In relation to people from BME communities (relative to the white population), there are concerns about the disproportionate number of admissions and detentions in psychiatric hospitals, greater conflict with carers and staff, fear of services, lack of engagement with (or poor access to) effective services, fears about contact with the criminal justice system (principally the police), poorer access to psychological therapies and ethnic variations in the use of drug treatment."[146] Ethnicity is a key determinant of mental ill health and a critical influence on access to care and quality of mental health service users' experience.

11.4 The issue of how P and his families' ethnicity affected their experiences of primary and secondary health care and the prison mental health care service responses has raised complex issues which are not readily amenable to either simple solutions or a single approach.

11.5 We noted that the initial investigation report did not identify P's cultural background as being a significant issue. We also noted that the investigation panel did not have any member from any BME group, service user or carer representative. Whilst we make no particular recommendation in this regard, we ask that the services reflect on this and consider how this could be improved in future.

# 12 Housing

12.1 P's mother reported to us that when social services visited the family after the incident where P hurt his younger brother (5 March 2009) they told her that due to the safeguarding concerns P needed to be moved out of the family home. She reported that she had felt in an impossible situation having to "choose between her two children". As she feared that she would lose custody of her younger son she secured P alternative private rented accommodation.[147]

12.2 She told us that she had attempted to apply for housing benefit but it required P to complete the relevant application forms which he was unable to do because of his mental health problems. She therefore continued to pay for the accommodation herself until he was in HMP Birmingham although it placed a considerable strain on the family's income. She also said that it was

[145] National Institute for Mental Health in England "Inside Outside – Improving Mental Health Services for Black and Minority Ethnic Communities in England" 10 March 2003,p11
webarchive.nationalarchives.gov.uk/.../http:/...uk/.../groups/dh.../dh_4019452.pdf
[146] Interventions designed to improve therapeutic communications between black and minority ethnic people and professionals working in psychiatric services: a systematic review of the evidence for their effectiveness" Kamaldeep Bhui, Rabbea'h W Aslam, Andrea Palinski, Rose McCabe, Mark RD Johnson, Scott Weich, Swaran Preet Singh, Martin Knapp, Vittoria Ardino and Ala Szczepura,, 31 April 2015 ,p1 http://www.ncbi.nlm.nih.gov/books/NBK285975/
[147] We have not been able to verify this as we did not have access to social service notes. P's mother was also unable to provide us with written evidence of this.

both expensive and of poor quality and that P did not like living there and would often ask to come back to live at the family home.

12.3 The initial investigation report notes that when P was in HMP Hewell he was "spoken to early on about his release/discharge plans and P indicated that he would be returning to the Walsall address. As part of the routine prison process at that time, P was asked if he needed to secure housing benefit to retain this address and P had confirmed that he did. Housing benefit forms were completed by the prison and sent to the Walsall housing benefit office. This was a standard routine process. As a result the system showed him as having accommodation on release/discharge and he left Prison with a £46 discharge grant."[148]

12.4 The address P gave was a bail hostel address but this was not identified or checked. When P was released from HMP Birmingham it was documented that he was of No Fixed Abode (NFA) and he said that he was intending to stay with friends. P's mother also reported that when she saw her son during the period, December 2012 to the incident in March 2013, P was wearing multiple layers of clothing to keep warm and that he appeared unkempt, suggesting that he was probably living on the streets.

## Arising issues, comment and analysis

12.5 The initial investigation report does not consider P's lack of adequate housing as being a factor in the deterioration of his mental health when he was released from HMP Hewell and Birmingham.

12.6 However The Honourable Mrs Justice Thirlwall did highlight P's homelessness as being a significant contributory factor. In her concluding comments in P's trial she said:

"Anyone who has read the many documents and statements will be disturbed to read that you were living in the community with an illness of that severity; living rough with no medical help or indeed any help at all …. It is difficult to understand how it came about that in December 2012 someone with your level of illness should have been sleeping rough with no one to look after you." [149]

12.7 We concur with this and consider that P's ongoing difficulties in obtaining appropriate, affordable and secure housing left him vulnerable in terms of his housing needs and is likely also to have exacerbated his mental health needs and social isolation.

12.8 The correlation between inadequate housing, unstable tenancies, homelessness and mental health is well recognised. It is reported that people who are homeless have 40-50 times higher rates of mental health problems than the general population and that they are one of the most

[148] "Homicide Investigation Report into the death of a child" Final Report– September 2014 Chair: Dr Alison Reed - September 2014 http://bhamcrosscityccg.nhs.uk/about-us/publication/safeguarding/674-final-pdf-report-september-2014/file Page 52

[149] Transcript of crown court hearing, p 40

disadvantaged and excluded groups in our society.[150] Research also indicates that individuals who have inadequate housing or experience homelessness often fail to receive the appropriate care and treatment for their mental health conditions for a number of reasons:

- "poor collaboration and gaps in provision between housing and health services;
- failure to join up health, social care and housing support services, and disagreements between agencies over financial and clinical responsibility; and
- Failure to recognise behavioural and conduct problems such as self-harm, self-neglect, tenancy issues such as substance misuse and anti-social behaviour." [151]

12.9 Other research has indicated that homeless young people are at an eight-fold increased risk of developing mental health problems if they are sleeping rough, living in hostels and bed and breakfast accommodation.[152]

12.10 As identified earlier it was acknowledged by the healthcare staff from both prisons that there was a lack of robust release planning for P and that it remains a common issue for many prisoners with mental health problems. It was reported to us that since this incident there had been some improvement in release planning in HMP Birmingham, although there remained problems in arranging after care for prisoners with early or unplanned release.

12.11 Based on many of the practitioner's reports we received it was apparent that services have developed and improved since this incident. However many of the fundamental concerns and issues in relation to the after care of prisoners upon release remain. There is a lack of assurance amongst these practitioners that things have changed sufficiently to prevent the occurrence of a similar event, concerning the release of a prisoner with mental health problems not engaging with after care services. We therefore recommend that the prison health care services in HMP Hewell and Birmingham and their commissioners seek assurance that the current pathway for released prisoners with mental health problems ensures that those in need have access to appropriate mental health care after release.

**NHS England Specialised Commissioning Health & Justice commissioners, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare).**
Recommendation 21: The above to seek assurance that the current pathway for released prisoners with mental health problems ensures that those in need have access to appropriate mental health care after release
**Priority 1**

[150] Department of Health. "No health without mental health: a cross-government mental health outcomes strategy for people of all ages". February 2011 https://www.gov.uk/government/publications/the- mental-health-strategy-for-england
[151] St Mungo's, Down and Out? Mental health and street homelessness, 2009 www.mungos.org/homelessness/.../1251_down-and-out-the-final-report-
[152] Stephens, J. "The mental health needs of homeless young people". London: Mental Health Foundation. (2002).

# 13 Forward Thinking Birmingham

13.1 Since this incident there has been a significant redesign and procurement of new children and young people's mental health services commissioned by NHS Birmingham South Central, NHS Birmingham Cross City, and NHS Sandwell and West Birmingham CCGs. In April 2016 the Forward Thinking Birmingham (FTB) service was launched. It is a consortium of providers of mental health services for children and young people from age 0 to 25 years. One of its core visions is that "Care will be delivered in a more joined-up manner across all services in the city to the benefit of patients and families."[153]

13.2 Whilst not a direct consequence of this tragic case, the commissioners have informed us of their intention to develop a more open, inclusive and accessible service for young people with mental health problems.

13.3 During our interview with FTB's quality and governance lead and medical director, we were told that they were aware of this tragic case and the impact that it continues to have in the locality and within mental health services.

13.4 We discussed with the NHS Birmingham Cross City CCG commissioners and FTB managers how this new service and pathways might have identified P's risks and support needs. We also discussed how accessible such services are, including to people from different cultural backgrounds, such as P and his family. We noted the following FTB services which may have provided the opportunity for P to receive the care and treatment he needed:

- 24/7 telephone help line offers "immediate access to mental health crisis support for all 0-25s, families, friends, health professionals, schools and anyone else with a concern".

13.5 This would have been an alternative source of support for P's mother at the time that she was feeling increasingly concerned about the deterioration in her son's mental health symptoms.

- Access Centre, acts as "the front door for all patients and referrers."[154] both parents and patients can self-refer directly via this service.

13.6 Such a direct referral route would have been extremely helpful for P's mother when she was experiencing difficulties accessing help after P had left school and been discharged from CAMHS.

- FTB provides support and therapy for not only the child or young person but for the whole family. Some services provide specific cultural or faith support services: for example Lateef Project or

[153] https://forwardthinkingbirmingham.org.uk
[154] The service is open from Monday to Friday (8am-8pm) and Saturday and Sunday (10am-3pm). Outside of these hours there is a direct emergency out-of-hours crisis service https://forwardthinkingbirmingham.org.uk

Pattigift. The latter provides psychotherapy and counselling founded on an African centred psychological understanding.

13.7 This service may have been able to engage P in a more culturally appropriate therapeutic support which had an understanding of his particular needs and experiences as a migrant young person.

- PAUSE city centre hub: operates seven days a week and offers a drop in for anyone under the age of 25 years old and includes open access for parents and carers, young people and young adults. Pause have access to sign-post anyone on to psychological and primary care services where indicated and is a service that will actively seek out appropriate services to meet a young person's needs.

13.8 These services may have been helpful to P when he had to move out of the family home and his mother was unable to secure affordable and secure accommodation with the support to help P obtain and maintain a tenancy.

- FTB have links with both the court diversion service as well as the street triage service.

- FTB has close links to St Basils, a third sector organisation that provides accommodation and support for young people, which includes emergency accommodation.

- Pattigift and Start again services provides emotional, housing, practical support to vulnerable young people.

13.9 If P had presented himself to such services when he was released from both HMP Hewell and HMP Birmingham, it could have been the pathway to an initial mental health assessment and access to secondary community mental health services. But this lies at the heart of the problem for P and similar young men. It relies on them accessing the services, not the services reaching out to engage with them.

13.10 Anawin Rehabilitation service: provides support for young women who attend voluntarily after a custodial sentence or as part of their community sentence. The focus on the service is rehabilitation after a custodial sentence and also prevention of re offending.

13.11 We were informed by West Midlands Police Detective Chief Inspector and Force Lead for Mental Health that he is currently involved in developing a service for young men of African and Caribbean heritage, who are over represented within their prisoner groups and who are most at risk of reoffending. Progress of this development is being monitored by their Mental Health Steering Group.

13.12 It is likely that the new services could have identified P as a vulnerable young man with mental health problems and could have accessed the appropriate assessment and support for P whilst he was detained in custody

and when he was living on the streets after his release from HMP Birmingham. However this would depend on the services being informed of his sentence in prison, his release date and P engaging with such services. However, based on the evidence that we have obtained, he persistently refused to acknowledge that he was experiencing any difficulties and was reluctant to engage with services. There is no certainty that this incident could have been prevented if we had not addressed the issue of early release from prison with no notification to mental health services.

13.13 We were reassured to be told that several of the services within Forward Thinking Birmingham would include support to access accommodation and advice if that was an issue as well as provide intensive case management support for young people with serious mental health issues who are also vulnerable, homeless and in the community. It was suggested to us that if P was presenting in the Birmingham area there are new services that would have become aware of him via the homeless services, the street triage, or his mother could have been alerting P's situation and her concerns about her son to the access centre.

13.14 As FTB is still in its infancy it has not been possible to review how robust their new services are in terms of referral and treatment pathways between HMP Birmingham (Healthcare), and indeed with other prison healthcare services when a prisoner is returning to the area. We recommend that in the light of our findings that one of the priorities for FTB, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare) be to undertake a review audit of the new service provision for young homeless patients who are being released from prisons to reassure both themselves and their commissioners that the referral pathways have been improved for prisoners, such as P.

**Forward Thinking Birmingham and HMP Birmingham (Healthcare) and HMP Hewell (Healthcare)**
Recommendation 22: Forward Thinking Birmingham, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare) should review the new service provision, to ensure that the referral and homeless pathways are effectively utilised to identify and support young offenders being released into the community.
**Priority 1**

13.15 FTB is a new service model and as it is in its early stage of implementation there is no outcome data currently available. However we were informed that each provider has stringent outcome and performance indicators within their five year contracts. This includes patient and family feedback. There are also governance, risk and quality frameworks in place and Birmingham's Children Hospital is the lead and managing provider. The whole service provision is to be evaluated by the University of Warwick.

13.16 The intention of commissioning FTB appears to be for a responsive service provision. We would recommend that Forward Thinking Birmingham continually assure itself and commissioner that its services are cognisant

and fully compliant with the lessons learnt and recommendations from both the initial investigation report and this report.

**Forward Thinking Birmingham and NHS Birmingham CrossCity CCG**
Recommendation 23: To ensure that the recommendations and lessons learnt from this incident continue to inform the development of services for vulnerable young people in contact with mental health and criminal justice services.
**Priority 1**

# 14 National recommendations

14.1 The initial investigation report made seven national recommendations for NHS England to action as the owner, through working with the Crown Prosecution Service, Courts, Police, Prisons, Ministry of Justice and Department of Health.

14.2 We spoke with senior figures in the Department of Health and NHS England to understand the progress with implementing these national recommendations. We have also read the Hansard record

14.3 We understand that these recommendations were made in good faith, with the intention of changing national policy. However, as we will see in the next section, with no single responsible body to oversee the implementation of these actions there has been limited follow up and no discussion between the initial investigation panel and other stakeholder recipients of recommendations.

- **National Recommendation 1:** There should be consideration of a system in place nationally to ensure that all assessments undertaken by Forensic Physicians in Police cells for fitness to process are reported to the offenders GP by the healthcare professional undertaking the assessment.

14.4 We were told that NHS England cannot be the owner of this recommendation as the responsibility for healthcare in police custody did not transfer as expected in 2016. This recommendation now needs to be directed to the Home Office. However there is already an ability to share information with the offenders GP providing the patient gives consent to the information shared.

14.5 Whilst this initially seems an appropriate response to issues where the transfer of information should be made routine, it is this need for consent that remains a stumbling block and could potentially bring such a blanket recommendation into conflict with the Data Protection Act (1998). Consent is necessary because it is not always appropriate to share such assessments with the GP, and individuals have a right to privacy. We were also told that where necessary and appropriate, the ability to share information already exists provided it is concerned with significant risk to the health of the person

or related people, and can be justified as being in the best interests of the person assessed.

- **National Recommendation 2:** In the light of this reports findings, and with a view to ensuring that in future all relevant information is available to prosecutors and Courts, the Crown Prosecution Service should review its current national legal guidance covering the law, policy and practice that prosecutors should apply when dealing with cases involving alleged offenders who have, or appear to have, a mental disorder. This review should consider whether additional guidance is required to ensure that relevant information is provided to and taken into account by prosecutors in those cases where there has been no formal diagnosis but where there are concerns held by the police or any other agency concerning an alleged offender's mental health.

14.6 NHS England told us that Liaison and Diversion (L&D) services have been designed to provide early intervention for vulnerable people as they come to the attention of the criminal justice system. The service provides a prompt response to concerns raised by the police, youth offending teams or court staff, and provides critical information to decision-makers in the justice system, in real time, when it comes to charging and sentencing these vulnerable people and enables diversion from custody where appropriate. L&D also acts as a point of referral and assertive follow up for these service users, to ensure they can access, and are supported to attend, appropriate treatment and support appointments.

14.7 NHS England is committed to expanding access to liaison and diversion services from the current provision available to around 50% of the population to reach all areas in England to 100% coverage by 2021.

- **National Recommendation 3:** Her Majesty's Court should ensure that fail-safe procedures are put in place to reinforce the existing rule that prisoner escort staff should remain whilst there is still a possibility of their services being required.

14.8 NHS England was unable to own or act on this recommendation. We were told that NHS England have no jurisdiction or legal responsibility for prisoner escort staff or the court service, and this needs redirecting to the Ministry of Justice to respond

- **National Recommendation 4:** Providers of Probation Services, the National Probation Service and Police & Prison (Public and Private) Senior Managers must ensure that the new arrangements for the supervision of under 12 month Prisoners are implemented with active consideration given to how best to integrate health & prison release/discharge systems. This recommendation should be passed to the Ministry of Justice for cross departmental consideration and would be relevant to all prison release/discharges.

14.9 Again NHS England cannot be the owner or fully respond to this recommendation as they have no jurisdiction or legal responsibility for probation services. However in regard to health discharge planning they have now procured a new clinical IT system for the secure and detained estate that fully integrates with the GP community system. Therefore where a patient gives consent for the information to be shared, the full electronic health record will be sent to the community GP. The prison GP will also have full access to the community record. It is expected that this system will be rolled out across the prison estate during 2016/17 but NHS England reiterated again that information sharing will only happen with full patient consent.

- **National Recommendation 5:** The Ministry of Justice and the Department of Health should review the current arrangements whereby a Prisoner can refuse access to their GP records.

14.10 NHS England has reviewed this action. Without changes to primary legislation on data protection and human rights it is unable to enforce this. NHS England agreed that information can and should be routinely shared where there is deemed to be a risk of harm to the individual concerned or others and NHS England is working with its providers on providing them with further guidance on this in line with the principles underlined by Dame Caldicott.[155]

- **National Recommendation 6:** The Ministry of Justice and the Department of Health should consider the development of a national system, which would ensure that Prison health records are routinely provided to GPs when a prisoner is released from detention.

14.11 We were told that a new integrated clinical IT system for the secure and detained estate that fully integrates with the GP community system is in the later stages of procurement with contract awarded but final negotiations are as yet incomplete. NHS England is expecting that completion will take place first quarter 2017.

14.12 Where a patient gives consent for the information to be shared, this will enable for a full electronic health record to be sent to the community GP. The prison GP will also have full access to the community record this system. It is expected that this system will be rolled out across the prison estate during 2016/17 but NHS England reiterated again that this will only happen with full patient consent

- **National Recommendation 7:** All prisons must ensure that all Health appointments are routinely transferred when a prisoner

[155] Following concerns over the potential use and misuse of patient confidential information through information technology the Chief Medical Officer commissioned a review. This led to the establishment of a committee to lead this review, under the chairmanship of Dame Fiona Caldicott. Its findings were published in December 1997.The Caldicott Report highlighted six key principles, and made 16 specific recommendations to safeguard the use of patient confidential information. Dame Fiona Caldicott was appointed National Data Guardian in 2014, and has recently completed a "Review of Data Security, Consent and Opt-Outs" https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/535024/data-security-review.PDF which makes recommendations to the Secretary of State for Health aimed at strengthening the safeguards for keeping health and care information secure and ensuring the public can make informed choices about how their data is used.

moves wing or is transferred to another prison. The current DNA rate for health appointments, which is reported to be currently around 40 - 50 %, needs to be addressed.

14.13 NHS England told us that they already have a policy in place that requests that arrangements should be made for healthcare appointments to follow prisoners when they move residential wing within an establishment or transfer between establishments. Clinicians can also put a 'medical hold' on a prisoner where they feel there is a risk to the patients' health or wellbeing if they are transferred out of the establishment into another establishment.

14.14 As there are many reasons why a prisoner may not attend an appointment, the Health and Justice Indicators of Performance (HJIPs) include a requirement so that Did Not Attend (DNA) incidents are reviewed by healthcare providers, local commissioner, and governors as part of the partnership arrangements in each prison. This should lead to agreed appropriate local actions to reduce the number of avoidable non-attendances.

14.15 There was also one recommendation made for all services.

- **National Recommendation, All services:** All services should ensure that GPs are routinely copied in to all healthcare providers' clinical correspondence relating to an individual, allowing the person's primary healthcare provider to be kept fully informed and facilitating a central access point for healthcare information to others.

14.16 Again, we were told that whilst there is currently a mechanism for sharing clinical correspondence, this can only take place with patient consent and can only be shared without consent where there is an assessed risk to the individual or other people by not sharing this information.

## Arising issues, comment and analysis

14.17 From our discussions with NHS England and the Department of Health it became clear there were two fundamental issues with regard to the national recommendations.

14.18 Firstly there was no single body to oversee the implementation of actions, or to provide a conduit for further consideration or discussion of these. We make a recommendation with regard to this in the next section.

14.19 Secondly, although to the outside reader the need to share information about a prisoners mental health with their GP will appear to be sound, such blanket recommendations would in fact breach an individual's right to privacy from agents of the state. Nonetheless, where required, any concern about significant risk to an individual's health will trump the right to privacy and confidentiality, provided it is in the individual's best interest. This provision already exists with no need to change any legislation. It would however, be useful for healthcare staff in prisons to be reminded of this.

# 15 Initial investigation and action plan

15.1 Because of the tragic death of Christina, this was never going to be a routine internal investigation into a serious incident.

15.2 The initial investigation was commissioned by Birmingham & Solihull Mental Health NHS Foundation Trust, as this was the last Trust whose services had been in contact with P.

15.3 Working with their commissioners they quickly convened a senior and experienced panel, with membership from across the West Midlands. The membership consisted of:

- Forensic Consultant Psychiatrist as Chair
- Senior mental health nurse with a background in clinical governance, quality and commissioning
- Senior probation officer experience
- Assistant director of children's services with responsibility for safeguarding from the City Council
- Independent senior nurse with a background in nursing education

15.4 The initial investigation was complex but extremely thorough. The panel reported to the BSMHFT Trust Board, and routinely provided updates to them.

15.5 The investigation was completed in September 2014, some 18 months after the death of Christina.

15.6 It made 51 recommendations for the organisations and services that had had some involvement with P since 2005 and his first contact with mental health services. This included national recommendations. We have commented on each services implementation of their action plan in the preceding pages. We have also identified where we believe further learning can take place and changes made to improve services and practice.

15.7 Since the completion of the initial investigation we have been struck by how diligently the services involved have worked on their action plans, so that they can say with some certainty that things have changed.

15.8 We have heard how each service has provided a degree of oversight and project management for their own implementation of these actions. We have also heard and seen how NHS Birmingham CrossCity CCG has sought to assure itself that the providers involved had implemented their respective actions. This was done in a letter to each provider in December 2015 asking for an update on progress.

15.9 We have also heard how the range of innovative services commissioned and developing in Sandwell and Birmingham should make a difference to vulnerable young people with mental health problems in contact with criminal justice services.

## Arising issues, comment and analysis

15.10 Because this was such a tragic incident, involving the death of a young girl at the hands of a stranger with mental health problems, it moved from the routine serious incident investigation into a more wide ranging investigation. There was a clear intention to ensure the investigation was robust, and minimise the need for a later independent investigation. This included having membership from a wider range of organisations than just the Trust. We are not sure why there was no one on the panel from the Sandwell/ West Bromwich health and social care services, since that is where P had spent most of his life, and had the most contact with services, nor from Worcestershire Health & Care NHS Trust, the providers of health care to HMP Hewell.

15.11 We have been told that despite the supporting statement in the initial investigation introduction, the investigation never was a Serious Case Review.[156] It could not be, since Christina was not a vulnerable child in contact with statutory services. As the initial investigation says, Christina was not known to agencies and was thriving in a loving and supportive family environment.

15.12 Instead, as we now know, the vulnerable person who was failed by services was P, who was by then an adult.

15.13 We were told by some of our interviewees that this incident could not be investigated through the normal investigatory processes following a mental health related homicide since P had not been in contact with statutory mental health services. This is wrong. P had been in contact with NHS mental health services since 2005, and his last contact with statutory mental health services was via HMP Birmingham (Healthcare), provided by BSMHFT, in December 2012 when he had been in contact with their in-reach service. This was three months before he killed Christina.

15.14 We were also told that this investigation fell outside the normal guidance for two other main reasons.

15.15 Firstly, because of its complexity, and the range and number of organisations involved.

15.16 Secondly, because when it happened, NHS commissioning organisations were on the brink of significant reorganisation. Under the recent reforms, at the end of March 2013, Strategic Health Authorities (SHA's) and Primary Care Trusts (PCTs) were being dissolved, to be replaced by NHS England Area Teams and Clinical Commissioning Groups (CCGs).

15.17 At the time of Christina's death the last vestiges of SHAs had limited authority, and many of the more experienced and senior staff with an understanding of the complexities of managing a mental health related

[156] "Homicide Investigation Report into the death of a child" Executive Summary – September 2014 Chair: Dr Alison Reed http://bhamcrosscityccg.nhs.uk/about-us/publication/safeguarding/660-executive-summary-september-2014/file page 6.

homicide were in the process of finding new roles. The emerging CCG at that time was also still finding its feet, and many of its roles and responsibilities were as yet unclear.[157]

15.18 Although there is now much more as to how to manage these very serious incidents, the NHS England Serious Incident Framework[158] was not published until March 2015.

15.19 However, the pre-exiting guidance had been in place since 1994[159] and updated in 2005.[160] The National Patient Safety Agency guidance on good practice in investigating serious incidents in mental health services was also available.[161] Despite the complexity of this case the available guidance covering this investigation was clear.

15.20 The other framework which might have helped guide the initial investigation is the Safeguarding Adults Review process, but this was not given legal force until April 2015 with the enactment of the Care Act (2014). Prior to this there was no legal duty on Safeguarding Adults Board to investigate an incident involving a vulnerable adult.

15.21 In hindsight we can see that the initial investigation departed from what we now know as best practice guidance and policy, because at the time there was limited organisational memory due to NHS reorganisation, the NHS guidance on such investigations had been superseded by structural change and not yet updated, and pending legislation had not yet been enacted.

15.22 All this notwithstanding, we acknowledge the sincere intention of those involved to undertake a robust investigation that would withstand scrutiny. We believe that they have succeeded in doing this and we commend the initial investigation panel for their diligence and astute work. There is nothing that we would disagree with, and we have added additional elements only because we have been able to build on their previous investigation and we were tasked with reviewing implementation.

15.23 The initial investigation made recommendations to improve practice, and not recommendations to oversee these changes. Despite the best of intentions the initial investigation was commissioned outside of normal processes, resulting in a lack of comprehensive oversight.

15.24 As we have discussed, we have seen that each organisation subject of the recommendations has gone on and implemented their separate elements. Nearly everyone has completed all of their actions. However, there appears to have been a lack of 'pulling together' the disparate points to bring the

[157] The Health and Social Care Act (2012) provides for the most recent reorganisation of the structure of the National Health Service in England. It abolished NHS primary care trusts (PCTs) and Strategic Health Authorities (SHAs) and transferred the commissioning of health care funds, from the PCTs to CCGs, partly run by GPs in England as membership organisations.
[158] NHS England "Serious Incident Framework: Supporting learning to prevent recurrence" March 2015 https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf
[159] HSG (94) 27 (LASSL (94)4) "Concerning the conduct of independent inquiries into mental health services."
[160] Independent investigation of adverse events in mental health services http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4113574.pdf
[161] NPSA "Independent investigation of serious patient safety incidents in mental health services: Good practice guidance" February 2008, http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60156

actions back into a system wide perspective, despite the efforts of the NHS Birmingham CrossCity CCG.

15.25 Because this was a complex investigation that crossed organisational and jurisdictional boundaries and because the incident happened at a time of significant NHS restructuring, we can understand why the lines of accountability had not yet become clear.

15.26 We expect now, in similar circumstances, a regional arm of NHS England to take charge.

**Oversight**

15.27 Our review of the investigation has found that it is not completely clear which organisation commissioned and 'owned' the initial investigation.

15.28 We were told by BSMHFT that they convened the investigation at the request of the commissioners (NHS Birmingham Cross City CCG). They recognised the need for someone to lead the investigation process and therefore 'stepped forward'.

15.29 We have also been told that the investigation belonged completely to BSMHFT.

15.30 There are no organisational logos on the investigation report. A search on the internet shows that the report is available from the website of NHS Birmingham CrossCity CCG. The CCG has agreed that it would be the agency to go to for information on this report.

15.31 We understand that once the investigation was complete the intention was for oversight to be provided by the Birmingham Children's Safeguarding Board. But this did not happen because it was realised it was not the appropriate body to do so, as Christina was never a vulnerable young person.

15.32 We have seen one set of update reports on progress of the implementation of action plans from HMP Hewell (Healthcare) required by NHS Birmingham CrossCity CCG. These were completed in August 2014 and reviewed again in December 2014. We have also seen a letter from this CCG requesting an update on progress from the main recipients of recommendations in the initial investigation from December 2014. We were told that there had been other updates required, and been told also that Birmingham Safeguarding Adults Board had received other updates. We have not seen these.

15.33 We have heard that where possible the Safeguarding Adult Board now seeks to provide some oversight for the implementation of recommendations in the initial investigation report, but this is complicated by the national recommendations and other jurisdictions involved.

15.34 We have also heard that because of the lack of clarity in the commissioning and ownership of the investigation, for some organisations it was not clear

who to refer to for clarification of recommendations. For example, recommendation 4 for HMP Hewell refers to both prison healthcare and the wider prison needing to ensure that where there are concerns in respect to a prisoner not having the necessary capacity to make a significant decision, that the guidance outlined within the Mental Capacity Act is enacted and that a Best Interest decision is made. They felt that this was too wide a ranging recommendation applying to too many staff, that warranted further discussion, but there was no forum for further discussion and clarification.

15.35 Similarly, we discussed earlier the difficulties faced by the national bodies in the implementation of some of the national recommendations. Again, without a forum for reporting back on these recommendations, these have not been given due oversight and discussion.

15.36 We have also noted in this report that although each local provider has implemented its own action plans, there has not been a wider sharing of experience and practice to inform all agencies involved.

**All local and national organisations involved in this case and the implications of the recommendations (BCPFT, Care UK/ HMP Hewell (Healthcare), BSMHFT (PICU and HMP Birmingham (Healthcare), Forward Thinking Birmingham, West Midlands Police, NHS Birmingham South Central CCG, NHS Birmingham Crosscity CCG, NHS Sandwell and West Birmingham CCG Sandwell Social Services, Birmingham Safeguarding Adults Board, NHS England and HMPs Hewell and Birmingham.**
Recommendation 24: There should be a local 'lessons learned' day, as soon as practicable, for each organisation to share with others an update on the progress made on the implementation of their action plans, seek clarification and share experiences. We also recommend that the outcome of the 'lessons learned day' is a shared understanding and agreement of how oversight of the recommendations made in this independent investigation will be taken forward, and which body is best placed with the appropriate authority to do this.
**Priority 1**

**NHS England**
Recommendation 25: Should provide clear guidance for the 'ownership', commissioning and oversight of future very serious incident investigations that cross organisational and agency boundaries, so that local responsibilities are very clear.
**Priority 1**

# 16 Predictability and preventability

16.1 Throughout the course of this investigation, we have remained mindful of the terms of reference and in particular, that we should consider whether the incident which resulted in Christina's death was either predictable or preventable.

16.2 In this investigation we have used the following definitions:

- Predictability is "the quality of being regarded as likely to happen, as behaviour or an event". We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.[162]

- Prevention means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring.[163]

16.3 While analysing the evidence before us we have had in mind the following definition of a homicide that is judged to have been predictable, which is one where "the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it".[164]

## Predictability

16.4 The initial investigation report "concluded that the homicide of Christina was not predictable".[165] We agree with this finding. Christina had never met P, and as she was unknown to him. Her death was not predictable.

16.5 However in our view there was sufficient evidence to predict a continuing deterioration in P's mental ill health. We have identified the following multiple risk factors in support of this:

- P was a young man with multiple complex needs who despite many assessments and the involvement of a number of agencies and qualified professionals, was released into the community without a risk management plan to support either his mental health or social care requirements and to reduce the risk he posed to himself and other people (in particular his mother and immediate family).

- P was arrested and charged with Common Assault on his mother and an assault on a Police Constable. He was convicted of Battery and received a 26 week sentence. He had threatened to kill his mother whilst in court under oath, and had previously threatened her with a knife in front of his younger brother. Since his adolescence he had been expressing anger towards both his family and others. He

[162] http://www.dictionary.com/browse/predictability
[163] http://www.dictionary.com/browse/preventable
[164] Munro E, Rumgay J, "Role of risk assessment in reducing homicides by people with mental illness". The British Journal of Psychiatry (2000), 176: 116-120
[165] Trust's executive Summary , p26

had a history of violent offences and police involvement, including being charged with possession of a lock knife at the age of 17.

- A further factor which should have given rise to professional concern was that P was in a continual state of denial, both at the time he was released from HMP Birmingham, regarding his mental health problems and actions whilst he was unwell. This state of denial is thought to be a good indicator that P's behaviours were unlikely to be mitigated without a risk management plan to address the multiple complex needs that were perpetuating his behaviours.[166]

- Although when exactly P would commit such a serious offence was neither known or predictable, it is recognised that the more pressing the multiple complex needs becomes the greater the likelihood of a further offence taking place.[167] This is a well-documented formula in evidence based practice and clinical risk assessment. It is the reason why risk assessments are undertaken at frequent intervals and always when the offender circumstances change. The aim is to identify corresponding changes in levels of risk and dangerousness and to alert professionals to instigate prevention and intervention. Looking at the circumstances leading up to the offence we could see how P had become more isolated from his family, especially his mother who had been the one person who had continually tried to support him and obtain professional for him. From December 2012 to the date of the incident P was homeless, without medication, psychiatric monitoring or support.

16.6 Based on the escalation of P's risk factors and his situation after he was released from HMP Birmingham in our view it was predictable that P was at significant risk of reoffending. Because of his previous offending history we also believe it was highly likely that the offence would involve an act of violence, and that this would have been directed at a family member, most probably his mother. That he would attack a stranger was not predictable.

## Preventability

16.7 In our consideration of the preventability of this incident, we have asked ourselves the following questions. Based on the information that was known, were P's risk factors and support needs adequately identified and assessed? Secondly, was it reasonable to have expected individual practitioners to have taken more proactive steps to ensure that he received the support he needed upon his release?

16.8 During our investigation it was clearly evident that over time there had been a systemic failure within multiple organisations and by some professionals to correctly asses and identify P's increasing risk of dangerousness. This was

[166] Nash, M. and Williams, A. "Handbook of public protection". Abingdon: Willan. (2010).
[167] As above

linked to his social isolation on release, homelessness, history of escalating erratic and violent behaviour, substance misuse and mental health needs.

16.9 This was compounded by other factors. Alongside what appears to have been a quiet and shy demeanour, it appears that P could manage his behaviours when assessed for a time, such that he was able to mask any underlying psychosis. Many of the services in contact with P failed to get in contact with other services who had known him previously, and no one was able to triangulate information received in order to build up a more comprehensive picture and to corroborate (or otherwise) the information P had provided.

16.10 This led to what appears to be an exponential failure in service provision. Despite having had frequent contact with multiple services and professionals, P received no support in the community once released from prison.

16.11 There had been a communication failure and misunderstanding between the in-reach psychiatrist in HMP Hewell (Healthcare) and the PICU unit. There was no risk management or support plan put in place on P's release from either HMP Hewell or HMP Birmingham.

16.12 Based on these findings we believe that P's risk factors and support needs were never adequately identified and assessed. We also believe that practitioners, within the various organisations P had contact with, could have taken more proactive steps to ensure that he received the support he needed upon his release. However the obstacles to doing so are part of the wider more systemic problem of ensuring appropriate mental health care for young people with mental health problems in prison, and the difficulty of accessing in-patient beds.

16.13 We therefore fully endorse the initial investigation findings that the homicide of Christina by P was directly related to his mental illness and more likely that the homicide might have been prevented if his mental health needs had been identified and met.

16.14 Although we do not know what P's mental state was leading up to his killing of Christina, within seven hours of him being arrested it was identified that he was experiencing a significant and profound mental illness and required a placement in a medium secure unit.

16.15 If all the measures that are in place now had been in place at that time, it is more likely that P's mental health would have been better monitored and he might have had access to a more supportive and caring environment, instead of being homeless and left untreated in the community.

# 17 Overall analysis and recommendations

17.1 During the course of this investigation we have identified many of the profound difficulties that faced both P and his family in his route through health and criminal justice services which led up to Christina's tragic death.

17.2 We fully concur with the findings of the initial investigation report that there were a number of missed opportunities to initiate a more appropriate response for Ps mental health care, starting with his initial contact with BCPFT's CAMHS, then from primary care services, and then his later contact with prison health and the criminal justice and prison services.

17.3 It is clear to us that since then the services involved have taken the findings of the initial investigation report seriously and have largely addressed and responded to all of the recommendations.

17.4 However it is of continued concern to us that despite the high number of reports and inquiries into high profile homicides, many of the same issues that arose in those investigations are identified in this report. Many of the underlying systemic changes needed to provide integrated mental health services still remain, despite the steady progress over recent years with new services such as In-Reach, Liaison & Diversion and Street Triage.

17.5 The largest concern shared by all on the investigation panel and many of the people we interviewed was that despite these efforts, the challenges to ensure appropriate after care on release for prisoners with mental health problems remain. If we were able to make just one recommendation to improve services and reduce the likelihood of such a tragic case happening again, it would be that the national services concerned (Department of Health, NHS England and Ministry of Justice) strenuously work together to improve the care and after care of prisoners with mental health problems.

17.6 Despite this we also want to recognise, not just the individual service efforts made to address the findings of the initial investigation report, but also the other wider changes made to services across the West Midlands that we hope will lead to earlier detection and access to more appropriate and timely intervention for offenders with mental health problems.

## Appendix A: Table of Recommendations

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| **Black Country Partnership NHS Foundation Trust** |
| Recommendation 1: The Child and Family Service Operational Policy must provide clear guidance on how CAMHS clinicians are to work with other partner agencies and the young person's family in the assessment and support planning processes. |
| **Priority 2** |
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| **Black Country Partnership NHS Foundation Trust** |
| Recommendation 2: The Trust's revised Record Keeping Policy must include reference to the importance of documenting the details and the involvement of other involved agencies. |
| **Priority 2** |
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| **Black Country Partnership NHS Foundation Trust** |
| Recommendation 3: Black County Partnership NHS Foundation Trust should ensure that the CAMH services are culturally sensitive to the needs of a patient and their families, and that they recognise and understand the potential impact of immigration on the family. |
| **Priority 2** |
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| **NHS Sandwell and West Birmingham CCG and NHS Birmingham CrossCity CCG and their GP practices.** |
| Recommendation 4: NHS Sandwell and West Birmingham CCG and NHS Birmingham CrossCity CCG and their GP practice members should share the learning from the initial investigation and roll out the enhanced safeguarding practices now implemented in Ps final GP practice. |
| **Priority 2** |
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| **NHS Sandwell and West Birmingham CCG and their member GP practices,** |
| Recommendation 5: NHS Sandwell and West Birmingham CCG and its member GP practices should review the systems they have in place to identify and support parents of children who have mental health problems to ensure that they are providing them with appropriate levels of support, including referral for a carer's assessment. |
| **Priority 2.** |
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| **West Midlands Police** |
| Recommendation 6: Before the decision is made by the police to remove safety and alert equipment from a victim of domestic violence West Midlands Police should ensure that a full risk assessment is undertaken to inform this decision. All relevant agencies and the victim should be involved in this assessment and decision. |
| **Priority 2** |
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| **HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)** |
| Recommendation 7: Healthcare staff at both HMP Hewell and HMP Birmingham who are undertaking CPA and risk assessments should familiarise themselves with the Home Office 'Adolescent to Parent Violence and Abuse Guidance for Practitioners' (2015) and be categorising incidents of violence by children on a parent and/or carer as incidents of domestic abuse. |
| **Priority 2** |
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| **HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)** |
| Recommendation 8: Staff undertaking the initial Care Programme Approach Plan must ensure that they liaise with all agencies who have been involved with the prisoner, in the community and/or during the court process, in order to obtain an accurate profile of their needs and risks to themselves and others. |
| **Priority 1** |
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| **Black Country Partnership NHS Foundation Trust** |
| Recommendation 9: The new EHR must facilitate the recording of other agencies involvement and contact details. |
| **Priority 2** |
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| **Black Country Partnership NHS Foundation Trust** |
| Recommendation 10: The Trust should assure itself that the new DNA/ No Access Visit policies are complied with. |
| **Priority 2** |
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| **Department of Health, NHS England, CCGs and local Police and Crime Commissioners** |
| Recommendation 11: To work in partnership to roll out and further develop the street triage service to reduce the impact of mental health crises on local police and emergency services. |
| **Priority 1** |
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| **HMP Hewell (Healthcare) and NHS England's Health and Justice Commissioning Team (North Midlands).** |
| Recommendation 12: NHS England's Health and Justice Commissioning Team (North Midlands) should discuss the findings of the original Trust report with the new provider of healthcare at HMP Hewell to ensure that implementation is still progressing and that lessons learnt are continuing to inform practices and policies. |
| **Priority 2** |
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| **HMP Hewell and HMP Birmingham** |
| Recommendation 13: Both HMP Hewell and HMP Birmingham introduce a requirement, supported by guidance, that all prison staff, including the governor's office and pastoral care services, should document any contact, either written or verbal, with prisoners' families in a prisoner's P-NOMIS record. |
| **Priority 3** |

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| **Birmingham and Solihull Mental Health NHS Foundation Trust** |
| Recommendation 14: The Trust should discuss their PICU guidance with all the prison health care services who refer to their PICU units. |
| **Priority 2** |
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| **NHS England Specialised Commissioning Health & Justice commissioners, prison health care providers and Ministry of Justice** |
| Recommendation 15 : The specialist health and justice commissioners, prison healthcare providers and the Ministry of Justice should work together to improve discharge planning of vulnerable prisoners with mental health problems who are released earlier than planned, and produce clear guidelines for all healthcare staff to refer to other mental health services. |
| **Priority 1** |
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| **HMP Birmingham (Healthcare) and Birmingham and Solihull Mental Health NHS Foundation Trust** |
| Recommendation 16: HMP Birmingham (Healthcare) should provide assurance to the Trust and their commissioners that the issues with SystmOne (accessing prisoner's full medical notes from the point of admission) have been resolved. |
| **Priority 2** |
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| **NHS England Specialised Commissioning Health & Justice commissioners, prison health care providers, G4S and Ministry of Justice** |
| Recommendation 17: to consider what action can be taken to allow healthcare teams in prisons to have access to the prison records P-NOMIS. |
| **Priority 3** |
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| **NHS England and Ministry of Justice** |
| Recommendation 18: To consider what protocols if any, within the current legislative framework can be developed and implemented to share relevant healthcare information about prisoners at risk of mental health problems who refuse consent to share information with GPs. |
| **Priority 1** |
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| **HMP Hewell and HMP Birmingham, BCPFT, BSMHFT, NHS Birmingham South Central CCG, NHS Birmingham Crosscity CCG, NHS Sandwell and West Birmingham CCG, West Midlands Councils, West Midlands Ambulance Service, the Crown Prosecution Service.** |
| Recommendation 19: The named partner agencies should work collectively to 'sign off' the information sharing protocol as soon as possible, ensuring wider membership as much as practicable across the West Midlands public sector so long as this does not delay completion. |
| **Priority 1** |
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| **West Midlands Police** |
| Recommendation 20: West Midland's Police should formalise the involvement of family and carers within their policies and protocols, relating to information sharing. |
| **Priority 2** |
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| **NHS England Specialised Commissioning Health & Justice commissioners, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare).** |
| Recommendation 21: The above to seek assurance that the current pathway for released prisoners with mental health problems ensures that those in need have access to appropriate mental health care after release |
| **Priority 1** |
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| **Forward Thinking Birmingham and HMP Birmingham (Healthcare) and HMP Hewell (Healthcare)** |
| Recommendation 22: Forward Thinking Birmingham, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare) should review the new service provision, to ensure that the referral and homeless pathways are effectively utilised to identify and support young offenders being released into the community. |
| **Priority 1** |
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| **Forward Thinking Birmingham and CrossCity CCG** |
| Recommendation 23: To ensure that the recommendations and lessons learnt from this incident continue to inform the development of services for vulnerable young people in contact with mental health and criminal justice services. |
| **Priority 1** |
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| **All local and national organisations involved in this case and the implications of the recommendations (BCPFT, Care UK/ HMP Hewell (Healthcare), BSMHFT (PICU and HMP Birmingham (Healthcare), Forward Thinking Birmingham, West Midlands Police, NHS Birmingham South Central CCG, NHS Birmingham Crosscity CCG, NHS Sandwell and West Birmingham CCG Sandwell Social Services, Birmingham Safeguarding Adults Board, NHS England and HMPs Hewell and Birmingham** |
| Recommendation 24: There should be a local 'lessons learned' day, as soon as practicable, for each organisation to share with others an update on the progress made on the implementation of their action plans, seek clarification and share experiences. We also recommend that the outcome of the 'lessons learned day' is a shared understanding and agreement of how oversight of the recommendations made in this independent investigation will be taken forward, and which body is best placed with the appropriate authority to do this. |
| **Priority 1** |
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| **NHS England** |

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| Recommendation 25: Should provide clear guidance for the ‘ownership’, commissioning and oversight of future very serious incident investigations that cross organisational and agency boundaries, so that local responsibilities are very clear. |
| **Priority 1** |

## Appendix B: Terms of reference

This case has been the subject of a Birmingham and Black Country wide Multi Agency Review, with resulting recommendations for the whole health economy and partner organisations. This Independent Investigation is intended to be a review of the outcomes of the multi-agency review, from a NHS perspective, to ensure that the recommendations and actions identified have been implemented and are being sustained.

The focus of the investigation will be on the present day services and current processes:

- Review the progress that the local NHS services have made in implementing the recommendations and the learning from the multiagency investigation
- Review the progress of the national recommendations across partnership organisations and NHS England
- Review the care, treatment and services provided by the NHS from the service user's first contact with services to the time of their offence
- Review the appropriateness of the treatment of the service user in light of any identified health needs
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming themselves or others
- Examine the effectiveness of the service user care plan including the involvement of the service user and the family
- Examine the referral arrangements and discharge procedures of the prison health services into the wider NHS services
- Review and assess compliance with local policies, national guidance and relevant statutory obligations
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate
- Establish if this incident was predictable and preventable
- Provide a written report to NHS England that includes measurable and sustainable recommendations
- Assist NHS England in undertaking a brief post investigation evaluation
- Undertake a six month review of implementation of recommendations detailed in the report and produce a summary for the families.

# Appendix C: Chronology from February 2012 to December 2012

| Date | Source | Event | Comments |
|---|---|---|---|
| February 2012 | Police records and interview with P's mother | P's mother obtained accommodation for P. | Mother paid for deposit and rent. Applied for benefits by P did not attend appointment |
| 9/5/2012 | Police records | P's mother contacted police to report that P had threatened to stab her.<br>P' younger sibling called police a second time to report that P had thrown an electric heater at his mother which struck her on the head, Officer attended and removed P. Matter treated as a Domestic Violence incident. Risk assessment completed by the police. | No further referral al made by police |
| 10/5/2012 | Police records | P's mother contacted the police reporting that following the incident P was repeatedly returning to her house intoxicated and causing a disorder. Police officers initially attended and removed P (08.45).<br>P returned to the house and police officers attended again and arrested P (12.05). | |
| 11/5/2012 | Police records | He was released and later there was another verbal altercation at P's mother house. When she refused to allow his access he broke a window. P was arrested. DASH assessment completed, DASH assessed risk as medium, as standard. P's mother requested victim support from police. SIG marker placed on address. | If DASH risk had been assessed as high it would have triggered a MARAC<br><br>SIG marker:<br>Police records indicated that there had been 6 calls to them from P's mother address in last 24 hours |
| 12/5/2012 | Police records | P appeared at Magistrates Court: pleaded guilty to criminal damage. Received 6 month conditional discharge. | No charges brought for assault's on P's mother |
| 13/5/2012 | Police records | P walked into a police station and asked for a pen, he wrote a note stating his name and that he had been sent by his parents "to get an apology to get his accommodation back." He did not speak. After officer spoke to him he left. | Not clear what the note P wrote to police meant or how the police officers responded |
| 14/5/2012 | Police records | Multi-agency review : risk raised to medium | Notes not available from this meeting |
| 18/5/2012 | Police records | P's younger sibling called police to report that P had broken a front window and run off. Police attended but P was not there and no further action taken. | |
| 20/5/2012 | Police and Home treatment team and MHP Hewell SystmOne records | P's mother called the police: reported that P had held a knife to her stomach and threatened to kill her.<br>P arrested. Whilst in the police car P assaulted a police officer.<br>DASH assessment completed: medium risks. SIG marker on P's mother address and also on police watch. Charged with Section 39 | Served 11 days @HMP Hewell : olanzapine: antipsychotic medication<br>Initial assessment identified mental health issues .admits using khat<br>Prescribed olanzapine 5mg. |

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| | | assault on his mother and assaulting a police officer .Remanded to MHP Hewell to service 4 weeks. | |
| 23/5/2012 | Police and SystmOne records | Multi-Agency Disciplinary review: | |
| 1/6/2012 | Police and SystmOne records | P was released from HMP Hewell to bail address. Bail address reported that P had not arrived. Police informed. | Bail conditions not to attend mother's address |
| 2/6/2012 | Police records | P arrived at bail address. | |
| 11/7/2012 | BCPFT CJMHT records | P appeared in court. His solicitors reported that he was unable to take instruction from P requested CJMHT involvement. CJMHT advised that a mental health act assessment (MHA) was required. Recommended to court that P be remanded overnight. | BCP: Black County Partnership<br>CJMHT : Criminal Justice Mental Health Team<br><br>Custody staff had left so P was given conditional bail with curfew to return to court on the next day. |
| 12/7/2012 | CJMHT records | P failed to attend court. Warrant issued. | Panic alarm fitted at P's mother address |
| 13/7/2012 | Police records | P arrested. Transferred to HMP Hewell. | HMP alerted re concerns about P's mental health |
| 14/7/2012 | HMP Hewell (Healthcare) SystmOne records | Urgent assessment by specialist forensic registrar. Admitted to the health care unit. Prescribed olanzapine 10 mg nocte and olanzapine 5mg PM. | |
| 17/7/2012 | CJMHT records | P returned to court: Mental Health Act assessment undertaken: concluded that P did not meet the criteria for detention under the MHA. P was found guilty of Battery. Sentenced to 24 weeks in custody with a restraining order for 2 years. | restraining order : not to visit mother home or place of work<br>letter sent to P's GP re MHA<br>CJMHT telephoned P's mother (18/7/2012): informed her that P did not want her to know where he was. |
| 19/7/2012 | HMP Hewell (Healthcare) SystmOne records | Specialist Registrar noted working diagnosis of "psychotic episode" but requires further assessment. | On health care unit: documented that P was<br>Significantly underweight.<br>Prescribed food supplements<br>Also recommended grief counselling re death of his grandmother |
| 4/8/2012 | HMP Hewell (Healthcare) SystmOne records | Specialist forensic registrar received fax from Crisis Team who undertook MHS assessment: noted "I do not accept the conclusion … my assessment and nursing observations would support a mental disorder of a nature and degree which warrants detention for assessment in hospital in the interest of the patient's health protection and for the protection of others. To discuss with MDT with a view to referral to hospital in the interest of P's health, it appears that he would not need conditions of a medium security and could be admitted to General Adult PICU." | MDT : multi-disciplinary team<br>PICU: psychiatric intensive care unit |

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| 9/8/2012 | HMP Hewell (Healthcare) SystmOne records | Referral made to consultant psychiatrist at PICU. | referral sent by email on the 10/8/2012 |
| 15/8/2012 | HMP Hewell (Healthcare) SystmOne records | P reviewed at MDT | |
| 24/8/2012 | HMP Hewell (Healthcare) SystmOne records | P reviewed again at MDT | |
| 1/9/2012 | HMP Hewell (Healthcare) SystmOne records | Second referral to PICU. | re referred to PICU |
| 6/9/2012 | HMP Hewell (Healthcare) SystmOne records | Specialist forensic registrar request that PICU referral be chased up. | |
| 12/9/2012 | HMP Hewell (Healthcare) SystmOne records | Telephone contact with PICU consultant psychiatrist secretary who reported that she had not received the referral. She asked that the referral be faxes faxed. | |
| 18/9/2012 | HMP Hewell (Healthcare) SystmOne records | Telephone call from PICU consultant psychiatrist secretary: she reported that she had received referral and had forwarded to ward manager to arrange assessment. | |
| 20/9/2012 | HMP Hewell (Healthcare) SystmOne records | PICU assessment. Concluded that P was not presenting with any major psychotic illness/symptoms. Therefore not suitable for PICU. Suggests that on release he would benefit from Early Intervention Service involvement. | 6 weeks after initial referral to PICU<br>note in file that specialist forensic registrar and consultant forensic psychiatrist agreed that P needed inpatient treatment and if PICU did not accept P then a referral to CMHT should be considered by PICU prior to P's release from prison |
| 24/9/2012 | HMP Hewell (Healthcare) SystmOne records | Entry by staff nurse that P was "due to be released soon and will then be followed up by his mental; health team." | CMHT were not involved with P |
| 1/10/2012 | HMP Hewell (Healthcare) SystmOne records | HMP Hewell (Healthcare) received letter from PICU: | 13 days after PICU assessment |
| 4/10/2012 | HMP Hewell (Healthcare) SystmOne records | PICU's decision discussed at MDT. Agreed that they needed to re-refer P with a recommendation that PICU refer him to a HTT if they do not consider that P requires hospital admission | HTT: Home Treatment Team ( at this point P was NFA) |
| 6/10/2012 | HMP Hewell (Healthcare) SystmOne records | Re referral sent to PICU: noted that based on their longitudinal assessment they remained of the opinion that P was "psychotic and requires assessment and treatment for his psychosis in hospital." Also notes that P was due to be released on the 15 October. Also asked that if they still felt that admission was appropriate they could they refer P to the | 2nd request re PICU and also HTT |

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| | | relevant HTT “so that he may be appropriate supported on his release.” | |
| 8/10/2012 | HMP Hewell (Healthcare) SystmOne records | Letter faxed to PICU. | PICU reported that they has no record of receiving the referral fax |
| 9/10/2012 | Police records | Panic alarm removed from P’s mother house. | unclear police if aware that P was to be released on the 15/10/2012 if address was still |
| 11/10/2012 | HMP Hewell (Healthcare) SystmOne records | Release from custody notice received: date of release 15/10/2012. Sentence expires 14/1/2013. | |
| 13/10/2012 | HMP Hewell (Healthcare) SystmOne records | P was last seen by speciality forensic registrar who documented “patient will require support from Home Treatment Team at the very least which we have requested from PICU, who initially saw the patient to organise.” | no indication of any action take to contact PICU re assessment or if they had referred P to HTT |
| 15/10/2012 | HMP Hewell (Healthcare) SystmOne records | P released from Hewell. Three days’ supply of medication. | Not documented where P was going to live.<br>weight 62.25 kgs |
| 20/10/2012 | Police records | P was seen by police tampering with a car in a police station car park. He was found to have 7 wraps of powder which P said was cannabis; He was arrested on suspicion of possession of Class A drugs (cocaine) and vehicle interference. And also that he had breached his licence. | 5 days after release |
| 22/10/2012 | Police records | P appeared in court and recalled to prison for 4 weeks. He pleaded guilty to interfering with a vehicle.<br>P was transferred to HMP Birmingham. | Initially first night assessment considered P to be a high risk CSRA (cell sharing risk assessment). Initial assessor aware of his history at Hewell |
| 23/10/2012 | HMP Birmingham (Healthcare) SystmOne records | Referred to primary care mental health gateway worker: Referred to In reach mental health nurse. MDT meeting: agreed that P was to be allocated a key mental health worker at the allocation meeting. Reference made to P non-compliance with medication and that his mental health had quickly deteriorated | Noted at MDT meeting that P had been referred to PICU. It was not documented if MDT were aware of the disagreement re P’s diagnosis or that Hewell had referred him again to PICU and had asked for a referral to HTT. |
| 26/10/2012 | HMP Birmingham (Healthcare) SystmOne records | Seem by in reach mental health nurse. | P on general wing |
| 30/10/2012 | HMP Birmingham (Healthcare) SystmOne records | MDT: in reach nurse reported that he had not been able to obtain information from HMP Hewell (Healthcare) and intended to email consultant forensic consultant regarding their PICU referral. | noted that P was vulnerable and denies any mental health symptoms |
| 6/11/2012 | HMP Birmingham (Healthcare) SystmOne records | MDT: P was not discussed. | |
| 7/11/2012 | HMP Birmingham (Healthcare) | P did not attend (DNA) his appointment with psychiatrist. | We were informed that there were several possible reasons why a patient may DNA |

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|---|---|---|---|
| | SystmOne records | | appointments. Reason was not recorded in P's notes |
| 13/11/2012 | HMP Birmingham (Healthcare) SystmOne records | MDT: in reach nurse reported that P was difficult to engage with , That it was unclear what the outcome of the PICU referral had been at Hewell and that DNA's his appointment with doctors. Action: nurse to continue to try to engage with P and to discuss at next MDT meeting. | letter from PICU were on system that HMP could access<br>Next MDT cancelled to HMIP inspection (20 /11/12 ) |
| 21/11/2012 | HMP Birmingham (Healthcare) SystmOne records | P DNA second appointment with psychiatrist. | |
| 4/12/2012 | HMP Birmingham (Healthcare) SystmOne records | MDT: noted that wing staff were concerned about P as he was isolating himself. In reach nurse reported that he was still having difficulties engaging with P. Plan to continue to monitor. | |
| 12/12/2012 | HMP Birmingham (Healthcare) SystmOne records | P seen by consultant psychiatrist with the in reach nurse. Noted that P denied any mental health systems or hearing voice and said that he was not involved with community mental health service. Concluded that P had no acute issues but that he should "link with teams on his release." | Not documented if psychiatrist knew P was being released the following day. Or if he had been aware of the PICU referral and subsequent disagreement. No referral plan to community services.<br>No inquiry made re P's housing on release. |
| 13/12/2012 | HMP Birmingham (Healthcare) SystmOne records | P was released. Discharged as NFA.<br>. | not on any medication<br>NFA: no fixed abode. |

# Appendix D: References

**List of documents consulted or referenced in this investigation.**


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**Legislation**

Police and Criminal Evidence Act (PACE 1984)
Offender Rehabilitation Act (2014)
The Health and Social Care Act (2012)
Mental Health Act (1983) (amended 2007)

# Appendix E: Glossary of terms

| Abbreviation | Description |
|---|---|
| ACCT | Assessment, Care in Custody & Treatment – On 1 April 2012 the 'Safer Custody' Prison Service Instruction 64/2011 came into force which replaces several Prison Service Orders relating to Safer Custody. Assessment, Care in Custody and Treatment (version 5) is a prisoner- centred flexible care-planning system which is designed to reduce the risk of suicide and self-harm. Those who manage offender health must adhere to the requirements of ACCT in order to manage individuals at risk of self-harm and suicide. |
| AMHP | Approved Mental Health Practitioner – a person responsible for organising and coordinating assessments under the Mental Health Act. The role is often held by specially trained social workers but can also be carried out by Occupational Therapists, Community Mental Health Nurses and Psychologists. This role replaced the role of an Approved Social Worker (ASW). |
| APVA | Adolescent to Parent Violence and Abuse |
| BASS | Bail Accommodation Support Service |
| BCPFT | Black Country Partnership Foundation Trust |
| BSMHFT | Birmingham & Solihull Mental Health Foundation Trust |
| CAIT | Crisis and Assessment and Intervention Team |
| CAMHS | Child & Adolescent Mental Health Services |
| CCG | Clinical Commissioning Group |
| CJT | Criminal Justice Team |
| CMHT | Community Mental Health Team |
| CPA | Care Programme Approach |
| CPN | Community Psychiatric Nurse |
| CPS | Crown Prosecution Service |
| CSRA | Cell sharing risk assessment |
| DASH Assessment | Domestic Abuse, Stalking and Honour Based Violence assessment |
| DNA | Did not attend |
| DoH/ DH | Department of Health |
| EDT | Emergency Duty Team |
| HMP | Her Majesty's Prison |
| HMIP | Her Majesty's Inspector of Prisons |
| IMR | Inmate Medical Record |
| Khat | A plant native to parts of Africa and the Arabian Peninsula. When chewed it is a stimulant that can make the user feel more alert, happy and talkative, but can also suppress appetite, induce insomnia, make existing mental health problems worse, and cause paranoid and psychotic reactions. It has been a Class C drug with effect from 24 June 2014. |
| LSCB | Local Safeguarding Children Board |
| MAPPA | Multi - Agency Public Protection Agency |
| MARAC | Multi - Agency Risk Assessment Conference |
| MASH | Multi Agency Safeguarding Hub |
| MDT | Multidisciplinary Team |

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|---|---|
| MHA | Mental Health Act 1983 (Amended 2007) |
| NFA | No Fixed Abode |
| NPSA | National Patient Safety Agency |
| OASIS | BCPFT electronic patient information system |
| OASys | Offender Assessment System (Risk categorisation) |
| ORA | Offender Rehabilitation Act (2014) |
| PACE | Police & Criminal Evidence Act 1984 |
| PER | Prisoner Escort Record – Conveys information about assessed risks that others need to be aware of |
| PICU | Psychiatric Intensive Care Unit |
| Police Watch | Local neighbourhood team who are aware of domestic abuse households they may want to take opportunity to engage with |
| PNC | Police National Computer |
| P-NOMIS | Prisoner National Offender Management Information System |
| Primecare | Primecare is an independent provider of primary healthcare, including out of hours services GP |
| RC | Responsible Consultant |
| RIO | BSMHFT electronic patient information system |
| SCR | Serious Case Review |
| Section 37 MHA | A Hospital Order made in Court for the provision of treatment for a mental disorder |
| Section 41 MHA | A Restriction Order made in Court with a Hospital Order, requiring case oversight by the Ministry of Justice |
| SHO | Senior House Officer (Junior doctor) |
| SIG | Street Index Gazetteer (Significant Warning Marker on Police National Computer) |
| ST-5 | Senior Trainee (Level 5) doctor |
| SystmOne | HMP Healthcare patient information recording system |
| TAG | Threshold Assessment Grid – This is a short, quickly completed rating assessment of the severity of an individual's mental health problems. It was developed to help identify people who should be referred to community mental health services for adults and older people |
| VPS | Victim Personal Statement |

# Appendix F: Glossary of services

**Services provided by Black Country Partnership NHS Foundation Trust**
**CAMHS Crisis Assessment and Intervention Team (CAIT)**
The service provides home based support and treatment for children and young people admitted following an act of self-harm, or who are presenting with significant mental health concerns.
**Criminal Justice Mental Health Liaison Team**
The team aims to help people who have, or may have, mental health problems and are in contact with the Criminal Justice System. They cover all areas of the Criminal Justice System, including courts, prisons, the probation service, and hostels.
**Crisis Resolution and Home Treatment Team**
The service is for people going through severe mental health crises, and to offer them support and treatment in their own home.
**Early Intervention Service (EIS)**
The EIS supports young people and adults aged 14-35 who are going through a first episode of psychosis, or who seem at risk of going through a first episode of
**Primary Care Liaison Teams**
The Primary Care Liaison Team offers non-urgent mental health care to people with common mental health problems, such as depression, anxiety and stress.
**Specialist CAMHS**
The service is the main service in CAMHS (Child and Adolescent Mental Health Service). It is for children and young people who have complex mental health problems.

**Services provided by Birmingham & Solihull NHS Foundation Trust**
**Meadowcroft PICU**
Provided by BSMHFT, the PICU provides intensive care for people with serious mental illness often with behaviours that challenge and who need a more secure environment but don't require medium security.
**HMP Birmingham (Healthcare)**
The service is provided for any individual within HMP Birmingham experiencing acute mental health distress, or severe and enduring mental illness, where the prisoner is known to psychiatric services.

**Services provided by Worcestershire Health and Care NHS Trust**
**HMP Hewell (Healthcare)**
In 2009 the healthcare service in HMP Hewell provided to prisoners, including mental health in-reach was provided by Worcestershire Health & Care NHS Trust. This is now provided by Care UK.

# Appendix G: People interviewed as part of this investigation

**Black Country Partnership NHS Foundation Trust**
Associate Specialist
Head of Governance and Quality
CAMHS Consultant Psychiatrist
Team Manager of Crisis and Home Treatment Team
Associate Director , Quality and Governance
Service Manager for Complex Care Services
Head of Nursing
General Manager Urgent Care
General Manager for Planned Care
Specialist Nurse Practitioner, CAMHS
CAMHS Consultant Psychiatrist
Associate Specialist, Sandwell Crisis Team
Executive Director of Nursing, Allied Professionals and Governance
Service Manager of Adult Recovery
Mental Health Group Director
Acting Team Manger Criminal Justice Team
Mental Health Nurse, Criminal Justice Team

**Birmingham Safeguarding Adults Board**
Chair

**Birmingham and Solihull NHS Foundation Trust**
Divisional Clinical Governance facilitator
Head of Service Delivery and Design
Executive Director of Operations
Associate Director of Governance
Forensic Consultant Psychiatrist
Consultant Forensic Psychiatrist and Clinical Lead at HMP Birmingham
Consultant Forensic Psychiatrist and Clinical Director, SecuriCare
Forensic Consultant Psychiatrist
Forensic Consultant Psychiatrist
Chief Executive
Community Psychiatric Nurse, HMP Birmingham
Nurse Matron
Ward Manager, PICU
Executive Director of Nursing
Head of Service Delivery & Design/Head of Investigations

**Care UK**
Head of Healthcare, HMP Hewell
Head of Healthcare HMP Long Lartin

**Forward Thinking Birmingham**
Quality and Governance Lead
Medical Director
Adult Safeguarding Manager
Associate Director of Nursing

**HMP Birmingham (Healthcare)**
Head of Healthcare

**NHS Birmingham CrossCity CCG**
Deputy Chief Nurse
Chief Nurse and Quality Officer

**NHS Birmingham South Central CCG**
Associate Director of Commissioning
Accountable Officer

**NHS Sandwell and West Birmingham CCG**
GP

**NHS England**
Business change and implementation manager, Health and justice information services

**NHS England (North Midlands)**
Health and Justice Commissioning Manager
**NHS England (West Midlands)**
Health and Justice Commissioning Manager

**Partnerships in Care**
Forensic Consultant Psychiatrist

**Queen Elizabeth Hospital, University Hospitals Birmingham NHS Foundation Trust**
Consultant Psychiatrist

**West Midlands Police**
Detective Chief Inspector and Force Lead for Mental Health