Report of the Independent Inquiry into the Care and Treatment of Sarwat Al-Assaf

A report commissioned by
Gedling Primary Care Trust, Nottingham

Published April 2004

PREFACE

We were commissioned by Nottingham Health Authority and subsequently by Gedling Primary Care Trust to undertake this Inquiry.

We now present our report, having followed the terms of reference and the procedure which was issued to all witnesses and their representatives.

GILLIAN DOWNHAM
Barrister

JOHN McKENNA
Consultant Forensic Psychiatrist

MOHAMMED JAMIL
Social Worker

ANTHONY DEERY
Registered Mental Nurse
& Senior Manager NHS

ROBERT SOUTHERN
Director, Mental Health Consultancy and Training Company
R.M.N., D.M.S.

ACKNOWLEDGEMENTS

Our grateful thanks are due to all of the following:

Members of the family and friends of the late Alan Clarke, including Susan Al-Assaf for their co-operation in a process that will have renewed painful memories

Mr Samir Al-Assaf, Sarwat Al-Assaf's brother for the trouble he took to travel from Egypt to give evidence

All professional witnesses for giving willingly of their time and recollections whilst enduring the stress caused by such an investigation

Dr Nadje Al-Ali of the Arab and Islamic Studies Institute, University of Exeter, for her comprehensive researches and expert advice

Margaret Wort & Co and all the team for their long hours providing quick and accurate transcription services

Lynne Winstanley and her PA Kath Anderson from Gedling PCT for providing the link between the Inquiry and the Commissioning body.

Diane Hammans and Sue Wolfe who together patiently ensured that this Inquiry ran smoothly, competently managing its administration and keeping in contact with all those giving evidence

Jeremy Taylor, Chief Executive of Nottinghamshire Healthcare NHS Trust, for his assistance at the final stage of drafting, ensuring that our recommendations are directed to the appropriate bodies.

Elaine Rowland for her support and help with precision proof-reading.

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Chapter 1

Background to the Inquiry

1.1 Introduction

1.1.1 On 29 July 2001 at Sheffield Crown Court Sarwat Al-Assaf was convicted of the murder on 6 November 2000 of Alan Clarke, his plea of guilty to manslaughter on the grounds of diminished responsibility having been rejected. He was sentenced to mandatory life imprisonment and has remained since his sentence in Leicester Prison.

1.1.2 Sarwat Al Assaf had been in receipt of mental health services during a period of two months prior to the homicide and Nottingham Health Authority commissioned this Independent Inquiry to examine the care and treatment he received in order to learn any lessons from the history and improve services where necessary.

1.1.3 Health Circular HSG (94)27 requires that an independent inquiry be held where an individual has been in receipt of psychiatric services prior to a homicide and in this case there had been two separate and unconnected homicides in the same month within the same Trust. The Inquiry was therefore asked to examine the care and treatment of both men. It was envisaged that there might be features in common concerning the provision of mental health services in Nottingham and that these would receive greater emphasis from combining the two investigations, with findings and recommendations contained in one report.

1.1.4 Although they were not known to each other, the men had in common that they had both very briefly been in-patients at the same hospital within a space of three months of each other. Each had attended at the Accident and Emergency Department of Queen's Medical Centre, Nottingham, and each had been transferred to one of the psychiatric wards within the same hospital building. Ethnicity issues were expected to feature in both cases. Management of the two inquiries together also had costs benefits.

1.1.5 In the event, each inquiry involved a very different set of circumstances and a decision was made, after drafting the final report in this case, that the two inquiry reports should be published separately, this being completed and published first.

1.2 The Inquiry Process

1.2.1 The Inquiry team was appointed by Nottingham Health Authority in October 2001 and Sarwat Al Assaf gave consent to the release of his confidential documentation on 29 January 2002.

1.2.2 Changes in the structure of local health services meant that the original commissioning body, Nottingham Health Authority, ceased to exist and for a while the Inquiry was in limbo. Delay also arose because of the unavoidable withdrawal through serious illness of the medical member of the panel. A replacement had to be appointed and we also chose to appoint an additional panel member in order to provide essential support on ethnicity issues.

1.2.3 By September 2002 Gedling Primary Care Trust (PCT) had become the commissioning body, the Inquiry panel and clerical support were in a position to proceed and the consent of both men had been obtained. Over the next five months confidential documentation concerning both individuals was obtained, written evidence sought and witness statements received. Terms of Reference and Procedure for the Inquiry are at Appendices A & B.

1.2.4 In order to preserve and respect the privacy of each person and their families, separate hearing times were allocated as far as it was practically possible. Written evidence concerning the care and treatment of Sarwat Al-Assaf was received from 32 individuals and oral evidence heard from 29 people over a period of 12 days between Tuesday 4 March and Friday Wednesday 9 April 2003. Witnesses are listed at Appendix C.

1.2.5 We are immensely grateful to all the professional and family witnesses who gave so willingly of their time. We recognise that it is distressing for relatives to re-live events, and stressful for professionals who were involved at the time. Without exception all witnesses were polite and co-operated fully in the Inquiry process.

1.2.6 We are indebted to the British Sign Language (BSL) interpreter, transcription and video team who assisted with recording of evidence. Our thanks also go to Dr Nadje Al-Ali of the Arab and Islamic Studies Institute at Exeter University, who gave us very valuable expert advice.

1.2.7 We have asked the commissioning body to ensure that counselling and support is available to family and close friends who were affected by this homicide, and who will feel, with the publication of this report that memories are revived once again. The Inquiry Panel offers its condolences to the family of Mr Alan Clarke and to Susan Al Assaf.

1.2.8 We now summarise briefly the background circumstances of the homicide and the main findings.

1.3 Summary

1.3.1 Sarwat Al-Assaf, profoundly Deaf[1] since his early childhood in Egypt, came to school in the UK, married and was for many years supported by Nottinghamshire Deaf Society and Nottinghamshire Social Services County Deaf Team.

1.3.2 He had no psychiatric history but, two months prior to the homicide and in crisis whilst his marriage was breaking down, Sarwat Al-Assaf sought and received mental health support from a number of services in Nottingham including his GP, the Queen's Medical Centre (QMC) and specialist services for Deaf people with mental health needs. He was assessed as suffering an acute stress reaction. Mrs Al-Assaf, who was not Deaf, also sought help on behalf of her husband.

1.3.3 Mr and Mrs Al-Assaf were separated by the date of the homicide. Sarwat Al-Assaf killed Mr Clarke, who was in a close relationship with Mrs Al-Assaf at the time.

1.3.4 At the criminal proceedings Sarwat Al-Assaf was found to suffer from an adjustment disorder. Not being a formal mental illness, this could not support a verdict of manslaughter on the grounds of diminished responsibility. Sarwat Al-Assaf was convicted of murder.

1.3.5 This Inquiry examines the evidence in terms of Sarwat Al-Assaf's Deafness and his cultural background.

1.3.6 The latter arises because in the course of giving evidence to the Inquiry a witness suggested that the homicide might have had a cultural component to it. After receiving expert advice on Egyptian culture and 'honour killings' we have rejected this suggestion. Nevertheless, the debate thrown up by our investigation of the point causes us to feel concern that there is much confusion over precisely how to deal with the subject of multi-ethnicity in mental health. We recommend increased ethnicity awareness training and suggest improvements in access to information about specific cultural and religious matters.

1.3.7 Sarwat Al-Assaf's Deafness is the main focus of this Inquiry and we comment on the difficulty of carrying out a psychiatric assessment of a disturbed, profoundly Deaf individual, out-of-hours, in the busiest Accident and Emergency Department in England, with his wife feeling under threat and with no BSL interpreter. We conclude that there is

[1] Note: we follow the convention described in *Sign of the Times*, page 6, of using 'Deaf' to describe the cultural and linguistic community for whom sign language is their first language. The word 'deaf' is used for those who use oral methods of communication.

an urgent need to provide an emergency service for Deaf people with mental health needs. Our findings echo and reinforce those of a previously published independent inquiry, that of Daniel Joseph[2].

1.3.8 We find that nothing about this homicide was predictable. Even with hindsight there were no clues. We do not think that any of the staff involved with the care of Sarwat Al-Assaf could have anticipated what happened. It is rare in an Inquiry of this kind to be able to say that nothing could have influenced the outcome. We express the hope that this does not diminish the impact of the recommendations we make. Sarwat Al-Assaf was entitled to receive services on the basis of his disability and his mental distress and we consider that he and Mrs Al-Assaf experienced a service that could and should have been more responsive to their needs when they were in crisis.

[2] Lewisham Health Authority (2000) *Report of the independent inquiry team into the care and treatment of Daniel Joseph*

Chapter 2

The History

2.1 Background

2.1.1 Sarwat Al-Assaf was born in Cairo, Egypt on 4 July 1962. One of four children, at the age of three he reportedly suffered a severe head injury following a fall from a balcony. This resulted in profound bilateral hearing loss. From the age of five he received specialist education at a school for the Deaf in Egypt, moving to a school in Lebanon at the age of seven and later returning to Egypt. His brother Samir remembers him as having been interested in sports and having many friends. Moving to England at the age of nineteen, Sarwat Al-Assaf attended the Royal School for the Deaf in Derby and then technical college, leaving at the age of twenty-three with a qualification in electrical engineering. Thereafter Sarwat Al-Assaf was employed in a variety of occupations, although not all of them used this qualification.

2.1.2 Sarwat Al-Assaf communicates using BSL which he learnt in England. He was particularly close to his brother Samir Al-Assaf, who also lived in England during part of the 1990's. Communication between the two of them developed as a unique sign language during their childhood and we heard that they understood each other well.

2.1.3 There was a first marriage in 1985 and two children were born. One child, a son now aged eighteen, lives with Sarwat Al-Assaf's mother in Egypt. The other child died as a result of cot death shortly after his birth in 1988.

2.1.4 Sarwat Al-Assaf met his second wife, Susan, in 1993. They lived together from 1994 and their daughter was born in 1995. Following his divorce in February 1997, they married in March 1997. Mrs Al-Assaf, who is not Deaf, told the Inquiry that she and her husband communicated using BSL although she was less proficient at the language than he. She described how, sometimes, when they were alone, he expressed himself to her using his voice and with some individual words.

2.1.5 The marriage began to experience difficulties when, despite being in employment, Sarwat Al-Assaf started to accumulate large debts. Working night shifts, he was increasingly absent from home without explanation. It was only later that it became clear he had been gambling. At the time his wife expressed concern to their General

Practitioner (GP) that her husband sometimes seemed to be disorientated and talked of hearing a voice telling him to do things. Sometimes he did not remember where he lived and would seem to get lost. At home he was anxious and spoke of severe headaches. After being seen locally by a consultant neurologist in 1998, Sarwat Al-Assaf underwent relevant investigations (a CT brain scan and electroencephalogram, EEG). No significant abnormalities were found.

2.1.6 Sarwat Al-Assaf's debts reportedly reached £30,000 and involved him forging his wife's signature. Eventually the matrimonial home was sold to pay off the debts. For a while during 1999 the couple separated and lived in temporary accommodation. Early in 2000 they moved into their last home together, this being a house in Mrs Al-Assaf's sole name. Then in August 2000 bailiffs arrived to remove Sarwat Al-Assaf's credit cards as a result of yet further debt.

2.1.7 On 20 September 2000 Mrs Al-Assaf endeavoured to tell her husband that she wished to end the marriage and that she wanted a divorce. In a state of distress Sarwat Al-Assaf tried to prevent her leaving the house, telling her that he would kill himself.

2.1.8 On 22 September 2000, having ensured that their daughter, age five would not be at home, Mrs Al-Assaf gave her husband a letter stating that she wished for a divorce. Sarwat Al-Assaf became extremely distraught. Both accounts of that evening are similar. Sarwat Al-Assaf, very upset and in tears, followed his wife around the house. On three occasions he physically prevented her leaving. Eventually, taking a kitchen knife he made superficial cuts to his wrist and although she persuaded him to part with the knife he obtained another one. In the garden he again made cuts to his wrist and began talking of killing himself. Once more she removed the knife, telling us *"I didn't know whether it was intentional that he was trying to harm himself, or whether it was an effect really".* She said he was *"trying to get hold of me, smother me".* Such was Sarwat Al-Assaf's distress that he collapsed and started to hyperventilate. It was out of concern for him that, after her parents arrived, an ambulance was called.

2.2 First Attendance at AED Friday 22 September 2000

2.2.1 Sarwat Al-Assaf was taken by ambulance, with his wife, to the Accident and Emergency Department (AED) of QMC, Nottingham. En route, he remained distressed, confessing to gambling for the first time and speaking of a man whom he believed had been a bad influence on him in the past. He described this man as a bad person inside of him that he was trying to cut out. Mrs Al-Assaf thought this person was probably imaginary.

2.2.2 At QMC AED Sarwat Al-Assaf was seen by a triage nurse and briefly by an AED Senior House Officer (SHO) then, in keeping with the procedure for assessing people presenting with self harm, also by Ms Donna Swinden, clinical nurse specialist from the Department of Psychological Medicine (DPM). Ms Swinden completed comprehensive assessment documentation. She recorded that Sarwat Al-Assaf had *"chased Susan with a carving knife. He did not harm her and instead turned the knife on himself. The cut was superficial but his wife felt very frightened of him and she told me in no uncertain terms that she did not want to take him home with her that evening. She … felt frightened for both her safety and her daughter's…*

… SAA stated that he had been becoming depressed over the last two to three years as his gambling habits spiralled out of control and his debts escalated…he said that the last straw was when his wife had said that she wanted to leave him.

… he also forged his wife's name on the mortgage and they lost their house ... Susan stated that Sarwat frequently told lies ...

… I was not able to get much history from Sarwat himself, but had to rely mainly on Susan…she did feel concerned from time to time Sarwat seemed to have short-term memory loss and would get lost in his own locality. She was worried that there may be some cognitive deficit…

Sarwat did manage to let me know that he has been hearing voices but it was difficult to assess this further due to the communication difficulties and his distressed state…I did not think that his voices were of a psychotic nature but I felt that my assessment was not as thorough or full as I would have liked…my conclusion was that he was of risk to his wife and his daughter due to the evidence that he had chased around the house with a knife and also had tried to confine her to the house. I concluded that he was of some risk to himself".

2.2.3 Ms Swinden noted *"wife and daughter need space away from Sarwat as he had been violent at home".* She concluded that he should be admitted to a psychiatric ward at QMC and she made arrangements for him to be seen there by an on-call psychiatrist, which was in accordance with usual practice at the time. Her written note for the doctor stated: *"He has threatened his wife and she is now frightened of him. Summary – clinical evidence of depression, in response to social crisis. Risk – risk to wife, daughter and himself is highly likely. Plan 1. Admit to acute psychiatric ward, 2. Refer to Emmanuel Chan (CPN for the deaf)".* She recalls that she took that note and a copy of her assessment to Ward A43 herself, leaving it with a nurse there.

2.2.4 She also wrote a letter to Sarwat Al-Assaf's GP summarising: "*This 38 year old man who has communication difficulties due to deafness, has a reactive depression due to his deteriorating social circumstances. He was very distressed, and I felt that he was of some risk to his wife and daughter and also to himself. I therefore arranged for him to be admitted to Ward A43 at the Queen's Medical Centre. I shall refer him to Emmanuel Chan, the Community Psychiatric Nurse, who works with people who are deaf, and I shall also inform social services that Susan and her daughter require some support."* She copied the letter to Mr Chan and to Social Services because of the perceived risk to the child.

2.2.5 After the superficial wound to Sarwat Al-Assaf's left wrist had been bandaged he was accompanied by his wife to the acute psychiatric admission ward, Ward A43, which was, and still is, within the same building at the hospital.

Good Practice
Sarwat Al-Assaf was appropriately seen by a clinical nurse specialist from DPM who carried out a thorough assessment of Sarwat Al-Assaf as part of an established local procedure for the management of patients presenting in AED following self-harm. This was a good procedure and resulted in good practice. The nurse believed she had arranged for admission to a psychiatric ward.

Psychiatric Assessment in AED
Sarwat Al-Assaf was assessed in a general AED setting when he was believed to represent a risk to himself and to his wife who was interpreting for him. The AED at QMC is, we were told, the largest and busiest in the country and that night, according to Ms Swinden, it was 'chaotic', exacerbating in her opinion the level of distress suffered by Sarwat Al-Assaf. We make recommendations for provision of more appropriate facilities for emergency psychiatric assessment.
Recommendation No. 3

2.3 Psychiatric assessment Ward A43

2.3.1 At Ward A43 of QMC Sarwat Al-Assaf and Mrs Al-Assaf were greeted by Staff Nurse Paul Bradley who was the nurse in charge that evening. An experienced Staff Nurse (SN), working on A43 for the first time in around six years, he spoke to the Al-Assafs shortly after they arrived on A43 at around 21.30 hours. In his evidence Mr Bradley recalled that he understood this was a planned admission. There was a bed identified, ready and made up for him.

2.3.2 Sarwat Al-Assaf however, said he did not want to be admitted that night but would return to the ward the following day. Mrs Al Assaf provides a different account. She believed he was content to stay.

2.3.3 Mr Bradley's nursing notes record that Sarwat Al-Assaf, through his wife, stated he was not suicidal and had self-harmed because his wife was leaving him. This is consistent with his comment to the Inquiry *"It was more a cry for help rather than an attempted suicide".* Sarwat Al-Assaf did not want to stay on the ward but nevertheless agreed to stay and talk to the doctor. Dr Rik Coetzee, the SHO on duty, carried out an assessment of Sarwat Al-Assaf having had sight of the summary from Ms Swinden. He could not recall having seen Ms Swinden's more comprehensive assessment although she remembers having taken all her notes to the ward. Dr Coetzee informed us that Sarwat Al-Assaf was not admitted at that point. Indeed, he was there to admit him: *"it is only once he has been seen by the medical staff and clerked in that they consider him to be admitted".* Mrs Al-Assaf again provided the interpretation for her husband. By now it was 10pm.

2.3.4 Dr Coetzee's assessment, as recorded in his medical notes, was at variance with that of nurse Swinden concerning diagnosis and risk. Sarwat Al-Assaf reported bad headaches and sleeping problems. He described feeling angry with himself and thought that his problems would stop after cutting his wrists. He felt he wanted to *"kill the bad"* and *"wanted the bad out of him"* and said he had a man in his head *"who tells him bad things. Started 1997. Tells him to go and gamble which he does. Second person. Talks to this voice and tells him God will think it is bad. Gambles ++. Tonight won't let his wife out of house – picked up knife and harmed himself.*

From wife – patient never threatened her or child with knife only himself.

Last Wednesday – argument – gambled house away – last Saturday wife told him divorce – led to tonight's argument. During Wednesday – lost control, screaming and shouting. Never been violent to anyone".

2.3.5 Dr Coetzee concluded: *"38 year old pt with long history of pathological gambling and marital difficulties. Now presents with impulsive episode of minor self harm following a domestic argument*

- *No evidence of a depressive disorder*
- *No evidence of a psychotic process at present*
- *Confirmed by wife that pt has never been violent*
- *Pt and wife both said that at no stage did Mr Sarwat threaten her*
- *Denies ongoing suicidal ideation."*

2.3.6 Dr Coetzee further recorded *"Patient did not wish to be admitted and based on this assessment is not detainable under the Mental Health Act".* In his evidence to the Inquiry he added *"Mr Al-Assaf was not aware at that stage that he actually had a choice about coming into hospital, that he was not detained as such. Otherwise he would not have agreed to come to the ward because he did not want to be admitted."* Sarwat Al-Assaf, referring to his wife's interpretation of events, told us *"..when they said I had to stay, she wouldn't explain why and she said 'You've got to stay'……then they asked me if I wanted to stay and I said 'Well, nobody's explained properly. Can I go?' and they said 'Yes' so I went'.*

2.3.7 Mrs Al-Assaf accepts that she became angry when she was told of the assessment and decision not to detain. Dr Coetzee's notes comment: *"They clearly had unresolved marital issues, and these seemed to be the main problem here 'You are being unfair to me, I married this man and had to put up with his problems all these years and now you are telling me he can go to my house!' His wife stormed off and Mr Sarwat followed. They were allowed to leave the ward".* In his evidence to the Inquiry Dr Coetzee said he thought Mrs Al-Assaf had been led to believe that her husband would be kept in hospital overnight and that he would be detained against his will, saying *"you can't really blame her for….being disappointed and angry".*

2.3.8 In her evidence to the Inquiry Mrs Al-Assaf said she had a *"row"* with Dr Coetzee, and walked out, followed by her husband. She also told us that Dr Coetzee's interview was the third that evening, she had *"signed"* in all of them, and that it involved difficult enquiries such as *'Do you want to harm your wife and child?'* She felt *"it was as though I wasn't there in terms of being someone that he needed to speak to … I only walked out because I felt that I wasn't being listened to*". Being prevented from leaving her house, she told us, was "*not seen as a problem"* by Dr Coetzee and yet she had felt *"under threat"*, *"like a hostage"*, and *"in danger of being harmed or held hostage".* In her oral evidence she described experiencing Dr Coetzee as *"flippant….. rude and unsympathetic…. arrogant, dismissive and insensitive…..".*

2.3.9 Mr Bradley's recall differed: he believed that, by agreement, Sarwat Al-Assaf was leaving with his wife, and would return the next day. His memory is of Mrs Al-Assaf having not been angry and distressed, but supportive and perplexed in relation to her husband's decision to go.

2.3.10 Nursing notes record that Mr Bradley was asked by Dr Coetzee to search for Sarwat Al-Assaf and persuade him to return, but since he was the only trained nurse on duty on A43 he could do no more than look out into the corridor without leaving the ward, and by this time Sarwat Al-Assaf had gone.

2.3.11 Dr Coetzee told the Inquiry panel that he then thought it prudent to seek the advice of Dr Kehinde Junaid, Specialist Registrar (SpR) on call, with whom he spoke on the telephone.

2.3.12 There is no detailed record of that conversation and although Dr Coetzee is certain that he told Dr Junaid about the discrepancy between his findings and the information he received from Ms Swinden, Dr Junaid does not recall that Dr Coetzee mentioned this nor, she told us, had she been made aware that the interview had ended abruptly because Mrs Al Assaf had become angry. She said that she suspected Dr Coetzee had called her because *"he may have had some doubts about whether he should have been allowed to leave."* She told us that Dr Coetzee had asked her *"what he needed to do"*, about contacting the police, for example.

2.3.13 Dr Coetzee recorded in the medical notes *"D/W Dr Junaid (SpR on call) → agrees with management → Does not feel any more assertive action i.e. calling police to locate Mr Sarwat is justified → Ask CMHT to provide some follow-up next week".*

2.3.14 Drs Junaid and Coetzee told the panel that there was no formal guidance about when SHOs should contact Specialist Registrars on call, and that such contact was not a common occurrence (Dr Junaid had been working as a Specialist Registrar for less than one month).

2.3.15 Dr Junaid has not been able to trace her records of the relevant events, but believes she made written notes at the time.

2.3.16 In the early hours of Saturday 23 September Mrs Al Assaf's father telephoned Ward A43 and spoke to Mr Bradley. He sounded *"worried",* according to Mr Bradley, and was advised to contact the police if he felt this was necessary. Mr Bradley said he relayed this information to Dr Coetzee when he saw him on the ward later that night.

2.3.17 In the morning the medical notes could not be found as they were with Dr Coetzee for writing up. After contacting the Department of Psychological Medicine (DPM), such was the continuing concern that a Community Psychiatric Nurse (CPN) visited Sarwat Al-Assaf's home but there was no reply.

2.3.18 In a letter to Dr Johnson (Consultant Psychiatrist, Nottingham Healthcare NHS Trust), written that morning, Dr Coetzee noted that Sarwat Al-Assaf had been *'very briefly'* admitted.

Family members as interpreters
The use of a family member for the purpose of interpretation may, though not intentionally, lead to inaccurate, biased or incomplete reporting, particularly where it concerns sensitive issues or experience of, beliefs about, and reactions to, risk. The Mental Health Act Code of Practice advises against it. Yet Mrs Al-Assaf interpreted for her husband on five occasions that night. She described to us her feeling that she was not listened to in her own right, commenting that she had even been asked to interpret for her husband when it involved clinical questions about possible risk to herself from him. She told us she was 'worn out'. Both Ms Swinden and Dr Coetzee were able to say to us that with hindsight this was not an ideal situation. Even when they volunteer, the limitations and difficulties of relatives or partners acting as interpreters needs to be explicitly recognised, particularly when they may be potential targets for violence.
Recommendation No. 2

Out-of-hours interpretation services
Staff in AED, the Clinical Nurse Specialist from DPM, the ward staff on A43 and the duty SHO all believed that it was not possible to obtain a sign language interpreter out of hours. This was incorrect. There was a contract for the provision of emergency signers for the Deaf with the Nottinghamshire Deaf Society. That service was available until 11pm on Friday evenings and could have been accessed by any of the professionals. This was, and still is, a little known service which should be publicised more widely throughout the QMC.
Recommendation No. 2

Trust policies
Trust clinical risk assessment policy should emphasise the importance of listening to relatives, who should be free of the task of interpreting in order to feel heard, especially in situations that are emotionally charged. Trust guidance to staff on the use of interpretation services should point out that an independent interpreter is needed not just for clinical assessment but in order to provide basic information about the process of admission and assessment.
Recommendations No. 2 and 5

Differing perceptions

In any complex situation, different people will have different perceptions and come to varying conclusions. This trend is particularly apparent when an incident is reviewed after a long gap, but that evening there were a number of differences, including whether or not Sarwat Al-Assaf had actually been admitted to hospital, the manner of his arrival on Ward A43 and the circumstances of his departure. It remains unclear why Dr Coetzee decided to call Dr Junaid when he expressed no doubts to the Inquiry concerning his assessment. Differences between Ms Swinden and Dr Coetzee over diagnosis and assessment of risk were particularly striking. Each heard different information and based their assessments on different understandings of risk. Mrs Al-Assaf told the Inquiry she felt she was "being listened to" in AED, but not on A43. We do not consider that there is any need to choose between the various accounts of events that night, simply to observe that under emotional circumstances the potential for misunderstanding is high and likely to be exacerbated by interpretation difficulties.

Unusual features of the psychiatric assessment

There were a number of unusual features associated with the assessment of Sarwat Al-Assaf that night. He was a profoundly Deaf Egyptian man who reported recent symptoms, referred to as 'voices' and a 'bad man' in his head, as well as possible cognitive difficulties. The subject of mental illness in Deaf people is a specialist area. Sarwat Al-Assaf was not previously known to psychiatric services. Two very different assessments had emerged that evening in terms of risk and diagnosis. The existence or not of mental disorder was itself in dispute. The person interpreting for him was his wife. She had announced earlier in the day that she was intending to divorce him, they were in crisis and according to one assessment she was at risk of harm from him. Dr Coetzee had completed two years of basic training and was not widely experienced in psychiatry. He had not before assessed anyone who is profoundly Deaf. He produced a detailed assessment, and to his credit made a diagnosis under difficult circumstances that was supported by subsequent psychiatric opinion. Whilst his decision not to detain under the Act cannot be considered incorrect, this unusual constellation of features would, in our view, have made it reasonable for Dr Coetzee to seek the advice of a senior colleague before completing his assessment.

Seeking advice
Trust Specialist Registrar arrangements should encourage SHOs to seek advice where the circumstances of an assessment are unusual. An emergency advice service for those dealing with Deaf people with mental health problems would also have provided Dr Coetzee with a source of specialist advice, and we make recommendations for such a service.
Recommendations No. 1, 4 and 10

Had Sarwat Al-Assaf been admitted to ward A43?
If Sarwat Al-Assaf had been voluntarily admitted to the ward, s5 Mental Health Act (MHA) may have been an option to prevent him leaving. But no-one was clear about whether an admission had legally taken place. Views differed quite substantially. Ms Swinden believed she had arranged admission, as SN Mr Bradley, who had a bed made ready on the ward, although he gave evidence that Mr Al-Assaf was not 'clerked in' or formally admitted. Dr Coetzee was sure that admission to the ward never took place, although the following morning he wrote a letter saying that it had. Dr Junaid, the Specialist Registrar (SpR), thought admission had taken place. Dr Johnson thought that admission did not take place until the assessment was completed. There was no conclusive position on the subject, even by the time of the Inquiry. The Trust Medical Director considered that an admission took place the moment a patient walked through the door of the ward.

Urgent need for clarification
This was, and is, very unsatisfactory. The position needs urgent legal clarification. Absence of a procedure also meant that both Mr and Mrs Al-Assaf were unclear when they arrived at the Ward A43 whether Sarwat Al-Assaf was being admitted or not. Patients and relatives referred from AED should be told clearly what to expect once they arrive on a psychiatric ward.
Recommendation No. 1

Ward A43 Staffing Levels

SN Mr Bradley informed the Inquiry that he was unable to respond to Dr Coetzee's request that he leave the ward to look for Sarwat Al-Assaf because he was the only qualified nurse on duty that night. Indeed, there were just two staff on duty; Mr Bradley was assisted by one untrained nursing assistant from a nursing agency, who had not before worked with mental health patients. In order to manage the medication Mr Bradley called in a nurse from Ward A42 at 11pm, 12am and 1am. This was an unsatisfactory state of affairs and we recommend that staffing levels be reviewed in conjunction with procedures for managing patients who leave the ward against advice, whether that be in the context of absence without leave or in connection with an informal patient.

Recommendation No. 12

Poor sharing of information

Concerns about risk, or lack of it, were not clearly shared between different professionals, from AED through to the Ward

- *Although Ms Swinden remembers taking her assessment to the ward Dr Coetzee recalls having seen only Ms Swinden's summary note.*
- *Ms Swinden and Dr Coetzee did not speak to each other since Ms Swinden's shift finished at 10pm and Dr Coetzee's began at the same time. It was not operational policy to hand over to the on-call doctor and no overlapping time was allowed for this.*
- *It remains unclear whether the information from Ms Swinden was discussed when Dr Coetzee sought advice from Dr Junaid.*
- *In the morning there was confusion about where the notes were, and no information from anywhere to indicate whether further action was necessary.*
- *In the event, a duty CPN was dispatched to follow the case up, with very little clear information to hand.*

Records from AED, DPM, ward nursing, and medical notes should be easily accessible to different professionals. There should be a review of the flow of information between AED and the psychiatric wards, especially as it concerns risk.

Recommendations No. 5 and 7

2.4 Further Psychiatric Assessment Sought by GP

2.4.1 On the following Monday, 25 September 2000, Sarwat Al-Assaf was seen by his GP, Dr Jacklin, who was concerned enough to telephone QMC where she spoke to the SHO to Dr Johnson, Consultant Psychiatrist. Sarwat Al-Assaf had again referred to a *"voice in his head"* and, although Dr Jacklin did not consider that wife and daughter were at *"acute risk",* she had difficulty making an assessment. It was acknowledged that Sarwat Al-Assaf would need a sign language interpreter. That afternoon the SHO discussed the matter with Dr Johnson who by that time had also received a letter from Dr Coetzee requesting follow up. This was Dr Johnson's first involvement with the case of Sarwat Al-Assaf. She telephoned immediately to the GP and it was agreed that an urgent referral would be made to Mr Chan, the specialist CPN for the Deaf.

Appropriate Referral
The decision by Dr Jacklin to refer to the consultant psychiatrist and the decision by Dr Johnson to refer to Mr Chan were appropriate actions taken to ensure the best and speediest response to Sarwat Al-Assaf's needs.

2.5 First Assessment by the CPN for Deaf People

2.5.1 Mr Chan received his initial information about Sarwat Al-Assaf from several sources. A telephone referral had been made by the ward manager of Ward A43, Dane Brennan, there was a letter from Dr Jacklin and a telephone message from Dr Johnson. He had also received a copy of the letter from Ms Swinden to the GP. Responding promptly, Mr Chan wrote to Sarwat Al-Assaf arranging an appointment. He telephoned Nottingham CDT and Dr Jacklin. In conversation with Dr Jacklin he was told that Mrs Al-Assaf had not said that her husband had chased her with a knife, nor had he ever hit her.

2.5.2 On 29 September 2000 Mr Chan saw Sarwat Al-Assaf for the first time. He concluded that Sarwat Al-Assaf was not an immediate risk to himself or others although he showed some physical symptoms of depression that required further assessment. Sarwat Al-Assaf agreed that Mr Chan could discuss matters with the CDT although he did not want their input.

2.5.3 Later the same day Mr Chan made a visit to CDT Team Manager, Jean Goodman, at her office, in order to alert her because there was a child involved. During their meeting Ms Goodman tried to contact the school and Health Visitor. Mr Chan spoke to the GP, Dr Jacklin, who reported that she had seen the daughter, had no immediate concern over her health, and did not believe she was at risk. Ms Goodman agreed to ask a social worker to visit Mrs Al-Assaf and her daughter the following week.

Prompt first response
The action taken by Mr Chan was prompt and comprehensive. He made immediate contact with Sarwat Al-Assaf and with all other necessary people. This was good practice.

2.6 First Assessment by the County Deaf Team

2.6.1 On 3 October 2000 Social Worker Linda Pask visited Mrs Al-Assaf. In the course of a lengthy discussion Mrs Al-Assaf described the history of the marital difficulties. The daughter was not considered currently to be at direct risk, but it was thought likely that if Sarwat Al-Assaf made more attempts to self-harm it could result in the child witnessing distressing events. Ms Pask concluded that support and intervention would be needed to prevent deterioration in the situation. She spoke to Mr Chan by telephone on 4 October 2000 and a 'couple meeting' approach was agreed. No social worker had been formally allocated at this time and Ms Pask had no further involvement with the case.

2.7 Further community support

2.7.1 Mr Chan visited Sarwat Al-Assaf at home again on 4 October 2000. Sarwat Al-Assaf said that he was still in love with his wife and wanted to keep the family together. He appeared pleasant and cheerful, denied any inappropriate experiences, reported that he did not suffer from headaches, was sleeping well and his appetite was fair. He blamed an ex-colleague for his gambling habit and debt, saying that he was so angry with this man that he wanted to kill him, though he did not reveal any plan to do so and did not know where he was. Mr Chan recorded that there were no signs of formal depressive illness but evidence of adjustment difficulty towards his marital conflict. It was agreed that Mr Chan would visit again on Monday 17 October and that the meeting between Sarwat, Mrs Al-Assaf, Mr Chan and a social worker would be arranged.

2.7.2 Mr Chan telephoned Dr Johnson on 6 October 2000. It was agreed that Sarwat Al-Assaf was not clinically depressed and there was no immediate need for psychiatric review. Dr Johnson agreed with the suggested plan for follow up and also agreed to discuss with the community team the provision of crisis cover for Mr Chan's period of absence from work due to annual leave and study leave commitments between 18 and 30 October.

2.7.3 Later, on 6 October 2000, Mr Chan met with Mrs Al-Assaf at her parents' home. Her husband, she explained, had changed since the recent incident of self-harm. He had become extraordinarily pleasant and cheerful, very clingy and attached, following her everywhere, to

work and even to the bath. She felt drained and tired, saying she would leave him soon because she could not cope with this behaviour.

2.7.4 Mr Chan talked over the history with Mrs Al-Assaf. She reported that Sarwat Al-Assaf had suffered from headaches for a long time and been seen by a neurologist a few years ago. He had also suffered from short-term memory loss and forgotten her name, things to do, and got lost on the road. She said he complained of hearing a male voice telling him to do bad things and that he had talked about these voices four or five times a year for the last five or six years. For the last few years he had also become disinhibited and ignored his self-appearance, sometimes not shaving or dressing properly.

2.7.5 Mrs Al-Assaf agreed that 'couple meetings' with her husband would be a good idea. Mr Chan planned to gather further information about Sarwat Al-Assaf's neurological investigations and monitor his cognitive state.

2.8 Second attendance at AED Sunday 8 October 2000

2.8.1 On Saturday 7 October 2000 Mrs Al-Assaf separated from her husband, leaving the matrimonial home and taking the couple's daughter with her. The following day, Sunday 8 October 2000, she returned to the house to collect her clothes, accompanied by the later victim Mr Clark, her sister and boyfriend. Sarwat Al-Assaf became distressed and in evidence described his frustration at being unable to sign because his arms were held; *"not being able to tell them to stop, it just made me powerless".*

2.8.2 Mrs Al-Assaf felt very concerned about Sarwat Al-Assaf, who was agitated and said to have slashed her car tyres and attempted to burn her car a few days before. Sarwat Al-Assaf reports that he later went to his parents-in-law's house with a handwritten note stating *"I will go home by myself and set fire to my body"*. Mrs Al-Assaf's sister called at Sarwat Al-Assaf's address where he told her he had poured petrol on himself. She telephoned Nottingham Social Services Emergency Duty Team reporting that Mrs Al-Assaf had fled, fearful of her husband's violence, and reporting that he had threatened her with a knife. Sarwat Al-Assaf was described as *"rigid with hysteria".* She was advised to contact his GP for a psychiatric assessment. However Sarwat Al-Assaf also threatened to set fire to himself and the house, pouring liquid over himself from a petrol can. Police attended and, although the liquid was found to be a mixture of water and petrol, Sarwat Al-Assaf was taken by the police, with his agreement, to the AED of QMC.

2.9 Psychiatric assessment at AED

2.9.1 Upon his arrival it was initially thought by staff that Sarwat Al-Assaf had been brought there by police under the compulsory powers of s135 MHA. Sarwat Al-Assaf was seen by duty psychiatric SHO, Dr A. Omer, who had access to the brief note from existing AED records written by Ms Swinden. The SHO made efforts to locate the medical notes but they were not where they were usually kept, in the medical records department. His assessment was therefore carried out without reference to Dr Coetzee's previous assessment.

2.9.2 With no-one to interpret for Sarwat Al-Assaf Dr Omer told the Inquiry that the interview was difficult *"I resorted to writing questions down and he responding in writing".* He added *"his grasp of English is not that brilliant and it took him time to understand what I wrote".* The one advantage for the Inquiry is that this record of communication remains available on the medical notes. It is clear that Dr Omer, who is Sudanese, made his initial overtures in written Arabic but Sarwat Al-Assaf preferred to write in English and that is how it then proceeded.

Availability of medical notes at AED
Notes seemed to exist separately at AED, the DPM, the medical records department and with those providing psychiatric care in the community. Dr Omer should have been able to access the previous mental health care records for Sarwat Al-Assaf. This would have provided him with more complete background information prior to making his own assessment.
Recommendation No. 7

Availability of sign language interpreter
The out of hours interpretation service operated only until 4pm on Sundays, making it unavailable on Sunday evening when Dr Omer saw Sarwat Al-Assaf. We recommend that the out-of-hours interpretation service be extended to 24 hour coverage.
Recommendation No. 2

Confusion over S135
Staff at AED were under the mistaken impression that Sarwat Al-Assaf had been detained by the Police under s135 MHA. That impression remained and was repeated in the Trust's internal review. It is unclear how this confusion arose.
Recommendation No. 6

2.9.3 Dr Omer was unable to contact Mrs Al-Assaf but did speak to her sister, who described Sarwat Al-Assaf as *"behaving very bizarrely recently i.e. 1. He was following Susan, his wife, everywhere even to the toilet; recently he locked her in at home. She told me that he is becoming very obsessional. Susan is very frightened of him. She ran away and she is staying with a friend at the present time. She doesn't want Sarwat to know where she is. 2. Sister-in-law thinks that he might harm her sister as he is very obsessed".*

2.9.4 On mental state examination Dr Omer did not detect any psychotic phenomena and found no evidence of psychomotor retardation or agitation. Sarwat Al-Assaf described his mood as *"hurt"* and objectively appeared worried and preoccupied. He was reported as having no insight.

2.9.5 In his evidence to the Inquiry Dr Omer spoke of one particular answer from Sarwat Al-Assaf that caused him to feel *"quite alarmed".* Dr Omer had asked *"Do you feel like killing yourself now?"* and Sarwat Al-Assaf had written in reply *"NO NOT ONLY FEEL HURT VERY BECAUSE MY WIFE TALK ME. I DO NOT WANT KILL ME MY FAMILY MY FAMILY ARABIC MILSIM. SOME TIME HURT."* Dr Omer told us that this *"rang alarm bells"* and made him think about risk to Mrs Al-Assaf. The reference to 'Arabic Muslim' was, he thought, "*significant"*. Dr Omer added *"I did have a conviction at that time that …..his wife was having a relationship with another man and probably that's why he was very, very hurt and upset. Because it is quite difficult for a man from an Egyptian background to accept that his wife is having an extramarital affair. It has a lot of repercussions on him. I did feel that his wife was at risk".* This suspicion arose out of Sarwat Al-Assaf's behaviour, including *"the continuous feeling of hurt which he expressed and the seriousness of what he has done, in terms of pouring petrol over himself, which I know… in the Egyptian culture [is] a very common suicidal attempt, and the fact that he was pursuing his wife everywhere. I felt there was some sort of morbid jealousy……his behaviour changed recently which made me think there was a genuine reason for him to behave in such an obsessional way".*

2.9.6 The implications of this, if true, concerned Dr Omer. He told us *"in Egyptian culture, the worst thing that could happen to a man, that his wife is having an affair with another man and the degree of distress caused by that would be extremely high and it does sometimes result in murdering one of the parties involved".*

2.9.7 At the time Dr Omer did not ask Sarwat Al-Assaf whether he knew or suspected there was an extra marital relationship because he did not wish to increase his distress or jeopardise the likelihood that he would agree to admission to hospital. Nor did he later pass this particular

detail of his concern on to the nurse in charge of Ward A44, SN De Soysa, recording more generally in the medical notes *"knowing the culture where Mr Al-Assaf comes from I do think that his wife is at risk. Since I was not able to speak to his wife directly, I felt that the situation is risky, so for the time being: 1. High observations due to a degree of risk to his wife 2. Level of obs. Should be reviewed after talking to his wife".* Being aware that his suspicions were sensitive and *"not based on reality"* he felt the situation needed to be clarified with Sarwat Al-Assaf's wife. Despite trying he was unable to reach her by telephone.

2.9.8 Although Dr Omer told the Inquiry that he found no evidence of depression or psychosis at the time, the history of depression evident from the AED notes and the information from Mrs Al-Assaf's sister led him to conclude that Sarwat Al-Assaf needed a period of in-patient assessment. The plan was *"Admission for crisis intervention"* and he was said to be *"detainable if he tries to leave".*

Good assessment of risk

Dr Omer took account of information from Susan Al-Assaf's sister and obtained a history when determining risk. He tried to telephone Mrs Al-Assaf and, failing to find her, his plan made clear the importance of confirming risk to Mrs Al-Assaf through speaking to her later. In the absence of an interpreter Dr Omer sought sensitively to communicate in Arabic with Sarwat Al-Assaf. In AED he looked for the previous notes, he organised admission, he recorded his assessment fully in the medical notes, he spoke to SN De Soysa and that information was later recorded in nursing notes. Under the difficult circumstances we think that this was an example of good practice.

The difficult management of the 'hunch'

Should Dr Omer have gone further and told other professionals about his suspicion that Mrs Al-Assaf was in an extra-marital relationship, along with his belief that, if he were correct, she or her new partner could be at risk of serious harm? He aimed to speak to Mrs Al-Assaf himself but he was unable to contact her. He was, of course, right about the new relationship. But his suspicions were at the time just that, and no more. Much more detailed background information was needed. We consider this point further at Chapter 5.

Communication with Sarwat Al-Assaf
Sarwat Al-Assaf's written communication was not easy to understand but not untypical of those who are profoundly Deaf and who usually communicate using sign language. Written English may be poor or in sign language word order and, therefore, will often appear incoherent or incomprehensible (See further at page 51 of this report) Sarwat Al-Assaf produced fluent typed information for the Inquiry.

2.10 Admission to Ward A44

2.10.1 Upon admission to Ward A44 during the late evening of 8 October 2000, the nurse in charge, SN De Soysa, having spoken to Dr Omer, completed comprehensive nursing assessment documentation. His nursing notes exactly mirrored the medical notes. SN De Soysa wrote *"knowing the culture where Sarwat comes from Duty doctor thinks that Sarwat's wife is at risk. Therefore for the time being to nurse Sarwat on high observations…level of observation to be reviewed after talking to his wife….detainable if Sarwat tries to leave the ward".* SN De Soysa told the Inquiry he had understood the risk to Mrs Al-Assaf arose out of the fact of her leaving her husband. His completion of a HoNOS[3] assessment registered Sarwat Al-Assaf's risk to others as being '4', the highest available score. He added *"high risk of harming his wife".*

2.11 Ward Round Monday 9 October 2000

2.11.1 Sarwat Al-Assaf fell asleep and the following morning at 9.30am was reviewed at a ward round chaired by Consultant Psychiatrist, Dr Johnson. Mr Chan attended and provided sign language communication support to Sarwat Al-Assaf. SHO Dr Artus and nursing staff were also present. Dr Johnson was able to review the medical records which contained the previous assessments by Ms Swinden and Dr Coetzee. She told the panel that she knew Sarwat Al-Assaf had reported hearing voices and was aware of Ms Swinden's concerns around risk to Mrs Al-Assaf.

2.11.2 Mr Chan had seen Sarwat Al-Assaf before the ward meeting. Describing the events of the weekend, Sarwat said he had not known what was happening, had experienced pains in both limbs and been too weak to attend the toilet. Since admission to Ward A44 he had been more settled. At the ward round Sarwat Al-Assaf insisted that he go home, saying he felt better and no longer wanted to hurt himself. He accepted

[3] Health of the Nation Outcome Scale, introduced in mental health services in 1996 is a brief, standardised assessment tool used for the purpose of measuring changes in health and social functioning (outcomes).

that his wife was leaving him and that the house belonged to her, saying he would move out. He planned initially to contact two friends, both deaf, with whom he believed he could stay.

2.11.3 Dr Johnson told the Inquiry that she had spoken that morning to Dr Omer who told her he thought Sarwat Al-Assaf *"was not mentally ill but he had had a very difficult interview and he had found it hard to get information. He said he was alarmed by what Mrs Al-Assaf's sister was saying to him, yet he could not get hold of Mrs Al-Assaf herself. He said he knew that culture, with his own experience of coming from a neighbouring country, and he said particularly in view of that, with a woman petitioning for divorce in that culture, he felt there was a potential for risk there. But he could not actually assess it or make a judgement on it without being able to speak to her…… he felt dissatisfied with the information he could get and he wanted the patient's own team to actually review it and pool it together. He felt that with what he had, he did not want to take a risk of letting him go. So he had admitted him."*

2.11.4 In her evidence to the Inquiry Dr Johnson described the weight she gave to the suggestion of a cultural component to risk *"It stood alone actually and there were lots of other things pointing in other directions. On its own it wasn't high enough to justify doing anything else but it obviously put him at a higher risk".* Dr Johnson explained that she had seen Dr Coetzee's assessment letter and spoken to the GP, who had seen Mrs Al-Assaf twice since Dr Coetzee. Mr Chan had also spoken to her three days previously. All of these contacts indicated that Mrs Al-Assaf did not feel at risk nor that her child was at risk. The cultural factor was *"one factor in a risk assessment but it did not actually lead me to conclude there was a high risk to his wife".*

2.11.5 On mental state examination Dr Johnson found Sarwat Al-Assaf to be *"calm and appropriate. He appeared relaxed, his mood was euthymic, and his affect was reactive. He had slept and eaten well in hospital. He was well presented and showing no signs of self-neglect. He reported no unusual experiences".* Adding to this in her evidence, it was Dr Johnson's view that the minor injuries he inflicted on himself had been insignificant and a rouse to stop his wife leaving, rather than a manifestation of any mental disorder. That view was, she understood, shared by others in the team. He denied any thoughts of harming himself and spoke fondly and calmly about his wife and child, accepting that he needed to move out.

2.11.6 For these reasons Dr Johnson did not feel Sarwat Al-Assaf was suffering from mental illness or mental disorder and considered that there were no grounds for detention under the Mental Health Act (MHA). Sarwat

Al-Assaf was offered informal admission for support in crisis but refused this and was therefore allowed to leave the ward.

2.11.7 Mr Al-Assaf did agree to be supported by Social Services and the CDT. It was decided that Mr Chan would contact the CDT who would provide advice with accommodation and in connection with gaining access to Sarwat Al-Assaf's daughter. Mr Chan's notes recorded the following plan:

1. *To refer Sarwat to the County Deaf Team.*
2. *To see Sarwat on Friday 13 October at home.*
3. *Sarwat to seek help as required and continue with the thioridazine (a major tranquillizer) 25mg at night and up to three times per day, if required.*

2.11.8 The outcome of the ward round was recorded in the medical notes by the SHO to Dr Johnson. Patient discharge documentation recorded that Care Programme Approach (CPA) aftercare was at Level 1, the standard level. Reference was also made on the form to Sarwat Al-Assaf's arrest shortly after discharge, but no further information on this could be found by the Inquiry. The discharge letter recorded that there was no risk to himself or his wife.

No written risk assessment on discharge

There was no requirement in the Trust for completion of any written risk assessment document upon discharge. The CPA document contained a risk assessment section but that form was not completed until 17 October 2000, eight days later. The SHO's note of the Ward Round recorded no assessment of risk. This was an unusual situation involving a profoundly Deaf man who refused informal admission, a suggestion of a cultural dimension to risk and a possible risk to his wife. Risk should have been formally assessed and recorded. Health Circular HSG(94)27 requires that a risk assessment always take place upon discharge. The Trust should ensure that responsibility for recording a risk assessment is clear to all professionals.

Recommendation No. 5

Diagnosis and use of the MHA

Sarwat Al-Assaf was considered at the time to be suffering an acute stress reaction. Dr Johnson's assessment that there was no formal mental illness was later supported by expert evidence following the homicide. Diagnosis and use of s2 MHA is discussed further at Chapter 3.

2.12 Discharge from hospital

2.12.1 On 9 October 2000, the day of Sarwat Al-Assaf's discharge from hospital, Mr Chan wrote to him by fax arranging an appointment on 13 October 2000. He also telephoned Mrs Al-Assaf, who believed it would be problematic for Sarwat Al-Assaf to stay with his friends. In telephone discussion with Janet Douglas at the CDT it was agreed that Sarwat Al-Assaf needed housing and legal advice as soon as possible. An appointment was made for him to be seen by a duty social worker at the CDT office on 11 October 2000. Mr Chan also sent a full letter to the GP, Dr Jacklin, detailing the family and social history and explaining the plan for Sarwat Al-Assaf's future support.

2.13 Continued community support

2.13.1 Mr Chan visited Sarwat Al-Assaf at home on 13 October 2000, noting that he appeared *"calm and stable. Pleasant and cheerful"* although he became anxious and preoccupied when the subject of divorce was brought up. He had lost two stones in weight over four weeks. Discussion was about housing, money and contact with his daughter. Mr Chan's notes record *"Not clinically depressed. No evidence to indicate he is at immediate risk to himself or others. However he clearly has problems to cope independently with his present situation and make appropriate adjustment to it".* The plan was to make contact with Welfare Rights Service, the Hope Centre and CDT and for further discussion with Dr Johnson.

2.13.2 By 16 October 2000 when Mr Chan next saw Sarwat Al-Assaf, Mrs Al-Assaf and their daughter had returned to the family home and Sarwat Al-Assaf had agreed, reluctantly, to leave. He had slept at a hotel for two nights and spent one night in his car. He said he would continue to sleep in his car.

2.13.3 Mrs Al-Assaf recalled that during this time he slept in the driveway to the house and also called repeatedly at her workplace, so that she discussed with her solicitor the possibility of seeking a court injunction. She expressed to us her concern for her husband: *"I felt he'd got problems….I didn't think he was capable of finding a house for himself and living there….I was concerned for Sarwat and I had tried…. for a period of time I had paid for him to be in a hotel in Beeston because nothing was being done but my funds weren't able to carry on with that….I'd hoped that he would have a normal existence by himself so I'd hoped that he would get some further support from Social Services and a proper assessment would be done in terms of his needs…, and that if he wasn't going to get support to live… on his own, that his family would take him back to Egypt with them".*

2.13.4 She added that she had been told: *"Support had been offered to him and he didn't want to go into a hostel so therefore it was down to him if he wanted to continue sleeping in his car".*

2.13.5 Mr Chan was to be on leave between 18 October 2000 and 30 October 2000, during which time it was agreed with Dr Johnson that Sarwat Al-Assaf would receive support from Broxtowe Community Mental Health Team. They would access an interpreting service when required.

2.14 Care planning

2.14.1 On 16 October 2000 Mr Chan completed CPA documentation for the planning of Sarwat Al-Assaf's care. There were two possible levels of care: Standard and Enhanced CPA. More detail on the operation of CPA is given in Chapter 4.

2.14.2 Present at a meeting to agree the care plan were Mr Chan and Sarwat Al-Assaf. The typed care plan indicated that the CDT and Dr Johnson were consulted separately. Mrs Al-Assaf was not included in the aftercare planning. The couple were, by this time, living separately. CPA documentation was sent out to the professionals and agencies involved on 17 October.

2.14.3 Although the handwritten CPA documentation was printed *"Level II"* it was described to us as Level 1 or standard level CPA. The typed copy gave no indication whether CPA was Level I or II, or Standard or Enhanced. The primary diagnostic issues were given as *"Adjustment difficulties related to the separation from his wife. Lack of coping skills. Recent incidents of self harm".* The keyworker was to be Mr Chan. A risk assessment was included and a box was ticked indicating that there had been a history of significant risk behaviour. This was described as *"dependency and lack of coping skills toward others. Self harm by cutting his wrists on 22.9.00. Threat to hurt himself by pouring petrol on his body on 8.10.00".* Current risk factors were given as *"Social isolation. Eviction from his home and currently nowhere to live. Inability to cope with the divorce proceedings and distressed by not seeing his daughter as often as he wants".* Risk of significant violence/harm to others was given as *"0"* on a scale of 0 to 4 where 0 = no apparent risk and 4 = serious and imminent risk. Risk of significant deliberate self-harm was scored as *"1"*.

2.14.4 The action to be taken in relation to Sarwat Al-Assaf's mental health was listed as

> *"(i) to provide support and reassurance*
> *(ii) to advise him re local sources of help*
> *(iii) to minimise his level of anxiety via appropriate relaxation techniques*
> *(iv) to review by Dr Johnson when necessary."*

2.14.5 Action in relation to his psycho-social condition was given as

> *"Through contact with keyworker and social services; E. Chan*
> *(i) to identify acceptable housing/accommodation; J Dicks*
> *(ii) to ensure his full sick benefit entitlement; Citizen's Advice Bureau Welfare Rights*
> *(iii) to establish some adequate informal support; Notts Deaf Society."*

2.14.6 There was to be two-weekly contact with the care co-ordinator, and it was also acknowledged that Sarwat Al-Assaf needed legal advice. Review was to be on 30 November 2000. The CPA document was typed up and signed on 31 October 2000, with copies sent to Jo Dicks, social worker at the CDT, Dr Johnson and Dr Jacklin, GP.

Timing of the CPA Care Plan

Sarwat Al-Assaf was discharged from hospital on 9 October and the CPA Care Plan agreed and completed with Sarwat Al-Assaf on 16 October 2000. Unsigned copies were sent out immediately and typed versions on 31 October 2000 upon Mr Chan's return from leave. There was no Trust requirement that the CPA Plan be completed in the ward round. In the circumstances of Sarwat Al-Assaf's brief admission, and with a need to gather further information for effective planning, we think that the care plan was produced at the earliest opportunity.

Level of CPA

The level of CPA to which Sarwat Al-Assaf had been allocated was not clear from the documentation although there was professional agreement that it was at Standard Level. His Deafness, emotional crisis and need for assistance with housing, benefits and legal advice suggest that Sarwat Al-Assaf's care was complex and we think it would have been equally appropriate for this to have been co-ordinated at Enhanced Level. In practice, the level of CPA was unlikely to have made any difference to the service Sarwat Al-Assaf actually received.

2.15 Hospital discharge summaries

2.15.1 Two hospital discharge summaries were completed by SHO Dr Artus during October. On 10 October 2000 a discharge summary was sent in connection with what was described as the 'admission' on 22 September 2000. The discharge summary for the admission 8 October to 9 October 2000 was sent to the GP on 31 October 2000.

Continued confusion over 'admission' to hospital
Although Dr Coetzee had thought there had not been an admission to Ward A43 on 22 September 2000 the completion of a discharge summary suggests otherwise.

2.16 The three weeks prior to the homicide

2.16.1 On 20 October 2000 Mrs Al-Assaf found that someone had broken into her house and that the driving licence belonging to the later victim of the homicide, Mr Clark, had been stolen. Believing that Sarwat Al-Assaf might be responsible, Mrs Al-Assaf and Mr Clark sought out Sarwat Al-Assaf, who confessed that he had placed the driving licence in their dustbin, where it was subsequently found. Police later discovered a photocopy of this driving licence, with details of Mr Clark's current address, in Sarwat Al-Assaf's car.

2.16.2 During October, Sarwat Al-Assaf's brother, Samir Al-Assaf, arrived from Egypt and attended the next appointment with Mr Chan on 30 October 2000. By this time Sarwat Al-Assaf had spent a few days staying with friends but then moved into a hotel. During his stay Samir Al-Assaf helped his brother by twice bringing him together with his wife to discuss matters, by accompanying him to a see a solicitor and helping to make arrangements for him to have contact with his daughter. He spoke twice on the telephone with Mr Chan. He also settled part of Sarwat Al-Assaf's debts before he left the country.

2.16.3 On his return from leave, Mr Chan contacted Sarwat Al-Assaf by telephone on 2 November 2000 and made arrangements to see him the following day. Sarwat Al-Assaf did not keep that appointment on 3 November 2000 and an arrangement was made to see him on 7 November 2000 at the Stonebridge Centre.

Family support
The Inquiry panel consider that Sarwat Al-Assaf was fortunate to have such committed support from his brother. We were impressed by the efforts he made on Sarwat Al-Assaf's behalf and consider that he could not have done more.

2.17 The homicide 6 November 2000

2.17.1 Sarwat Al-Assaf kept his appointment with Mr Chan at 11.00am on 7 November 2000. He apologised for not keeping the previous appointment and Mr Chan recorded that Sarwat Al-Assaf *"appeared calm and pleasant".* Unknown to Mr Chan, this was the day after the homicide had been committed. The previous evening Sarwat Al-Assaf had killed the new partner of Mrs Al-Assaf with multiple stab wounds. There was no evidence that he had made any attempt to seek out or harm Mrs Al-Assaf.

2.18 After the homicide

2.18.1 Sarwat Al-Assaf was arrested during the afternoon of Wednesday 8 November 2000, and charged on the morning of 11 November 2000. He was immediately taken into custody and has been on remand in prison, or serving his sentence in prison, continuously since that date. During the stressful period of the criminal trial, and leading up to it, he requested and was given antidepressants. This, we were informed, was not unusual. Since then he has neither sought nor been prescribed any medication for mental disorder. No sign or symptom of any mental illness has been reported to the prison healthcare unit.

Chapter 3

Diagnosis and Deafness

3.1 Diagnosis

3.1.1 At the criminal trial on a charge of murder the matter of Sarwat Al-Assaf's mental health was the subject of a number of reports intended to examine whether, at the time of the killing, he suffered from mental illness. All the reports concluded that he did not. His conviction for murder indicates that he was considered to have had the criminal intention to kill or cause serious bodily harm. Decisions were also made, during the period of Sarwat Al-Assaf's care and treatment, that he could not be detained under the MHA because he was not mentally ill or mentally disordered. This Chapter considers the complex matter of diagnosis where there is also profound deafness. We spoke with Sarwat Al-Assaf at the prison with the benefit of an interpreter. This was not a clinical or diagnostic assessment. We have relied upon assessments as revealed in the documentation and provided to the Inquiry by professional witnesses. Some specialist studies have proved useful and we refer to them.

3.2 The difficulty of diagnosis with Deaf individuals

3.2.1 All mental health assessments of Sarwat Al-Assaf necessarily relied on interpreting the sign language used by a profoundly Deaf man. Particularly, but not exclusively, for people unskilled in this area, it is fraught with potential difficulties. It has been noted that:

"Interpreting in any language means translating the meaning and concepts as represented in one language to another. Clearly it is not possible to be 100% accurate, particularly when interpreting nuances or where there is no generally accepted translation for complex ideas".[4]

3.2.2 The assessment of psychotic symptoms in Deaf patients can be particularly problematic. Interpreters may inadvertently gloss over subtle disturbances in the patient's signing, and symptoms are then missed. Written English may look disordered, due to limited literacy skills or BSL word order.[5] Because of these difficulties Deaf people can be misdiagnosed and wrongly treated.[6]

[4] Turner J, Klein H and Kitson N (2000) Interpreters in mental health settings. In *Mental Health and Deafness* (eds Hindley P and Kitson N), Whurr Publishers, London.
[5] The NHS HAS *Forging New Channels*, page 90.
[6] *Sign of the Times*, page 9, quoting Ridgeway, 1997.

3.2.3 Available studies suggest that the incidence of schizophrenia in Deaf adults is not raised (or lowered), but there may be a higher likelihood of diagnosis of personality disorder or behavioural or adjustment disorders.[7]

3.3 Professionals' views of Sarwat Al-Assaf's mental state

3.3.1 Sarwat Al-Assaf reported experiencing *'voices'* to his brother and to his wife. Ms Swinden did not regard these experiences as associated with a psychotic illness and Dr Coetzee concluded that they were Sarwat Al-Assaf's *"own thoughts"* and *"originated from his own mind".*

3.3.2 Mr Chan was also satisfied that there were no signs of mental illness. He felt that Mr Al-Assaf showed longstanding difficulties in coping, and that he was then experiencing a *"difficult adjustment to his marital situation".* Dr Omer elicited no evidence of psychotic symptoms. Dr Johnson regarded Mr Al-Assaf as suffering from an adjustment disorder.

3.3.3 Mr Al-Assaf denied hearing voices to Mr Chan (on 29 September 2002), although he did refer to a particular former work colleague, (S), *"as if he's still pestering him"*. Mr Al-Assaf attributed some blame for his gambling behaviour to S. He described being able to *"visualize what his voice was like"*, adding *"it wasn't really his voice".* Although she had never met him, Mrs Al-Assaf described S to the panel as a former colleague of Sarwat's, who had been friendly and receptive to him, and who introduced him to gambling.

3.4 Experts' opinions

3.4.1 During the period January 2001 to July 2001, and in connection with legal proceedings, Mr Al-Assaf was assessed by at least five senior mental health professionals, three of whom have specialist experience and expertise in the assessment and management of hearing impaired and Deaf people with mental health problems (Dr N A Zaki, Consultant Forensic Psychiatrist, Rampton Hospital; Ms S O'Rourke, Consultant Chartered Clinical Psychologist, Rampton Hospital; Dr B Monteiro, Consultant Psychiatrist, National Centre for Mental Health and Deafness, John Denmark Unit, Mental Health Services of Salford). These clinicians reached a high level of consensus concerning (retrospective) diagnosis.

[7] Department of Health Discussion Document on Developing Deaf Services *A Sign of the Times, 2002*, Merton Sutton and Wandsworth Health Authority, and Lambeth Southwark and Lewisham Health Authority (2000) *Report of the independent inquiry team into the care and treatment of Daniel Joseph* and in *Forging New Channels*.

3.4.2 Dr H Johnson (Consultant Psychiatrist, Nottingham Healthcare NHS Trust) noted in her psychiatric report of 26 January 2001:

"His diagnosis was one of an adjustment disorder …We considered that his prognosis was good and he was unlikely to need long-term support or follow-up from psychiatric services". In her later evidence to the Inquiry she thought a diagnosis of adjustment disorder was hard to justify because there were no persistent symptoms, her preference being that Sarwat Al-Assaf *"was presenting in distress relating to marital breakdown which was of particular significance for him due to cultural factors".*

3.4.3 Ms O'Rourke noted:

"I would support the conclusion of Dr Johnson that he was suffering from an acute adjustment reaction at this time. I would also agree that there is no evidence of psychosis, clinical depression or acute suicidal intent".

3.4.4 Dr G Hayes (consultant forensic psychiatrist, Nottinghamshire Healthcare NHS Trust), describing the homicide as purposeful and goal directed, concluded:

"At the time of the offence, the defendant was undergoing an adjustment reaction to the break up of his marriage … It is possible that he was suffering from a degree of depression at the material time. Even if this was the case, then there is no strong evidence to support the case that it was anything other than mild … there is no evidence that he was labouring under any psychotic illness at the material time".

3.4.5 Dr Zaki concluded:

"In my opinion at the time of his alleged index offence, Mr Al-Assaf was suffering from an Adjustment Disorder, with Mixed Disturbance of Emotions and Conduct (F43.25-ICD 10)".

3.4.6 Dr Monteiro concluded:

"In my opinion, there was no evidence of Mental Illness or Mental Disorder within the meaning of the Mental Health Act (1983), either preceding or at the time of the alleged offence".

3.5 Adjustment Disorder

3.5.1 As defined in the International Classification of Diseases, tenth edition[8] (ICD 10; WHO, 1992), adjustment disorders are:

[8] World Health Organisation (1992) Tenth Revision of the International Classification of Diseases and Related Health Problems (ICD-10). Geneva: WHO.

"states of subjective distress and emotional disturbance, usually interfering with social functioning and performance, and arising in the period of adaptation to a significant life change or to the consequences of a stressful life event...

The stressor may have affected the integrity of an individual's social network...

The manifestations vary, and include depressed mood, anxiety, worry (or a mixture of these), a feeling of inability to cope, plan ahead, or continue in the present situation, and some degree of disability in the performance of the daily routine.
None of the symptoms is of sufficient severity or prominence in its own right to justify a more specific diagnosis.

The presence of [stressful event, situation, or life crisis] should be clearly established and there should be strong, though perhaps presumptive, evidence that the disorder would not have arisen without it …"

3.5.2 It may be possible to specify the particular clinical form or predominant features of an adjustment disorder – for example, as a brief or prolonged depressive reaction, a mixed anxiety and depressive reaction, or a picture involving predominant disturbance of other emotions (such as worry, tension and anger).

3.5.3 Hence, adjustment disorders are thought of as fairly common responses to, adaptations to, or continuing effects of various causal stressful events. Symptoms resolve rapidly in the majority of cases.

3.5.4 There can be an indistinct border between such disorders and normal (adaptive) reactions, and there are controversies about the category's validity.[9]

3.5.5 Controversy arises because of the association with very ordinary life events. Indeed in the Oxford Textbook of Psychiatry[10] the term Adjustment Disorder refers to the psychological reactions arising in relation to adapting to new circumstances, including divorce and separation.

[9] Casey P, Dowrick C and Wilkinson G (2001) *Adjustment disorders (Editorial).* British Journal of Psychiatry, ***179****: 479 - 481.*
[10] Gelder M Mayou R and Cowen P [2001] *Shorter Oxford Textbook of Psychiatry;* Oxford University Press, Oxford.

3.5.6 The Oxford Textbook of Psychiatry continues:

"Stressful life events may precipitate depressive …and other psychiatric disorders; for this reason the diagnosis of adjustment disorder is not made when diagnostic criteria for another psychiatric disorder are met. In practice, therefore, the diagnosis is usually made by excluding an anxiety or depressive disorder…An essential point is that the reaction is understandably related to, and in proportion to, the stressful experience when account is taken of the patient's previous experiences and personality".

3.5.7 Of course, Sarwat Al-Assaf's previous experience and personality will have been shaped in part by his Deafness. It has been said *"An inability to communicate can have a serious effect on a person's life experience, including their acquisition of knowledge and education. It can influence their ability to form strong family relationships, and significantly impede their understanding of society and the social skills required to function in the wider world".*[11]

Use of Section 2 MHA
Section 2 MHA refers to 'mental disorder' as a single category, requiring this to be of a nature or degree warranting assessment, with detention being in the patient's interests or for the protection of others. Adjustment disorder is now a widely recognized diagnosis and could easily fulfil these criteria, for example, after overdose. We think that in the case of Sarwat Al-Assaf it would have been sufficient to qualify as mental disorder within the meaning of the MHA, and could have justified detention under s2 MHA if the other criteria had been met. We consider that it warranted a formal assessment under the Act. However, it is still a difficult and somewhat controversial diagnosis since, by definition, it requires an absence of psychosis, anxiety or depressive disorders. We cannot conclude that a decision not to use the Act was inappropriate at the time.

3.6 Cultural influences on diagnosis

3.6.1 Although there was, by common agreement, no strong evidence for depression, there were somatic presentations of weakness in legs, headaches and abdominal pain.

3.6.2 'Somatization' is a term used to describe the expression of emotional distress in the form of bodily symptoms that do not have adequate organic or physical explanation. The distinction between soma and psyche assumes that one is problematic where the doctor finds nothing wrong with the other.

[11] *Forging New Channels* page 14.

3.6.3 There is a debate about whether psychopathology is, or can be, culture-specific, or whether psychopathology is universal[12]. The culture-specific view would be that the mental illness is itself different between cultures. The latter view holds that cross-cultural differences derive from culturally different types of illness behaviours (e.g. subjective complaints) or pathoplastic influences (i.e. psychosocial shaping of symptoms).

3.6.4 Whatever the explanation, the WHO is one of the authorities that has reported that somatization is a characteristic of non-Western patients with depression[13].

3.6.5 Repeating the theme, the recently published *Inside Outside – Improving Mental Health Services for Black and Minority Ethnic Communities in England* states

"People from ethnic minority communities are also less likely to make or accept a strict distinction between mental health and physical health problems and the explanatory models relied on by different cultural groups might not be congruous with the explanatory models of Western psychiatry".

3.7 Conclusions

3.7.1 The preferred diagnosis of adjustment disorder given by most of the clinicians seems to us to be well supported by descriptions of the disorder. The available evidence does not suggest that an alternative (or differential) diagnosis should have been considered appropriate. In particular it seems most unlikely that Mr Al-Assaf suffered from a psychotic disorder such as schizophrenia. The references to 'voices' or apparently hallucinatory experiences, while obviously difficult for clinicians to elicit and interpret, were considered at the time, and were not associated with the 'external' or 'ego-alien' qualities associated with psychotic disorders.

3.7.2 Sarwat Al-Assaf described hearing the 'voice' of his former colleague in the following way: *"I hear through my eyes. I can't hear but what I see is what I hear.……So in my dreams yes I have a link with this guy and I visualise what his voice is like and basically that's it ….I was trying to get rid of the memory that was in my mind….I just thought 'S' had a good attitude, that's what that was about, but to me it didn't seem like a problem".*

[12] E.g. Cheng, ATA (2001) *Case definition and culture: are all people the same?* (Editorial) British Journal of Psychiatry, 179, 1-3 and Binitie, A (1975) *A factor analytic study of depression and cultures* (African and European) British Journal of Psychiatry, 127, 559-563

[13] World Health Organisation (1983) *Depressive disorders in different cultures*. WHO, Geneva.

3.7.3 In other words, this mental content or event was not apparently experienced as alien, unusual, or distressing, and some aspects of it were understandable as reassuring or at least familiar. Nothing persuades us that there is any reason to disagree with the views of other professionals that these were not psychotic in origin.

3.7.4 We conclude that Sarwat Al-Assaf was probably suffering from an adjustment disorder at the time of the killing. This was manifested in signs of distress and mild depression. The verdict of murder made plain that Sarwat Al-Assaf bore criminal responsibility for his actions. We have heard nothing which causes us to doubt that this was a sound verdict.

3.7.5 The existence of criminal responsibility does not mean that any services could or should have been denied to Sarwat Al-Assaf. We accept the evidence we have heard that adjustment disorder is a valid reason for offering psychiatric care and treatment, particularly where there is the added component of profound Deafness, which is likely to have deepened Sarwat Al-Assaf's sense of crisis and frustration.

3.7.6 This Inquiry could find no connection between Sarwat Al-Assaf's probable diagnosis of adjustment disorder and his killing of Alan Clarke. None of the evidence before the Inquiry hinted at it. Even with hindsight it was a surprising outcome. From this we conclude that the homicide was unpredictable and could not be foreseen on the basis of the diagnosis.

Chapter 4

Care and Treatment

4.1 This Chapter examines the care and treatment of Sarwat Al-Assaf. It is appropriate to say at the outset that we have found evidence of good practice amongst the professionals involved in his care. Although we make criticisms and identify areas of weakness in service provision, we cannot say that any improvements, if made at the time, would have prevented this tragic outcome. The homicide was, we find, not related to any mental disorder and was therefore essentially unpredictable and unforeseeable by the health and social care teams. Of course, the care of any individual examined in depth and with hindsight will identify shortcomings and practices that can be improved. Sarwat Al-Assaf was a man disadvantaged by his Deafness. His manifest distress entitled him to services which provided him with respect, care and dignity. Our findings and recommendations are directed towards identifying and improving the quality of care and treatment for others who might find themselves in receipt of similar services.

4.2 Sarwat Al-Assaf was fortunate to have received care from one of the few specialist local mental health services for the Deaf in this country. He also received support from the Nottingham Deaf Society and the family were assisted by the Nottingham County Deaf Team. His GP was in contact with Sarwat Al-Assaf and with the other organisations involved with his care. During two crisis admissions to the QMC AED he received care from non-specialist psychiatric services.

4.3 Expansion of BSL interpretation services out-of-hours is, we conclude, an urgent need. The absence of an emergency service for Deaf people with mental health problems should be addressed as an area of weakness in an otherwise good specialist service.

4.4 A history of services for mentally ill Deaf people

4.4.1 There are 8.5 million people in Britain who are Deaf or hearing impaired. Approximately 75,000 of these consider themselves part of a cultural and linguistic minority group whose preferred language is British Sign Language (BSL). This group is usually referred to as the *'Deaf Community'.*[14]

4.4.2 The mental health needs of this group were first recognised in the 1960s with the pioneering work of individual doctors. For many years expansion in the service relied upon the dedication of a few clinicians, as opposed to any overall co-ordinated strategy.

[14] See Appendix D

4.4.3 National recognition of the need for a planned approach came with the publication of two key documents, *Forging New Channels* in 1998,[15] and the Department of Health's *Sign of the Times*[16] in 2002.

4.4.4 Although there remains no consensus on what the appropriate service model should look like, the latter document set out a vision of the principles to which it should subscribe:

- Mental health national service framework standards should apply equitably to people who are Deaf
- The Deaf community should be able conveniently to access mental health services that are communicatively and therapeutically appropriate to their needs
- Deaf people should play a leading role in the provision of such mental health services
- These principles can best be achieved by the development of more local services.

4.4.5 A main driver behind *Sign of the Times* was the *Report of the Independent Inquiry into the Care and Treatment of Daniel Joseph* (2000), a profoundly Deaf young man who suffered from a severe mental illness. Daniel Joseph was younger than Sarwat Al-Assaf and the nature of his mental health needs quite different. However, one key finding, concerning the lack of an emergency service for Deaf people with mental health problems, resonates across both cases.

4.5 National Deaf Services

Currently there are three specialist providers (the National Deaf Services or 'NDS') of mental health services for Deaf people in England based at the following Trusts.

- National Deaf Service, South West London and St George's NHS Trust (formally Pathfinders) – 18 beds
- National Centre for Mental Health and Deafness, the Mental Health Services of Salford NHS Trust – 24 beds
- National Deaf Mental Health Services, The South Birmingham Mental Health Trust – 12 beds

4.5.1 The three mental health services provided by the NDS offer assessment, diagnosis and treatment of psychiatric, behavioural, emotional, communication and social problems affecting the mental health of Deaf people. The service covers the spectrum of need, from those who require counselling to the more severely ill in need of inpatient care, including those transferred from high secure hospitals.

[15] NHS Health Advisory Service publication
[16] Department of Health (2002) *A Sign of the Times. Modernising mental health services for people who are Deaf.*

4.5.2 The catchment areas for these services are not clearly defined and each one accepts referrals from across the UK. There is still some fragmentation of services as a result of the ad hoc expansion in earlier years. As with Nottingham, some additional services have been developed locally.

4.6 Mental health services for the Deaf in Nottingham

4.6.1 At the time of the homicide, Nottingham City was one of only a few areas in the country to have developed a local service for Deaf people with a mental health problem. The service comprised an H-grade Community Psychiatric Nurse, Mr Chan, based at the Stonebridge Centre in Nottingham.

4.6.2 Developed in 1999 in consultation with the NDS in Birmingham, Social Services' City and County Deaf Teams and the Nottingham Deaf Society, the intention was to create an accessible, specialist and local secondary service for Deaf people with moderate to severe, or more serious mental health problems. Since the homicide, an additional community support worker post has been appointed.

4.6.3 We heard that the service in Nottingham is held in high regard by the Deaf community and has won recognition nationally for its innovative work.

4.6.4 A proposal for the establishment of a Trust-wide, county-wide, multi-disciplinary service has been formulated and submitted to the Department of Health for consideration, to enable the service to become one of five national specialist services across the country.

4.6.5 The Nottinghamshire County Deaf Team was, and still is, a team of social workers providing a generic social service to all types of Deaf users and their families. Except, that is, those suffering from mental illness, who fall within the ambit of Mr Chan's service. Where a Deaf individual also has a family who need help, both services might be involved, as was the case with Sarwat Al-Assaf and Mrs Al-Assaf.

4.6.6 At the time of the homicide, the CDT consisted of a Team Manager, one full time social worker, two social workers undertaking a full time post through a job-share arrangement, and two social work assistants.

4.6.7 There is also a Nottingham City Deaf Team, the two organisations having been created in 1998 following the local government review.

4.6.8 Nottingham Deaf Society, a local voluntary organisation, has for about 20 years, provided a range of services to Deaf and hard of hearing people, and its premises are used to enable members of the Deaf community around Nottinghamshire to meet together regularly. Mr George Reynolds has been the Chief Executive of the organisation throughout this period.

4.6.9 The Deaf Society was, and is, used as a resource for health and social services. The Nottinghamshire Healthcare Trust accesses an annual programme of Deaf awareness training from the Society, with sessions publicised and available to all staff across the Trust.

4.6.10 At the time of Sarwat Al-Assaf's contact with the mental health services, a BSL interpreting service was available to the Trust through an agreement with the Nottinghamshire Deaf Society. This was funded by the previous Health Authority and is now funded by the four Greater Nottingham Primary Care Trusts.

4.7 Services received by Sarwat Al-Assaf

4.7.1 Sarwat Al-Assaf received services from the following organisations;

- Mental Health Services for the Deaf
- Nottingham County Deaf Team
- Nottingham Deaf Society.
- QMC Trust in the form of AED and DPM.
- Nottingham Mental Healthcare Trust in-patient services
- General Practitioner services

Sarwat Al-Assaf's first contact with Mental Health Services for the Deaf came with the personal crisis of his marital separation, six weeks before the homicide. However, for many years prior to that, Sarwat Al-Assaf had been a part of the Deaf community in Nottingham and been in touch with the Nottingham Deaf Society and Nottingham County Deaf Team. Emergency assessment at QMC AED by DPM and referral to mainstream mental health in-patient services came in the period of Sarwat Al-Assaf's emotional turmoil prior to the killing.

4.8 Nottingham Deaf Society

4.8.1 Sarwat Al-Assaf first became known to the Nottingham Deaf Society approximately 15 years ago, after he arrived in the UK. Mr George Reynolds told us that Sarwat Al-Assaf's communication and signing skills were initially very poor, but they improved considerably and he could engage in conversation with other people signing in BSL.

4.8.2 He was an infrequent visitor to the Deaf Society's premises in Nottingham, seeking assistance as required with interpreting and finding employment. Sarwat Al-Assaf was included in a group photograph used in one of the Deaf Society's annual reports depicting activities within the Deaf Centre and is pictured completing an application form or curriculum vitae.

4.8.3 Sarwat developed a number of close friendships within the Deaf community, and George Reynolds confirmed that he was aware of Sarwat's visits to the casino, sometimes with those Deaf friends, although not on a regular basis.

4.8.4 At the time of the difficulties between Sarwat and his wife, Sarwat Al-Assaf used the Deaf Society services more frequently in his attempts to arrange and discuss issues relating to accommodation and access to his daughter. George Reynolds, a qualified interpreter in BSL, was the interpreter who assisted Sarwat Al-Assaf during his arrest and questioning following the homicide.

Good support to Sarwat Al-Assaf
Over many years Nottingham Deaf Society offered Sarwat Al-Assaf support and sometimes friendship. We heard that there was no sign of any memory problem. No bad temper or behavioural disturbance had been witnessed. Described as "well-groomed", the picture gained of Sarwat is of a balanced man who used the services of the Deaf Society appropriately.

4.9 The County Deaf Team

4.9.1 Sarwat Al-Assaf first received help from the CDT in 1986 when he asked for assistance with benefits and with finding work following his arrest for shoplifting. Between 1986 and March 1996, Sarwat had contact with the Deaf team on a total of 10 occasions. Four of these recorded contacts were during the latter half of 1988, and related to his first born son who died of a cot death in October of that year. Other contacts were to request interpreter services or equipment.

4.9.2 There were no recorded contacts between the Al-Assaf family and the County Deaf team from March 1996 onwards until 28 September 2000 when a referral was made by Mr Chan, alerting social services to the support needed by Mrs Al-Assaf and her daughter following the crisis at home. At this point it was they who became clients of the County Deaf Team.

4.9.3 Records indicate significant liaison between the County Deaf Team, Mr Chan and the General Practitioner, Dr Jacklin. The County Deaf Team also made enquiries through other agencies, such as the daughter's school and primary healthcare teams, to assist in the risk assessment and assessment of other needs relating to Mrs Al-Assaf and her daughter.

4.9.4 It was concluded that there was no physical risk to the child, though there was concern that she might witness distressing arguments between her parents.

4.9.5 Since there was a child involved, Social services' procedures required that case be allocated to a social worker. It was therefore 'technically' allocated to Jo Dicks, a qualified social worker within the County Deaf Team. This allocation, we were told, did not mean that Ms Dicks *was* the allocated Social worker; most of the entries in the social work records were entered and signed by Jean Goodman, the Team Manager. Ms Goodman took the initial call into the office and appeared to manage the case herself, involving other members of the team as she thought appropriate.

4.9.6 Ms Dicks arranged to see Sarwat Al-Assaf at the 'Duty Point' on 11 October and again on the 25 October 2000. Ms Dicks recalls that she discussed Sarwat Al-Assaf's housing needs with him, advising him that he should contact the local authority housing department. She did not know that she was the allocated social worker. She believed it was Linda Pask.

4.9.7 Social worker, Linda Pask, in a 'Duty' capacity, contacted agencies to establish information concerning the daughter and her care, and met with Mrs Al-Assaf on 3 October 2000, completing comprehensive records of a lengthy conversation.

Unsatisfactory allocation system

The allocation system evident at the time of the referral of Sarwat Al-Assaf to the CDT appears to have been 'system led' rather than needs led. This produced a situation where the Team Manager acted as the main social worker but because the computerised system did not allow a Team Manager to hold a case load it had to be allocated on the computer to someone else. Ms Jean Goodman, the Team Manager said, "in a case like this, we couldn't wait for the allocation meeting" and so Jo Dicks was technically allocated to the case and may have been expected to undertake the initial assessment. We heard that this might result in a transfer of responsibility to another worker. Mr Chan was under the impression that Jo Dicks was the allocated social worker as he sent a copy of the CPA documentation to her which included tasks allocated to her.

Recommendation No. 9

Appropriate involvement of the CDT
Mr Chan correctly involved the Deaf Team and there is evidence in the clinical and social work records that regular and appropriate discussion did take place between Mr Chan and the County Deaf Team concerning members of the Al-Assaf family.

4.10 The Care Programme Approach in Nottingham

4.10.1 CPA was introduced nationally by the Department of Health in 1991[17], providing a framework for care to all mentally ill people referred to, and accepted by, secondary mental health services. Key features were the assessment of both the health care and social care needs of patients, the drawing up of individual care programmes with a written care plan, the appointment of key workers and the holding of regular reviews. In 1994 a further Health Circular[18] reiterated the principles of CPA and emphasised the need for risk assessment prior to discharge from hospital.

4.10.2 An integrated health and social services CPA was created in 2000[19] and two levels of CPA specified: 'Standard' and 'Enhanced'. CPA in Nottingham was in line with national standards. Level I was used to denote Standard level and Level II used to indicate Enhanced Level CPA.

4.10.3 Standard Level CPA was designed for those service users who required low level input from one or more agencies or professions. Enhanced Level was prescribed for those service users whose needs were assessed as more complex, often with a severe and enduring mental illness, although not exclusively.

4.11 Care planning for Sarwat Al-Assaf

4.11.1 Where, as with Sarwat Al-Assaf, an admission is short and a discharge unplanned, comprehensive advance planning is difficult.

4.11.2 CPA documentation for Sarwat Al-Assaf was completed a week after Sarwat Al-Assaf's discharge from hospital. No mention was made of Mrs Al-Assaf as the carer with her own needs, but by then of course she had moved out and ceased to be a carer. The risk assessment contained no reference to the cultural concerns hinted at in hospital,

[17] HC(90)23/LASSL(90)11
[18] HSG(94)27
[19] Guidance provided by the NHS Executive and Social Services Inspectorate in their policy booklet *"Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach"* issued in 1999

but there had been nothing further to suggest any risk to Mrs Al-Assaf. She told the Inquiry panel that she had explained her fears and anxieties to Mr Chan and he had been *"very pleasant and very helpful".* Although it was going to take a few weeks to arrange a 'couple meeting', mediation meetings were discussed and facilitated by their solicitors and Sarwat Al-Assaf's brother during his visit to Nottingham.

4.11.3 CPA documentation for Sarwat Al-Assaf did not make clear the level of CPA he was receiving, but Mr Chan and Dr Johnson were in agreement that it was Standard Level CPA.

4.12 The Care Co-ordinator

4.12.1 Mr Chan, as Care Co-ordinator for the purpose of CPA, co-ordinated the care planning. He had experience in the management of CPA and at the time had other clients who were also subject to CPA. He told the Inquiry that a majority of these were at Standard Level of CPA. Sarwat Al-Assaf's case was not at the extreme end of complexity in that diagnostically he was not suffering from a major mental illness.

4.12.2 Mr Chan received managerial supervision from Mr Garry Bevis, his line manager. Because of the specialist nature of his work, Mr Chan received clinical supervision from Dr O'Rourke, a clinical psychologist employed at Rampton High Security Hospital in north Nottinghamshire. The supervision was set up through a formal contract between Mr Chan and Dr O'Rourke, and the funding made available through Mr Chan's line manager, Mr Bevis. Sarwat Al-Assaf was not discussed in the management supervision with Mr Bevis, since no sessions had been arranged and Mr Chan was on annual leave for two weeks. However, his care was raised in clinical supervision with D O'Rourke on 30 October 2000.

4.12.3 In the period from Friday 29 September until Wednesday 8 November, a period during which Mr Chan was absent on leave for twelve days, Mr Chan saw Sarwat face to face a total of seven times (including once at the ward round), and recorded a further three telephone contacts with other professionals. He met Sarwat's brother once and had two telephone contacts with him. He also met Mrs Al Assaf once and had a telephone contact with her.

4.12.4 There is clear evidence that after each contact the interim care plans were reviewed and amended as required. CPA was developed over a period of two and a half weeks as the various assessment results became available, and a formal care plan was documented on 16 October. The initial plans were clearly recorded, reviewed and revised after each contact.

Competent Care Planning
There are clear and concise records which demonstrate the assessment, care planning, implementation and continual review of the care provided to Sarwat Al-Assaf. This was documented by Mr Chan and is detailed at paragraph 2.14 of this report. Although it is unclear from the CPA documentation which level of CPA Sarwat's care was being delivered under, it is clear that the CPA Care Co-ordinator, Mr Chan, had undertaken the initial assessment process and the care planning competently, involving other agencies and professionals appropriately. It is unlikely that this process would have been improved by clearly assigning either a Standard or Enhanced level of CPA to the case, although for completeness a level of CPA should have been clearly identified.

There is no suggestion that anything was missed in the assessment process led by Mr Chan, or in the final CPA care plan or Risk Assessment. Any risk that may have been present at the time was, we find, unrelated to mental disorder and it does not reflect on Mr Chan's work or abilities that the homicide risk was not identified during the period of his involvement. We are satisfied that Mr Chan's assessment and care planning practice, including his involvement of other agencies and professionals under the CPA, were appropriate and comprehensive in the circumstances at the time.

4.12.5 All who gave evidence on the structure of the Deaf mental health service in Nottingham considered that plans for its expansion to become a county-wide multi-disciplinary resource were positive. We agree.

Integration of services
We were impressed by the service provided by Mr Chan, but it is vulnerable since it is dependent on the presence of one individual, who works alone, under pressure. We heard that it would be a logical development to bring people from this service together with the City and County Social Services Deaf Teams to form one dedicated team covering the whole county. There could be considerable benefits for service users who, like Sarwat Al-Assaf and his wife, used both services. It would be consistent with a trend nationally towards integration of health and social care, and consistent with the main messages in Sign of the Times about developing local services.
Recommendation No. 11

4.13 Emergency assessment at QMC

4.13.1 Sarwat Al-Assaf was assessed in emergency and out-of-hours by non-specialist services at QMC on Friday evening, 22 September 2000 and on Sunday evening, 8 October 2000. Psychiatric assessments were undertaken by the DPM and by the local psychiatric in-patient services.

4.13.2 We have examined the circumstances of these assessments in some detail in this report. They were unsatisfactory in a number of ways and this reveals the difficulty experienced by Deaf users of mainstream mental health services. That difficulty is magnified when under the pressure of an emergency.

4.13.3 One area, above all others, stood out as unsatisfactory. This was the absence of an independent interpreter for Sarwat Al-Assaf when he was assessed out-of-hours.

4.14 BSL interpretation Services in Nottingham

4.14.1 Nottingham Deaf Society had negotiated a contract with the previous Nottingham Health Authority, which was current at the time of Sarwat Al-Assaf's contact with mental health services in 2000. This contract was for the provision of interpreter services for Deaf people attending health services within Nottingham.

4.14.2 The service level agreement provided for the service to be available within and outside office hours. An emergency service was provided between 9am and 11pm on weekdays and Saturdays and between 9am and 4pm on Sundays and public holidays.

4.14.3 Five full-time interpreters, with a manager working on a part time basis, were employed by the Deaf Society, and they also had access to a number of freelance interpreters. Posters advertising the service were distributed to local hospitals and records of the service indicate that it was used regularly.

4.14.4 Yet none of the professionals concerned with assessing Sarwat Al-Assaf in AED or on the psychiatric wards during the evenings concerned made an attempt to obtain an interpreter for Sarwat Al-Assaf, nor were they aware that any service was available out-of-hours.

4.14.5 Some Deaf people may choose to use a family member, either for convenience or because the family member is present. The Deaf Society nevertheless advise that an independent interpreter be used in these circumstances, as it protects both the service provider and the Deaf

person. This approach is further strengthened by guidance contained in the Code of Practice to the Mental Health Act[20] that:

"The patient's relatives and friends should not normally be used as an intermediary or interpreter. When the need arises staff should make every attempt to identify interpreters who match the patient in gender, religion, dialect, and as closely as possible in age."

4.14.6 George Reynolds, of the Nottingham Deaf Society expressed to us his disappointment that the interpretation service had not been used:

"We've put on our service to enable Deaf people to be independent and to find out the information themselves direct, so it gives them the right to question doctors, in terms of what treatment they're providing, and to give themselves the background to whatever reason they're in hospital. So our service has been provided at the request of Deaf people but we've worked very hard at trying to publicise this service and we get very disappointed when the service doesn't get used, but we can't force that issue either to the Deaf person or to the service provider."

4.15 The absence of an interpreter for Sarwat Al-Assaf

4.15.1 The failure to access an available interpretation service on the evening of 22 September 2000 meant that each interview in the assessment process was conducted using Mrs Al-Assaf as the interpreter, and she was the wife who was seeking to divorce him.

4.15.2 Distressed, angry, confused and feeling misunderstood, this couple presented with all their marital problems overflowing into the interpretation and assessment process.

4.15.3 Sarwat Al-Assaf could not feel confident that he was receiving objective information. He told us that he thought his wife would have only given him the information that she wanted him to receive; *"there was a lot of conversation between the doctor or nurse and Susan. I had to keep reminding her, 'Can you tell me what is going on?' and her replies were very, very brief".*

4.15.4 Equally, the pressures on Mrs Al-Assaf, interpreting when questions to him involved issues of possible risk to her, were unacceptable. Although there was an opportunity for a 'private' conversation with the professional in front of her agitated and excluded husband, this was very unsatisfactory for her and unfair on Sarwat Al-Assaf.

[20] The Code of Practice to the Mental Health Act, 1983 *(Department of Health & Welsh Office; Third edition; March 1999)* included, in the Guiding Principles at Chapter 1.6.

4.15.5 Even at a practical level there was a problem. Mrs Al-Assaf told the Inquiry that she signed BSL at Level 1, a basic level of competence. Her husband's signing capability was said by Mr Chan to be at level 3. With the need to respond to complex questions in a psychiatric assessment, it cannot be assumed that Mrs Al-Assaf was able to interpret to a level sufficient for the medical and nursing staff to complete a full and comprehensive assessment of Sarwat Al-Assaf's mental health.

4.15.6 The problems were different on the evening of 8 October 2000. This was a Sunday and the contract with Nottingham Deaf Society extended only until 4pm. Mrs Al-Assaf was not present and the psychiatric assessment was conducted by the SHO, in the only way possible, by an exchange of notes. This in itself was limited because Sarwat Al-Assaf's written expression, typical of those who sign[21], was not easy to understand. Complex ideas about cultural attitudes towards infidelity emerged as the SHO grappled with the possible implications of certain words and phrases used by Sarwat Al-Assaf.

4.15.7 On each evening the consequences of an absence of interpreter went beyond the immediate communication difficulty. On 22 September there were misunderstandings about exactly what was happening, exposing weaknesses in the admissions process, risk assessment and procedure for seeking senior psychiatric advice. On 9 October, the day after the assessment, the possibility of a cultural dimension of risk to Mrs Al-Assaf was still being discussed.

4.16 Improving accessibility of services to Deaf users

4.16.1 As a Deaf person, Sarwat Al-Assaf did not receive an effective mental state examination on either of the occasions that he presented in emergency at QMC. For the two Trusts concerned, the QMC Trust and the mental health care Trust, this must be seen in terms of a need to improve accessibility of services to Deaf users.

4.16.2 The principle of accessibility is not new. Though stated recently in *Sign of the Times,* it has its roots in the NHS Plan[22]: "*The NHS of the 21st century must be responsive to the needs of different groups and individuals within society, and challenge discrimination on the grounds of age, gender, ethnicity,* ***disability*** *and sexuality."*

4.16.3 Then the Disability Discrimination Act 1999 (DDA) made it clear that services have to take *'reasonable steps'* to enable and facilitate the use of services by disabled people. They must *"provide a reasonable alternative method of making the service in question available to*

[21] *Forging New Channels* page 14
[22] *NHS Plan* Department of Health, 2000a

disabled persons". The Act actually used the example of providing a sign language interpreter.

4.16.4 *It is encouraging that the Mental Healthcare Trust is seeking to broaden its access to general interpreting services for those patients whose first language is not English. A communication strategy has been commissioned by the Trust's Equality and Diversity forum to identify how the Trust can increase the awareness of, and access to all service users, carers and staff through improved information and publicity. This will apply to those for whom BSL is their first language.*

Improving interpretation services in Nottingham
The Trust should work jointly with Nottingham Deaf Society to improve accessibility to BSL interpretation services. It should seek to make provision for 24 hour availability of an interpretation service for Deaf users. Those services that exist should be publicised. Staff should understand how to obtain an interpreter, and Deaf awareness training should be included as part of induction procedures. Local Implementation Teams should examine the training and availability of BSL interpreters as recommended in Sign of the Times.
Recommendation No. 2

4.17 No specialist emergency service

4.17.1 There was, and is, no specialist emergency service for Deaf people with mental health needs in Nottingham.

4.17.2 The Daniel Joseph Inquiry report stated: *"the inability of the specialist service for deaf people who have mental health problems to provide an emergency service is at the heart of this Inquiry".* With two unsatisfactory out-of-hours assessments, we can say that this finding is echoed in the case of Sarwat Al-Assaf.

4.17.3 An effective emergency service goes beyond provision of an interpreter.

4.17.4 Most mental health professionals in mainstream local services do not have an understanding of the implications of deafness. They may make assumptions on the basis of a patient's behaviour, attitude, literacy, general knowledge or academic achievements[23]. Their needs are often misunderstood and there is a risk of misdiagnosis and inappropriate treatment[24]. The Daniel Joseph Inquiry points out that assessment of the mental state of a Deaf person is extremely difficult

[23] *Forging New Channels* page 90
[24] *Sign of the Times* page 9

for the non-specialist, and the fact that non-specialists have to be relied upon in times of crisis is totally unsatisfactory[25].

4.17.5 *Forging New Channels* (BMHSD 1998) comments[26] *"many errors of diagnosis have been made because of inadequate understanding by professionals of what Deaf people are trying to express".*

4.17.6 Even with an interpreter, an understanding of the significance or otherwise of Sarwat Al-Assaf's *'voices'* was not going to be straightforward. Diagnosis was difficult and assessments of risk varied. None of the professionals from the local psychiatric services had assessed a profoundly Deaf person before.

4.17.7 Could a specialist emergency service to Deaf users be provided? Or failing that a duty advice service of some kind?

4.17.8 *Sign of the Times* concedes that the three specialist centres cannot provide 24 hour access to an emergency service.[27] Simply, there are insufficient specialist staff, and difficulties with recruitment and training. This is despite the National Service Framework standard for around the clock contact with local services.

Standards for specialist emergency services
The absence of emergency provision for Deaf users of mental health services remains very unsatisfactory. It seems to us to be a fundamental need. We are of the opinion that a standard needs to be set for the 24 hour availability of BSL interpreters, and some basic provision for telephone advice or call-out of a specialist mental health worker to assist individuals or staff in emergency. This should provide the framework for future development of services.
Recommendation Nos 2, 4 and 10

4.18 The future of mental health services for the Deaf

4.18.1 Mental health services for the Deaf struggle with the problem that there are, effectively, two systems of mental health care - Deaf and "non-Deaf" - and they do not have good access arrangements to each other.[28]

4.18.2 Sarwat Al-Assaf's care illustrates this perfectly. He received services from two entirely different healthcare systems: the Deaf service provided by Mr Chan and the "non-Deaf" service in the local psychiatric hospital. Neither could alone meet his needs. The missing area was in the effective provision of an emergency service.

[25] *Daniel Joseph Report* page 3
[26] At page 2
[27] *Sign of the Times* page 16
[28] *Sign of the Times* page 12

4.18.3 Nationally, the issues for Deaf mental health services are complex and we add a separate note summarising the points made within recent publications on the subject. [29]

4.18.4 Locally, we were impressed with the enthusiasm, professionalism and commitment of staff providing specialist services. Improving accessibility will require that this commitment extend to joint planning with local psychiatric services, Regional Deaf Centres and service users themselves.

[29] See note at Appendix D

Chapter 5

Culture and Risk

5.1 Was there a cultural component to risk?

5.1.1 Most professionals who had contact with Sarwat Al-Assaf defined him by his deafness. But he was also a Muslim and from Egypt. He wrote a little in Arabic, although his chosen written language was English.

5.1.2 Dr Omer comes from the neighbouring country of Sudan. He shared religion and family language with Sarwat Al-Assaf.

5.1.3 Dr Omer gave evidence to the Inquiry which we take very seriously. In particular he indicated that if Mrs Al-Assaf was in an extra-marital affair, that could, in Egyptian culture, result in *"murdering one of the parties involved".*

5.1.4 This has caused the Inquiry to investigate whether this was likely to have been what is known as an 'honour crime'

5.1.5 It has also led us to explore further the extent to which mental health risk assessment should take account of cultural components of risk.

5.2 Was the homicide an 'honour crime'?

5.2.1 This title is used to describe a range of crimes, usually committed against women in the name of individual or family honour, across a whole spectrum of cultures, communities, religions and ethnicities in a wide range of countries around the world. We have been assisted greatly in our understanding of so-called 'honour crimes' by the expert advice provided to the Inquiry by Dr Nadje Al-Ali, of the Institute of Arab and Islamic Studies, University of Exeter. The Inquiry's letter of instruction to her and the full text of her advice is included at Appendix D.

5.2.2 Dr Omer told us that he was surprised by the homicide: *"I expected, if there was a murder, his wife to be murdered".* He did not, at the time that he saw Sarwat Al-Assaf, indicate to other professionals that he thought anyone other than Mrs Al-Assaf might be at risk.

5.2.3 Dr Omer stressed that he was expressing his personal view. He believed that, because of his own understanding of the cultural issues, he was in a better position than others to perceive the possibility of serious harm.

5.2.4 We asked Sarwat Al-Assaf's brother whether the homicide might have been culturally determined.

5.2.5 He told us that Sarwat Al-Assaf's main worry was that he might lose his second wife, and with her his daughter. Sarwat Al-Assaf's second concern was that it would be very difficult for him to enter into a third relationship or marriage.

5.2.6 Describing to us the situation if it were to occur in some rural areas of Egypt, we heard that although the proper route would be to go through legal divorce proceedings, *"sometimes a husband might kill the wife".* He believed that the practice was becoming less common.

5.2.7 Mr Al-Assaf went on to say *"But this is in the rural areas. In Sarwat's case….he was born and brought up in Cairo, the capital, so it's completely different".* The matter would be dealt with by means of legal proceedings.

5.2.8 Certainly, Sarwat Al-Assaf had never spoken to him about anything connected with honour crimes. Mr Al-Assaf went further, adding that before the incident his brother had spent almost eighteen years in the UK and accepted the lifestyle. Sarwat Al-Assaf was, he understood, not a strict Muslim. He thought that the relationship with the other man would not bother him as much as the possibility that he might lose his daughter.

5.3 Expert advice

5.3.1 Dr Nadje Al-Ali summarised her opinion as follows:

"My overall assessment is that Mr Al-Assaf's action cannot be explained by a particular tradition or attitude. In my view, an explanation based on a particular cultural practice or attitude would not only obliterate differences with respect to social class and place of residence, but would also reduce an obviously complex array of physical impairment, mental instability, individual character and personal misfortune to a single factor. "

5.3.2 In reality the position is more complex:

"Neither Egyptian nor Muslim culture are homogeneous. Attitudes towards marriage, divorce, infidelity etc. vary according to social class, particularly based on educational and professional background, as well as place of origin and residence."

5.3.3 She adds:

In Egypt, 'honour crimes' are much more frequent in the country-side of upper Egypt and the lower Nile Valley than urban areas. Within Cairo, the cosmopolitan capital of Egypt, there are also huge differences based on social class….. amongst middle class Egyptians…..I can say with confidence that the killing of a wife for whatever reason is not a culturally acceptable phenomenon".

5.3.4 And:

"I think what also needs to be stressed is the fact that Mr Al-Assaf was living in the UK and not Egypt at the time of the killing. His own family, who are still living in Cairo seem to have been supportive and tried to help him through the crisis. In other words, there was no prevalent 'cultural climate' that would have encouraged the murder of his wife or her lover."

5.3.5 Distinguishing between 'honour crimes' and 'crimes of passion' she comments:

"The so-called 'honour crimes' should not be confused with the concept of 'crimes of passion'. Whereas the latter is normally limited to a crime that is committed by one partner (or husband and wife) in a relationship on the other as a spontaneous (emotional or passionate) reply (often citing a defence of 'sexual provocation'), the former may involve the abuse or murder of (usually) women by one or more close family members (including partners) in the name of individual or family honour."

5.3.6 Dr Al-Ali concludes with this:

"At the end, Mr Al-Assaf did not kill his wife but her lover, which, in my mind, is more congruent with western cultural patterns than certain Arab/Muslim ones. Another point I would like to stress is that Mr Al-Assaf's previous attempts at suicide are not 'typical' or common in terms of prevailing cultural codes and attitudes. If anything, suicide is frowned upon in Islam and considered to be a sinful act. "

Not an 'honour killing'
Dr Al-Ali's view mirrors that of Sarwat Al-Assaf's brother and the Inquiry panel is satisfied that this was not a killing which arose out of religious or cultural attitudes. It was not, we think, a so-called 'honour killing'.

5.4 Cultural determinants of risk

5.4.1 We think that on the night of 8 October 2000, when he assessed Sarwat Al-Assaf, Dr Omer used his cultural understanding to form what was really a provisional view. It was to Dr Omer's credit that he was able to see through Sarwat Al-Assaf's Deafness to the cultural context beyond. He was right to consider the possibility of harm to Mrs Al-Assaf or someone else. However he needed much more information to finalise a view about risk based upon culture. He needed to know about family background, class, upbringing in Egypt and attitudes.

5.4.2 We therefore sound a note of caution. Any assessment of risk based upon an individual's religious or cultural background must be approached very carefully.

5.4.3 At best, it might represent good, ethnically sensitive practice and lead to the protection of a vulnerable individual. At worst, it could be a discriminatory judgement of a person's dangerousness based upon simplistic and stereotypical attitudes towards their race or culture. And the information could be inadequate to form a clear view – as we think was the case here.

5.4.4 Best practice would be to make a full record of the rationale for any risk assessment based upon cultural factors. This should include recording what is not known as well as what is known.

5.4.5 Neither Dr Omer nor Dr Johnson had enough information to decide whether they could confidently dismiss the idea of an 'honour crime' or whether the notion deserved more serious investigation.

5.4.6 Nor indeed did the Inquiry, until it sought the opinion of Sarwat Al-Assaf's brother and Dr Al-Ali.

5.4.7 Where there is doubt or suspicion this should be dealt with by seeking further information and by openly expressing the reasons for concern to other professionals.

5.4.8 Nor should it be forgotten that 'honour crimes' are precisely that. They are criminal in intent rather than connected with mental illness or mental disorder. If it had been thought that Mrs Al-Assaf was in immediate danger from her husband based on real evidence of cultural attitudes there would have needed to be a breach of confidentiality to inform her or the police. In the end, no-one did form that view and, as it happens, they were right.

Assessing cultural influences on risk assessment

It must be remembered that Mrs Al-Assaf was not killed. Her new partner was. This was not characteristic of an 'honour killing'. Nothing from the facts, expert evidence or from informed family background persuades us that the homicide had its origins in any culturally influenced tradition. Where there is a reason to be concerned about a possible cultural component to risk, this should be clearly recorded and then tested through sharing the concern and seeking further information. The Trust should ensure that training, information and advice is available on cultural traditions, so that clinicians know where and how to seek help.

Recommendation No. 8

Chapter 6

Conclusions

6.1 General Commentary

6.1.1 Sarwat Al-Assaf was an unusual man for those professionals who had no previous experience of profound Deafness. However, without the Deafness, this was not an unusual presentation to mental health services. There had been no known previous psychiatric history and the catalyst for contact appears to have been the marital crisis, the eventual decision by Mrs Al-Assaf to take their daughter and leave, triggering a reaction and prompting intervention by a number of services.

6.1.2 Sarwat Al-Assaf was seen in both primary and secondary care settings, the safety of their child was appropriately considered, and Sarwat Al-Assaf was referred to a specialist local mental health service for the Deaf which provided a professional who could communicate with him using BSL.

6.1.3 At no point did the psychiatric professionals consider it appropriate to detain Sarwat Al-Assaf under the Mental Health Act 1983 and this was a decision within the parameters of reasonableness. Sarwat Al-Assaf was therefore a voluntary patient and his contact with services relied on his willingness to engage with the help offered. A concerted effort was made to work with him and there was in fact substantial contact. Sarwat Al-Assaf did not appear to have fallen into an inter-agency gap, which is a common feature of so many confidential inquiries.

6.1.4 Whilst Sarwat Al-Assaf experienced extreme distress in the marital crisis, no-one has suggested that, because of his Deafness, he was more likely than a hearing person to commit a homicide.

6.2 Key Findings

6.2.1 We find that Sarwat Al-Assaf probably suffered from an adjustment disorder at the time of the homicide. This was a temporary state manifested in distress and mild depression. It was correctly diagnosed early on in the developing marital crisis. We find no evidence of any direct connection between the adjustment disorder and the homicide.

6.2.2 Nothing we have heard causes us to question the verdict of murder.

6.2.3 The Inquiry heard no evidence of any risk to Alan Clarke. Indeed he was not known to any of the professionals involved. No obvious signals were missed. Even with the advantage of hindsight, the killing was, we find, unpredictable and unforeseeable

6.2.4 Although improvements in service provision may have reduced Sarwat Al-Assaf's levels of distress, we cannot say that this would have reduced the likelihood of the homicide.

6.2.5 Sarwat Al-Assaf was entitled to receive services in order to relieve his distress, and we find that in doing so Sarwat Al-Assaf was disadvantaged by his profound Deafness. ***We recommend a local policy across Trusts and social services addressed to the needs of Deaf mental health service users.***

6.2.6 This disadvantage was evident on the two occasions that Sarwat Al-Assaf presented out of hours to AED and was transferred to the psychiatric wards in QMC. The process was unsatisfactory in a number of ways:

- The facilities for emergency psychiatric assessment in AED lacked space and privacy. ***We recommend improved facilities in AED.***
- Sarwat Al-Assaf was not offered a sign language interpreter. On one occasion a doctor had to carry out a psychiatric assessment through an exchange of written notes with Sarwat Al-Assaf. On another occasion Mrs Al-Assaf had to interpret for her husband when questions directly concerned her risk from him. As a direct result of this her own needs as carer and potential victim were insufficiently assessed. ***We recommend access to 24 hour BSL interpretation services.***
- Sarwat Al-Assaf presented with complex problems. There was no formalised procedure or protocol for junior medical staff to seek senior advice. ***We recommend guidance be given to junior psychiatrists on when to seek advice***.
- There was no source of crisis advice for clinicians dealing with the highly specialised area of Deaf people with mental health problems. ***We recommend the establishment of a 24 hour crisis advice service for Deaf users and professionals***.
- There was no clear admissions procedure and no shared understanding between AED and the psychiatric wards. This led to misunderstanding and confusion. ***We recommend an admissions policy which can be understood by users and staff.***
- Records were not easily accessible between AED, DPM, nursing and medical records. ***We recommend a review of records and information systems across the Trusts.***

6.2.7 Having heard convincing family and expert evidence we reject the possibility, raised by a psychiatrist in October 2000, that Mrs Al-Assaf or her new partner might have been at risk because of factors connected with Sarwat Al-Assaf's Egyptian background. But this was an area where most professionals were without expertise. ***We recommend that information on ethnic and cultural traditions be made available to clinicians.***

6.2.8 There was no written risk assessment completed upon Sarwat Al-Assaf's discharge from hospital on 9 October 2000. CPA documentation was not completed until a week later. ***We recommend that Integrated Care Programme Approach risk assessment documentation, or alternative risk assessment documentation, always be completed at the point of discharge.***

6.2.9 Notts County Deaf Team recorded the Al-Assaf family as an open case but there was no allocated social worker. ***We recommend that the system of social work allocation be reviewed.***

6.2.10 Nottingham was, and is, in the advantageous position of having one of only a few specialised local mental health services for the Deaf in the country. However, this service is under pressure. ***We recommend that the service be reviewed in conjunction with the social services County Deaf Team and an integrated service considered.***

6.3 Final comments

6.3.1 Sarwat Al-Assaf received care from committed professionals who put considerable effort into understanding his mental health needs.

6.3.2 We sought to reach inside the mind of this man, as others had done at the time, and we add a final comment from Sarwat Al-Assaf himself, written to the Inquiry panel after we had heard oral evidence from him: *"I have explained to several doctors and people at work that I hear through my eye!…This expression is my way of saying the lack of hearing is compensation by my eyes which have to be my ears. It is no more complicated than that! There is no deep rooted strange behaviour involved."*

6.3.3 It is refreshing to be able to say in a homicide inquiry that there are no lessons to be learned from the homicide itself. But there are lessons to be learned from this close-up look at one Deaf individual and his family's experience of services. Our findings and recommendations should be regarded as no less important because they do not arise directly from the killing.

Chapter 7

Recommendations

No.	Recommendation	Organisation	See report pages
1.	➢ Seek urgent legal advice on the definition of admission to the psychiatric wards at QMC. ➢ Produce guidance to all staff on when an admission takes place and who has the power to admit. This guidance should link with the policy on s5(2) and s5(4) required by the Code of Practice. ➢ Establish a procedure for assessment on admission, including guidance on SHO use of senior clinical advice. It should be routine to discuss all complex cases. ➢ Make it a requirement that staff inform patients and their relatives what to expect at each stage of the admission process.	Nottinghamshire Healthcare NHS Trust	14
2.	➢ Ensure that a contract is in place to provide 24 hour sign language interpretation when needed at the AED and psychiatric wards of QMC. ➢ Provide information about this service clearly displayed in AED and on each ward and with the QMC switchboard. ➢ Produce guidance to all staff on how to use the service, why they should use it and the problems associated with the use of relatives for interpretation, citing the Code of Practice at paragraph 1.6. Reference should be made to the need for Deaf individuals to receive basic information on admission and legal rights under the Mental Health Act, as well as ensuring appropriate clinical assessment. ➢ Provide induction training on the use of interpretation services for all new medical staff.	Nottinghamshire Healthcare NHS Trust, Accident and Emergency Department Queen's Medical Centre and Nottingham Deaf Society	12, 19, 51, 52

3.	➢ Make provision for emergency psychiatric assessment facilities on AED, offering privacy and safety.	Nottinghamshire Healthcare NHS Trust, Accident and Emergency Department Queen's Medical Centre	8
4.	➢ Commission a 24 hour regional emergency service for Deaf people suffering from mental health problems, to be accessed by minicom for those who are Deaf or by telephone for hearing professionals or relatives. The service should be capable of providing advice to Deaf users, professionals and relatives, ensuring that local services are appropriately accessed and interpretation services obtained. ➢ Develop alongside this service a program of Deaf Awareness induction training for all new medical staff.	Gedling Primary Care Trust, 'Trentcom' Specialist Commissioning Forum and Nottingham Deaf Society	14, 52
5.	➢ Review the clinical risk assessment policy and if necessary revise it to ensure that it emphasises the need to listen to relatives where they may be at risk from a patient. ➢ Review information flow concerning risk between AED and psychiatric wards. ➢ Review procedures for risk assessment upon discharge from hospital to ensure that they comply with the requirements of HSG(94)27. ICPA risk assessment documentation should always be completed at the point of discharge.	Nottinghamshire Healthcare NHS Trust	12, 15, 24
6.	➢ Agree a joint procedure for receiving patients under s135/136 MHA with arrangements for interview facilities and access to psychiatrists. ➢ Provide training for all those who will use the procedure.	Nottinghamshire Healthcare NHS Trust, Accident and Emergency Department Queen's Medical Centre and Nottinghamshire Constabulary	19
7.	➢ Review the records systems within AED, DPM and nursing, and medical records on psychiatric wards, to ensure that each is accessible to the other and to on-call doctors.	Nottinghamshire Healthcare NHS Trust	15, 19

8.	➢ Develop and circulate to clinicians a cultural awareness policy. ➢ Provide an information base on cultural and religious customs. ➢ Provide and publicize a list of experts to whom clinicians can turn for information on an aspect of religious custom or cultural tradition. ➢ Provide a mandatory program of cultural awareness training for all qualified nursing and medical staff.	Nottinghamshire Healthcare NHS Trust and local representative minority ethnic groups.	59
9.	➢ Review the process for allocation of cases to social workers within the CDT. ➢ Put in place a procedure which will ensure that all open cases have an allocated social worker. ➢ Review the IT support provided to CDT to ensure that it correctly records the allocated social worker	Nottinghamshire County Social Services	44
10.	➢ Submit to the Department of Health the view of this inquiry that the Government's proposed strategy for development of mental health services for the Deaf should include a commitment to provision of 24 hour regional crisis advice services, capable of offering minicom and telephone advice. The service should be able to offer specialist advice to clinicians, assist Deaf users with access to local psychiatric services, and be capable of arranging for the provision of interpretation services.	Department of Health	14, 52
11.	➢ Jointly review the local specialist mental health service for the Deaf, with a view to establishing a local policy across Trusts and social services addressed to the needs of Deaf mental health service users, and examining the possibility of a merger of health and social services.	Nottinghamshire Healthcare NHS Trust, Nottinghamshire Social Services Department and Nottingham City Social Services Department	47
12.	➢ Review staffing levels on Ward A43	Nottinghamshire Healthcare NHS Trust	15

APPENDIX A

Terms of Reference

Terms of Reference for the Independent Inquiry into the Care and Treatment of Sarwat Al Assaf[30]

With reference to the homicide of Mr Alan Clarke on 8 November 2000, to examine the circumstances of the care and treatment of Sarwat Al Assaf by the mental health and social care services.

The Inquiry to review:

1. The quality and scope of Sarwat Al-Assaf's health and social care including

   - The circumstances of his admission to Acute Mental Health Wards at Queen's Medical Centre in September and October 2000 and his support by Mental Health Services in the community between September and November 2000.

   - The communication between Mental Health Services for hearing impairment as they affected the case of Mr Al Assaf.

2. The suitability of treatment, care and supervision provided including:

   (a) assessment of health and social care needs,
   (b) any past psychiatric history or other factors influencing assessment of health and social care needs,
   (c) the actual and assessed risk of potential harm to self and others,
   (d) any relevant cultural, ethnic, religious or disability needs.

3. The extent to which the care provided complied with statutory obligations, the Mental Health Act Code of Practice, local operational policies, relevant Department of Health guidance and recognised good practice.

4. The processes for training and development of staff in risk assessment.

5. Collaboration and communication between the agencies involved and assessment of whether all appropriate professional agencies were involved.

[30] Note that the Terms of Reference here refer only to Mr Sarwat Al-Assaf. In their original form they also included reference to Mr Mahtab Alam.

6. The adequacy of support, information and liaison with the patient's family.

7. To prepare a report of Inquiry's findings and make recommendations as appropriate to Nottingham Health Authority (or its successor body).

8. To review progress made into implementation of the Inquiry's recommendations against an agreed action plan.

APPENDIX B

Procedure to be adopted by the Inquiry

Procedure to be adopted for the Independent Inquiry into the Care and Treatment of Sarwat Al Assaf[31]

1. The following describes the procedure which the Inquiry will follow in order to obtain evidence and produce its report.

2. Following a review of the documentation the Inquiry will consider which individuals should be invited to give evidence.

3. Each witness of fact identified by the Inquiry will receive a letter which will:

    - Inform them of the Terms of Reference and the procedure to be adopted by the Inquiry.
    - Invite them to provide a written statement outlining the issues which should be covered by them in that statement.
    - Explain that after receiving their statement the Inquiry will decide whether they should also be invited to attend the Inquiry to give oral evidence.
    - Inform them that if/when they attend the Inquiry they may bring with them a friend, relative, member of a trade union, lawyer, member of a defence organisation, advocate or anyone else they may wish to accompany them, with the exception of another Inquiry witness.
    - Inform them that it is the witness who will be asked questions and who will be expected to answer.
    - Inform them that their evidence will be recorded and a verbatim transcript sent to them for their signature confirming its accuracy.

4. Witnesses of fact will be asked to affirm that their evidence is true.

5. Any point of potential criticism will be put to a witness of fact, whether orally when they give evidence or in writing at a later time, and they will be given a full opportunity to respond before the report is written.

6. Representations may be invited from professional bodies and other interested parties as to present arrangements for persons in similar circumstances.

[31] Note that the Procedure here refers only to Mr Sarwat Al-Assaf. In its original form it also included reference to Mr Mahtab Alam.

7. Anyone else who feel they may have something useful to contribute to the Inquiry may make written statements for the Inquiry to consider.

8. All sittings of the Inquiry will be held in private.

9. The evidence which is submitted to the Inquiry, either orally or in writing, will remain confidential to the Inquiry, save as disclosed within the body of the Inquiry's final report and executive summary.

10. Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments which appear within the narrative of the Report and any recommendations will be based on these findings.

11. The findings and recommendations of the Inquiry will be contained in a final report which will be presented to Gedling Primary Care Trust and which will be published.

APPENDIX C

Sarwat Al-Assaf
Witnesses interviewed/who provided written statements or other information[32]

Name	Relationship/Title/Position – People interviewed at hearings
Sarwat Al-Assaf	Patient
Susan Al-Assaf	Wife of patient
Samir Al-Assaf	Brother of patient
Norma Clarke	Mother of victim
Julie Clarke	Sister of Victim
George Reynolds	Chief Executive, Nottinghamshire Deaf Society
Sgt Raymond Clarke	Nottinghamshire Police
Linda Pask	Notts County Council Social Services – Disability Services Team
Jo Dicks	Notts County Council Social Services – County Deaf Team
Jean Goodman	Notts County Council Social Services – County Deaf Team
Sandra Duckworth	Notts County Council Social Services – Emergency Duty Team
Garry Bevis	Nottinghamshire Healthcare NHS Trust, Service Team Leader, Deaf Mental Health *(at time of incident)*
Emmanual Chan	Nottinghamshire Healthcare NHS Trust, Care Co-ordinator Deaf Mental Health
Dr Rik Coetzee	Nottinghamshire Healthcare NHS Trust, Duty SHO Ward A43, Queen's Medical Centre *(at time of incident)*
Paul Bradley	Nottinghamshire Healthcare NHS Trust, Staff Nurse Ward A43, Queen's Medical Centre *(at time of incident)*
Dr Hazel Johnson	Nottinghamshire Healthcare NHS Trust, RMO – Broxtowe & NW Mental Health Team
N De-Soysa	Nottinghamshire Healthcare NHS Trust, Nursing Staff, QMC
Dane Brennan	Nottinghamshire Healthcare NHS Trust, Ward Manager A43, QMC *(at time of incident)*
Donna Swinden	Nottinghamshire Healthcare NHS Trust, Nurse Practitioner, QMC
Dr Amin Omer	SHO Dept of Psychological Medicine, QMC *(at time of incident)*
Dr K Junaid	Nottinghamshire Healthcare NHS Trust, Duty Specialist Registrar, QMC

[32] Some of these provided information in connection with both inquiries.

Cont'd. **Name**	**Relationship/Title/Position – People interviewed at hearings**
Clive Duckworth	Associate Director of Nursing, Nottinghamshire Healthcare NHS Trust
Steve Williams	Senior Nurse, Nottinghamshire Healthcare NHS Trust
David Henry	Equal Opportunities, Nottinghamshire Healthcare NHS Trust
Richard Turner	Medical Director, Nottinghamshire Healthcare NHS Trust
Jane Craig	Manager for Nursing & Quality, Nottinghamshire Healthcare NHS Trust
Mark Morgan	Chief Executive, Rushcliffe Primary Care Trust *(Director of Nursing, Nottinghamshire Healthcare NHS Trust at time of the incident)*
Jeremy Taylor	Chief Executive, Nottinghamshire Healthcare NHS Trust

Name	**Relationship/Title/Position People who provided written statements or other information**
Mike Caston	Senior Nurse – Mental Health – Gedling PCT
Geoff Grinnell	CPN
Dr Jacklin	GP
Dr Mansford	GP
Geoff Metcalf	EDT, Notts County Social Services
Karen Nicholls	Senior Nurse, QMC
Anne Wilton	Team Manager Assessment Team- Social Services Beeston
Dr Ulrike Artus	Psychiatrist, QMC
Dr G Sawle	Consultant Neurologist, QMC

APPENDIX D

Mental Health Services for Deaf People

A Summary[1]

1. Demographics

1.1 The term 'Deaf community' has demographic, linguistic, political, psychological and sociological dimensions. Britain's Deaf Community shares characteristics born from common experiences, beliefs, values and norms. Most importantly, the community bonds through a common language (BSL) and a shared culture. The degree to which a deaf person participates in the Deaf community depends upon:

- The age of onset of their deafness.
- The degree of deafness that they experience.
- The age at which the diagnosis of deafness is made, and the effectiveness of the counselling and support that parents and carers are given.
- The type of education that the deaf person receives. That is, whether their schooling was/is based on oral/aural methods or BSL.
- Their ethnic background.
- Their exposure to, and identification with, the Deaf community.

1.2 Whilst recognising that the Deaf community share a language and a culture, services should be wary of assuming that their cultural identity, needs and aspirations are homogeneous. Diversity of ethnicity, age, gender, sexual orientation, ability and disability impact on this community, as on any other. For example, sign language variations have been developed by Black-Deaf people and gay-Deaf people.

1.3 Deaf people with mental health problems share much in common with their hearing counterparts. They require access to the same range of effective mental health services, provided by the same range of agencies and professionals, as conveniently located as possible

2. Current issues for the service nationally

2.1 In addition to the regional Deaf services developed nationally, there are, throughout England, a small number of localised and highly specialised

[33] Taken from Department of Health Discussion Document on Developing Deaf Services *A Sign of the Times, 2002*; and Merton Sutton and Wandsworth Health Authority, and Lambeth Southwark and Lewisham Health Authority (2000) *Report of the independent inquiry team into the care and treatment of Daniel Joseph* and in Forging New Channels.

mental health services for Deaf people which have grown out of the dedication of individual clinicians rather than through a co-ordinated, strategic development.

2.2 Nationally, this has produced service development which has been uncoordinated and piecemeal, with the result that health and social services are unable to provide an accessible and comprehensive service close to home for all Deaf patients.

2.3 In addition, even where specialist services have made some progress in offering local and accessible services to Deaf patients through the development of community and satellite outpatient clinics, the overall development of adult Deaf services has followed a different path from mainstream local mental health services. There has not been the same development around crisis intervention, assertive outreach or community forensic teams, and consequently care pathways are not as clear, sometimes leaving Deaf people unable to access the part of the service from which they might benefit most.

2.4 This is a complex issue for Deaf services. The patchy concentration of expertise has implications for local and national services. *Sign of the Times* highlights that very few local services have been *'grown'* from the specialised services. It recognises that recruitment and retention of staff is already an acute problem and the training of hearing staff in BSL is resource intensive. Services are therefore very vulnerable as they rely on a relatively small number of people who are highly skilled and any depletion of this resource can have a disproportionate affect on the capacity of the service.

2.5 Those concerns are echoed by the findings of the Mental Health Act Commission's 2001 National Visit, a National Consultation on Mental Health and Black and Minority Ethnic Communities, included the statement that *"access to good quality interpreting services was reported as being* ***expensive and difficult****."*

2.6 The three documents - *The Daniel Joseph Inquiry* (the short summary of Deaf services at Appendix 1 is useful)*, A Sign of the Times* and *Forging New Channels* - together provide a good reference point for any more detailed examination of issues concerning Deafness.

APPENDIX E
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APPENDIX F

Glossary of Terms

AED	Accident and Emergency Department
BSL	British Sign Language
CDT	County Deaf Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
DDA	Disability Discrimination Act
DPM	Department of Psychological Medicine
GP	General Practitioner
HoNOS	Health of the Nation Outcome Scale
MHA	Mental Health Act 1983
NDS	National Deaf Service
PCT	Primary Care Trust
QMC	Queen's Medical Centre, Nottingham
SHO	Senior House Officer
SN	Staff Nurse
SpR	Specialist Registrar