VERITA

INQUIRIES - INVESTIGATIONS - REVIEWS

Report of the independent review of the care and treatment of Sherzad Muhamed

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1. Summary

In July 2003, Sherzad Muhamed, a Maidstone resident who was receiving NHS outpatient treatment for anxiety and depression, committed a murder for which he was convicted in September 2004. After his arrest and before his trial Sherzad Muhamed was transferred from prison to a secure inpatient mental health unit under section 48 of the Mental Health Act 1983.

West Kent NHS and Social Care Trust (the Trust) conducted its own investigation into the care they had provided to Sherzad Muhamed prior to the offence. Subsequently Maidstone Weald Primary Care Trust, with the support of Kent and Medway Strategic Health Authority, decided to commission an independent review to determine whether the services provided to Sherzad Muhamed had been appropriate in the circumstances.

This independent review concludes that with some few qualifications the care provided by both the GP and the Trust was appropriate. Sherzad Muhamed had been in contact with local NHS services for about one year before the offence. He was able to access services without difficulty; both the GP and Trust took measures to overcome communication problems (albeit with limited success); referrals were prompt; the assessment and investigations were reasonable in the circumstances and there were indications that treatment was having effect. The team found nothing to suggest to the clinicians that Sherzad Muhamed was a significant risk to himself or others. However, the review found that Sherzad Muhamed himself had a poor understanding of his diagnosis and treatment and how this was planned to continue.

The services did not comply with the Trust's own policy and procedures for following the Care Programme Approach (CPA) to planning and delivering mental health services, but there was no evidence in this case that this had significant bearing on the care provided to Sherzad Muhamed or on his subsequent actions. The review also found that those in contact with Sherzad Muhamed were not clear

how best to deal with his concerns about welfare benefits but again there was no evidence that this influenced subsequent events.

The recommendations from the review address these points.

Since the period under investigation the Trust has improved compliance with the CPA procedures and now provides access to welfare advice.

2. Introduction

2.1 The background

In September 2004 Sherzad Muhamed, a Maidstone resident, was convicted of the murder of Richard Cromarty on 15th July 2003 at 67 Kingsley Road, Maidstone, a lodging house where both men had been living. At the time of the offence Sherzad Muhamed was receiving treatment under the NHS for a "mixed anxiety and depressive disorder". In November 2002 he had been referred by his GP to the specialist mental health service of West Kent NHS and Social Care Trust (the Trust) and since then had been seen four times as an outpatient. A further appointment had been arranged for 1st August 2003.

An Iraqi Kurd, Sherzad Muhamed was 28 at the time of the offence. From his own accounts to others, it appears that he came to the UK seeking asylum in late 1999 or early 2000. (In 2003 he was granted the right of permanent residency). Sherzad Muhamed initially spent some 18 months in hostel accommodation in West Bromwich before moving to Kent. He took up work at a bakery in Maidstone, living initially in Gravesend and then moving to Maidstone where he occupied a room in rented accommodation at 67 Kingsley Road. In June 2002 he was registered with a local GP Practice. He was employed at the bakery for six or seven months before stopping work on the grounds of ill health. Thereafter he subsisted on sick pay for three months and subsequently on other welfare benefits. He continued to live at the Kingsley Road address until the day before the offence, when he moved out of the property apparently without making alternative arrangements.

After his arrest on 17th July 2003, Sherzad Muhamed was held in custody at Elmley Prison. Following assessment in the hospital facility within the prison he was transferred on 16th December 2003 to the Trevor Gibbens Unit, a medium-secure mental health inpatient service, under Section 48 of the Mental Health Act 1983.

When notified of the offence and the arrest of Sherzad Muhamed, a patient under active supervision as an outpatient, the Trust investigated the case as a serious untoward incident. The ensuing report - a "clinical practice review" - was submitted to the Kent and Medway Strategic Health Authority (the SHA) and to Maidstone Weald Primary Care Trust (the PCT) on 25th March 2004. Subsequently both the SHA and PCT decided to commission Verita to conduct an independent

review of the circumstances and to establish what if anything might be learned from the case.

2.2 Terms of reference

The terms of reference for the review envisaged an initial phase of fact-finding from documentary evidence followed if necessary by further investigation including interviews. The full terms of reference are set out in appendix 3.

This report incorporates the findings of both phases of the investigation.

2.3 Conduct of the review

The review was conducted for Maidstone Weald Primary Care Trust by Roger Townsend (chair), a Verita associate, and Mark Edmond from Hampshire Partnership NHS Trust. Inquiry administration was provided by the PCT. Brief credentials of the panellists are in Appendix 1.

The PCT having obtained Sherzad Muhamed's consent to disclosure of these documents for the purposes of this review, the team was provided with a copy of the full medical record for Sherzad Muhamed held at the Trust (including documents relating to the period following the offence); relevant Trust policies and procedures; the police report relating to the offence; and the transcript of the judge's summing up at the trial. The team was unable to see the patient's GP medical record. This had been seized by Sherzad Muhamed and taken from the surgery shortly before the offence. It has been unavailable since and is presumed to have been lost. The GP (Dr Patel) was unable to retrieve any computer records relating to Sherzad Muhamed; the practice had changed computer system in August 2004 and it appears that relevant records were not transferred. The GP practices with which Sherzad Muhamed was registered previously provided details of his medical history before registering with Dr Patel. The team had access to the notes relating to Sherzad Muhamed's single outpatient attendance at The Maidstone Hospital for cardiology investigations.

Having reviewed the available documents, the team identified the need to clarify a number of matters with the clinicians responsible for assessing and treating Sherzad Muhamed and to obtain further background on the relevant Trust procedures and practice at the time. Finally the team interviewed Sherzad

Muhamed (through an interpreter) to hear his recollection of events. Mark Edmonds could not be present for two interviews; his place was taken by Barry Morris, a director of Verita. The individuals interviewed are listed in Appendix 2. The team felt that the information obtained from these interviews was sufficiently comprehensive to enable them to answer the terms of reference and that no further interviews were necessary.

2.4 Chronology

In this and the following sections Sherzad Muhamed is abbreviated to SM.

SM first registers with GP in Birmingham	19th July 2001
SM transfers to GP in Gravesend	27th October 2001
SM moves to Maidstone	February 2002
SM registers with GP practice (Dr Patel)	27th June 2002
GP refers SM for cardiology investigations	23 August 2002
GP refers SM to the Trust mental health service	26 November 2002
Appointment for mental health clinic sent to SM	3 December 2002
First mental health outpatient attendance (SHO Dr Uzodike)	18 December 2002
Cardiology outpatient attendance	6 January 2003
Second mental health outpatient attendance (Dr Sivakumar & SHO Dr Joshi)	29 January 2003
Third mental health outpatient attendance, with Interpreter (Dr Sivakumar)	9 April 2003
Appointment in clinic cancelled at short notice	28 May 2003
Letter from GP requesting early alternative	29 May 2003
Fourth mental health outpatient attendance, with Interpreter (Dr Thapa)	11 June 2003
Murder of Mr Cromarty	15 July 2003
SM arrested	17 July 2003
Outpatient appointment mental health	1 August 2003
SM transferred to Trevor Gibbens Unit	16 December 2003
Trial	28-30 September 2004

3. Findings

3.1 The suitability and appropriateness of services provided to Sherzad Muhamed

3.1.0 Contacts with the NHS before June 2002

Prior to his move to Maidstone and registration with the Holland Road Surgery (Dr Patel) on 27th June 2002, SM had been registered successively with GP practices in Birmingham (from 19th July 2001) and Gravesend (from 27th October 2001).

The computer record at the Birmingham Practice (Victoria Road Surgery) indicates that SM attended twice for essentially routine purposes and then on a final occasion, on 11th September 2001, consulted the GP with concerns about his weight, which the GP recorded was normal.

During his eight months with the practice in Gravesend (Gravesend Medical Centre) SM consulted twice. On 30th October 2001 he was treated for conjunctivitis, but the notes also record some stress-related symptoms (palpitations and sleeplessness), and SM mentioned his father having died 3 weeks previously. SM returned to the GP on 22nd January 2002, with the same stress-related symptoms (again mention was made of his father's death). He was prescribed a 28-day course of citalopram and asked to return if he did not feel better after the treatment. According to the practice records he did not return. The team found no reference by SM before or after the offence to his contacts with the NHS prior to his arrival in Maidstone.

3.1.1 Primary care in Maidstone

SM appeared to have no problem registering with a GP practice close to where he was living in Maidstone, though it is not clear why he delayed in doing so after his arrival in the area. It is unlikely this is significant since the team found no reference to this period in any of the documents available to us.

After registering in June 2002, SM consulted his GP feeling himself to be physically ill on several occasions. He ceased work for reasons of ill health and Dr Patel ratified his claim for sickness benefit. On 23rd August 2002, Dr Patel referred SM to The Maidstone Hospital for cardiology investigations and then after a further

consultation in November 2002 Dr Patel referred SM for a mental health assessment. Feeling that language difficulties were obstructing communication, Dr Patel arranged an interpreter to be present for the consultation with SM on two occasions.

Dr Patel told the team that he was not convinced that SM had genuine physical symptoms warranting specialist cardiology investigation nor was his mental ill-health at the time such that it could not be managed within primary care. During this period Dr Patel initiated medication for depression. This was citalopram, the same drug prescribed in January by the Gravesend practice, which by implication had helped SM previously (since he did not return with symptoms after the initial course of treatment). This medication was continued whilst SM was being seen as an outpatient. However, Dr Patel judged that it would reassure SM to be checked by specialist services and felt this would contribute to restoring SM's confidence in his own health and help him to "find his feet".

The outcome of the cardiology assessment, notified to Dr Patel in a letter written on the day of the appointment (6th January 2003), confirmed his view that the physical symptoms were "psychogenic"; a range of investigations and tests had found nothing physically abnormal. The cardiologist did however comment on SM's anxiety and reference to unspecified social problems, and suggested that he might benefit from psychiatric help. By this time SM had already attended his initial appointment with the Trust mental health service. It appears that Dr Patel did not pass on the results of this cardiology assessment to the Trust, nor did the Trust follow this up with Dr Patel.

Dr Patel said that SM often asked him to write a letter which would help SM "get more money". Dr Patel had repeatedly advised that he could not do this; he assumed that SM would be in contact with the relevant welfare agencies since he was already receiving benefits. It was in part because he felt that SM was failing to understand this that Dr Patel sought the services of an interpreter (which he said was the first time that as a GP he had ever found this necessary).

Dr Patel reported that SM had on two occasions taken away medical record documents - firstly a letter, which was returned shortly after, and then the record in its entirety. Following the first incident Dr Patel had warned SM that any

repetition would be reported to the police. When the full record was taken, Dr Patel informed the police though he believed that SM would return the documents in due course. Dr Patel was unable to give the exact date when the record was taken though he recalled that this was a matter of only a few days before the offence and SM's subsequent arrest. The team understood that further action to retrieve the records was overtaken by events and SM was not able to shed any light on their whereabouts.

No reason was found why the non-medical aspects of SM's situation that might have had a bearing on his mental health - housing, employment, social contacts, family and personal relationships, use of alcohol or drugs - should have suggested to the GP the need for other agencies to be brought into the picture at this time. There is no evidence that SM had involvement with local Social Services - the team can see no reason why he should have had. However, what the team heard about SM's persistence that he should receive more benefits does suggest that he did not have a good understanding of what he might reasonably expect. The review has not investigated the nature of SM's contacts (if any) with other agencies.

In May 2003 SM attended for his appointment at the hospital to find that the mental health outpatient clinic had been cancelled. Upset at this, the next day SM went to his GP (Dr Gaston) and said that he would report this to the police. Dr Gaston dissuaded SM from this (SM said that he was advised "not to tell anybody") and immediately wrote (faxed) to the hospital asking for an early appointment, saying that SM was "exceedingly distressed, verging on the suicidal and obviously unable to wait six weeks".

SM told of one further contact with the NHS. About a year before his arrest he said he had been treated at The Maidstone Hospital Accident & Emergency Department for injuries caused when he was assaulted. The injuries were apparently minor and SM said that the treatment was satisfactory but he found Dr Patel unhelpful following this incident, though the substance of the complaint was not clear to the review team. Dr Patel could not recall such an incident.

This history suggests that SM had no difficulty accessing primary care NHS medical services - registering with and being seen by a GP - either locally or before his move to Maidstone. SM was able to confirm this. In Maidstone he appears to have

enjoyed normal access to his GP and to have received appropriate and sympathetic treatment including referrals for specialist opinion. The GP recognised the need for and organised an interpreter, and forewarned the Trust about this. When one clinic was cancelled, the GP immediately asked the Trust to rearrange an early appointment. However, SM expressed dissatisfaction with his relationship with Dr Patel; he had begun to feel that his treatment was not effective (he believed that the medication was simply to help him sleep) and he felt that Dr Patel did not show him and his problems sufficient consideration. He said he was personally offended by Dr Patel's attitude, which culminated in his removing his medical records.

3.1.2 Secondary care

The Trust received SM's referral on 28th November 2002. Dr Patel referred SM to a named consultant, Dr Sivakumar, which the review team understands was usual practice at the time. Dr Patel referred in his letter to SM's "symptoms of severe anxiety and underlying depression - mainly to do with body image ... continually maintains that he is ill, weak and is rather paranoid about the way he looks!". Dr Patel had started SM on anti-depressant therapy and medication to help him sleep. From this information the Trust assessed SM as "medium" urgency and gave an appointment on 18th December. Thereafter outpatient appointments were arranged at approximately six weekly intervals.

SM was initially assessed and thereafter seen exclusively by doctors as an outpatient in what was a conventional medical model of practice. The team believes that this will not have been unusual at the time.

The notes of the initial consultation indicate that the assessment was methodical - successively addressing SM's own account of his symptoms, psychiatric and medical history, use of alcohol, smoking and recreational drugs, family and personal history, social circumstances, mental state and how SM presented at the interview. Although no interpreter was present (see below), the notes suggest that SM was able to give a detailed account of his symptoms and anxieties and was questioned about matters and events that might have had a bearing on these, for example the circumstances of his leaving Iraq, including his imprisonment for five days, and the subsequent death of his father from a heart attack. The notes do not mention specific enquiries about body image or paranoia associated with this but they do

record that SM attributed "all these problems with his body" to a number of physical complaints including chest pain radiating to the arm, palpitations, back ache, tiredness, difficulties sleeping. He described feeling unhappy, loss of appetite, occasional tearfulness. He admitted to occasional thoughts of self-harm which he attributed to the pains he was experiencing, but said that he would not act on them. There were no indications of psychosis. The notes record that SM had few friends and was not in any relationships. SM wanted to get well and felt that "coming to hospital can help". The notes record the need for routine blood tests and a cardiac assessment and the decision to continue present medications. The team found these notes to be reasonably thorough and the facts recorded to be consistent with the notes of the later consultations at which an interpreter was present. However, neither these notes nor those of later consultations were recorded in the format required by the Trust's policy relating to the Care Programme Approach (CPA) - see below - with the implication that neither did the process of assessment and questioning comply with the CPA methodology.

The notes record difficulties in communication that had been predicted by Dr Patel but no interpreter was present for the initial or for the second appointment. Dr Sivakumar said that it had not been straightforward to arrange an interpreter, initial informal efforts having failed, but an interpreter was requested and available for SM's attendances in April and June. However, the absence of an interpreter appears not to have prevented the SHO who first interviewed SM (Dr Uzodike) from taking a satisfactory history. Later interviews with the interpreter present did not add to this information any new details that as far as the team could judge changed the assessment or treatment.

Unsurprisingly SM was not able to give a clear account of the successive outpatient consultations, though he recalled that one doctor (we infer Dr Uzodike) had sought out a colleague to help with interpreting. SM recalled that throughout this period he understood some but not all of what was said during his appointments and that he was not always able to explain how he felt, even when an interpreter was present.

Dr Sivakumar said that his judgement had been first to investigate any possible physical causes for the alleged physical symptoms that dominated SM's account of his problems. At the same time he concurred with the GP's assessment that SM had

an anxiety and depressive disorder, but not such as to represent a significant risk to himself or others, nor to need any immediate change to medication. The results of the blood tests and cardiac investigations were not available for SM's second appointment on 29th January (although the latter had been completed and reported to the GP). The notes suggest that little new emerged at this consultation - SM again reported chest pain and anxieties about dying with a heart attack, explicitly relating these to the death of his father with similar problems. It was decided to continue current medication.

Dr Sivakumar was aware that SM had been referred by the GP for cardiac investigation. Dr Sivakumar could not recall obtaining the results of these investigations and he did not believe that he had been informed specifically of the outcome, though SM had mentioned that his ECG had been normal (and Dr Sivakumar had recorded this in the notes of the consultation on 9th April), from which he inferred that the cardiac investigations had found nothing abnormal. The blood tests undertaken following SM's consultations with the mental health service had been normal.

At the third consultation on 9th April, at which an interpreter was present, Dr Sivakumar rehearsed SM's personal history, confirming the account given previously and evidently went further in exploring the circumstances of SM's imprisonment - the notes record specifically that SM had not been tortured. This episode was explained as related to SM being "asked to change religion". (In a later interview, after his conviction, SM explained that the imprisonment and his decision to leave Iraq were because of pressure to relocate to a Kurdish area of the country). SM again referred to chest pains as the source of his main problem, feeling "fearful, depressed, tearful ... somewhat hopeless". The notes record that "the interpreter feels that it may be to do with his father's death". At this consultation SM had no thoughts of self-harm or suicide and reported no loss of appetite, which were changes since the initial assessment. Dr Sivakumar requested further blood and urine tests and prescribed an alternative anti-depressant, mirtazapine.

Dr Sivakumar said that the clinic in May had been cancelled because his sick leave had been extended unexpectedly. The team heard that it was normal practice in these circumstances for clinic staff to inform patients beforehand, typically by

phone or failing that and if time allowed, by letter. Any such efforts evidently did not reach SM. On attendance he was apparently told that he could be seen in six weeks time but the Trust did arrange an earlier appointment (within two weeks) following representations from the GP on the following day.

The notes of SM's final outpatient attendance (11th June, again with interpreter present), and the ensuing letter to the GP record his condition as having improved - SM "is feeling better and less anxious than before ... is eating and sleeping well and did not complain of chest pain". SM confirmed that this was likely, but that this improvement was not stable; his symptoms continued to fluctuate. SM had raised questions about welfare benefits - and the psychiatrist (Dr Thapa - Dr Sivakumar was still on sick leave) had suggested he speak to the GP about these. Consistent with the earlier assessments there is no suggestion that SM was a significant risk to himself or to others. An appointment was made for SM to attend the CMHT in August.

Dr Sivakumar explained that from referral until the fourth outpatient attendance in June 2003 SM remained under assessment - there were no indications that SM needed particular support from any other agency. The appointment arranged for August, which was with the Community Mental Health Team (CMHT), would have resulted in a care plan for SM under CMHT supervision. The review team was told that this would have been a typical progression for a patient who had been medically assessed and was responding to treatment but who might benefit from the specialist support and supervision available from a multi-disciplinary team. SM had no recollection of what further treatment or care was intended for him at that point.

3.2 Compliance with best practice

The canon of best practice most relevant to this review is the Department of Health guidance relating to the Care Programme Approach (CPA), first set out in *HC(90)23* and developed in successive publications including *"An audit pack for monitoring the CPA"* (1996), *"Effective care co-ordination in the mental health services: modernising the CPA"* (1999), *"The journey to recovery: the Government's vision for mental health care"* (2001). The overall context for the delivery of services and in particular the implementation of CPA is the *National Service Framework for Mental Health Services* (NSF) published in 1999.

The principle requirements of the NSF and specifically the CPA in relation to this case can be summarised as:

- Ready access to services and prompt and appropriate referral
- Systematic assessment of medical and social needs
- Care planning to meet these needs
- The allocation of a key worker or co-ordinator of care
- Regular review

For the reasons set out below, the findings in this case lead the review team to focus on the process and more specifically the recording of the needs assessment, particularly around risk, and whether this had any bearing on the outcome. There is also a question about the status of the care planning for SM.

In September 2002 the Trust formally adopted "The Kent and Medway CPA - Policy and Procedures", which was a unified health and social services approach setting out the process and documentation to be followed for all those referred to secondary care mental health services. Compliance with this policy would have fulfilled the requirements of the DOH guidance.

Those interviewed at the Trust were frank in admitting that although this was current policy, at that time (November 2002) compliance with every detail of procedure was at best patchy. In particular it was said that medical staff had not yet been persuaded to document their assessments using the standard forms and that some aspects of the process - for example the single point of referral (rather than referral to named consultant) - had yet to be introduced. The team was told that there was still some resistance to accepting the need for the paperwork, although Dr Sivakumar recalled that the relevant forms were not actually available to front-line staff at the time. In summary, although there was corporate support, conditions were not yet in place for the policy to be adopted as normal practice throughout the Trust.

Several factors were put forward to account for this. The Trust had only recently been established following merger (in April 2002) and the process of consolidating the organisation and standardising practice was still underway. The Trust's information system was not capable of supporting implementation and the change in practice was recognised to be a profound one which would realistically be implemented only through a sustained programme of training, support and maintenance, monitoring and audit.

The review team was told that the failure to use the prescribed forms (CPA2 and CPA4 - Appendix 4) did not imply that the process of assessment was deficient. The team was assured that the assessment of patients would have addressed both medical and social needs and that all the risk factors identified in these forms would have been considered as a matter of course. The team accepts that the medical notes of the initial consultation with SM are largely consistent with this picture - the notes address the great majority of the risk factors and topic fields set out in forms CPA2 and CPA4 (the principal omissions are reference to sexual risks, religious and cultural needs, advocacy, housing and work situation). The notes of the subsequent consultations are not as thorough or methodical (and those of the January and June consultations are particularly brief by comparison), although SM's housing and work situation were mentioned in the April consultation. The failure to follow the CPA assessment process meant that there was no explicit, structured account recording the consideration and subsequent re-consideration of all potential risk factors bearing on SM and his circumstances. This is clearly less than ideal even though it does not appear in this case to have resulted in factors significant to SM's mental state at the time being overlooked.

Whilst SM was not - in the strict terms of the Trust policy - designated as needing "standard" CPA, this was in effect the outcome of the initial assessment. It appears from the notes and was confirmed through subsequent consultations that in virtually all respects SM met the conditions of a typical candidate for standard CPA. On the evidence recorded:

- His needs were primarily for the services of the NHS. There was no evidence that he might need even low key support from other services

- He appeared able to self-manage his treatment.

- He presented little danger to himself or others.

- He readily maintained contact with services.

However, in one respect - in that he did not have an active informal support network of family and friends - SM was less typical, and was potentially vulnerable. His ethnicity and status as a former refugee may have accentuated any vulnerability. It is arguable whether in the circumstances this in itself should have prompted the psychiatrists to hasten a referral to the CMHT or to involve some other agency to support SM. However, although the notes record the fact of his isolation from family and lack of close friends they give no indication that this aspect of his situation was particularly significant to SM himself. There is no mention of his feeling lonely or of his shunning social contact (as was suggested in Dr Patel's referral letter). It is not clear from the notes how far this was probed by the psychiatrists. Dr Sivakumar said that he had formed the view of SM as a shy individual but he did not recall that lack of social contact was a problem for him. (In an interview after his conviction, SM said that he had made friends locally, including a girlfriend, and would often go out into the town centre. During the interview with the review team SM also referred to friends.)

The CPA requires that following assessment a care plan should be drawn up, a copy given to the patient and a care co-ordinator assigned. The medical notes and initial letter to the GP record decisions about how SM was going to be managed - the essentials of a care plan - and the team heard that these were explained to SM, but no plan was issued. This was perhaps not unusual given the decision to maintain current medication and continue the assessment until possible underlying physical causes had been investigated, but at interview SM appeared not to understand the rationale for his treatment nor how it was to continue. The team was told that a comprehensive care plan would have been produced on SM's adoption by the CMHT. Given the way that SM was being managed during this period of assessment, the formal allocation of a care co-ordinator would have been rather notional.

3.3 Collaboration and communications

Communication between the GP and the Trust was generally satisfactory (in both directions) and on occasion notably prompt and effective. It did not appear that there was contact between the two specialist services (in separate Trusts) that were seeing SM. In his referral letter, Dr Patel had mentioned that he had referred SM for cardiac opinion. The team found no evidence that the Trust had followed this up either with the GP or directly with the cardiology service. In the circumstances - where concern about his heart was a dominant cause of anxiety for SM - the team would have expected this, to ensure there was no confusion about the results of any investigations. It appears that the Trust may have relied on SM's own account of the outcome of the cardiology appointment.

Communication with SM was recognised as problematic by the GP and later by the Trust clinicians. Steps were taken by both to address the language difficulties, albeit in the Trust case not until the third appointment, even though the GP had recommended at the outset that an interpreter would be useful. In the event this delay in arranging an interpreter did not delay the initial assessment or investigations of SM, and it was decided to continue with the drug therapy initiated by Dr Patel. Following the initial consultation arrangements should have been made for an interpreter to be present at the second consultation (in January). The team was unable to establish why an interpreter was not requested formally until after this appointment.

The case does suggest a lack of clarity or possibly understanding about roles and responsibilities with regard to accessing advice and help with non-NHS services. At the outpatient appointment in June, Dr Thapa advised SM to take up his questions about welfare benefits with the GP but Dr Patel took the view that he was not equipped to deal with these. He believed that the onus was on SM to pursue matters of this sort with whoever he was already in contact about his benefits. SM said that he had attended interviews about benefits and filled in forms as best he could (with the help of friends), but it was clear from his account of this and other aspects of his experience that SM found dealing with the various public services difficult and confusing.

4. Conclusions

Having seen records relating to the offence and the period following SM's conviction, the review team formed the view that SM cannot have been an easy patient to assess and understand in the relatively brief period during which he was being seen as an outpatient (a total of some two & a half hours contact over the period December to June). Communication with SM was significantly complicated by difficulties with language and cultural unfamiliarity. At interview SM was co-operative but appeared diffident and reticent about aspects of his experience. He appeared confused about events before and since his offence and it was not always easy to follow his explanations. The fact that the review team saw SM together with an interpreter with whom he was familiar gave some indication of the difficulties that must have arisen without an interpreter or with an unfamiliar interpreter. For these reasons one could not have been confident how well SM understood his diagnosis and treatment (though he was emphatic that he complied with prescribed medication). Nevertheless, the review team found the clinical management of SM in both primary and secondary care to have been generally satisfactory.

The services provided to SM were appropriate, readily accessible and generally prompt, with the exception of the provision of an interpreter for the initial outpatient appointments. The team accepts that the clinical evidence obtained from the successive outpatient consultations supported the treatment plan of controlling or alleviating the symptoms of depression whilst excluding the possible physical causes that evidently pre-occupied SM. This was consistent with the GP's original diagnosis. The prescribed drugs are conventional first-line treatment for depression, within the guidelines of the National Institute for Clinical Excellence. The notes also suggest that this treatment was proving effective to the extent that at his final outpatient attendance SM reported feeling better and being free of his earlier symptoms. SM recalled that at that time his condition was "up and down" and that he had said this to the doctors. There is no mention of this in the notes.

There is one aspect of SM's reported condition - the concerns about body image mentioned by Dr Patel in the original referral - that does not appear from the notes to have been mentioned by SM nor to have been explored specifically in the outpatient consultations. The notes do record that SM associated all the problems with his body with a possible heart problem and there is no reference to his

mentioning any concerns about his appearance but in the light of the referral letter the team would have expected the assessment to have addressed this question explicitly and the notes to have recorded this. SM confirmed that he did not raise this as a problem during the outpatient consultations but could not explain why.

The team found that the consultations with SM had considered but found no evidence for psychosis. The notes contain no explicit reference to the possibility of post-traumatic stress disorder, but the team was assured that this was considered as a matter of course. It is reasonable to infer this from the notes, which record that the consultations explored the circumstances around SM's decision to leave Iraq and that SM had not been tortured. He made no mention of having suffered or witnessed extraordinary maltreatment or abuse nor did he describe intrusive memories or flashbacks. The team found no reference to a prior traumatic experience in any of the notes of interviews with SM.

The Trust can be faulted on process in not complying with their own CPA policy, specifically not using the risk assessment documentation (CPA4). The team accepts some mitigation on this point for the reasons given in section 3.2 and believes that it would not have been unusual at that time for mental health services elsewhere to be in a similar position with regard to implementing CPA procedures. However, the failure to follow the structured approach to recording history, assessing and subsequently re-assessing risk enshrined in the Trust's own CPA policy and procedure manual is regrettable. From the evidence available in this case the team cannot say that the assessment and treatment of SM would have been any different had the clinicians used the process and record forms set out in the Trust CPA policy, but this is a possibility.

However, the team found that the clinicians could not reasonably have concluded from the evidence available to them that SM was at risk of behaviour dangerous to himself or others such as subsequently occurred. In the team's view it would not be reasonable to hold that SM's behaviour around the time of the offence or subsequently could be predicated on the symptoms and behaviour he had shown whilst being seen as an outpatient.

The team found that the Trust should have followed up the results of SM's cardiac investigations. This would be normal practice in such a case. That this apparently

did not occur suggests oversight, although the team does not believe this to have influenced subsequent events.

The non-medical aspects of SM's circumstances - *as he reported them* - were not sufficiently problematic to have prompted other interventions at the time. The question of how SM should have been helped to clarify questions about his entitlement to benefits is an exception, and though the team sees no reason to believe this had any bearing on subsequent events, this might be viewed as one indication of a more general vulnerability. Having accepted SM as an appropriate referral and having heard that he was concerned about his entitlement to benefits - which may have contributed to his anxiety - the onus should have been on the Trust to steer SM towards the advice he needed. This may have occurred later, had SM been taken on by the CMHT. The team believes that it would also be reasonable to expect primary care to be capable of sign-posting patients towards appropriate forms of welfare advice and support, for example the Citizen's Advice Bureau.

The Trust must accept criticism for the delay in arranging an interpreter when the GP had clearly recommended this. In the event the notes of the initial outpatient assessment appear thorough but it is reasonable to assume that communication would have been easier - and the consultation in January possibly more informative -had an interpreter been involved from the start. However, it was not clear that SM felt the involvement of interpreters at the consultations in April and June made a crucial difference to what he communicated or understood. The team noted that a different interpreter attended the consultations in April and June; there would be obvious advantages in continuity and familiarity if the same interpreter could be used for all contacts with a patient.

At interview, SM described a gradual loss of trust in his GP, Dr Patel, to the point at which he removed his medical record from the surgery (though without any clear idea of his next steps). Dr Patel recalled some difficulties in his encounters with SM (for which reason he had brought in an interpreter) but he did not believe that the relationship with his patient had broken down in the way SM described. The team could not fault Dr Patel's actions, firstly in commencing treatment then subsequently referring SM for specialist assessments and bringing in an interpreter, and could not reconcile these conflicting views.

5. Recommendations

In the light of the conclusions the team makes the following recommendations recognising that the Trust has made significant progress implementing the CPA since the period under review. The team was reassured that although the Trust information systems still lack the full capability to support the CPA, procedures are audited on a regular basis, compliance had steadily improved and there is commitment from the medical staff to introduce improved formats for standard records, care plans and letters to GPs. The team was also told that the Trust now provides access to a welfare and benefits adviser.

- The Trust should ensure that patient assessments including explicit risk assessments are conducted and documented as required in the CPA policy.

- The Trust should ensure that effective arrangements are in place to share relevant clinical information when a patient is being assessed by or is receiving treatment from other specialist services.

- The Trust should ensure that all patient services are able to expedite access to interpreters. Where possible the same interpreter should be available throughout the course of a patient's treatment.

- The PCT should ensure that all GP practices are able to direct patients to specific contacts for welfare advice.

Appendix 1

Roger Townsend has worked in health care management for over 26 years including significant experience as a consultant overseas. Roger held senior management positions in hospital, primary care and health authority sectors of the NHS and has been responsible at one time or another for most of the general management functions within a Health Authority, having worked at Board level for over 12 years. He was Chief Executive of West Sussex FHSA and latterly a senior director of West Sussex Health Authority. As an independent consultant Roger has worked in the fields of substance misuse, the criminal justice system and prison healthcare and with Professor Robert Tinston has recently conducted independent inquiries at the Royal National Orthopaedic Hospital (Stanmore) and Royal Wolverhampton Hospitals NHS Trust.

Mark Edmond is currently the Team Manager of a CMHT in Hampshire Partnership NHS Trust. Mark held various nursing and senior nursing positions in the UK, specialising in forensic mental health and intensive care before moving to Australia to work for New South Wales Corrections Health Service. Diversifying into acute adult mental health Mark managed inpatient services, crisis resolution and assertive outreach teams before returning to the UK to develop assertive outreach services in Mid Hampshire.

Verita is a specialist consultancy which undertakes the management and conduct of inquiries, investigations and reviews in the public sector in the UK, including adult social care, children's services and the NHS.

Appendix 2

Interviewees

- Dr S A Patel (Sherzad Muhamed's GP)
- Dr K Sivakumar (consultant psychiatrist)
- Mr Kevin Lindsay (Trust director of Adult Mental Health Services)
- Ms Margaret Vickers (Trust Care Programme Approach manager)
- Sherzad Muhamed (with interpreter)

Appendix 3

Maidstone Weald PCT independent review into the care and treatment of Sherzad Muhamed

Commission

The independent review is commissioned by Maidstone Weald Primary Care Trust in accordance with guidance published by the Department of Health in circular HSG(94)27, *The Discharge of Mentally Disordered People and their Continuing Care in the Community*.

Terms of reference:

Stage 1 – Fact finding from available documents & initial evaluation:

1 to review available documentation (internal management review, case records and local operational policies) and prepare a preliminary report on the treatment and care provided to Sherzad Muhamed by health and social care services from his arrival in the United Kingdom until the time of his arrest in July 2003.

2 on the basis of available information, to assess the suitability and appropriateness of those services in view of the patient's assessed health and social care needs.

3 on the basis of available information, to review the extent to which those services corresponded with statutory obligations, relevant national guidance and local operational policies and to identify any deficiencies.

4 on the basis of available information, to examine the adequacy of collaboration and effectiveness of communication with/between all agencies who had contact with Sherzad Muhamed.

5 to assess the adequacy and comprehensiveness of the information gathered, and in light of the known facts about the case, to provide an assessment of the requirement for further investigation, including additional documentation to be gathered and interviews to be held.

Stage 2 - Further investigation through interviews (if necessary) & concluding evaluation:

6 to conduct interviews as required to establish further material facts or clarify matters raised during stage 1.

7 to prepare a report on the findings and to make recommendations to the responsible bodies so that as far as possible in similar circumstances in the future, harm to patients, staff and the public is avoided.

Approach

The panel will conduct its work in private and be expected to take as its starting point the internal management inquiries and medical and social care records. Additional source documents will be reviewed and interviews conducted as determined by the panel.

The panel will follow established good practice in the conduct of interviews, for example offering the opportunity for interviewees to be accompanied and given the opportunity to comment on the factual accuracy of notes.

Timetable

The initial fact finding phase should be completed within 4 weeks of the documents being made available to the panel.

The precise timetable of the second phase of the review will be dependent on a number of factors, including the panel's own assessment of the need for information and the number of interviews necessary. The panel is asked to aim to have completed the review, or a substantial part of it, within 6 months of starting its work. Monthly reports on progress should be provided to the Primary Care Trust.

Publication

The outcome of the review will be made public. The nature and form of publication will be determined by the Primary Care Trust. The decision on publication will take into account the views of the chair of the review panel, relatives and other interested parties.