REPORT OF THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF MARIAM MILES

December 2006

Commissioned by North East London Strategic Health Authority and published by its successor organisation NHS London

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CONTENTS

INTRODUCTION

Background

1. On 5 July 2004 Mariam Miles was convicted of the manslaughter of her husband, Edward Miles, a 45-year old school teacher. The incident took place on 2 May 2003. His body was discovered at the family home in Tower Hamlets in London, in a bath of water, following an emergency call to the police made by Mrs Miles. The post mortem revealed that he had been stabbed repeatedly with a knife and was dead before he was put in the bath.

2. Mrs Miles was arrested on 3 May but initially she denied any involvement in the killing. Sheikh Mohammed Danish, who was thought to be an accomplice in the killing, was arrested on 17 May. Mrs Miles and Mr Danish were both charged with murder and they each pleaded not guilty. She was remanded in HMP Holloway. On 30 December 2003 she was transferred to a secure psychiatric ward in the John Howard Centre, under the provisions of the Mental Health Act 1983. In July 2004 Mrs Miles changed her plea to guilty of manslaughter on the basis that:

   2.1 She suffered from schizo-affective disorder which, at the time of the killing of Edward Miles, would have substantially impaired her responsibility.

   2.2 She suffered from delusions that she was being persecuted by her husband.

   2.3 Motivated by the delusions, she complained to Mr Danish that she was being abused and badly treated by her husband.

   2.4 She encouraged Danish to “teach her husband a lesson”.

   2.5 She took no part in the physical beating but was present, sitting on the bed, whilst Mr Danish beat her husband with a piece of wood and later stabbed him with a knife. She accepted that by her presence she encouraged Mr Danish to do this, and that she intended such

encouragements. She believed at the time that it was necessary to free her from persecution.

3. Following her conviction for manslaughter on the grounds of diminished responsibility, on 5 July 2004, a hospital treatment order, under section 37 of the Mental Health Act 1983 with additional restrictions set out in section 41 Mental Health Act 1983 (without limit of time), was made on 9 July.

4. On 6 March 2006 Sheikh Mohammed Danish was convicted of the murder of Edward Miles and sentenced to life imprisonment with a recommendation that he be deported upon his release from prison.

5. Mrs Miles had been receiving treatment for mental illness (diagnosed as schizo-affective disorder in 1999) since July 1996. She had been compulsorily admitted to hospital on four occasions, most recently discharged on 16 December 2002. She was being treated as an outpatient and under the enhanced level of the Care Programme Approach at the time of the killing. Between 1996 and 2000 her care and treatment was provided through the Tower Hamlets Healthcare NHS Trust. Responsibility for Mrs Miles' care and treatment was assumed by the newly formed East London and The City Mental Health Trust (ELCMHT) upon its creation in April 2000.

6. Following Mrs Miles' arrest for the killing of her husband in May 2003, ELCMHT carried out an internal review of the incident. On 11 September 2003 Doctor Trevor Turner (Consultant Psychiatrist) and Jan Murray (Lead Nurse at Tower Hamlets at the time) prepared the internal report for the Trust. Their conclusions were set out as follows:

    1. Ms MM has been well-known to the CMHT and the attached ward since her first admission in 1996, having had four admissions in all for a relapsing schizo-affective psychosis. She has responded to treatment in the short term. Assessment and treatment plans (in terms of medication and follow-up) have been appropriate in the medical sense, and there has been appropriate use of the Mental Health Act.

    2. Despite her relapsing illness and limited insight, Ms MM has been closely monitored and reviewed by her Care Co-ordinator (Ms GS) and there was no evidence that her mental state was relapsing in the month prior to the alleged homicide. On the contrary, the evidence both before and after that event is that her mental state was apparently stable. This would be compatible with the known fluctuating nature of her underlying diagnosis, whether or not she was complying with medication.

3. There is limited evidence of co-ordinated care, using the CPA, or involving a multidisciplinary team approach as one would expect with a CMHT. The picture is of isolated individuals or organisations (e.g. the ward; the CPNs; the RMO) with limited communication, and limited ability to delivery formally planned care. Neither MM's CPA plan nor her risk management (RM) assessment had been updated after the most recent admission (November to December '02). There was no crisis plan, no carer's assessment, and no range of agreed steps to be taken in the light of her relapsing. Treatment and early intervention essentially depended on the individual qualities of the Care Co-ordinator, GP, and her husband, operating without any sense of a coordinated team approach.

4. The general organisation of the notes (community care file and medical notes) is only in part satisfactory, the on-going written medical notes being somewhat jumbled in order, and the medical files not containing social / community orientated documents. This 'separation' of files very much reflects the separation of ward and community teams. The poor documentation of CPA reflects this as well, but also reflects the complexity and length of the official document, with its many redundant spaces. Given the importance of care planning we recommend a single sheet document, containing all the relevant information, including a care plan and crisis plan as well as basic needs outlined, and regularly updated.

5. Both the medical notes and the community care file (or the joint file if used) should have updated copies of the following documents

   a) CPA form with Care Plan monitored by Care Co-ordinator

   b) Carer's Assessment, completed annually

   c) Risk Assessment, reviewed in line with CPA and after each admission

   d) Crisis Plans (and Relapse Signature if relevant) should reflect agreed time frame of interventions so as to enhance effectiveness.

   An updated training package on care plans / crisis plans / relapse prevention and monitoring should be undertaken to establish good practice in this area.

6. Despite these organisational limitations there is no evidence at present that the alleged homicide of 2.5.03 could be attributed to any immediate failures in care of MM, given her continuing support and stable mental health at the time.

The conduct of the Inquiry

7. This Inquiry was commissioned by the North East London Strategic Health Authority (NELSHA) on 10 November 2004, in accordance with Department of Health Guidance HSG (94) 27. We have had regard to the amended guidance, published after this Inquiry was commissioned: "Independent investigation of adverse events in mental health services"[1].

8. The Terms of Reference were agreed and are at Appendix A

9. The Procedure adopted by the Inquiry is at Appendix B. We followed this procedure in all respects except one: we decided not to issue a public

[1] 15 June 2005. Available on the Department of Health website, www.doh.gov.uk.

statement requesting information (see paragraph 23 of the Procedure). Once we had had an opportunity to familiarise ourselves with the nature of the issues involved and the evidence required it was apparent to us that no useful purpose would be served by issuing such a statement.

10. There is a list of witnesses at Appendix C.

11. The Inquiry Panel met over several months, interviewing or taking written evidence from the witnesses. Interviews took place between 21 March and 11 July 2005. Doctor Falkowski was re-interviewed on 5 June 2006. We also provided relevant extracts from the draft report to some witnesses to enable them to respond to points of potential criticism, prior to the report being finalised, in accordance with the Inquiry Procedure. A number of individuals provided written responses. We reviewed a large volume of documentation, including all available files on Mrs Miles, relevant files concerning health or social services provision to other members of the family, and documents relating to applicable policies at the time and organisational and policy reforms that have occurred since May 2003. The most recent documentary evidence to which we have had regard was provided to us on 6 February 2006, save for the final Equality and Diversity Action Plan which was provided to us in May 2006. Save for that document, the last interview with Doctor Falkowski and the written responses of other witnesses, we have not had regard to any evidence after 6 February 2006. We have had regard to all relevant documents provided to us by that date.

12. The work of the Panel was delayed and made more difficult by the problems we suffered in securing the necessary documentation:

    12.1 Although Mrs Miles' medical notes were first requested from the Trust on 1 October 2004, at the time the Inquiry was commissioned no documents were available save for the Trust's own 28 day investigation report. The absence of any other documentation at that time, and the subsequent difficulties we encountered in obtaining necessary documentation, meant that we could not access all the

relevant information at the outset and determine the scope of our inquiries. This led to delays in commencing our hearings.

12.2 The Inquiry Manager first requested copies of Mrs Miles' inpatient medical notes, CMHT notes and GP notes in around the middle of September 2004.

12.3 On 15 November 2004 the Trust claimed to have traced Mrs Miles' medical records and sent them to the Inquiry Manager. However, these comprised only the post-2 May 2003 records.

12.4 On 17 December 2004 the Trust notified the Inquiry Manager that the medical files for Mrs Miles were sent from St Clements Hospital to the John Howard Centre (where Mrs Miles was and remains admitted) on 30 December 2003. The John Howard Centre could not find a record of receiving them. It was not known if the police, who had taken copies, still had them. The Trust was still trying to track down the missing files. The inpatient medical notes relating to Mrs Miles' admissions to St Clements Hospital were finally received on 21 January 2005.

12.5 The inpatient files were in an appalling muddle. Some of this may have been a consequence of previous photocopying of the notes (for instance, for the purposes of the criminal investigation) which were then not returned to the files in the proper order. However, some of the muddle clearly arose from the way in which the notes were kept at the time. The Panel Chair reviewed the original inpatient records and found that the notes were not kept consistently or in chronological order. Thus one entry was found on the same page as another entry made over four years earlier. Another entry was entered alongside an entry made over three years earlier. Notes were not consistently made in chronological order. This has led to a number of problems including that, where there are gaps in the notes, it is not immediately obvious whether that is because pages are missing or because the notes never existed. We make findings about this in the body of our report. In addition the Mental Health Act records are incomplete. We

do not know if relevant documents were ever created or whether they have been created and subsequently lost.

12.6 The inpatient nursing notes have never been found.

12.7 The GP notes were not received until early January 2005.

12.8 Although some copies of the community mental health team ("CMHT") notes were provided in late 2004, the complete originals were not located until 31 January 2005, when they were found in a filing cabinet in Jan Murray's office. The CMHT records were also muddled.

The approach of the Inquiry

13. Our starting point in this Inquiry was to examine the care and treatment of Mrs Miles. We have set out in Chapter One the principal facts relating to this. As we make clear in the main body of this report, we conclude that it could not have been predicted that Mrs Miles would kill or be involved with the killing of Mr Miles or any other person. However, we have also concluded that Mrs Miles did not receive adequate care and treatment. In particular we believe that she was prematurely discharged from hospital on 16 December 2002. Subsequently, she did not have a care plan drawn up in accordance with section 117 of the Mental Health Act 1983 and the Care Programme Approach. Mrs Miles should have received care, treatment and follow up under a properly formulated care plan. Had these failings not taken place, it is possible that Mr Miles would still be alive.

14. We believe that some of the failings that we have identified arose from the particular approach taken by clinicians directly responsible for the care and treatment of Mrs Miles. Others find their roots in the way mental health care provision was organised and delivered within Tower Hamlets at the time. This led us to examine the principal underlying themes in respect of the organisation and delivery of mental health services in Tower Hamlets which are relevant to this case. These are examined in Chapters Two, Three and Four.

15. We consider that we should be careful not to blame individuals simply because things have gone wrong. It is important not to judge the actions of individuals with the benefit of hindsight alone. We have endeavoured to

identify mistakes in order to assist in the process of learning and creating change in order to avoid repetition and improve mental health services. Nonetheless, occasionally it is right to identify individual responsibility for certain failings.

16. Our findings and conclusions are based on the evidence that we received and therefore are made in respect of circumstances prevailing at the relevant times, as indicated in the body of the report, and up to, but not later than, February 2006.

Summary of issues and recommendations

17. Although our Report covers a wide range of matters, we have limited our recommendations to those key issues arising from our findings that we consider to be most significant in terms of the quality and effectiveness of mental health services in Tower Hamlets. In particular:

    17.1 The evidence makes it clear that there have been significant shortcomings in clinical practice within Tower Hamlets. These include insufficient clinical involvement in day-to-day patient care, poor integration of consultants in the community team, inadequate care planning and treatment plans, poor follow-up of treatment plans, and inadequate supervision and support for junior doctors. We have heard evidence that the Trust (ELCMHT) is making attempts to improve clinical practice, but the evidence available to us also indicates that not all of the consultants in Tower Hamlets wholly subscribe to the processes of change that the Trust is introducing and, in some cases, actively obstruct them. Some of the consultants working in Tower Hamlets appear to feel alienated from the processes of change. We are not satisfied that the Trust is yet delivering the necessary changes in Tower Hamlets.

    17.2 We have also identified inadequate liaison between the consultant psychiatrist and the community mental health team in the case of Mrs Miles. In general, the consultants in Tower Hamlets are not working closely enough with the community teams. We make specific

recommendations designed to achieve greater integration of the psychiatrists and community teams.

17.3 We have found significant errors and failings by Doctor Falkowski, the consultant psychiatrist responsible for Mrs Miles, in respect of the care and treatment of Mrs Miles, and make specific recommendations with regard to him.

17.4 We make recommendations designed to increase the availability of therapeutic options available to patients, as we have heard evidence indicating a lack of such options at present and that, historically, there has been a narrow medical focus within Tower Hamlets in respect of the care and treatment of patients.

17.5 The evidence that we have seen indicates that, during the period when Mrs Miles received treatment from the local mental health services in Tower Hamlets, CPA[2] reviews were not taking place regularly or, in some cases, not at all. Recent patient surveys (in 2004 and 2005) show that within ELCMHT there is very poor awareness amongst patients of their CPA plans. We are aware that CPA policy has been revised since then, and that paperwork has been reviewed and simplified. In this area we consider that there is little to be gained from making further detailed recommendations: the most effective outcomes will be achieved by full implementation of the CPA. However, we have found that, while Mrs Miles was in hospital, reviews were irregular and haphazard. There appeared to be no standardised model for such reviews nor protocol as to who should attend. We do therefore make a specific recommendation regarding the conduct of reviews of patients on acute admissions wards. We

[2] Care Programme Approach: CPA is the care management process for those in contact with specialist mental health and social care services. SG (94)27/LASSL (94)4 states that key elements of the CPA are: systematic assessment of health and social care needs; a written care plan agreed between relevant professional staff, patient and carers; the allocation of a key worker to keep in contact with the patient, monitor the delivery of the agreed programme of care and take action if it is not; regular review of needs. This is described in further detail in Chapter Two.

have also identified issues as to the approach to the needs of the children of Mrs Miles.

17.6 Our findings regarding the Trust's procedures for dealing with serious untoward incidents, both at the time of the death of Mr Miles in May 2003 and at the time of commissioning this Inquiry in November 2004, find strong resonance with the serious criticisms of the Trust made by the Commission for Health Improvement in its review of the Trust in February 2003. We note that since then the Trust has adopted an Incident Reporting Policy which addresses most of the concerns identified. This policy must be implemented effectively.

17.7 Finally, we have found significant issues in respect of the Trust's responses to the cultural diversity of its service users. The Trust has a new Equality and Diversity Action Plan, but we consider that the Trust needs to identify more concrete and measurable actions to deliver the objectives. In addition, we consider that the Trust needs to explore means of delivering its services in a way that more effectively meets the diverse needs of its patients.

18. The recommendations that we make in this report must be followed up effectively. We understand that, upon receipt of our report, the Trust Board will agree an action plan in consultation with the Strategic Health Authority, Tower Hamlets Primary Care Trust and the London Borough of Tower Hamlets with specific timescales for implementation. The success of the steps taken must be judged by results not processes. There will be resource implications if our recommendations are accepted and implemented, and the Primary Care Trust and other commissioning agencies should ensure that sufficient resources are allocated to enable the Trust to implement our recommendations in full. Our recommendations represent areas for priority action for the Trust. The Strategic Health Authority or its successor must manage and monitor the implementation of any action plan arising out of our recommendations, in accordance with the timescales. We do not include any of this activity in our recommendations as it is our understanding that this will happen as a matter of course.

Acknowledgments

19. We would like to thank all those who have given up time to give evidence to the Inquiry, whether orally or in writing. We are grateful for the willingness of many witnesses to talk openly about difficult issues. We are particularly grateful to those members of the family of Mariam and Edward Miles who have assisted us, providing us with valuable insights into the background to the tragic events with which this Inquiry has been concerned.

20. We thank Doughty Street Chambers for hosting the majority of the hearings and the meetings of the Inquiry Panel.

CHAPTER ONE

THE HISTORY OF MRS MILES AND HER MENTAL HEALTH CARE UNTIL 2ND MAY 2003

Mrs Miles

1. There is surprisingly little known about Mrs Miles' background prior to her arrest, despite her previous seven year history of involvement with the mental health services. The information that we have about Mrs Miles' background has been obtained from information collected about her while she was at the John Howard Centre, after her husband's death in May 2003, and from the Panel's interviews with Mrs Miles and with her sister-in-law and brother-in-law, Sally and Peter Miles. There is nothing in her case notes to demonstrate that, in the seven years that she was being treated prior to May 2003, any of the professionals involved attempted to obtain a detailed personal history from her, in particular of her life in Pakistan before she came to England. When her mother visited her in London in 1997, Doctor Bhandari (the Senior Registrar in psychiatry working with Mrs Miles' consultant at the time) did visit Mrs Miles and her mother at home. However, it does not appear that there was any detailed discussion with her mother as to Mrs Miles' background or her condition in general. We believe that the general poverty of information concerning her background indicates a lack of interest in her personal narrative. Had any real interest been taken in Mrs Miles' background, then there may have been a better understanding of the nature of her illness, its antecedents and the problems that she was facing as a result of her mental health problems. It would appear that there was a singular lack of attention paid to her cultural and social context, in particular her experience as a Muslim woman of Pakistani origin with very little in the way of social support after her arrival in England. If a detailed understanding of her background had been available, we believe that this would have helped in formulating a more acceptable and appropriate care plan for her. What follows about her background are our findings based on the limited evidence that has been available to us.

2. Mrs Miles was born in Pakistan in January 1961. She was the third eldest of seven siblings with whom she grew up in Lahore. Her father owned a clothes shop. There is no information about any particular problems in her home life when she was a child. A psychiatric report dated 29 June 2004 by her consultant at the John Howard Centre, Doctor Ratnam, recorded that Mrs Miles had stated that she was not happy as a child because her parents were always arguing. However, she described her childhood to Professor Coid, in a report dated 12 December 2003 prepared for her trial, as happy. When we met her, she described her childhood and early life as "nice".

3. Mrs Miles attended school between the ages of 5 and 16 and, after a couple of years at home, went to college where she obtained a BA in Islamic studies and Education. She had intended to be a teacher. She has described herself as being shy and submissive and without many friends, and said that the first two years of college were difficult because she had no friends.

4. When she was about 23 years old, she married her first husband. This was an arranged marriage. Her first husband was a business man. She described him as a "brutal" and "very aggressive" man. He used to try to hurt her feelings by saying that he had affairs with other women, and he would become easily angry with her, but there was no physical violence. They had one daughter (Fatima) when Mrs Miles was 24 years old. When Fatima was a baby or very young child, Mrs Miles and her first husband separated and her husband subsequently divorced her.[3] Mrs Miles went to live with her mother. Her daughter continued to live with her father, who re-married.

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[3] This chronology is taken from the medical reports prepared for Mrs Miles' trial, the information in which was itself derived from information provided by Mrs Miles during her admission at the John Howard Centre. It is not clear how long the marriage lasted but it seems that it must have been over by December 1986 when Mrs Miles first met Mr Miles.

Mr Miles

5. Mr Miles was born to a white family in England on 7 January 1958. Mr Miles was one of three children along with his older sister, Sally, and his brother Peter. Along with Peter's wife, Linda, they formed a close-knit family. There was also an older half-brother.

6. Mr Miles graduated from university with a degree in maths and comparative religion. He then took a teaching degree and became a maths teacher in East London.

7. In 1985 he went to Pakistan at the invitation of a friend. He enjoyed it so much that he negotiated a sabbatical and returned in the summer of 1986, travelling via Syria and the Middle East. He had been an active Christian and was treasurer in his local church. He became interested in Sufism and, in around November 1986, while he was in Pakistan, he became a Muslim.

Mr and Mrs Miles meet

8. Shortly afterwards, in around December 1986, Mr and Mrs Miles met each other. They were introduced by a friend of his who was also a relative of Mrs Miles'. Mrs Miles told us that she had liked Mr Miles when she met him and they got on well. They were married in April 1987. Mrs Miles said it was a big wedding, organised by her family. Mr Miles' family was not present. Mr Miles returned to UK in July 1987 to arrange for Mrs Miles' subsequent arrival in August that year. She left her daughter from her first marriage, Fatima, in Pakistan.

Life in London

9. Mrs Miles arrived in London in August 1987. Mr and Mrs Miles' first child within a year of her arrival in the UK. Laila was born on 21 May 1988. They had two more children, Jafar born on 8 January 1992 and Idris born on 16 July 1995.

10. Mrs Miles said that she was not upset to leave her family in Pakistan but that, when she arrived in the UK, she found that she had no friends and nobody spoke her language. She was very homesick. She said

that, although she could speak English when she came to England, she found it easier to communicate in Urdu. Our own observation of Mrs Miles is that, even after having lived in England for eighteen years, her English is adequate but not fluent.

11. Both Peter and Sally Miles thought that Mr and Mrs Miles' relationship appeared to be good at first. Mrs Miles was intelligent and had a sense of humour, and she and her husband would share jokes. Mrs Miles described Mr Miles as a good husband and said that he looked after her. But she said, soon after they started to live in the UK, he stopped talking to her as he used to. She wanted to chat in the evenings, but he did not do so and instead preferred to listen to his music. As will become apparent from the narrative below, the domestic situation deteriorated over the subsequent years, particularly as Mrs Miles' mental health worsened. In retrospect Mrs Miles described Mr Miles as a "bad man" who did not care for her and who she thought wanted to separate her from the children. This perception is at odds with every other observation that we have heard about him: Mr Miles was described by everyone else as a caring man who tolerated a great deal of difficult behaviour by his wife. We gain the impression, from descriptions that we have heard, that he was a rather reserved man. It may be that this was understood by Mrs Miles him showing indifference to her.

12. Our impression is that Mrs Miles felt isolated in almost every respect during most of her life in the UK. She did not integrate comfortably either into Mr Miles' extended family or within her neighbourhood. The impression that we have gained both from Mrs Miles and from the accounts given by others who knew her, including her care co-ordinator[4] from March 2000 to May 2003, Ms Gerrie Semper, is of general and continuing social and cultural isolation.

[4] Until 1999 those responsible for the coordination of the CPA care plan had been known as "key workers". As a result of "Effective Coo-ordination in Mental Health Services; modernising the Care

13. Mrs Miles described to us that she felt "strange" coming into a big English family. She said that Mr Miles' family welcomed her at first but subsequently did not. She said there were no arguments or fights, but that they were "just indifferent". Sally Miles told us that the Miles family wished to welcome Mrs Miles as a new member but that, although she was warm and friendly in the family, her integration into the family was inhibited by what Sally Miles described as Mrs Miles' strange behaviour. Sally Miles thought that some of this behaviour may have been a reflection of language and cultural differences.

14. Peter Miles said that Mrs Miles did not speak good English on her arrival in UK, although she understood a lot. She talked to Mr Miles in Urdu, which he understood but did not speak. Later, she also spoke to the children, particularly Laila (the oldest child), in Urdu although the main language at home was English. Mr Miles later (at the time of Mrs Miles' first hospital admission) described her as being quiet and reserved.

15. Mrs Miles did develop some friendships with Muslim women, but they were not in the main Urdu speakers. The Urdu-speaking women that she met did not become close friends. She told us that the neighbours were not friendly. We heard from one of their neighbours at that time (Anthony Stevens), who had been a personal friend of Mr Miles since 1974, that he felt that, when Mrs Miles arrived in the UK, she was overwhelmed by life here. He was the only person to tell us that the couple experienced considerable unpleasantness from certain racist neighbours including having eggs thrown at the kitchen window and nuisance from children.

16. Mrs Miles went to the mosques in Walthamstow and in Forest Gate, but she described people there as indifferent and uncaring. She said that they were involved with their own families, the implication being

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Programme Approach" (Department of Health 1999) the key worker was replaced with the care co-ordinator. Throughout this report we describe those performing that function as "care co-ordinators"

that they did not have time for her. Save for the visit by her mother in 1997, Mrs Miles had none of her own family around and, although she went to Pakistan on several occasions, that was not enough. As she said: "you need to have friendship, everyday life. Every day you need to have some chat in your life." She told us that she had been "language sick".

17. Religion appears to have been an issue between Mr and Mrs Miles. Although Mr Miles had become a Muslim before they married, he did not adhere as strictly to some of the religious conventions as Mrs Miles did. The family did not eat pork. Mr Miles did not drink alcohol when Mrs Miles was present, but he would do so at other times. He did not go to the mosque. Mrs Miles prayed regularly and religion played an important part in her life. After the birth of the children, and as the children grew older, religious and cultural differences became a source of greater conflict between Mr and Mrs Miles. For instance, Mrs Miles thought that Mr Miles was trying to bring the children up with an English way of life which she saw as in conflict with her wish to bring them up in the Islamic way. This conflict played itself out over a variety of matters including, for instance, the children's piano lessons: Mrs Miles opposed the lessons, which seemed to represent the different identities that Mr and Mrs Miles wished for the children. She told us that Mr Miles was opposed to her taking the children to the mosque, and so she taught the children to pray at home. As Laila grew older, she used to argue with her mother about praying.

Onset of mental health problems and first hospital admission – July 1996

18. Mrs Miles' mental health started to deteriorate in around the middle of 1996, when Idris was approaching his first birthday. The problems were first brought to the attention of the health service by Mr Miles who approached the health visitor, Mary Harris. She visited on 10 July 1996 and noted that "Mariam appeared very disturbed". She made an appointment for Mrs Miles to see the family GP, Doctor Pollen, later that day. Mrs Miles refused to go and Mr Miles went to the appointment

alone. The GP entry for that day describes him as reporting Mrs Miles' bizarre behaviour which had been going on for weeks but had been worse over the previous two weeks. The GP notes describe that he reported her wandering, staying up late, being "anorexic", not always picking up the children from school, taking the baby out undressed, and not always talking. He said that she had hidden all the kitchen things and some of Mr Miles' things and had disappeared. Doctor Pollen noted that this "sounds like organic brain disorder or possibly psychosis", and Mr Miles was advised to take her to Accident and Emergency. He did so, and she was admitted that night to the Lansbury Ward, St Clements Hospital. She was admitted under the care of consultant psychiatrist Doctor Nick Bass.

19. On 17 July, on a ward round at which Mr Miles was present, it was noted that Mrs Miles had reported to the police that Mr Miles wanted to murder her, that she had been complaining to the school about female teachers, that she appeared not to take care of the children. She had not been sleeping or eating. Mr Miles considered that this was a sudden development: he would not have accepted that she could be like that three months previously. The conclusion noted in the medical notes was that she was suffering from a "psychotic illness". Because of her unwillingness to stay in hospital, she was initially detained under section 5(2) Mental Health Act 1983[5] on 16 July 1996, and then under section 2[6] on 19 July. The reason given on Form 12 for applying section 5(2) included "she is a clear danger to herself and others".

20. Reports prepared for a Mental Health Review Tribunal on 9 August 1996 provide a more detailed picture of Mrs Miles' condition at that

[5] Section 5(2) MHA provides for the compulsory detention of patients who are already in hospital, for a period of up to 72 hours where the doctor in charge of the patient's treatment reports that an application under section 2 or 3 should be made.

[6] Section 2 MHA provides for the admission of a patient to hospital and detention therefore a maximum period of 28 days for the purposes of assessment, or assessment followed by medical treatment.

time. Alan Mountain, Approved Social Worker in the Bethnal Green Mental Health Team, wrote:

> "The problems appear to be quite recent. Mr Miles had noticed his wife's behaviour becoming odd over the last few months. This has taken the form of obsessional traits e.g. constantly collecting clothes that she intends one day to send to Bosnia, not allowing the children out to play because she is frightened of dogs in the local park & also believing that she must evangelise her religious beliefs.
>
> The actions themselves have become a problem when they have intruded into all areas of Mariam's life.
>
> …At the time of the application Mariam was very preoccupied she was constantly responding to a voice that she was hearing that told her she must be a good Muslim & spoke to her about morality.
>
> She alternated between sitting quietly responding to the voice & preaching to fellow patients & staff that they must believe that Mohamed was the last prophet of God & if they didn't they would burn in hell. She would particularly target Asian women nurses on the ward telling them that they dressed immodestly & would burn in hell.
>
> Mariam was quite clear that she wishes to be discharged from Hospital to be with her children & husband & does not feel that she needs to be in Hospital.
>
> Mariam's key nurse feels that Mariam is obsessed by her religious beliefs & her perceived need to let others know what she believes. She is not sure if Mariam is still responding to auditory hallucinations though Mariam has told her that she is not hearing the voice any more." [sic]

21. The psychiatric report for the same tribunal noted similar behaviour and that her husband reported her to be "quite isolated" and that she did not have many social outlets. The psychiatric report stated that she suffered from "a psychotic illness which is probably of a schizophrenic type", that if she were to leave the hospital at that time she would constitute a serious risk to herself and the safety and development of the children, and that she should continue to stay in hospital and be treated with neuroleptic medication.

22. When the Inquiry Panel saw her at the John Howard Centre on 19 May 2005, Mrs Miles described her experiences in hospital as very bad. She explained this:

> "My children were away from me. I was put in a mental [sic]. Other people are mental. Other people are smoking. I was not mental. I just need a holiday, I was so much depressed and he put me in a depressing place. Life was awful. Life was awful. Whenever I have depression he put me in the mental hospital instead of taking me to some park, having a chat with me, taking me to some friends' houses. Because I am a human being, I need refreshment. I do not need hospital. He always put me in the hospital. Every time I have any depression he put me in the hospital but I should be going to some friend's house, have a chat with them, have a talk to them, some refreshment."

23. During this admission Mrs Miles was treated with anti-psychotic medication and it would appear that she recovered. The section 2 application was allowed to expire after 28 days and, having had some home leave, she was discharged on 23 August 1996.

24. The plan was for Mrs Miles to be treated in the community by the Bethnal Green Community Mental Health Team ("CMHT") at Pritchards Road. This was one of four CMHTs operating in Tower Hamlets at the time, and was at that time headed by the consultants Doctor Jan Falkowski and Doctor Nick Bass. She was referred to the CMHT from the ward on 19 August 1996, a few days before her discharge from hospital. The referral to the CMHT noted that there was a risk that she would not be compliant with medication on discharge, and that her Community Psychiatric Nurse needed to monitor this and her mental health state.

1996-2002

Mrs Miles' mental health during this period

25. In around November 1996 Mrs Miles was transferred from the care of Doctor Bass to the care of consultant psychiatrist Doctor Jan Falkowski, the latter having been abroad at the time of Mrs Miles' admission in July. She remained under his care until the killing of Mr Miles.

26. Mrs Miles was compulsorily admitted to hospital on three further occasions: On 1 June 1998 she was admitted to hospital voluntarily. On 15 June 1998 she was detained under section 5(2) followed by section 2 on 17 June 1998 and she was discharged on 29 July 1998. On 12 May 1999 she was again admitted voluntarily. She was detained under section 5(2) on 26 May 1999 and under section 3[7] on 28 May 1999. She was discharged on 30 June 1999. The last

[7] Section 3 MHA provides for the compulsory admission of a patient to hospital and detention there for the purposes of treatment.

admission was on 13 November 2002 to which we will return in more detail.

27. Apart from the above hospital admissions, Mrs Miles' care and treatment took place within the community under the supervision of Doctor Falkowski and the CMHT. Although Doctor Falkowski saw Mrs Miles in hospital during each of those admissions, there is no evidence that he ever saw her personally as an outpatient or in the community until 11 February 2003.

28. Throughout this time Mrs Miles was also under the care of her own GP, Doctor Pollen. Doctor Pollen told us that, from the time of her first admission onwards, she cannot recall any time when Mrs Miles seemed to be in a state of good mental health. Although at times she demonstrated typical psychotic symptoms such as delusions and auditory hallucinations, for most of the time her illness was more subtle in its presentation. Mrs Miles was often hostile and suspicious in her manner and it was not easy to gain a sense of rapport. She would make efforts to appear compliant with planned medication or supervision but her manner could switch very rapidly from pleasantness to strong resistance. Doctor Pollen gained the impression at such moments that she was depressed but masked it by pretence of being cheerful.

29. During this period Mrs Miles developed a habit of giving money to the poor and of hoarding old clothes and food to send to the poor. Sally Miles described one occasion when she stayed with the family in May 1998 whilst Mr Miles was attending a compulsory school staff residential weekend. Mr Miles had decided to entrust the then ten-year-old Laila rather than Mrs Miles with £50 contingency 'rainy day money'. There was an occasion when, in late 1999, a cheque for £3000 was received through the post from an aunt of Mr Miles. Sally Miles said that Mr Miles told her that Mrs Miles took the money 'for the poor'. On another occasion Mrs Miles took £1000 from the (then) joint bank account. At some point Mr Miles closed the joint account and gave Mrs Miles an allowance for her personal use. He did the family shopping.

30. Sally Miles told us that Mrs Miles increasingly paid attention to the needs of others over and above those of her children, even in terms of meeting basic needs such as feeding them. She had a habit of going out suddenly and without explanation, and never told anyone where she went.

31. Ms Gerrie Semper, Mrs Miles' care co-ordinator, described how Mrs Miles used to give the household food away. Ms Semper recalled that she would spend a lot of time trying to get Mrs Miles to understand that she should limit what she gave away and spend only her own money rather than giving away the household's food. Mr Miles had to do the shopping in smaller quantities so that she could not give away large amounts of food.

32. Mrs Miles would fill the garden with black bags full of old clothes and other things that she intended to give to the poor, but she did not take them to charity shops. She wanted to send the bags away but did not have the resources to do so. Sometimes the garden was so full that the children could hardly use it.

33. From 1997, a year after her first contact with mental health services, Mrs Miles started bringing strangers into the house. When we saw her in the John Howard Centre, she told us that this was because she had been lonely. Peter Miles said to us that it seemed that she would bring back anyone she met if they were perceived by her to be needy. She would give them clothes, soup or other things. On one occasion, a stranger that Mrs Miles brought home stole Mr Miles' wallet. Because of the risks to the children from strangers being in the house, Mr Miles started to arrange for the children to be out of the house when he was not there. They would go to friends' houses after school.

34. Mary Harris, the Health Visitor, also observed other problems which gave rise to concerns for the children's safety: Mrs Miles was not sufficiently aware when she was with children on the road, and she took insufficient care that the young children were not near her when she was cooking. Sally Miles made similar observations.

35. All those who gave evidence to us and knew the family described Mr Miles as very supportive of Mrs Miles and as a caring and loving father. He took the children out, made sure that they were eating properly, took an interest in their schooling and their health, and was very involved with their welfare. It was said that he was never seen to criticise Mrs Miles and he seemed to take her behaviour very much in his stride. Yet the reality was that, though he did not often show it, the situation was very difficult for him. In a letter dated 2 September 2000 to Doctor Falkowski (which for some unknown reason he did not send at that time but eventually he gave it to Doctor Falkowski on 11 December 2002 when Mrs Miles was in hospital), Mr Miles described the situation as follows:

> "Living with Mariam and bringing up three young children, Laila 12, Jafar 8 and Idris 5, is becoming increasingly frustrating and difficult. Mariam is increasingly more of an unpredictable other person who moves in and out of our lives throwing up challenges and problems rather than a mother and wife.
>
> Mariam has a mission, which is to help the poor and needy of the world, in particular those in Pakistan. To this end she gives away money, and she has invited home people she has met in the streets begging (for example one group of six or seven people from Bosnia, who lost their ability to communicate in English when they found me home). Mariam has been collecting clothing for poor people – she has brought into the house huge quantities of old, tatty and dirty clothes which are piled up in our bedroom, and behind chairs in our sitting room, and in various cupboards around the house – these clothes are sometimes washed by Mariam (by hand since our washing machine has not been working) but only rarely do they leave our home. In order to save money, Mariam brings in fruit and vegetables from markets – the sort of produce that is left over at the end of the market day, which stall holders would probably otherwise throw away – in huge quantities and usually either already gone bad, or just about to go off with the result that I often have to throw away rotten fruit and clear out the refridgerator [sic] of rotting vegetables.
>
> Mariam usually assumes that I will be at home to look after and feed the children. I have taken responsibility for all the children's needs except their evening meals and collecting them from school. However Mariam will often not collect them from school, or be so late that the school has contacted me to collect them (when I have had to excuse myself from meetings at my place of work). Throughout the children's summer holidays I have been responsible for preparing all their meals except for one or two occasions.
>
> Looking after home and children on its own, though with its own stresses and challenges, is not beyond my capabilities, however with the constantly challenging, unpredictable and simply unco-operative behaviour of Mariam I often now find myself at my wits end. In order that I might have more reserves of strength for my family I have had to resign from my responsibilities as a teacher at a special school in Hackney[8].

[8] It does not appear that Mr Miles did in fact resign, but he reduced his working days to four

> Mariam will often come home from I do not know where, having been out all day long, and complain to me that I do not express love and affection for her. For short bursts she will be very loving and affectionate, but if I do not agree to whatever she says she will become angry – as she will when I request that she dispose of some of the heaps of old clothes she has accumulated or I ask her to take her medication.
>
> I am concerned with the affect all this must be having on my three children. When she is angry or depressed or both, Mariam will state that she does not want to live in our home any longer, she will say that she hates it here, but she is only staying because of Idris – she has often said this in front of the children. The Special Educational Needs Co-ordinator for Jafar's school has contacted me with concerns for Jafar's behaviour and well being and through her I am arranging for some support from Rosemary Loshak of the Child and Family Consultation Service.
>
> Mariam herself has acknowledged that something is not right at home, and feels that she needs some sort of rest or break from us. I feel that if I do not get a break from Mariam, before too long, I shall not be able to continue maintaining my family."

36. Mrs Miles did not accept then, nor has she ever done since, that she was mentally ill. She said to us, when we visited her at the John Howard Centre, that it was a good thing that she wanted to help the poor and that she never endangered the children in bringing people home as she did not bring them in when the children were around, and that there were no valuables or money at home which could lead to her being robbed.

37. As we have described, there were a total of four hospital admissions, all involving the Mental Health Act. Each followed a similar pattern to the first. Her mental health and her behaviour would deteriorate until the concerns for the safety of herself or her children were such that she was admitted to hospital. She would be placed on medication and, once her mental health appeared to improve, she would once again be discharged. On each occasion the care plan consisted of little more than maintaining her medication, and monitoring and reviewing her mental state.

Monitoring and medication

38. Given her diagnosis of schizoaffective disorder, Mrs Miles was advised to take antipsychotic medication on a regular basis. Managing and supervising her medication while she was in the community was one of the main objectives of her follow-up and care in the community. However, throughout her contact with the local mental health services,

her clinical team and in particular her care co-ordinators, faced significant difficulties in achieving this objective. We do not believe that satisfactory medication compliance was achieved at any time.

39. In between her admissions, Mrs Miles was indeed monitored and reviewed. Her care co-ordinator (this was Bernadette Healy, an occupational therapist, from August 1996 to March 1999[9]; followed by Maria Wadding, a Community Mental Health Nurse, from March 1999 to February 2000; and finally Gerrie Semper, a social worker, was her care co-ordinator until May 2003) visited her regularly and encouraged her to take her medication. She was seen on a 6 weekly basis by different doctors at the Bethnal Green CMHT base at Pritchards Road.

40. It was known that for much of the time she did not comply with her medication. She did not think it was necessary as she did not consider that she was ill. Sally Miles told us that, after her first hospital admission, it became apparent that Mrs Miles' treatment was "culturally unacceptable" to her. Indeed there is reference in the hospital notes to the fact that Mrs Miles did not approve of western medication[10]. Mrs Miles would trick nurses and others into believing that she was taking her medication by, for instance, holding it in her mouth and then spitting it down the drain once the nurse had left. When she did take the medication it was often at the wrong time of day so that she would be awake all night and sleeping during the day. During her mother's visit in 1997, her mother took some medication to persuade Mrs Miles that it was harmless. Unfortunately it produced side effects in her mother that so frightened her that she ceased to attempt to persuade Mrs Miles to take it.

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[9] Initially Ms Healy was involved with Mrs Miles jointly with a community psychiatric nurse, but then took over as care co-ordinator.

[10] Although, as we point out below, Mrs Miles would seek sleeping pills and inappropriate medication from her GP.

41. Mrs Miles also visited her GP on occasion, but often because she wished to ask for sleeping pills or inappropriate medication. Doctor Pollen prescribed the medication that had been advised by the hospital or subsequently determined on review by her, but she had no power to force Mrs Miles to take it.

42. Mrs Miles continued to be seen at outpatients on a regular basis. The letters written to her GP following each appointment noted Mrs Miles' bizarre behaviour, her obsession with religion, giving clothes to charity and other difficult behaviour as we have already described in some detail. She did not help out at home and the doctors noted the considerable burden on Mr Miles. There were reported conflicts between Mr and Mrs Miles over managing the household duties and over religion. In a number of the letters the doctors commented on relationship problems between Mr and Mrs Miles and suggested that they might benefit from help in that regard. It was regularly noted that Mrs Miles was not taking her medication. The care plan involved continued weekly CMHT visits and three monthly outpatient appointments.

43. Despite the fluctuations in her mental illness and the fact that Mrs Miles was plainly not complying with her medication, the specialist mental health services did not succeed in identifying other treatment that could be attempted or any means designed to secure compliance with medication which was acceptable to Mrs Miles. The need to address this problem was not given any sufficient priority within Mrs Miles' care plan. There was no strategy for action to be taken should efforts to secure compliance prove unsuccessful. Alternatives, such as the use of depot, were not fully explored. Periods in hospital were not used as an opportunity to introduce measures which might assist in compliance upon discharge. Even when those in the community mental health team plainly struggled to cope, there was no change to the response. Thus, for example, on 16 April 1999 Maria Wadding, the Community Mental Health Nurse who, at around that time, had taken over the case from Bernadette Healy as care co-ordinator, wrote to Doctor Nolan at

St Clements stating that she was very concerned over Mrs Miles' presentation. She said that Mrs Miles was very restless and agitated, showed some extra-pyramidal side effects, had stopped taking some of her medication and became angry and hostile at the mention of it. Her personal self care was said to have deteriorated and her mood regarding her husband was described as very labile. A review was booked at outpatients for 4 May, but we do not know if Mrs Miles attended. On 7 May 1999 her husband called the emergency doctor reporting that Mrs Miles was very aggressive and threatening to kill him. He had phoned the community psychiatric nurse but had received no call back. It was only after Mr and Mrs Miles visited Doctor Pollen a few days later that steps were taken to assess her. Following this, Mrs Miles was admitted to Lansbury Ward, St Clements Hospital on 12 May 1999.

44. Before she was discharged following that admission, Mr Miles had expressed concerns to Doctor Falkowski about her medication and there was some discussion about a dosset box. However, the care plan summary of 30 June 1999 made no mention of any plan regarding compliance with medication and no additional steps were taken to secure compliance.

45. From 1999 onwards Ms Wadding and then Ms Semper were aware of the problems with medication. In addition to encouraging her to comply, counselling and group therapy were discussed with Mrs Miles but Mrs Miles refused to consider these. She regarded counselling as an intrusion into her personal life. The only support provided by the psychiatrists involved in her care was to encourage Mrs Miles at her reviews to comply. Doctor Falkowski could not remember whether there was any discussion with him about the problems of non-compliance while she was an outpatient. However, nearly all the reports of her regular reviews at Pritchards Road refer to the problem with non-compliance without any serious attempt to address it.

46. Doctor Falkowski could not recall having discussed depot injections[11] as a means of ensuring compliance. He said to us that he thought they must have been discussed and there must have been good reason not to pursue the option. There is no explanation of such an approach being considered at any time in any of the records.

47. The only evidence of any attempt by the psychiatrists who saw her at her outpatients appointments to understand the medication issue was by Doctor Nolan (Senior Registrar to Doctor Falkowski) who reviewed Mrs Miles on 10 December 1999 and noted that she claimed not to take her tablets sometimes as some sort of revenge because she was angry with Mr Miles. Doctor Nolan discussed some of the conflicts between Mr and Mrs Miles, and Mrs Miles agreed to a referral to the Children and Families Services (part of London Borough of Tower Hamlets Social Services Department). The involvement of social services with the family throughout the period is described below.

Services to the family

48. The first contact between social services and the Miles family took place in August 1996, after Mrs Miles' discharge from hospital. The records show visits by Bernadette Healy, the Occupational Therapist who was Mrs Miles' care co-ordinator at the time, and the Health Visitor. Mrs Miles went to Pakistan from around October 1996 to April 1997.

49. On 29.4.97 Bernadette Healy wrote to the Child and Family Consultation Service (a specialist service that was set up as part of the Child and Adolescent Mental Health Service within the Mental Health Trust) asking for an assessment of the Miles family. She noted that Mrs Miles was displaying some psychotic symptoms and that Mr Miles had expressed concern for himself and his children, saying that Laila had become quite upset and tearful about her mother at times, and that

[11] Depot injections enable controlled release of medication over a period of time and therefore can be administered at fortnightly or even monthly intervals.

Jafar was avoiding contact with his mother. There was also an independent referral from the Speech Therapy Department (which Jafar had been attending).

50. The referral resulted in Rosemary Loshak, psychiatric social worker employed by London Borough of Tower Hamlets to work in the Child and Family Consultation Service, discussing the case with Ms Healy and a community psychiatric nurse. Mrs Miles did not know about the referral. They noted the need for information and reassurance to Mr Miles about the children's development and for support in parenting. They noted that the family seemed isolated and that Mr Miles needed encouragement to link up with teachers and others who were involved on a day-to-day basis with the children. Mr Miles wanted Jafar to be seen in the Child and Family Consultation Service without Mrs Miles being involved. Ms Loshak thought it would not be helpful to proceed without Mrs Miles' knowledge or involvement and that there should be discussion with both parents about this before offering an appointment. Discussions took place with Mr Miles about this. In addition, Mr Miles had attended an appointment with the community psychiatric nurse to discuss his and the children's needs. Ms Loshak remained in communication with the speech therapist concerning Jafar.

51. In early 1998 Mr Miles said that he did not wish to pursue a referral to the Child and Family Consultation Service and, at that stage, the file was closed. Ms Loshak explained that there was no suggestion of neglect or significant harm that would indicate a referral to statutory social services teams at that point. On 22 January 1998 Ms Loshak wrote to Ms Healy[12], explaining the reasons for closing the file but said that Mrs Miles appeared to have a serious mental illness and, should there be worries about the children's needs in the future, the CFCS would discuss a future referral.

[12] Ms Loshak told us that she wrote in similar terms to all the professionals involved in the case, but the records we have seen only include the letter to Ms Healy

52. In the meantime, on 13 August 1997, Ms Healy had written to the Child and Family Social Work Team (within the London Borough of Tower Hamlets Social services Department) with a referral of the Miles family, stating that the family would be a high priority for the Team's intervention when Mrs Miles' mother (who was at that stage staying with the family) returned to Pakistan in September. Ms Healy said that Mrs Miles would need help with the care of her children and she expressed particular concerns for Idris as Ms Healy believed Mrs Miles would stop taking her medication, which would lead to a relapse of her mental illness which in turn would affect her ability to care for Idris. She followed this up by letter dated 20 August suggesting that a fully subsidised childminder should be provided. We have not seen a record of any response from the social work team at that time. Ms Healy told us that Mrs Miles would not accept home help or childminding services, although she did accept a one-off nursery respite place.

53. On 9 September 1998 Ms Healy wrote again to the Child and Family Social Work Team (within London Borough of Tower Hamlets Social Services Department), with a copy to Doctor Falkowski, with ongoing concerns about the welfare of the children, in particular the impact of their mother's mental ill health on the children. She complained about insufficient social work input and said that the family needed an allocated social worker rather than for the case to be dealt with on a duty basis. On 17 September London Borough of Tower Hamlets social services department replied that it provided assistance to the family mainly through advice on childcare facilities, that they had advised Mr Miles to seek a child minder, that a referral might be made of Mrs Miles to the Mental Health Social Work Team and that, as there were no specific child protection concerns, Ms Healy should specify how she felt that the children may be at risk, what concerns she had and what role an allocated worker from the Child and Family Division could play. On 16 November 1998 Alan Dixon, Team Manager of the Mental Health Social Work Team wrote to the Team Manager of the Children

and Families Team (London Borough of Tower Hamlets) stating that, as other professionals were involved in the monitoring and care of the children, that answered some of the questions posed by Ms Healy regarding the risk of neglect or issues relating to the children's development, and suggesting that the case could be reconsidered for allocation when enough resources became available. Ms Loshak, who was aware of Ms Healy's earlier concerns, did not know about this referral to social services. Ms Healy said that she did refer Mrs Miles to the Mental Health Social Work Team but that they did not feel that Mariam was appropriate for their service. Ms Healy told us that she felt very frustrated by these responses and that the children's services were confusing as there were "different teams for different issues in different venues".

54. On 15 December 1999 there was a further referral addressed to the "Children and Families Consultation Group" from the Mental Health Social Work Team based at Pritchards Road. The letter outlined Mrs Miles' circumstances including those of the children. It then went on to say that there were reports that:

> "... Mr Miles recently threatened Mariam verbally and physically and that her eldest child has struck the two youngest on recent occasions."

55. The letter was explicit in seeking advice, support and information. It said:

> "my team cannot become involved in marital discord/guidance. We have advised Mr Miles to contact support groups with regards to his own self-identified needs, whilst we have recommended and advised Mariam to use any appropriate services with regards to her needs".

56. The letter went on to say that the case raised

> "cultural and personal issues that present as ongoing and unresolved, and with this in mind I am referring Mariam to your team with a view to requesting any advice, support and information that you can offer the family as a unit."

57. We note that the addressee was incorrectly written in hand on the top of the letter, although it seems that the intention was to address it to the Child and Family Consultation Service: the telephone number written in hand under the name of the addressee of this letter was the telephone number for that service. Ms Loshak did not receive this letter.

58. We do not know if the letter was received by anyone else but we found no evidence of any action taken as a result of this letter by anyone. It was, however, clear from that letter that the Child and Family Team (Social Services) were aware of the family's problems as that referral was made on that Team's recommendation.

59. On 8 June 2000 the family was referred to the Child and Family Consultation Service once more, because of concerns by the Special Educational Needs Co-ordinator at the Hague Primary School that Jafar was becoming withdrawn and isolated, and having occasional temper outbursts. Ms Loshak made five home visits between September 2000 and June 2001. Mrs Miles was present at the first two, but then was abroad. She had returned by the time of the fifth visit, but Mr Miles was late back from work on that occasion.

60. Ms Loshak's main concern was to assess the needs of the children and offer them an opportunity to talk about their worries, and she focussed particularly on Jafar. She also put Laila in touch with the Young Carers Project, with Mr Miles' agreement. The Project did not appeal to Laila at the time, although she was sent information about events and trips from time to time. She did not want to meet other teenagers and explain why she was considered to be a "young carer", and she did not want assumptions to be made about her.

61. According to Ms Loshak:

> "The children were quite reticent although Mr Miles at that point seemed to welcome the idea. And then in June[13] they said they felt that things were improved and it seemed that they were unwilling to have any freer discussions in case this provoked further conflict or that their mother became ill. And we agreed that they would contact me if they wanted further sessions."

62. The family did not contact her after the last visit in June 2001 and Ms Loshak discharged them from the service in January 2002 shortly before she herself left to take up a new post. Ms Loshak explained to us that she sought to engage the family in therapeutic work, unless the

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[13] 2001

concerns reported indicated a need for child protection investigation or that other services could more appropriately be provided through the Children and Families Team. Thresholds for such a referral are high and, at those times, she did not have concerns about the children at a level at which she would have considered such a referral necessary or indeed helpful.

63. The Health Visitor, Mary Harris, was also involved with the family from June 1989 to around March 2000. Her primary concern, as a health visitor, was with the health and welfare of the children and their mother. Her involvement only became frequent from June 1996, after the onset of Mrs Miles' mental health problems and as concerns developed about her ability to care appropriately for the children. Ms Harris became involved in giving support and guidance to Mrs Miles primarily to ensure the children's safety. Ms Harris did not have a mental health role but she did take it upon herself to talk to relevant professionals when she identified a mental health issue. Thus it was she who first contacted Doctor Pollen in July 1996, following concerns expressed by Mr Miles, just before Mrs Miles' first hospital admission. She also put Mr Miles in touch with a clinical psychologist, with whom he had a number of appointments during 1998 in order to discuss his very difficult situation.

64. The stress on Mr Miles was obviously very great. Between July and October 1996 he was provided with doctor's certificates to be absent from work on grounds of emotional stress. In November 1996 he told his GP that he had walked out of class in tears because of the stress he was under. On a number of occasions he visited his GP suffering from anxiety or stress because of the situation. Mrs Miles' condition plainly affected the whole family as, for instance, is indicated by the

report of incidents in the letter of 15 December 1999[14] and the letter that Mr Miles wrote to Doctor Falkowski on 2 September 2000[15].

65. As Mrs Miles' illness progressed, more and more of the family responsibilities devolved to Mr Miles. Mr Kevin McDonnell, who was deputy head teacher of Mr Miles' school (Stormont House School) when Mr Miles was working there, wrote to us that the strain of coping with Mrs Miles' behaviour caused Mr. Miles to take considerable time off work due to clinical depression and that, in around September 2000, he reduced his working days to four[16].

66. Despite the obvious stresses on the family, and on Mr and Mrs Miles as a couple, and despite the repeated references by the psychiatrists treating her to the marital problems suffered by them (for instance in letters written to the GP after her CMHT reviews), there was no work done with Mr and Mrs Miles specifically as a couple. When support was extended from Mrs Miles to other members of the family, the approach taken was to embrace the whole family.

67. We consider that, given the reluctance of the children to engage with family support services, further efforts should have been made to work in a focussed way with Mr and Mrs Miles. We accept that this was difficult. Mrs Miles was not willing to engage in counselling offered to her and her husband as a couple and, as Ms Loshak told us, it was difficult to work with a couple if they were not both willing to participate. Notwithstanding these difficulties, as poor marital relations were recognised as an issue in respect of Mrs Miles' illness, then alternative strategies to engage them as a couple should have been explored. Her care plan should have recognised this need. It should have identified ways in which the reluctance of Mrs Miles to engage in

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[14] See paragraphs 54-56

[15] See paragraph 35

[16] He subsequently increased his working days to 4 ½.

counselling might have been overcome, and the position should have been monitored and reviewed over time.

Hospital Admission: November 2002

68. The events of and surrounding this, Mrs Miles' last hospital admission before her husband's death, are particularly important. This admission occurred against a background of several years of fluctuating mental health, and a pattern of hospital admission at the most acute points of Mrs Miles' illness followed by apparent recovery, discharge, and further inadequate treatment in the community, as we have described, until her health once more deteriorated to the extent that she was again readmitted.

69. By August 2002 Mrs Miles was once more hearing voices talking about the hungry people of the world[17]. She was bringing strangers home and hoarding old and rotten fruit and vegetables.

70. On 16 August 2002 a review of Mrs Miles was carried out by Doctor Mirza in Ms Semper's presence, at Pritchards Road. Doctor Mirza was a locum consultant psychiatrist and of Pakistani origin. The interview was conducted in Urdu and English. The outcome of this was that she was advised to continue with her medication.

71. On 23 August 2002 Doctor Mirza saw her again and, in a letter of 27 August to Doctor Pollen, noted that Mrs Miles probably had not been taking her medication for some time as, on superficial enquiry, she said she was taking it regularly but then, on detailed enquiry, admitted that she was not. It does not appear that any further action was contemplated at this stage by Doctor Mirza or by the CMHT.

72. The notes of Mrs Miles' contact with Ms Semper from August 2002 show that Mrs Miles was becoming more ill. The situation at home was deteriorating and Mrs Miles complained bitterly about her husband, without being able give any examples of the behaviours she

[17] Hospital records note that she was hearing voices at the time of her previous admissions

complained of. She said she wanted to leave home. Mr Miles also spoke to Sally Miles at around this time about the possibility of living separately.

73. On 7 November 2002 Mr Miles told Ms Semper that the situation was becoming unbearable and that he feared for the safety of himself and the children in the home as Mrs Miles was continuing to bring strangers home, unaware of the possible risks.

74. On 12th November 2002, Ms Semper spoke to Alan Mountain, who was the manager of the Bethnal Green CMHT, and they agreed a plan of action. Two of the agreed items were first of all to contact the Child and Adolescent Consultation Service (they specified in their notes Ms Loshak, although she was not working in that service at that time) for advice about support for the children, and the other was a referral to the Children and Families service (which was within London Borough of Tower Hamlets Social Services Department) with a request for child in need assessments. It is not clear if a formal referral was made to social services.

75. Ms Semper made arrangements with Mr Miles, Doctor Pollen (the GP) and Doctor Agbodo (the Specialist Registrar to Doctor Falkowski) for an assessment to be carried out at the Mr and Mrs Miles' house on 13 November 2002 in order to consider detention under section 3 Mental Health Act. Doctor Pollen believed that the plan was for her to be detained in hospital and then for her to go into supported housing. Doctor Pollen explained to us that, in her view, she considered that this was the only way forward, to break what had become a recurring cycle of Mrs Miles becoming progressively unwell, it taking a long time to section her, having a brief spell in hospital where she would improve with medication, and then deteriorate again on discharge. Doctor Pollen told us that she put pressure on Mr Miles to cooperate because she took the view that, if he could not ensure that the children were safe (for example because they were coming home to strangers in the house when Mr Miles was not there), then care proceedings could be taken against him. She considered that she had to use this threat to

coerce not only Mr Miles but also Doctor Falkowski and the mental health team to make Mrs Miles safe.

76. Doctor Pollen described her approach as follows:

> "She would phone up from Zurich[18] having been at home Monday because she met someone who needed help and went with them to Zurich and then rang Edward in the middle of the night because her Barclaycard had run out or something. Or they went on a family picnic and she would see a family who looked interesting, she would wander off and forget her entire family and their afternoon's picnic and find out what their problems were, this other family, and try to sort them out and carry on. So she went from one need to another without reflecting on the time of day or her relationship and I think Edward had got used to this and the children had got used to this in some way or another. …
> So it was up to Gerrie and I, who said, technically this is not safe and, if you cannot provide someone to supervise them, they will be removed."

77. Doctor Agbodo saw Mrs Miles at home and agreed to Mrs Miles being sectioned. He told us that he found it a very hard decision to take. Nonetheless, he remembered that Mr Miles felt unsafe living in the house, with young children, when she was bringing strangers home. On the day of assessment she did not appear to be "acutely psychotic". In fact, Doctor Agbodo was not totally convinced that she was psychotic as she was quite rational in her explanation of things. His concern was that she was putting the safety of the family at risk and so he agreed to admit her to hospital for assessment. He said he erred on the side of caution and leaned on Doctor Pollen's knowledge of Mrs Miles because, in the way that Mrs Miles presented, it was difficult to draw a line between marital difficulties and psychiatric illness.

78. Mrs Miles was admitted to the Lansbury Ward, St Clements Hospital, under section 3 Mental Health Act 1983 on 13 November 2002.

79. The Pre-Registration House Officer (PRHO), Doctor Osbourne, who wrote up the admission notes on the Lansbury Ward, on 14 November, noted:

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[18] There had been a visit by Mrs Miles to Zurich earlier in the year, where it is thought she may have met Sheikh Mohammed Danish

> "Mariam does not come across very ill at the moment. The SpR[19] who saw her yesterday is also unconvinced. However history (what little there is) suggests otherwise."

80. On 15 November Doctor Osborne had a long telephone discussion with Doctor Pollen and wrote:

> "Mariam is well known to her and she was very informative regarding Hx and the fact that Mariam has never been compliant with meds but is very intelligent so masks her bizarre behaviour and appears very sane to new doctors, employing tactics of "You would hate to be in my position" and rationalising bizarre behaviour. She can not appreciate the danger within her "generous" behaviour. Can not judge people or distinguish between the emotional ties her family have for her and strangers. There are also child protection issues as her behaviour unintentionally endangers family. She has no insight or remorse. She is presently under a child protection order[20] and awaiting supported accommodation in Varden Street."

81. Doctor Osbourne commenced Mrs Miles on new medication (2mg of Risperidone) on 15 November 2002. We have seen no evidence that she was under prescription for Risperidone at the time of her admission. Despite the decision to commence this medication being taken by the most junior member of the medical team, there was no discussion with, reference to nor supervision by anyone else. Nor is there any evidence that Doctor Falkowski subsequently reviewed Mrs Miles' medication. Doctor Falkowski agreed in his evidence to us that a PRHO should not prescribe new medication in this way. New medication should not have been prescribed by a PRHO without reference to Doctor Falkowski or another doctor of appropriate seniority. The fact that it was allowed to happen suggests lack of clarity as to demarcation of responsibilities and poor level of supervision by Doctor Falkowski of the PRHO working under him We are left wondering whether this was a one-off or whether it represented custom and practice on Lansbury Ward.

82. On the 18th November, 3 days after Mrs Miles' admission under section 3 of the MHA, Doctor Osbourne authorised escorted leave for Mrs Miles to go to the shops. This is not a decision that a PRHO is entitled

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[19] Specialist registrar

[20] This is wrong: there was not in fact any order in respect of the children.

to take. Yet there was no sign in the documentation of any section 17 forms signed by the consultant, Doctor Falkowski. We cannot tell whether this leave was properly authorised by RMO (responsible medical officer) at the time.

83. Doctor Falkowski held a ward round each Wednesday, although not every patient of his would be seen on each ward round. On a Monday there would be a management round, at which new admissions and any problems that had arisen over the weekend would be reviewed. Doctor Falkowski told us the management round would be conducted by his Specialist Registrar, who was at that time Doctor Agbodo. However, Doctor Agbodo told us he was not present on the ward on a Monday so he could not have carried it out.

84. The ward round following Mrs Miles' admission took place on 20 November. Doctor Falkowski was not present. The most senior medical practitioner present was Doctor Kandeth, a Senior House Officer. Doctor Kandeth was not at that time directly involved in the care and treatment of Mrs Miles, but she later became involved when Doctor Osbourne (PRHO) left some time in December.

85. Because there was no more senior medical practitioner present on the ward that day, Doctor Kandeth conducted the ward round. She told us that she found it difficult to make decisions regarding Mrs Miles because she had had no warning in advance that she would have to conduct the ward round. She did not know Mrs Miles. She said she had to go through Mrs Miles' notes at the time and told us that it was "not a very good experience".

86. Doctor Osbourne was also present along with a medical student (who took the notes), an occupational therapist and occupational therapy student, and an advocate from MIND[21], Ms Semper, the staff nurse and the ward manager (Stephanie Garrett). A general review took place of Mrs Miles' circumstances and it was agreed that she would

[21] the National Association for Mental Health

have some unescorted ground leave and escorted leave (the latter presumably to be off the hospital site), and have time with the occupational therapist which was intended to address her loneliness. Doctor Kandeth realised that she was taking a risk in allowing her leave without a proper risk assessment, without her knowing much about Mrs Miles, and on the basis only of some discussion with staff. She would however have seen a file note of 18 November that she had been allowed escorted leave to the shops by the PRHO.

87. Doctor Kandeth spoke to Doctor Falkowski the following day. She told us that she was really angry about having to conduct the ward round but that Doctor Falkowski did not say very much in response. Doctor Falkowski did not remember this conversation, though he did not at first deny that Doctor Kandeth had been angry. Later in our interview with Doctor Falkowski he denied that she had complained to him. Given the inconsistency in Doctor Falkowski's evidence, we accept Doctor Kandeth's evidence on this point.

88. In the meantime, Ms Semper was pursuing a plan, which Mr Miles agreed with, to secure supported accommodation for Mrs Miles. On 21 November Ms Semper visited accommodation which she thought would be suitable for Ms Miles. She decided to progress an application for that accommodation and to take Mrs Miles to see it when she was well enough to leave hospital.

89. The hospital inpatient notes, in which all ward rounds would have been recorded, contain no reference to any formal review of Mrs Miles, for three weeks, between 20 November and 11 December. Ms Semper's notes show that there was a CPA review on 27 November, at which "staff, doctors and Mariam" were recorded as being present. Ms Semper's notes show that, at this meeting, some improvements were noted, but that home leave was not considered to be appropriate. It was agreed to give more ground leave and to continue with leave to the shops. There is no note of this review in the inpatient file. Ms Semper's notes do not indicate that there was any risk assessment carried out at that meeting. Ms Semper's notes do not include any

reference to any discussion at that meeting of independent accommodation.

90. Ms Semper's notes also indicate that there was a further review on the ward on 4 December. Her note is incomplete, simply stating

> "Mariam has made good progress. Has been granted 2 hrly leave after ward has es " [sic].

91. There is no note in the inpatient records of this review and so we cannot tell what was decided at that review.

92. On 15 November Mrs Miles had applied for a Mental Health Review Tribunal. A hearing was fixed for 10 December. On 6 December 2002 Ms Semper wrote her Approved Social Worker report for the Tribunal. Her recommendation was:

> "Although Mariam has made progress with treatment, she remains ambivalent about taking medication if she were to be discharged. Her mood still swings between happy and sad tearful and angry. I feel she would benefit from a longer period of inpatient treatment which would increase stabilisation and hopefully enable her to gain more insight. I am not sure that she will comply with treatment after discharge as this has been the pattern in the past.
>
> There are also issues about where Mariam will live after discharge. …Mariam stated that she wants to live away from her husband. Mr Miles, after struggling to hold on to hopes of a change in Mariam's views about safety, felt he could no longer keep their home safe, and that he was now also in agreement with her wishes….
>
> Further discussions will be arranged as soon as Mariam agrees to another joint meeting including her husband.
>
> Nearest Rel. View
>
> Agrees she has made some improvement but believes it would not be sustained without continued treatment which she is not likely to take as she denies m. illness. the concerns about his ability to act as her carer and issues of safety for her and home environment. She maintains need to pick up poor from street - strangers or not…"

93. Ms Semper told us that one of the difficulties that she faced at that time in progressing the move to alternative accommodation was that Mrs Miles kept on changing her mind about moving out of the family home.

94. No medical report was prepared for the Tribunal.

Mrs Miles is taken off section – 10 December 2002

95. On 10 December Ms Semper arrived at the hospital for the Tribunal hearing. She found that there was no-one else present for the Tribunal and so she contacted the ward. She was told that there was no medical report prepared and that Doctor Falkowski would be visiting Mrs Miles

on the ward to take her off the section. According to Ms Semper, the Tribunal was not happy about this. Ms Semper's notes show that Mrs Miles' solicitor and Ms Semper were called into the Tribunal which expressed concerns about the way that the matter was conducted.

96. Doctor Falkowski did indeed rescind the section that day. It is not at all clear what the basis for doing so was. Doctor Kandeth knew nothing about the circumstances in which the section was rescinded. We cannot tell from the available records whether Doctor Falkowski saw Mrs Miles at any time during her admission between 14 November 2002 and 10 December. Doctor Falkowski thought he would have examined her during that period, probably at ward rounds on 27 November and 4 December. As we have described, there is no inpatient record of those ward rounds having taken place and Ms Semper's notes do not indicate whether Doctor Falkowski was present at those reviews.

97. None of the notes that we have seen record any review or discussion of Mrs Miles' readiness to be discharged having taken place prior to 10 December. On the contrary, Ms Semper's note of 27 November recorded that it was agreed that home leave was not to be approved at that time, and that Mr Miles would be contacted to discuss a home visit when Mrs Miles had improved sufficiently. This is not consistent with there having been any discussion that she was or might soon be ready to be taken off the section. In addition, Mr Miles did not want her back at home and around that time (probably shortly afterwards) he changed the locks to the home.

98. Ms Semper told us that there was no prior discussion about discharge. This is consistent with her report for the Mental Health Review Tribunal dated 6 December in which she opposed discharge. She made no mention in her report of there having been any discussion on the ward about discharge.

99. Doctor Falkowski, as the Responsible Medical Officer, was responsible for ensuring that a medical report was provided for the Tribunal[22] but this was not done. Doctor Falkowski provided no satisfactory explanation as to why there was no report in this instance. He speculated that it may have been that it had been decided during the previous week's ward round that the section may well be rescinded. However, as we explain, the evidence does not indicate that this was the position. Had he provided a report this would have indicated his opinion of Mrs Miles' mental state at the time.

100. Doctor Turner, one of the co-authors of the SUI report[23] following Mr Miles' death, thought he was one of the first people to see the ward notes after Mr Miles' death. When he saw them there had been little or no opportunity for any other person to copy, remove or mislay parts of them. He told us that he could not remember whether he had found any notes of Doctor Falkowski's reasoning for rescinding the section. There was no mention in the SUI report of Doctor Falkowski's reasoning for discharging Mrs Miles from her detention under the Mental Health Act. Ms Jan Murray (the other author of the SUI report) said that she recalled being surprised that there was little evidence in the notes of thought having been given to Mrs Miles' case between admission and discharge. She said that, at the time of carrying out the SUI investigation, it had been an issue that the notes were very scant.

101. In his evidence to us, Doctor Falkowski claimed that he saw Mr Miles on at least two or three occasions during Mrs Miles' last hospital admission. The inpatient notes show that Doctor Falkowski saw Mr Miles on 11 December but there is no evidence that he saw Mr Miles before that. Neither the inpatient notes nor Ms Semper's notes indicate that Mr Miles was present at any ward round or other review prior to

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[22]It would probably have been written by a junior doctor after discussion with Doctor Falkowski.

[23] SUI means Serious Untoward Incident. Any homicide by a patient would be treated as a SUI and subject to an internal inquiry by the Trust within 28 days of the incident

the ward round on 11 December. It may be that some of the inpatient notes for that period are missing, as Doctor Falkowski asserted. We have no way of knowing this. In the circumstances, we have to decide on the evidence that is available whether, before 10 December, Doctor Falkowski discussed the proposal to rescind the section with Mr Miles. Doctor Falkowski could only point to one factor that, he claimed, indicated that he had had a discussion with Mr Miles prior to 10 December: he said that Mr Miles had handed to him a letter (written some time earlier) about the difficulties that he faced caring for and living with Mrs Miles[24]. However, inpatient notes show that that letter was in fact given to Doctor Falkowski by Mr Miles on 11 December; the day after the section was rescinded. Not surprisingly, given the passage of time, Doctor Falkowski's recollection in this respect is not reliable.

102. A far stronger indication that Mr Miles was in the dark about any plans to rescind the section is to be found in the GP records. These show that Mr Miles called Doctor Pollen at 5.55 pm on 10 December and left a message recorded in the GP file as follows

> "There was a meeting about her today which he did not know about Mariam is no longer sectioned husband very upset and would like to know what to do next" (sic)

103. From this we conclude that Doctor Falkowski did not have any discussion with Mr Miles about his intention to rescind the section prior to his decision rescinding it on 10 December.

104. We cannot tell whether, at any time prior to 10 December, anybody conducted a detailed examination of Mrs Miles' mental state. Doctor Falkowski agreed that one would have expected there to have been an examination of her mental state at least twice a week and that this should have been evidenced by an entry in her notes. He said he would have expected himself, as the most senior doctor, to have

[24] This is the letter referred to at paragraph 35 of this chapter

reviewed her mental state on the ward rounds. Contrary to this expectation, there was in fact no such note after the initial assessment by Doctor Osbourne on admission. The notes of the ward rounds on 20 November and 11 December do mention aspects of Mrs Miles' behaviour and her state of mind at the time, but there is no note of anyone, at any time after admission, carrying out a detailed mental state examination to establish the nature or degree of her illness. We do not know what examination of Mrs Miles' mental state took place at the reviews on 27 November and 4 December. The only evidence that we have of any detailed assessment of Mrs Miles is of the examination that took place at the time of her admission when she was checked in by the most junior member of the medical team, a Pre-Registration House Officer.

105. Doctor Falkowski did conduct an examination of Mrs Miles on 10 December, before he rescinded the section. However, it seems that, before examining her, he was already strongly inclined to rescind the section because, when Ms Semper arrived for the Tribunal hearing, she was told that

> "Doctor Falkowski would be visiting Mariam on ward with view to take her off section"

106. The only contemporaneous explanation of the decision to rescind the section is Doctor Falkowski's note of 10 December. It is extremely brief:

> "Settled, agreed to go on leave, no longer warranting detention under MHA, taken off section"[25]

107. Doctor Falkowski explained to us that he would have based his conclusion on his knowledge of how Mrs Miles had been progressing. He said he would have read the notes and the social worker's report for the Tribunal, if that was available, and would have talked to the ward

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[25] As Doctor Falkowski explained to us, if she was prepared to go on leave she was also prepared to return to the ward

staff. However, Doctor Falkowski could not remember. He could not tell us what information he had in fact seen or to whom he had spoken, if anyone, when he decided to rescind the section. He said that he would not have taken her off the section if she had not agreed to stay on the ward.

108. Whether or not Doctor Falkowski had examined Mrs Miles prior to 10 December, the basis of his decision to rescind the section was plainly wrong. First, there is no evidence that she was in fact ready to come off the section and the available evidence indicates the contrary. She was plainly not ready to come off section on 27 November: at that time, it was agreed that even home leave was not appropriate. Nor was she ready to come off section on 4 December, when she was limited to 2 hourly leave.

109. Second, Gerrie Semper concluded on 6 December that discharge was not appropriate. Neither her report nor her notes indicate that the doctors took a different view at that time.

110. Third, there was no proper basis for concluding that Mrs Miles would stay voluntarily on the ward. The GP notes record a telephone call from Ms Semper on 10 December as follows:

> "she says she is not going to stay on the ward; husband feels he cannot care for her at home…patient still has delusions about commands from Allah."

111. Fourth, it was known at the time of admission that her presentation belied her true mental state. The fact that she was cooperating with her medication and not bringing strangers home was an inevitable consequence of her being detained in hospital but did not of itself signify an improvement in her mental health. We agree with Doctor Pollen who said to us,

> "if there was a case for her being in hospital in November, there was a case for her being in hospital in December".

112. Fifth the decision was taken without consultation with and contrary to the opinion or wishes of Doctor Pollen, Ms Semper and Mr Miles.

113. Moreover, the critical factor, that she was not in a position to go back to the family home, was not addressed. Doctor Pollen said she could have accepted *some form of* supervised discharge of Mrs Miles to accommodation other than the family home, but at that time no alternative accommodation had been secured for her. Sally Miles described the decision to rescind the section as devastating to Mr Miles, "as if every support had been pulled from under him".

114. Mrs Miles was admitted to hospital because of grave concerns expressed by Doctor Pollen about her mental state. Doctor Pollen actively pressed for her admission in November 2002. The inpatient entries show that the psychiatrists took a different view. It did not seem to be appreciated that Mrs Miles was able to put on a very good front, although this was apparent from her previous history and from the information provided by Doctor Pollen to the hospital shortly after admission. Lack of attention to the implications of information that was or could have been provided by the GP, care co-ordinator and family (all of whom knew Mrs Miles and her circumstances far better than the hospital staff) contributed to the ill-informed and hasty decision to rescind the section.

115. For all these reasons we conclude that Mrs Miles' section should not have been rescinded at that time or in the way that it was. Doing so considerably disadvantaged Mrs Miles and her family, as will be seen from the account of subsequent events.

Mrs Miles' last week in hospital

116. Without the compulsion of detention, the management of Mrs Miles' care and treatment depended on her continuing to remain in hospital on a voluntary basis. As we have seen, even on 10 December Ms Semper was reporting to Doctor Pollen that Mrs Miles would not stay on the ward.

117. Because of her concerns about the situation, Doctor Pollen telephoned Doctor Falkowski prior to a ward round that took place on 11 December. The note made by Doctor Pollen of that conversation

recorded that Doctor Falkowski agreed to try to persuade Mrs Miles to stay on the ward as she was agitated, to have Mrs Miles investigated for neuropsychiatric disorders and to try to get her rehoused. But Doctor Pollen made this note about the conversation:

> "overall tenor, though was that she would be 'within her rights' to ask for access to her property – I argue that Mr Miles can put child protection issues first and risk being sued for denying her such access…"

118. This referred to the fact that, around that time, Mr Miles had changed the locks to the house. Doctor Pollen told us that she had in fact advised Mr Miles to do so.

119. Doctor Pollen said that, during this conversation, Doctor Falkowski spoke

> "fluently and rapidly so that it was difficult to get a word in edgeways or … it was in a reassuring tone of voice, that it was all quite all right and things were taken care of. In other words, he did not become upset or angry or suggest that I was being inappropriate. He continued to just say that things were as they were and that is how they were going to be."

120. Doctor Falkowski conducted the ward round on 11 December. Ms Semper was not there, but Mr Miles was. The inpatient note of the ward round includes a short record of the telephone discussion between Doctor Pollen and Doctor Falkowski, including Doctor Pollen's concerns regarding child protection issues. The note also records Mr Miles being unhappy because he was not informed of his wife returning from hospital nor of the tribunal, and that he had asked that Mrs Miles should not return home to live with family.

121. The record also notes that Mrs Miles became agitated during this ward round:

> "repeating 'I want to see children'
> I will do what you ask me'
> I don't want to be without children
> Give me a chance'
> Mariam became – Tearful
> Agitated
> Pacing around [*illegible]*

Grabbing husband"

122. The plan was recorded as follows

> "– To remain in hospital
> - To have Day leave to see children – 2 hrs in evening
> * husband to telephone - ?↑ to 4 hrs if First * goes well.
> - Can have overnight leave to friends house."

123. It is not at all clear that this note accurately reflects what was agreed, in so far as it indicates that Mr Miles was in agreement over her leave. It is inconsistent with the discharge summary of 18 January 2003 which noted that, at this ward round, Mr Miles agreed that Mrs Miles was better but he did not want her home. It is also inconsistent with the fact that Mr Miles had changed the locks to the house.

124. On 13 December 2002 Doctor Kandeth noted that the locks to Mrs Miles' house had been changed so that Mrs Miles had no access to her home. She was advised to take legal advice or advice from the advocacy service but Mrs Miles refused saying that she wanted to talk to her husband and come to an arrangement with him. She said that she wanted to go home and live with her husband and children.

125. Mr Miles had made it clear he did not want her home and that he had fears for the children's safety. Yet, once the section was rescinded, the hospital's advice to Mrs Miles to take legal advice both undermined the attempts that Mr Miles was taking to protect the children and displayed a failure to understand the problem that his wife presented. This episode illustrates the failure of the psychiatrists to take into account the role of the GP and social worker, or to address the needs of the closest relative and carer. It also reveals an approach that focussed on Mrs Miles' presentation in isolation from her circumstances.

Discharge from hospital

126. On 14 December (a Saturday) Mrs Miles went home on leave. There was no prior discussion between the ward staff and Mr Miles before this leave was organised. If there had been a telephone call to Mr Miles before the leave was granted it would have become clear that she

would not be able to go home for leave. When she arrived home her son, Jafar, refused to give her the keys to the house and she slapped him on the face. Mr Miles would not let her in that night and she stayed with a friend.

127. On 16th December (Monday), before Mrs Miles returned to hospital, Ms Semper received a call from Mr Miles to register his concern about incidents over the weekend when Mrs Miles refused to go back to hospital after the home visit and reported her hitting Jafar. Ms Semper's notes indicate that there was a detailed record made of what Mr Miles told her, but that is not now on the file. Ms Semper advised Mr Miles to report the incident to the Children and Families Team and gave him the telephone number. He later called back to say he had done this and that the Team would contact him after a discussion with the manager.

128. Ms Semper then spoke to Mrs Miles on the telephone at home to ask how things had gone over the weekend. She said "fine" and denied hitting her son. Ms Semper advised her to go back to hospital. She noted that there was a baby crying in the background and a woman's voice. Mrs Miles told her that this was her friend. Ms Semper reminded Mrs Miles of her agreement not to bring people to the house while Mr Miles was out. At this point, the file note records that Mrs Miles became verbally aggressive and hung up the phone. Ms Semper called Mr Miles to tell him about this and, in case bedrooms were open, to advise him to secure personal items. She called the ward to inform them of the present position and left a message for Doctor Falkowski to update him. Doctor Kandeth told us that she did not think that she was informed that Ms Semper had telephoned with concerns. Doctor Kandeth told us that there was no system, if Doctor Falkowski was not available, for his secretary to contact any other doctor who was available. Doctor Falkowski told us that he could usually be contacted and, in any event, there was a system for contacting other senior doctors in his absence. In any event, no senior doctor was contacted.

129. Mrs Miles went back to the ward sometime during the 16th December. Doctor Kandeth saw Mrs Miles on the ward. She was not clear about how this came about, but she thought that she had been called to the ward by staff because Mrs Miles was threatening to leave and the ward staff wanted Doctor Kandeth to try to persuade her to stay.

130. Doctor Kandeth did not persuade her to stay: she discharged Mrs Miles that day. She noted the discharge as follows:

> "Came back from leave – home leave on 16/12/02. Enjoyed her leave - said it was good to be back home. Wanted to be discharged. Said she has been here longer than she should have been. Has no problems at home. Wants to go back to her husband and children & care for her children. Does not want to be separated from them as she loves them very much. Agreed to attend outpatients appointment and comply with medication.
>
> Plan: Discharge on 16/12/02
> Outpatient appointment on 21/1/03
> Continue Risperidone 2mg daily"

131. Doctor Kandeth was very unclear as to her thinking when deciding to discharge Mrs Miles. She thought that she may have been unable to prevent Mrs Miles from leaving the ward and so she may have been discharged against medical advice. She agreed that she should have made a note if the discharge was against medical advice and she had not done so. She said that there was a form which was usually filled in if someone left against medical advice. No such form was in the notes.

132. The discharge summary, which was dictated by Doctor Kandeth on 23 December, recorded: "her mental state was reviewed and it was felt that she was doing well". This does not suggest discharge against medical advice but, rather, that Doctor Kandeth considered that discharge was appropriate.

133. Doctor Kandeth was uncertain whether she had discussed the decision to discharge Mrs Miles with anyone else. She told us that Doctor Falkowski was not present on the ward that day, and had not left a mobile phone number. She said that he was not always easy to get hold of, but Doctor Falkowski denied this. He said it would have been

normal practice for a senior house officer to discuss with him a decision to discharge a patient who had been detained under section 3. It would also, he said, have been reasonable for her to have discussed it with Doctor Agbodo, as the next most senior doctor, instead.

134. Doctor Agbodo told us there would always be a consultant to talk to: Doctor Falkowski and Doctor Bass provided cross-cover for each other. Doctor Agbodo's opinion was that Doctor Kandeth should not have discharged Mrs Miles. If Doctor Falkowski was not there and Mrs Miles was progressing well, she could have been granted leave and asked to come back to see the consultant.

135. It is clear to us that Doctor Kandeth did not discuss the decision to discharge Mrs Miles with any other doctor. It does not seem that she spoke to any ward staff about the decision. Before Mrs Miles was discharged, Ms Semper had phoned Lansbury Ward and informed them of the current state of affairs (this would have included the events over the weekend, including slapping her son, and Mrs Miles' behaviour on the phone to Ms Semper that morning). Ms Semper also left a message for Doctor Falkowski to update him. Had Doctor Kandeth spoken to the ward staff she would, presumably, have been told of this worrying information from Ms Semper. There is no mention of any such conversation in the medical notes.

136. Doctor Kandeth thought she had spoken to Doctor Falkowski the following day because she was very displeased that she had not been able to find him on the 16th. She said that she told him what she had done and what was arranged. She said that he did not criticise the decision or make much comment on it at all. Although Doctor Falkowski did not remember that discussion, he told us that the discharge would have come to his attention at the very latest at the next ward round (which would have been 18th December). He accepted that it was his responsibility, once he became aware of this, to explore the issue and that this was not done by him.

137. Discharge of Mrs Miles at that time was inappropriate, for a number of reasons:

137.1 Mrs Miles' account of her home leave was plainly at odds with that given by Mr Miles to Ms Semper. Doctor Kandeth made no checks with either Mr Miles or Ms Semper before deciding whether to discharge.

137.2 Mrs Miles' wish to live at home with her children was plainly contrary to the wishes of her husband as noted at the ward round of 11 December.

137.3 The plan at the ward round on 11 December was to increase the two hourly home leave to four hourly only if Mr Miles reported that the shorter leave had gone well. There had been no review since then that could justify a decision to increase the home leave, let alone to discharge her.

137.4 Doctor Kandeth knew as recently as 13 December that Mr Miles had changed the locks to the house.

137.5 Doctor Kandeth's decision was taken in the face of ward staff calling her to the ward to try to persuade Mrs Miles to stay.

137.6 Although it was known that compliance with medication was an ongoing problem, there was no plan to secure compliance.

137.7 Discharge was not justified on the grounds that Mrs Miles was determined to leave the ward. There were a number of other strategies that could have been deployed to keep Mrs Miles in hospital or to avoid her discharge.

137.8 It is inappropriate for a junior doctor to take such an important decision without reference to a more senior Doctor This is an issue which has already been addressed in a previous inquiry involving the care and treatment of a patient during Doctor Falkowski's term as Medical Director: "Report of the Independent Inquiry Team into the Care and Treatment of DN" (September 2002) which recorded concerns about unclear boundaries and

guidelines in existence at that time as to discharge decision-making. The recommendation was "No patient should be discharged by an SHO (other than as part of an existing plan) without consultation with a senior colleague". It does not seem that any steps had been taken to clarify the boundaries and guidelines since that report, even though Doctor Falkowski would have been fully aware of the report and the recommendation in it. Doctor Falkowski would have learned of the discharge (as he said, no later than 18 December). We are surprised that there was no attempt made to re-evaluate her mental condition as a matter of urgency.

December 2002 – May 2003

138. The first Ms Semper knew of the discharge was when she telephoned the ward again, at about 2.15 pm that day, and was told by staff that Mrs Miles had been discharged about one hour earlier.

139. Doctor Kandeth told us that, if a patient is discharged against medical advice, there is usually a face to face contact seven days later. In Mrs Miles' case an outpatient appointment was made for her for 21 January 2003. Doctor Kandeth could not remember if she had had a discussion with Mrs Miles about coming to the ward seven days after discharge. However, when the ward told Ms Semper of the discharge, Ms Semper was reminded of the need to visit Mrs Miles within seven days.

140. Doctor Falkowski claimed that it was open to Ms Semper, having seen Mrs Miles within 7 days, to arrange for her to be seen at fortnightly CMHT reviews. However no suggestion to this effect was made to Ms Semper after Mrs Miles was discharged. In any event, because of the Christmas holidays, the CMHT was closed until 2 January. Doctor Falkowski told us that he was available during the holiday if needed and he was relying on the experience of Ms Semper to ask for a medical assessment earlier if needed.

141. Mrs Miles was discharged without a CPA review or any up-dated care plan or section 117 discharge plan[26]. The only planning document at the time was the "In-Patient Nursing Discharge Summary" which was completed on 18 January 2003. This noted that Mr Miles did not want her at home. The document stated

> "Staff explained to the husband that the doctors felt that she was well in mental state and she was discharged on 16.12.02"

142. This is not accurate in that there was no discussion with Mr Miles before discharging her.

143. The discharge summary set out the plan as follows:

> "- discharged to home address
> - 2/52 TTA[27]s given
> - enhanced CPA level
> Gerrie Semper CPC[28] and has care plan and contact and crisis forms in place
> Gerrie liaising with child and family over issues at home
> 7 day face to face contact identified, Gerrie to carry out
> O/P[29] review to be arranged in 4-6 wks time"

144. The care plan referred to was attached dated 16 August 2002. There was no subsequent care plan and therefore nothing that took into account Mrs Miles' circumstances at the time of discharge

145. The care plan of 16 August 2002 is the only attempt at a complete CPA assessment that we have been able to find. There were a few incomplete CPA assessment and planning forms in the CMHT file, and a number of care plan summaries, but there was no full CPA assessment and plan save for this one of August 2002.

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[26] The requirements in this respect are explained in more detail in Chapter Two.

[27] to take away

[28] care programme coordinator

[29] out patients

146. Not only was there no CPA meeting at the time of discharge, none took place at any time afterwards. Ms Semper told us it was the Trust's responsibility to organise one and that she did not know why they did not.

147. On 17 December Ms Semper spoke to Mr Miles about the situation and how he might ensure that the children were safe when he was at work. He said that he felt that Mrs Miles would sabotage whatever arrangements were put in place. He was disappointed that she was back given that, months prior to her admission, she had said she wanted to live separately. He talked of taking legal advice.

148. On 18 December Ms Semper spoke to Mrs Miles at home and noted that she sounded stressed and low.

149. On 17 December Mr Mountain had told Ms Loshak about Jafar having been hit by his mother. Ms Loshak told him that the Children and Families Team should be informed and she herself telephoned the Team and left a message to call her back. On 19 December Ms Loshak telephoned the practice manager at the Children and Families Social Services Team, and was told that Mr Miles had contacted them and asked for support. The practice manager did not say anything about Mrs Miles having hit her son. The computerised record held by social services of Mr Miles' contact with that Team records that Mr Miles reported that Mrs Miles was not cooperating with her care plan and had a history of non-cooperation, failure to take medication and bringing strangers home, but includes nothing about any hitting incident. Ms Loshak told the practice manager what she knew of the incident. On the same day, Ms Loshak was in the Bethnal Green CMHT office and looked at Mrs Miles' file. There was nobody at the office but she put a note on the file saying that the incident of Mrs Miles hitting Jafar had not been noted by the Children and Families Team and that there needed to be a referral by the CMHT to the Children and Families Team rather than by Mr Miles. Ms Semper did not seem to appreciate this as she spoke to Mr Miles on 20 December and he said that he would contact the Children and Families Team again and

repeat the details of the hitting incident. In fact it does not appear that he did so. No action was taken by social services.

150. Mr Dave Hill (Head of Children and Families Services in the London Borough of Tower Hamlets) said that, had the CMHT made a direct referral to the Children and Families Service and informed them that a child had been hit, "it would have been an absolute clincher in terms of us doing an initial assessment". Although the usual procedure was for a direct referral to the Children and Families Service to be made by the CMHT, it is difficult to understand why no action was taken on the information provided by Mr Miles that his wife was bringing strangers home. Mr Hill confirmed to us that, even if no information had been provided about a child being hit, the issue of bringing strangers to the house ought to have alarmed social services. Whether or not an initial assessment was called for would have depended on a range of judgments being made about what was occurring in that case. In retrospect Mr Hill said that, on the basis of what was in fact occurring, there should at least have been an initial assessment of whether the children were in any danger. On the other hand, he felt that there were not in fact serious child protection concerns being raised and it may well have been that the incident would not have been sufficiently serious to raise any further action by social services.

151. Nonetheless, the lack of any action on Mr Miles' report of his concerns to the London Borough of Tower Hamlets and the failure by the CMHT to ensure that the Children and Families Service was aware that a child had been hit, illustrates the lack of effective coordination between the agencies.

152. Ms Loshak told us that she might now, with the benefit of more experience in the post, have been more assertive in checking whether things had been done. At that time, having put a note on the file and talked to people about it, she assumed action was being taken. She was then new in her post (she had taken up the post as Coordinator for Children in Families with Mental Illness in February 2002).

153. The purpose of Ms Loshak's post was to provide consultation to the mental health teams about the children of their patients, to identify vulnerable children, to facilitate access to appropriate services and to develop closer working between adult mental health and children's services. She was responsible for the publication of a joint working protocol in July 2002 by the Trust and London Borough of Tower Hamlets, "Parenting and Mental Illness", which was designed

> "1.3.1 To improve and develop our service to families in which there are dependent children with parents with a severe mental illness…
>
> 1.3.2 To establish good co-operation and communication between children's services and integrated mental health teams in order to achieve improved access to resources and collaborative decision making.
>
> 1.3.3 To ensure safe management of risk while providing a responsive service to families which is sensitive to their special needs."[30]

154. According to that protocol, the children should have been referred by the CMHT to the Children's Duty Service. The referral may have involved no more than the sending of a standard letter but, if there were concerns for the children's welfare, there could have been a more active role for the Children's service. There was no referral at all. Ms Loshak explained that there were real difficulties at that time securing compliance with the procedures, although she thinks that this is much improved now.

155. After her discharge, the family spent Christmas together. Sally Miles was there and she said that Mrs Miles' behaviour was noticeably bizarre. She described her as being in a world of her own, wandering around the house and not relating to anyone else, holding her body in a strange posture with her head on one side and one arm stretched backwards and twisted round, and constantly muttering to herself. She absented herself for much of the day.

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[30] Protocol para 1.3

156. Mr and Mrs Miles reported to Ms Semper that things seemed to be under control over the Christmas holidays. Ms Semper noted on 15 January that Mrs Miles was saying that she was tired, though sleeping well, and an appointment was made for them to meet on 22 January. Mrs Miles failed to attend her outpatient appointment on 21 January. The following day, when she was due to see Ms Semper at the CMHT offices, she phoned one hour before hand to cancel and rearranged it for 31 January.

157. Following the missed outpatients appointment, Doctor Kandeth wrote to Mrs Miles to make a new appointment for 11 March. Doctor Kandeth said that she contacted Doctor Falkowski to say that Mrs Miles had not turned up because she was concerned that, if Mrs Miles was not attending her appointments, she may not be complying with her medication. Doctor Kandeth was unable to remember what Doctor Falkowski's response was. Doctor Falkowski denied the contact had been made with him. It is not clear on what basis Doctor Kandeth decided that offering the next available appointment was a sufficient response.

158. It is surprising that, in the light of Mrs Miles' history and the circumstances of her discharge, no steps were taken to follow up her non-attendance at the clinic other than to offer her a further appointment for several weeks later. The appointment offered for 11 March would be the first time Mrs Miles was seen by a psychiatrist since her discharge from hospital on 16 December.

159. The next contact by the mental health service with Mrs Miles was 31 January, when she called to see Ms Semper at the CMHT office. Although Mrs Miles told Ms Semper that she was taking her medication, Ms Semper's notes recorded that Mrs Miles presented as very tired looking and said that she did not feel well. She was tearful at times and, although on 8 January she had told Ms Semper that she was happy at home, by 31 January she said that she wanted to live elsewhere as she was unhappy at home.

160. Doctor Pollen and Ms Semper spoke to each other on 3 February about Ms Semper's concerns about Mrs Miles' non-compliance with medication. Doctor Pollen then telephoned Doctor Falkowski to voice her concerns and then wrote to Doctor Falkowski on 3rd February as follows:

> "Request for urgent senior psychiatric review with a view to Section.
>
> Since discharge from St Clement's on 16.12.03 [sic] Mariam has not been compliant with her Risperidone. She has, today, put in an inappropriate written request for citalopram which is not part of her current medication. She has not made any appointments to see me to discuss or obtain medication. She did not attend her out-patient review on 21.1.2003.
>
> I have discussed these observations with her key worker Gerry Semper today. Gerry adds to this picture of psychotic relapse, telling me that Mariam has lied to her about continuing to get prescriptions of Risperidone from my surgery.
>
> In summary, this woman is a psychotic patient who is non-compliant with medication and is currently living with her three young children who are thus at risk from her inappropriate behaviour. This situation resulted in her being sectioned in November 2002. If anything the situation has deteriorated since then. In view of recent concerns about the lack of coordination between public services about children's safety I hope that you can let me know by the end of today on which day she will be sectioned.
>
> I would be grateful if you could use another approved doctor rather than myself for the section process. On each occasion that I have sectioned Mariam, she has been allowed to leave hospital against medical advice and has not been followed up by a physician. In effect my clinical opinion has always been discounted by your medical staff."

161. In her evidence to us, Doctor Pollen described her thinking behind writing this letter as follows:

> "…apart from short periods of time when Mariam was sedated, perhaps, between 1995, 1996 and 2003, she had not altered for the better at all in any convincing way, from the point of view of her psychiatric illness. Her family did not feel supported by any of the health service or social services available to help them. Even where perhaps, like myself or Gerry Semper, we were trying to help them, it did not actually result in any very effective changes as to what might have happened, really, had we done almost nothing at all. So … in effect, Mariam decided when she would take treatment and when she would not and what sort of treatment she would take. And before this time, but it only became obvious I suppose as the case built up, her children were vulnerable, Jafar was neglected and we were all responsible partly. But, as I said before, the only treatment that actually worked in the sense of at least relieving her distress - because she was distressed when she was unwell - and apart from relieving her distress from making her family safer, was when she was taking medication, because she did improve enough for all the staff on the ward to agree that she could go home on some of the occasions that she was in hospital. She did not like being sedated so it seemed that that was the only thing to do, to manoeuvre the structures around her so that she was better in the technical psychiatric sense, no longer hallucinating or behaving bizarrely, and her children were therefore probably safer because she was sedated.

> So, that letter was borne of frustration in that the only technical tool that we had which worked, which was to supervise her medication in hospital, had been overruled…
>
> So, at that point, it was frustrating also because she was difficult to diagnose. But … the consultant made the diagnosis in the mid-1990s…There was no evidence that that assessment of her having a psychosis was wrong or inaccurate or could be qualified by other contextual information. She suffered from a psychosis, and she did not always appear obviously psychotic. So, all the people involved in her care had, in my opinion, to remind themselves that she was psychotic even if she did not look crazy and therefore they should be mindful of all the responsibilities that they had as regards her management. And her care outside hospital seemed to me ineffective because there were not the resources… It seemed no matter how strongly you put your view that something was going wrong and that children were at risk, the other people in the team, such as the psychiatrist or social workers, would say, or housing officers, that unfortunately they could not help, although they appeared to have heard what you had said. So it seemed that you could say as loudly as you liked that a psychotic woman was putting her children at risk and if she could be sectioned or given independent housing her children would not be at risk -- because if she was in independent housing, Edward would have had to have had childcare in the afternoons and nobody could do that…
>
> It seems to me that if people in the street knew that untreated psychoses where children were involved had no other intervention than being encouraged to take tablets that had no systematic supervision, they would be horrified."

162. Doctor Falkowski did not accept Doctor's Pollen's plea for Mrs Miles' readmission to hospital. His response to the letter was to review Mrs Miles in outpatients on 11 February. He wrote to Doctor Pollen on 25 February, as follows:

> "I reviewed Mrs Miles in outpatients on 11th February 2003. She complained of feeling lonely and isolated. She spends most of her time at home. She told me that her relationship with her husband had improved. Although they interact little, they do not row. As he says very little to her and does very little with her, she feels rather isolated. If anything, she said her mood is worse in the evenings. She would like friends to visit. I discussed this with her at some length and she stressed that these were friends she had known for a long time.
>
> I asked Mrs Miles about her marriage. She said her husband no longer talked about separating as the situation had been better over the last few weeks. She described herself as feeling down. She does not have any biological features of depression at present. She clearly finds her marital situation difficult and this leads to her feeling lonely and isolated. I gather she sees Gerrie Semper regularly. I suggested we continue to monitor her and I will review her again at Pritchards Road in due course."

163. This letter gives the impression that it has been written without reference to any communication from Doctor Pollen. Doctor Falkowski did not mention the problems of Mrs Miles' compliance with medication nor her lying about collecting prescriptions. There was no attempt to

address the issues of compliance. He did not mention the risk to the children.

164. When we put this to Doctor Falkowski he responded to us that medication and risk to children were both ongoing issues for the community team so he said that one could assume that this was being dealt with. We are not prepared to make that assumption. Non-compliance with medication had been an issue for years, and yet no concrete steps had been taken at any time to address this. We put to Doctor Falkowski that it seemed strange that he did not respond to Doctor Pollen's concerns but he did not accept this. He said that Doctor Pollen had not actually seen Mrs Miles for several weeks, so he was surprised that she had requested an urgent section assessment. Doctor Falkowski told us that he thought the Doctor Pollen's concerns were reasonable but not her sense or urgency. In contrast, he had talked to Ms Semper and had seen Mrs Miles on 11 February. In taking this position, Doctor Falkowski failed to take into account the fact that part of Doctor Pollen's concern was that Mrs Miles did not come to see her, but that Ms Semper (who did see Mrs Miles on a regular basis) added to a "picture of psychotic relapse". Mrs Miles had failed to attend her outpatient appointment, she was making inappropriate requests for medication which was not part of her current medication, and she was lying about collecting her prescriptions. There were also concerns about risk to children. None of Doctor Pollen's concerns, which were based on up-to-date information about Mrs Miles' behaviour, were addressed by Doctor Falkowski. Moreover, although Doctor Falkowski had on 11 February seen Mrs Miles more recently than Doctor Pollen had done, Doctor Pollen had a much greater knowledge of Mrs Miles. She had seen Mrs Miles on a regular basis for years, not just at the time of hospital admissions. Indeed Doctor Pollen told us that she did not feel confident that Doctor Falkowski could have spoken as discursively about Mrs Miles as she herself could have done. Although he would have seen Mrs Miles at times when he could have formed

quite an impression of her, Doctor Pollen did not get the impression that he had an individual view of her. We agree.

165. When Doctor Falkowski was asked by the Inquiry what the plan was for Mrs Miles in respect of her mental health, he said that they were trying to review her mental state and encourage her to comply with her medication. The only plan he could identify to achieve this was

> "hopefully to be able to help her recover if she was in a less stressful, more supportive environment, and, if she complied, then her mental state would improve as well"

166. Doctor Falkowski relied on the fact that the support previously provided in the community was all available, and that Ms Semper was trying to find her accommodation. Further, she was on a prescription of 2 mg Risperidone. This is at the bottom end of the recommended dosage range and, when it was put to him, Doctor Falkowski conceded that he did not know if she might have responded differently to higher doses of medication. Doctor Falkowski agreed, however, that she was never fully treated as she did not comply with medication consistently:

> "I do not think she was fully treated, no, I do not think she was fully treated. She never consistently over the course of many years took medication on a regular basis, and part of the changes in her mood state may be because she was not regularly complying, so she may have been sort of -- clearly she responded to treatment and she was much better when taking medication regularly, but whether she ever was fully is very difficult to know."

167. 11 February was the last time Mrs Miles was seen at outpatients.

168. Ms Semper visited Mrs Miles at home on 24 February. Mrs Miles said she was taking her medication but she seemed very tired, and was moving around as they talked. She appeared agitated with pressure of speech. She said she was not happy and she did not want to speak to her husband any more. She had put her planned holiday in Pakistan on hold because she was not ready to go, and said she was going to divorce her husband first. She talked of getting her own place to live. She felt that Mr Miles wanted to keep her away from the children. We do not know if this comment, made with hindsight, reflects the actual situation at that time. However, it is consistent with the fact that Mrs Miles frequently changed her mind about moving from the family home.

When we saw her at the John Howard Centre, Mrs Miles told us that she had decided at some point not to get her own flat because she was worried about being separated from the children.

169. Some time in early March, Mr and Mrs Miles signed Islamic divorce papers.

170. On 4 March Ms Semper spoke with Mr Miles. He explained that he had purchased a ticket for Mrs Miles to go to Pakistan, at her request, to leave on 26 February but that she had changed her mind the day before. She said she had changed her plans and wanted to set up a business with another person. We do not know if Mr Miles was fully aware of the identity of this other person but we now know that this was Sheikh Mohammed Danish. She had met Danish through his sister, Anila, a Pakistani woman who was a neighbour and had become friends with Mrs Miles. Mrs Miles told us that Danish also became a friend. Mrs Miles told us that she liked the fact that Anila and Danish spoke Urdu. Mrs Miles wanted to start a business with Danish, buying clothes from Pakistan and selling them here. Mrs Miles told us that she wanted to do this because she wanted to keep busy. It seems she had known Danish for some time. The prosecution summary prepared for Mrs Miles' trial noted that Mrs Miles had gone to Zurich in June 2002 to assist Danish who was at that time in a transit camp. Mrs Miles was upset that her husband was not supporting the business idea and was unwilling to give her the money to finance it. Further, he had told her that she could pay for the cost of changing the ticket out of the weekly allowance that he gave her.

171. Ms Semper visited Mrs Miles at home again on 13 March. She noted that Mrs Miles seemed to be less depressed and said she was eating and sleeping well. She was anxious to talk about moving to her own place. She said she was taking her medication when she needed it and questioned why it was being mentioned.

172. On around 14th April Mr Miles took the children to visit friends in Geneva until 25 April. Mrs Miles stayed at home.

173. Mrs Miles was to have attended an outpatient's review on 15 April but she did not turn up. The medical team responded with a standard letter to the GP dated 25 April notifying her that she had not turned up for her appointment and that a further appointment would be sent "in due course".

174. Ms Semper spoke to Mrs Miles on the telephone on 17 April. She noted that Mrs Miles sounded tired but told Ms Semper that she had slept well and was taking her medication. Mrs Miles told her that she had not received the letter about the review on 15 April, then changed her explanation and said that she had forgotten about it. Ms Semper arranged to visit Mrs Miles on 24 April but, when Ms Semper went there on that date, Mrs Miles was not in.

175. Sally and Peter Miles last saw Mr Miles alive on Saturday 26 April 2003, at Peter Miles' house, for their regular Easter gathering. Mrs Miles was also there. Sally Miles described her behaviour on that occasion as bizarre, as it had been on Christmas Day. Peter Miles told us that Mrs Miles' condition was worse than it had ever been. On that occasion, for the first time, Mr Miles mentioned to Linda Miles (Peter Miles' wife) that he was thinking about divorce. Sally Miles did not know about the divorce at the time, but she recollected that she was worried about Mr Miles at the time because Mrs Miles seemed to be out of control and Mr Miles was having to hold everything together.

176. On 30 April Ms Semper and a colleague visited Mrs Miles at home to assess her for supported accommodation. The CMHT file notes that she was depressed but agitated; she appeared pre-occupied and restless and was unable to engage with the assessment in a realistic manner. She said she had been taking her medication but, when pressed, admitted that she might not have taken it for as long as 4 weeks. She agreed to go to the GP's surgery later that afternoon to collect a prescription. Ms Semper told us that she did not consider that Mrs Miles was so ill that she needed to be in hospital.

177. Later that day, Ms Semper telephoned the GP's surgery. Doctor Pollen was not in and Ms Semper left a message with the receptionist who stated that Doctor Pollen would be in on Friday (3 May). The receptionist confirmed that Mrs Miles had come into the surgery and had made an appointment for the following Tuesday.

178. On 2 May Doctor Pollen called Ms Semper. Doctor Pollen agreed to do a prescription straight away and get the receptionist to call Mrs Miles to collect it in order to start medication that afternoon. Doctor Pollen did telephone Mrs Miles but there was no reply.

179. Later that day Mrs Miles contacted the police and reported that she had found her husband dead at home. The circumstances are set out in summary in the Introduction to this Report.

180. After Mr Miles' death, Peter and Linda Miles took the children back to their house. They obtained a residence order and have cared for them ever since.

Perspectives on the killing of Mr Miles

181. Mrs Miles denied to us that she had anything to do with Mr Miles' death, and said it was Danish who killed him. Mrs Miles said that she used to tell Danish that she was very depressed and that her husband did not care for her. Mrs Miles said that she did not know why Danish killed her husband, but said perhaps he became angry with her husband.

182. Doctor Pollen said that it never occurred to her that Mrs Miles would plan to murder her husband. She thought that it was possible that she could, in an argument, get into a physical fight and even try to grab a knife, but it would not have occurred to her that Mrs Miles would plan to kill him when he was unable to defend himself. Doctor Pollen confirmed that in her view all care of psychotic patients needed to be underpinned by the theoretical perspective that if a person is psychotic and untreated their behaviour is unpredictable.

183. Ms Semper also said it never occurred to her that Mrs Miles would harm anyone. The concern was to protect her from harm from people

who would exploit her kindness, or come into her house and harm her or the children. Ms Semper said that she never detected any psychotic state in Mrs Miles that would lead to her killing her husband.

184. Sally Miles told us that, by around April 2003, she did have fears that Mr Miles would be killed: not by Mrs Miles but by someone in her family or an acquaintance of hers, perhaps because Mr Miles was becoming "inconvenient". However, Sally Miles also commented that Mrs Miles was very warm, loving and good humoured at the last family get-together on 26 April. Sally Miles said that she had not seen any spark of violence or frenzy in Mrs Miles. She was very surprised at what Mrs Miles did on 2nd May.

185. As far as risk was concerned, Doctor Falkowski told us that he was confident to rely on Ms Semper, who he described as experienced, thorough and able, to monitor Mrs Miles and to ask for an assessment of her psychiatric state if that was needed. However, Doctor Falkowski knew (because of Doctor Pollen's letter of 3 February) that Ms Semper was concerned about Mrs Miles and added to the "picture of psychotic relapse". Moreover, when we interviewed Doctor Falkowski he had some sympathy for the view that there were circumstances which demanded more psychiatric attention than was in fact given: discharge, chaotic family circumstances, risk issues for the children, non-compliance with medication, and missed appointments. He was unable to explain why the issues were not addressed more urgently at the time. He suggested that it may have been due to workload; although, when questioned about this, he said that the workload would not prevent him from seeing somebody if appropriate. He agreed that the mental health services were under enormous pressure and that it was likely that the obviously extreme cases were prioritised. Thus, Doctor Falkowski said "she was not the most obviously difficult or dangerous patient to manage". The issues that she presented with would have made her an ideal candidate for the outreach team, but that team did not exist at that time.

186. Doctor Pollen clearly took the view that Mrs Miles' illness was not treated with the gravity it deserved. She set this out graphically in her letter of 3 February. When interviewed by us, she explained the approach taken to Mrs Miles' treatment as follows:

> "I think that she is a test case in the sense that the expression of her illness was not such as to invite immediate restraining interventions. So that means it was harder to know exactly when she was unwell or not unwell from her symptoms. But over many years, the pattern of non-compliance with medication and the fact that she had a label of psychotic illness meant that actually it was perfectly clear when she was not well or when she was well. But in a way, many people preferred to go by her symptoms and presentation rather than taking the technical view. And with psychotic patients, sometimes it is better not to make a subjective assessment when you are trying to decide whether to section someone or not, or to change medication or not, but to make a technical assessment in the first place and then see what the subjective rapport, emotional context is."

187. We consider that Doctor Pollen was impressive in her care of Mrs Miles and her attempts to resolve Mrs. Miles' position. She was the only doctor that we interviewed who attempted to understand Mrs Miles' own perspectives, and who fully realised the gravity of her illness and the risk to her children. She was the most persistent in attempting to secure adequate care and treatment for Mrs Miles. She was clearly enormously frustrated by the inadequate response of the specialist mental health services. We put to Doctor Pollen that she could have taken her concerns to a higher level within the ELCMHT (for example, to the Chief Executive) when, in February 2003, she was driven to write the letter to Doctor Falkowski and yet he failed to take any effective action. She replied that the focus on Mrs Miles had never been that she would harm somebody, but rather that harm might occur to the children as a result of her behaviour. Mr Miles was responsible for the children. Moreover, Doctor Pollen felt that GPs are not in a position where their opinion is able to change the practice of psychiatrists and it is difficult for a GP to find alternative arrangements for psychiatric care of their patients.

188. We conclude that, while Mrs Miles did present identifiable risks, particularly arising from bringing strangers to the house, no-one (either professionals responsible for her care and treatment, or family or friends) had identified that there was a risk of her harming someone.

No-one could have predicted that Mrs Miles would participate in the killing of her husband, nor that she would deliberately seriously harm any other person. This conclusion is shared by Professor Jeremy Coid, who prepared psychiatric reports on Mrs Miles for the purpose of the criminal proceedings, and wrote to the Panel in March 2005 that no-one involved with Mrs Miles could have been expected to identify any risk of her harming another. That is not, however, the same as saying that this tragedy was not avoidable. We consider that it might have been.

189. From the weeks preceding her last admission in November 2002 to the date of Mr Miles' death we believe that Mrs Miles was mentally unwell. A number of observations were made by professionals involved with her, both during her last hospital admission and after her discharge, which indicated the need for a more careful approach to the treatment of Mrs Miles and possibly for admission to hospital. It is possible that if appropriate action had been taken, Mrs Miles' condition would have improved and she would not have acted in the way she did in relation to the index offence. While we accept this is speculative and we have the benefit of` hindsight when we make this suggestion, it is nonetheless a possibility that cannot be discounted. It was, for example, accepted at the time of her trial that Mrs Miles' participation in the killing of her husband was influenced by her delusions concerning him and that her responsibility was impaired by her mental illness. The key failings were as follows:

189.1 First and foremost, for the reasons that we have already set out, the section should not have been rescinded when it was nor in the way that it was.

189.2 Second, Mrs Miles should not have been discharged from hospital when she was, in the light of the known risks and the concerns expressed by others. Mrs Miles should not have been discharged without a substantial improvement in her clinical condition. As it was, she had only just started her new treatment shortly before she was discharged. It was too early to say if this

would be effective. Doctor Kandeth, as a junior doctor should not have been left to make the discharge decision without supervision or support.

189.3 Third, if, however, the considered clinical assessment was that she could cope in the community then Mrs. Miles should have been discharged with a suitable care plan in place for her which was capable of being implemented. Constructing such a care plan would have required the full involvement of the multi-disciplinary team as well as the active participation of her husband and GP, in order to ensure that Mrs Miles received proper supervision, support and treatment as well as a plan to deal with family concerns and social needs. This, critically, should have included provision of suitable accommodation for her away from the family home; an appropriate level of supervision at her accommodation; and a plan for the maintenance of her medication regime.

189.4 Fourth, once she had been discharged there were a number of opportunities when her consultant or other psychiatrist of appropriate seniority should have reviewed her treatment. The first occasion when this should have occurred was when Doctor Falkowski found out that Mrs Miles had been discharged by a junior doctor, without a risk assessment or care planning. Any serious review of her mental health at that time would have made it clear that she was no less ill than she had been when admitted. There was corroborative evidence from a reliable source (Mr Miles) that, in the period after discharge, her behaviour became even more erratic. Steps should have been taken to follow up Mrs Miles after her failure to attend the outpatient's appointment on 21 January. In addition, although Mrs Miles was formally reviewed by Doctor Falkowski on 11 February, the serious concerns expressed by Doctor Pollen, requesting urgent admission to hospital, were not heeded Mrs Miles remained untreated, inadequately supported and there were inadequate arrangements in place to ensure the welfare and safety of herself or her family.

189.5 Fifth, we consider that Doctor Falkowski, as Mrs Miles' consultant psychiatrist for over six years, had no coherent and co-ordinated plan for her treatment. Doctor Falkowski's approach was to treat the more acute episodes of her illness, which resulted in hospital admission, through medication (which she only took regularly when under coercion in hospital). Once medication had succeeded in attenuating the effects of her illness, she was discharged. Inevitably, because her illness was never treated fully, partly because she did not consistently comply with her medication regime, her condition remained largely unchanged with periodic exacerbation of her symptoms and deleterious consequences for her overall functioning. On each occasion the symptoms of her illness would recur. The reality was that, although symptoms fluctuated, Mrs Miles had been seriously ill for many years and her illness was never fully diagnosed or addressed. In our opinion, it is likely that she was just as ill when she was discharged from hospital on 16 December 2002 as when she was admitted one month earlier. Moreover, unlike previous occasions, at the time of her last discharge there was no valid evidence of an improvement in her mental health. She had not been long enough on her new medication for it to be able to achieve such an effect. Doctor Falkowski himself was uncertain as to the state of Mrs Miles' health between admissions. His opinion is as summarised in the SUI report as follows:

> "Whether she remained reasonably well in between admissions he was uncertain about, considering that she probably had underlying and chronic paranoid ideation related to activities such as her hoarding and inviting people in. Certainly her compliance with medication was noted to be very poor, as was her willingness to attend routine outpatient appointments on a number of occasions."

As we have already described, Doctor Falkowski told us that he did not think she was fully treated.

190. In addition to the above, our investigations into Mrs Miles' care and treatment raised some more general issues. As we consider in more detail in Chapter Two, there was an inadequate approach to multi-disciplinary practice or compliance with Trust policies and guidance on

CPA and care planning. Collaboration between agencies in respect of the children was particularly inadequate. There was a failure to ensure effective support for the children that was acceptable to them. The point is well illustrated by a point made by Sally Miles to us. She recalled that, on the way back from Mr Miles' funeral Jafar raised the question of what would have become of the children if Mr Miles had died through illness or an accident. He wanted to know whether the children would have been left to struggle on alone with Mrs Miles. We do not know the answer to this but cannot discount the possibility.

191. In addition, Mrs Miles' preoccupations with poverty and religion coupled with her intense loneliness meant that she continued to seek a variety of relationships which were not necessarily appropriate. Although, as we describe further in Chapter Three, there had been attempts by those working with her in the community to integrate her into her local community for instance by helping her to make contact with a local Pakistani women's group, these were largely unsuccessful because Mrs Miles would not take up any offers of help that were made. There is no indication that the secondary services made any serious attempt to address this. It was not addressed as an issue following her last discharge from hospital

CHAPTER TWO

THEME 1: CARE PLANNING AND THE CARE PROGRAMME APPROACH

Background and service requirements

1. The Care Programme Approach ("CPA") is at the heart of care planning. It is expected that all mental health services should follow the CPA methodology in ensuring appropriate assessment and follow up.

2. The CPA was introduced by Circular HC (90)23. This imposes joint health and social services responsibility for implementation of the CPA, although health authorities[31] are to lead through inter-agency agreements with social services authorities.

3. Initially, the focus was on those being discharged from hospital. Guidance on discharge was issued in 1994 HSG (94)27. This guidance sought to ensure that patients were discharged only when and if they were ready to leave hospital; that any risk to the public and the patients themselves was minimal; that discharged patients should receive the support and supervision they required from responsible agencies.

4. The CPA applies to all adults in contact with the secondary mental health system (health and social care). According to the guidance, the "essential elements" of an effective care plan are (i) systematic arrangements for assessment (ii) a care plan which identifies the health and social care required from a variety of providers (iii) the allocation of a key worker (care co-ordinator) and (iv) regular review. The Code of Practice issued under the Mental Health Act states that it is the responsibility of the responsible medical officer (RMO) to ensure, in consultation with the other professionals concerned, that the patient's

[31] At that time the responsible health bodies were the health authorities. Now responsibility falls on the mental health trusts.

needs for health and social care are fully assessed and that the care plan addresses them, before a decision is taken to discharge or grant leave to the patient. The RMO is also responsible for ensuring that a proper assessment is made of risks to the patient or other people.

5. It is essential that arrangements for discharge and aftercare are agreed and understood by the patient and everyone else involved, including carers. In particular everyone should have a common understanding of the community care plan's first date of review; information relating to past violence and assessed risk of violence; the name of the care co-ordinator; how the care co-ordinator and other service providers could be contacted if anything goes wrong; and what to do if the patient fails to attend for treatment or to meet other requirements or commitments.

6. There must be a full assessment before discharge by both the multi-disciplinary team responsible for the patient in hospital and by those who will take responsibility for the patient's care in the community. Those involved must agree the findings of a risk assessment, the content of a care plan and who will deliver it. There must be a contemporaneous note of the outcome of any risk assessment and of any management action deemed necessary and taken.

7. Subsequently, the Department of Health circulated an aftercare form designed to be used for all patients discharged from psychiatric inpatient care including those subject to section 117 Mental Health Act 1983. The use of the form, although not mandatory, was strongly recommended as constituting good practice and was devised in response to the Clunis inquiry[32]. The form contains a number of sections (i) patient information (ii) nominated contact (iii) key worker details (iv) after care plan (v) information included in after care plan (vi) availability of information (vii) review (viii) transfer of patient responsibility for after care (ix) discharge from after care.

[32] The Report of the Inquiry into the Care and Treatment of Christopher Clunis. (HMSO, 1994)

8. The Department of Health guidance "Building Bridges: arrangements for inter-agency working for the care and protection of severely mentally ill people" (November 1995), stresses that the CPA is the cornerstone of government's mental health policy. It emphasised the need for a "tiered approach" involving adjusting the complexity of the CPA as appropriate to different levels of need, and a full assessment of risk and needs.

9. The care co-ordinator is the linchpin of the CPA. S/he is vital to the success of the whole process. Those taking decisions have a duty to consider the patient's safety and the protection of others. No individual should be discharged from hospital unless and until those taking the decision are satisfied he or she can live safely in the community, and that proper treatment, supervision, support and care are available.

10. The National Service Framework for Mental Health (NSF)[33] set out the basis for effective services (including CPA). The NSF stipulated that all mental health service users on the CPA should: (i) receive care which optimises engagement, prevents or anticipates crisis, and reduces risk; (ii) have a copy of a written care plan which includes the action to be taken in crisis by service users, carers and care co-ordinators, advises GPs how they should respond if service users need additional help, is regularly reviewed by the care co-ordinator; and (iii) should be able to access services 24 hours a day, 365 days a year.

11. The NSF states that assessment should cover a number of matters including psychiatric, psychological and social functioning, risk to the individual and others, and personal circumstances including family. It also requires mental health services to develop and demonstrate cultural competence

12. The NSF also requires each service user who is assessed as requiring a period of care away from home to have a written copy of his/her after care plan agreed on discharge, which sets out the care and

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[33] Department of Health, 1999

rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis.

13. There is a specific standard for carers as part of the NSF. In relation to the CPA there is emphasis on caring about carers: this stipulates that all individuals who provide regular and substantial care for a person on CPA should have an assessment of their caring, physical and mental health needs, repeated at least on an annual basis, and have their own written care plan which is given to them and implemented in discussion with them.

14. Following the NSF, additional guidance was issued in relation to the CPA: "Effective Care co-ordination in mental health services; modernising the care programme approach - a policy booklet"[34]. This sets out the changes to the CPA based on available evidence and experience. Key themes are (i) integration of the CPA and care management; (ii) appointment of lead officers within health and social services; (iii) the introduction of 2 levels of CPA (standard and enhanced); (iii) replacing the key worker with the care co-ordinator; and (iv) abandoning the supervision register. The guidance emphasises the importance of risk assessment, and a care plan which gives proper attention to the service user's culture and ethnicity. It also emphasises the importance of taking account of the needs of the wider family and, in particular, the needs of the children and carers of those with mental health problems.

15. Section 117 Mental Health Act 1983 provides for specific statutory duties owed by health and social services to provide after-care services to patients who have been detained under section 3 of the Act when they are discharged and leave hospital. The 1999 guidance makes it clear that the CPA applies to such patients.

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[34] Department of Health, 1999

CPA and after-care for Mrs Miles

16. It is clear from the evidence that we heard that the services failed to provide Mrs Miles with care and follow up according to the CPA. She was entitled to after-care services under section 117 of the 1983 Act until the relevant authorities were satisfied that she no longer required such services. It would appear that she was never formally made subject to care and follow up under section 117 although she had two periods of inpatient care under section 3 of the Mental Health Act (May 1999 and her last admission in November 2002).

17. As a minimum, services should have been set up and implemented to (i) support, engage and supervise her in the community (ii) monitor any changes in her mental state and risk (iii) ensure treatment in the form of medication. There have been failures in all these aspects of her care and our judgment is that these failures were, to a large extent, a direct product of the lack of care planning and care co-ordination.

Assessment

18. Mrs Miles did not appear to have had a full, multidisciplinary assessment of her health and social care needs at any time during her contact with mental health services (nearly 7 years). We accept that she was seen regularly by her care co-ordinators and, less frequently but regularly, by psychiatrists. However, on the whole, the assessment of her mental health needs over the years appears to have been poorly co-ordinated. The assessment was dominated by a narrow medical diagnosis. No detailed assessment of her social and cultural needs was ever undertaken nor was there sufficient and sustained attention given to the need for family based assessment. The impression that we have gained from Mrs Miles herself and from the accounts given by others who knew her, including her care co-ordinator from March 2000 to May 2003, Ms Semper, is of Mrs Miles' general and continuing social isolation. While we acknowledge that there were difficulties in doing so, we do not believe that this was ever addressed in a meaningful way by those caring for her.

19. Mrs Miles had four hospital admissions between July 1996 and December 2002, when she was last discharged from hospital. As we have set out in Chapter One, these admissions followed a similar pattern. From the outset, it was clear that she had significant mental health problems but she was, by and large, unwilling to accept the explanations of her doctors and others involved in her care that she had a mental illness. This invariably resulted in her stopping her medication and gradually disengaging from follow-up. Her mental health and her behaviour would deteriorate until the concerns for the safety of herself or her children were such that she was again admitted to hospital. She would be placed on medication and, once her mental health appeared to improve, she would once again be discharged. Unfortunately, on each occasion her care plan consisted of little more than maintaining her medication, and monitoring and reviewing her mental state. There was no effective action taken in response to the fact that she never fundamentally accepted that she required treatment or assistance. Insufficient attention was paid to the fact that her explanations for her behaviour and the responses to her by her family and professionals were different from the explanations adopted by the professionals working with her. In the long term, we believe that this resulted in her further disengagement from clinical services and possibly contributed to her reluctance to see her care co-ordinator.

20. As we explain in more detail in Chapter Three, we conclude that there was a failure to pursue any form of cultural interpretation of Mrs Miles' actions and behaviour. This arose out of the failure to assess her social and cultural needs in a meaningful way in the first place. Both within her clinical notes and in the accounts given to us by the clinicians who had been involved in her care, there was no clear acknowledgement of her cultural, religious and spiritual needs in the context of trying to engage her in long term mental health care and in ensuring appropriate care and treatment.

21. Although Mrs Miles' reluctance to accept medication or medical supervision raised significant difficulties in managing her mental health

care in the community, the challenges that Mrs Miles presented to the clinical team were not in themselves, unusual or unique. We heard in evidence that the CMHT had a number of patients on its case load who were difficult to follow up because they did not accept that they needed to take medication or see a mental health worker. What we find disappointing is that at no stage was there any attempt to understand and deal with the reasons behind Mrs Miles' reluctance to engage with clinical services.

22. Problems with medication, although well understood (that she did not comply with it), were never adequately dealt with. A reasonable care plan, formulated on the basis of a full assessment of the patient's needs, would have addressed this particular difficulty. The clinical team appeared to have no strategy other than persisting with regular exhortation to Mrs Miles that she should comply with her treatment. Yet it was clear from the beginning that this had no impact on her whatsoever. Thus, even though medication compliance was the focus of much of the clinical attention during her community follow up, she continued to reject medication and the clinical team had little success in ensuring that Mrs Miles took medication on a regular basis.

23. Mr Alan Mountain (manager of the Bethnal Green CMHT from early 2001 to June 2003) wrote to us that the CPA across the borough, not just in Bethnal Green, was not implemented as it should have been. He told us that the CPAs were "medical reviews chaired by the Doctor with the care co-ordinator and patient in attendance" and that the CMHT managers had very little control over the process. He said that the medical model was predominant across Tower Hamlets, though it differed in intensity depending on who the catchment area consultant was. In his view, the problems with CPA were not unknown but that, at that time, there was not the necessary commitment from senior management to do something about it.

24. We believe that Mrs Miles never received the full benefits of the various psychiatric drugs that were prescribed for her because of her poor compliance with medication and the failure of the clinical team to

ensure that she took her medication. This was a singular failing which was not addressed fully because of the lack of a detailed care plan which encompassed this issue and the failure to have regular multidisciplinary review meetings under the CPA. Had these taken place, the attention of the clinical team may have been more focussed on the need to take effective action to address the issue.

25. We found no updated CPA forms in Mrs Miles' case notes. The last set of CPA documentation was dated August 2002. There was no evidence that these were updated after her last admission to hospital in November 2002. Previous inquiries (e.g., "SH"[35] and "DN"[36]) had highlighted significant failures in ensuring and integrating the care programme approach within the Trust or its predecessors. We heard in evidence from the previous Chief Executive of the Trust (Mr Peter Horn) that there had been significant problems in implementing the CPA in the Trust. The evidence of the approach taken to Mrs Miles' case leads us to believe that, at the time of Mrs Miles' last admission to hospital (November 2002), the Trust had not achieved satisfactory integration of CPA within day-to-day clinical practice within Tower Hamlets. The HASCAS review[37] also highlighted problems with the CPA at that time. The current Medical Director and the Chief Executive each told us that the situation has improved significantly in the last three years and that regular CPA audits are being carried out to ensure good practice. However, patient surveys continue to show that significant numbers of Trust patients remain unaware of CPA and do not receive copies of their care plans.

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[35] "Report of an Independent Inquiry into the Care and Treatment of SH" (North East London Health Authority, July 2002)

[36] "Report of an Independent Inquiry into the Care and Treatment of DN" (North East London Strategic Health Authority, September 2002)`

[37] See Chapter Three paragraph 32

Risk

26. We found no evidence that a formal risk assessment was carried out at any time. Although Doctor Falkowski told us that he expected there to be a review of all risk factors at the weekly ward rounds for inpatients, there was nothing to suggest that this had happened in the case of Mrs Miles when she was an inpatient. There was no CPA documentation of any reviews which took place during her last admission to hospital. We believe that, if Mrs Miles had had a detailed risk assessment while she was in hospital towards the end of 2002, there would have been greater urgency in formulating a risk management plan in relation to her undoubted risk to her own health as a result of non-compliance with medication and disengagement from community follow-up. The risks that she continued to pose to her children, at the time of her discharge, similarly were not identified as requiring a specific and robust risk management plan.

Care Co-ordinator

27. Care Co-ordinator arrangements were in place for Mrs Miles while she was being followed up by the CMHT. However, there were few regular reviews of Mrs Miles' care and progress through multidisciplinary team meetings. We heard in evidence that the clinical supervision arrangements in the CMHT were insufficient, and there was poor co-ordination between the CMHT and acute inpatient wards. This was exemplified by the failure to consult Ms Semper, Mrs Miles' care co-ordinator at that time, when taking decisions to discharge Mrs Miles from her section and subsequently from inpatient care.

28. Ms Semper told us in evidence that she would usually be involved with the hospital in drawing up the care plan prior to a planned discharge and that, after discharge there would be a 6 week review of the patient. Ms Semper would usually attend if there was a review at the CMHT, at least if scheduled well in advance, and would speak to the doctor a little before the patient was seen. No such review of Mrs Miles took

place after her discharge from hospital on 16 December 2002. According to Ms Semper, this was not unusual as she saw her patients at the CMHT but the doctors, including the consultant, often saw patients for medical review on their own at the outpatient department. Ms Semper said that sometimes she was unable to fit a patient in for a regular review because of the workload. Arrangements for multi-disciplinary reviews appear to have been rather haphazard. In spite of the absence of multidisciplinary reviews Ms Semper felt that she was really on top of Mrs Miles' case, understood the family and had a good working relationship with Mr Miles and Laila.

29. The absence of multidisciplinary and co-ordinated care planning for Mrs Miles left the GP, Doctor Pollen, very isolated. She told us that her experience was that there was (and is) no role for the GP in the care planning and provision of services for a patient who suffers from mental health problems. She found it difficult to intervene if she had concerns over the patient's management, as it was often difficult to get through to the mental health team. While it was easy to do routine things such as prescribing drugs or arranging a lithium test, she felt that it was burdensome

> "…to put a spanner in the works and say 'I do not think things are going well' or 'nobody is telling me what is going on' or 'I do not understand why she is asking for this drug rather than another'… [It] would involve quite a lot of time and negative results on the whole discouraged you from doing it again the next time."

30. Doctor Pollen told us that discussion with a consultant would not be fruitful as she expected the consultant's reply would be along the lines that "if she needs sectioning then fix it with the social worker." Doctor Pollen was not clear whether the consultants were part of the CMHT. She thought that it would be useful to have an annual review meeting involving the GP and the CMHT.

Review Plans.

31. Although dates for review were set, these were not formal multidisciplinary reviews as expected under the CPA but medical

reviews by doctors in outpatient clinics, and they did not involve the care co-ordinator. As far as we know there were no multi-disciplinary discussions concerning Mrs Miles outside of the hospital.

Copy of the care plan

32. There is no evidence that Mrs Miles had a copy of the care plan.

After-care plans

33. There was at no time any section 117 meeting for Mrs Miles nor was there any evidence of after-care plans. In June 1999, when section 117 applied upon her discharge, the only documentation relating to after-care was a "care plan summary" the contents of which did not reflect the discussions that had taken place on the ward about planning for Mrs Miles' after care (including consideration of a dosset box and discussion of some form of contact with an Urdu women's group) and it said nothing about medication problems. Doctor Falkowski thought that it was surprising that there was nothing in the summary about compliance with medication "given the seriousness of that concern".

34. The only discharge documentation that we have seen following her last hospital admission is the discharge summary produced by Doctor Kandeth, in which the Discharge Plan was noted as "To attend outpatient appointment. Continue Risperidone 2mg daily", and the "In-Patient Nursing Discharge Summary" with the August 2002 Care Plan attached to which we refer in Chapter One.

35. Tony Bamber, the Service Director for Tower Hamlets from April 2003, told us that there were a few serious untoward incidents, including that involving Mrs Miles, which gave the same headline message at around the same time. This included confusion as to responsibility for the care plan when a patient is discharged and that discharge planning did not appear to be done very well. He described incidents of communication breakdown between community services and inpatients, particularly at the point of discharge. He said that, around May 2003, discharge summary letters were not always written.

Carer Issues

36. We are struck by the fact Mr Miles was not at any time formally identified as a carer for his wife. Ms Semper and others working with the family recognised that he was, in fact, fulfilling the role of carer, but the care plan did not identify him as such. He was not involved in the decision to take her off section or to discharge her from hospital. This is surprising for the reasons already set out and given that Mr Miles was living with his wife and was trying his best to ensure that she received support and treatment. He was better placed than anyone else to give a reasonable account of Mrs Miles' mental state and her day to day behaviour and had, in fact, taken the initiative on several occasions to alert the clinical team of deterioration in her mental state. Furthermore, he was left with the responsibility for caring for the three children, especially in the latter stages of Mrs Miles' contact with the local mental health team. It was also clear that his own mental health was under threat and he had sought help for himself because he was finding it increasingly difficult to cope with his wife's ongoing mental illness.

37. We did not receive an adequate explanation from any of the witnesses that we saw for the failure formally to identify Mr Miles as a carer. We were told that Mrs Miles did not want the clinical team to talk to her husband about her mental health care and treatment. We were also told that he declined the offer of respite. Notwithstanding this, however, it would have been possible for the clinical team to carry out an assessment of his needs and produce a plan for carer support. The failure to do so further confirms that the clinicians involved in Mrs Miles' care and treatment did not understand their obligations under the CPA.

Care Planning within Community Mental Health Teams

38. Doctor Reed, a senior consultant psychiatrist working in Tower Hamlets (although not for the Bethnal Green catchment area) was the Clinical Director of adult services until 2004. He told us that Bethnal

Green CMHT was a "very poorly performing CMHT" which was "administratively incapable of organising their work". He admitted that the morale in the CMHT was low and there was a "persecutory culture" within the organisation at the time. According to him the consultants found it difficult to work with the CMHT:

> "They could not organise the appointments going out. They could not organise a clinic. They could not book a clinic. They tried to set it up repeatedly. They made themselves available to go to CMHT for community review clinics, and it just did not happen, because the patients had not been told, the patients did not turn up, the staff did not turn up. It was just impossible. It was a mess… it was very frustrating. It was very dispiriting."

39. Doctor Reed was clear that the way the Bethnal Green CMHT functioned compromised the clinical care of patients.

40. Mr Alan Mountain (who was manager of the Bethnal Green CMHT from early 2001 until June 2003) did not accept Doctor Reed's analysis. The sharp divergence of opinion between the two illustrates a more general division between consultants and CMHTs at that time. It was clear that consultants working in the borough did not see themselves as part of the CMHT. According to Doctor Dolan, the present Medical Director, this has changed following the recent introduction of new consultant posts in Tower Hamlets. He told us that, at present, consultants are expected to spend a minimum of three programmed activities in the CMHT. However, the integration of consultants within CMHTs still remains problematic as indicated by the difficulties in co-locating consultant staff and other staff working in the CMHTs. A recent internal review of the working arrangements within community mental health teams in the Trust[38] shows that consultants, on average, devote only 14 hours per week in CMHTs (compared to the national standard of 30 hours per week).

41. The failure to integrate consultants working within CMHTs and the problems in fully implementing the CPA within adult services has in all probability contributed to the disappointing findings from the National

[38] The Review of Teams in Adult Mental Health Services in Newham, Tower Hamlets and City and Hackney (2006)

Patient surveys of 2004 and 2005. In the most recent patient survey seen by us (2005) the Trust is identified as falling within 20% of the worst performing trusts nationally on most items relating to care planning and care co-ordination. The internal review referred to above identified general dissatisfaction with current CPA documentation which is seen as excessive and "not focussed on important clinical matters", unnecessarily repetitive and time consuming and not easily accessible if needed at times of crisis

Recent developments

42. According to Sheila Foley, the Chief Executive, a revised CPA policy is now in place (the most recent version seen by us was endorsed by the Trust Clinical Governance Committee on 10 January 2006) and regular audit of CPA is taking place within the Trust. Paperwork has been reviewed and it is intended that the paperwork is simplified. It is important that the current policy is fully implemented. It is particularly important that practical steps are taken to ensure implementation of paragraph 15.3 of that policy so that there is an identifiable individual responsible for discharge planning in every case. The relevant clinical team leaders, as identified in that paragraph, should continue to be responsible for ensuring implementation of the CPA in all cases within their teams.

Needs of the Children

43. One of the major failings that we have identified in the care and treatment given to Mrs Miles is the absence of a co-ordinated and effective strategy in addressing the needs of her children. The statutory agencies involved in Mrs Miles' mental health care had a legal responsibility to safeguard and promote the welfare of the children. The Department of Health has set out the requirements in relation to agencies and practitioners in safeguarding the interests of children [39].

[39] "Working Together to Safeguard Children – a Guide to Inter-Agency Working to Safeguard and Promote the Welfare of the Children." (Department of Health 1999)

All agencies working with children, young people and their families are expected to take all reasonable measures to ensure that the risks of harm to children's welfare are minimised. In addition, where there are concerns about children's welfare, all agencies are required to take appropriate actions, in full partnership, to address these concerns by working to agreed local policies and procedures. We are not persuaded by the evidence that we have heard that this was applied in the case of Mrs Miles and her children.

44. It was recognised that Mrs Miles, along with her husband, had responsibility for their three children, Laila, Jafar and Idris. The children remained at home throughout Mrs Miles' contact with mental health services. In Chapter One we describe the various attempts, between 1997 and 2002, by those involved with Mrs Miles to secure support for the children. None of these was effective:

    a. The referral to the Child and Family Consultation Service in April 1997 led to some limited work taking place with the family, including the children, but Mrs Miles did not engage and Mr Miles wanted Jafar to be seen without his mother. However, the Service was only willing to work with the whole family.

    b. The referral to the Children and Family Social Work team in September 1998 did not result in any action being taken.

    c. Ms Loshak of the Child and Family Consultation Service was not told of the September 1998 referral.

    d. Ms Loshak did not receive the letter of referral from the mental health social worker to the Child and Family Consultation Service in December 1999 and no action was taken on that letter.

    e. A referral to the same Service in June 2000 resulted in five visits to the family but the children were uncomfortable with the visits and did not wish to continue with them.

    f. It does not seem that anyone followed up on the plan agreed by Mr Mountain and Ms Semper in November 2002 to contact Ms

Loshak and to make a referral to the Children and Family Social Services Team for children in need assessments.

g. There was a complete breakdown in liaison between the CMHT and Children and Family Social Services Team in December 2002, following Mrs Miles' striking of Jafar and the ongoing concerns about her bringing strangers home, so that no action was taken in response to this incident.

45. In his evidence to us, Mr Dave Hill, Head of Children and Families at London Borough of Tower Hamlets, acknowledged that, given the concerns expressed by various people at the time, including Mr Miles, that last referral should have resulted in a more robust response from the Children and Family Social Services team. Mr Hill told us

> "…if I heard the words "strangers coming into the house where there are children" and if I heard the words "children being hit", both of those things would bring us to the notion that we should make at least an initial assessment… One would expect that set of information to lead to at least an initial assessment".

46. From our analysis of all the evidence it is clear that the serious concerns expressed by a variety of people involved with the Miles family about the welfare and safety of the children did not result in appropriate and effective responses from the statutory agencies aimed at safeguarding and promoting the welfare of the children. The organisational arrangements and professional responsibilities for identifying and dealing with child welfare and protection issues within ELCMHT and social services were fragmented and poorly co-ordinated. The arrangements did not ensure effective inter-agency working and training of mental health staff on child protection issues. The absence of multi-agency and multi-disciplinary meetings to discuss individual cases and the failure to implement effective CPA working within mental health services further impeded if not undermined the ability of individual professionals to deal with family and child protection issues. We have referred to the frustrations experienced by Ms Healy as a result of this. Ms Loshak told us that her post of Coordinator for Children in Families with Mental Illness, created in February 2002, was

designed to improve inter-agency working because, historically, there had been a lot of duplication and fragmentation.

47. These comments are directed at the arrangements and gaps that existed in the way that services were organised and functioned at that time. They are not intended to direct criticism at any specific individuals. Each of the social or mental health workers of whose involvement with the children we are aware had to work within the limits of the system and structures at that time.

48. We note that there have been significant organisational changes within the mental health trust in addressing the needs of children. The Trust has set up a Safeguarding Children Team and Safeguarding Children Committee (which reports directly to the Board). However, there have been difficulties in ensuring the appointment of named nurses for child protection in each of the boroughs (Annual Progress Report of the Safeguarding Children Team April 2004 –March 2005) although appointments to these posts are now made. Training on child protection is taking place and between January 2004 and January 2006 approximately 1000 staff had attended the basic induction training. In her oral evidence to us the Chief Executive reassured us that, because of the assurance arrangements in place such as having a Safeguarding Children Team (with sector leads) and a lead Director for safeguarding children's welfare within the Trust, a similar situation to that which pertained in relation to Mrs Miles and children would not happen today. She considered that there is now a much clearer system for enabling communication between different teams within the system. Thus she felt that, now, Mrs Miles would not have been discharged without there first being communication with those who had responsibility for protecting the children. Ms Hunt, the present Nursing Director, also told us that she believed that there was much greater awareness of the importance of considering the needs of the children of a patient and including their needs in the CPA process.

49. We commend the efforts made in terms of organisational change and staff training. It is still early days to assess the effectiveness of these

developments. In addition, the Trust must satisfy itself that the current arrangements for CPA and interagency working necessarily address children's needs on a routine and systematic basis. One way of understanding the effectiveness of current strategies and procedures would be to carry out regular clinical audits of the work of the CMHTs with a special emphasis on child welfare and child protection issues.

CHAPTER THREE

THEME 2: CULTURE AND ETHNICITY

1. Mrs Miles' illness cannot be understood without addressing her background, her cultural context and her identity. She was born, brought up and educated in Pakistan, in a Pakistani family, with very different experiences and expectations of family and social life to those that she faced in the UK. The differences were cast into sharper relief for her by the fact that she married into a white British family. She held strongly to her Islamic beliefs and perceived that those around her, including her own family, betrayed those beliefs. She lived in an area of rich cultural diversity but with dominant ethnic communities of which she, as a Pakistani woman, was not part. Her native language (Urdu) was not widely spoken in her neighbourhood and only imperfectly spoken at home.

2. As the account of Mrs Miles' life in England shows, she had an acute sense of loneliness and isolation both within her marriage and in her community. This was revealed in some of the manifestations of her illness, for instance in bringing strangers home and spending large amounts of time out of the house. It appears that her religious beliefs combined with her sense of identity with or responsibility towards the poor of Southern Asia provided the foundation for her mission to relieve poverty. Her conviction that she was right and behaving rationally, and her mistrust of the decisions by the doctors treating her as to medication, led to grave difficulties in securing compliance with her medication.

3. It does not seem that the mental health services fully recognised the importance or meaning of these issues. As a result, no serious attempt was made to deliver services that were culturally sensitive to Mrs Miles. The shortcomings in this respect are illustrated by the failure even to address the most fundamental issue of language: no-one involved in Mrs Miles' treatment at the time appears to have identified that English being her second language could have caused difficulties for her both

in integrating socially and in communicating with those involved in her treatment. A number of witnesses reported to us that Mrs Miles spoke very good English. We found this surprising because, when we met her, her English was far from fluent. The issue of fluency in English is, however, not the point. The point is that Mrs Miles' first language is Urdu and that is her preferred means of communication. This should have been attended to as a priority in her treatment and care.

4. When we visited her at the John Howard Centre, Mariam Miles gave her own assessment of the ways in which the mental health service had failed to address her particular needs:

   4.1 She described her intense feelings of loneliness but she could not recollect anyone talking to her about these feelings.

   4.2 She thought that she could have been helped to meet Pakistani people and, in particular, Urdu speaking women. For instance, she said that there was an Asian women's group in East Ham which she would have liked to be involved with.

   4.3 She would have liked to speak Urdu in hospital, but nobody there spoke it. Doctor Mirza, who spoke Urdu, only came to her home twice

   4.4 The hospital could have arranged for her to see an Imam or someone else from the mosque.

5. In respect of the last of these points, we are surprised that no such arrangements were made because Mrs Miles' religious beliefs were central to the manifestations of her illness in particular hearing voices that exhorted her to be a good Muslim and her preoccupation with evangelising her Muslim beliefs.

6. However, contrary to Mrs Miles' assertions, we are satisfied that attempts were in fact made to put Mrs Miles in contact with a Pakistani women's group. In April 1997 Bernadette Healy did refer Mrs Miles to an Asian women's group in Newham, having been unable to find any mental health resources in Tower Hamlets which cater for people who speak Urdu. The contact record kept by Ms Healy indicates that Mrs

Miles procrastinated about attending that group, although she did eventually start to do so in around August 1998. She would not tell Ms Healy how she spent her time there and there are no further records as to her involvement with that group. Ms Semper told us that Mrs Miles had her own Pakistani women friends in Forest Gate who she visited, and that she refused to consider attending day centres as that would involve acknowledging that she had a problem. Ms Semper arranged for Mrs Miles to have a bus pass and that made her happy because it enabled her to go out. However, she did not want any assistance in facilitating social contacts.

7. Although there was some recognition of Mrs Miles' cultural needs, the approach taken was limited, focussing on the more obvious solutions relating to religion and community groups, and did not result in any effective action. It was difficult because Mrs Miles resisted the assistance that was offered. However, this should have alerted the professionals to take a different approach. They did not do so. Her care plan did not identify any strategy for addressing Mrs Miles' cultural needs.

8. The limited nature of the approach taken is particularly apparent in the approach to the critical issue of compliance with medication. Most people we talked to described Mrs Miles' failure to take her medication as a consequence of her lack of insight. We had no sense of anyone in the service trying to understand Mrs Miles' perspective on her needs, her mental illness and the requirement to take medication in the light of her cultural background. The fundamental differences between the perceptions of Mrs Miles and those of the professionals treating her as to the nature of her problems were never addressed in the course of her care and treatment:

    8.1 She was diagnosed as mentally ill and requiring medication. However, Mrs Miles did not accept that she was ill and so would not cooperate with her medication.

8.2 The professionals interpreted her preoccupation with the requirements of religious observance and her responsibilities to the poor as symptoms of her mental illness. Mrs Miles considered these to be appropriate responses to the world around her arising from her genuinely held religious beliefs.

8.3 Equally, her hoarding of food and inviting strangers to the house were taken by the professionals to be simply symptoms of her mental illness. For Mrs Miles they were simply means of helping the poor and alleviating her loneliness and isolation.

9. We do not suggest that Mrs Miles' behaviour was in fact "normal" nor that it was a rational or balanced response to the issues that she endeavoured to address, but simply that it was important that those attempting to treat and support her fully acknowledged her perception of her behaviour and built a treatment plan that recognised those differences in perception. No attempt was made to do so. Instead, she was described as lacking "insight" and a treatment plan was maintained that depended wholly on her compliance with medication. Thus Mr Mountain said to us:

> "…it was difficult to get Mariam to comply with medication because she did not have…any insight. She did not see there was anything wrong. She wanted to be a good Muslim and everybody was conspiring against that.
>
> …If somebody refuses medication, there was no power to actually force them to take it. What more could we do?"

10. It seems to us that, without acknowledging and understanding the differences between the explanatory models adopted by the professionals on the one hand and Mrs Miles on the other, there was no realistic chance of securing compliance with medication and so the treatment plan for her was doomed to failure. Indeed, none of the doctors working with Mrs Miles who we interviewed, save for Doctor Pollen, truly engaged with her at an individual level or acknowledged her social and cultural views.

11. We do not suggest that the individual social workers were professionally at fault. The problem lay in the system that adopted a

narrow medical model and the limited approach to addressing cultural diversity as we describe in more detail in the following section.

12. We put to Ms Foley our perception of the lack of insight into Mariam Miles' perspectives by those treating her. She responded:

> "I am really quite saddened by the fact we are an East London Trust working in this diverse culture that we have, that basically we are not leading edge in terms of what we are doing about ethnicity and diversity… I think it is a really big area for me and one we have to make a lot of progress in… I do not think we deal with men particularly well but I think we deal with women even less well and that is still a big issue."

13. Ms Foley was frank about the fact that there is still a long way for the Trust to go. She considered that, as things are within the Trust at present, it would still not respond to Mrs Miles' situation as well as it should. Her view is reinforced by the evidence we heard from other witnesses, as outlined below, and what we saw of Mrs Miles' present treatment: it appeared to us, when we visited her, that her cultural needs continued to be unmet and she was as isolated as ever.

Approaches in the Trust to cultural and ethnic diversity

14. When we asked witnesses from both the clinical and management disciplines of the Trust about the Trust's approach to cultural and ethnic diversity we received a variety of responses. What they showed was that there were conscious efforts to address the needs of the dominant ethnic groups (particularly Bangladeshi and Caribbean), but little or nothing was done for those from other groups. Thus Mr Mountain told us that Bethnal Green CMHT had no specialist provision for someone of Pakistani descent and that the services were particularly targeted at Bangladeshi and Caribbean people.

15. Ms Upex, Sector Manager for Tower Hamlets, told us that the Trust had the competencies to deal with Bengali, Somali, Vietnamese and Chinese patients, but not to deal with the "one offs".

16. Doctor Bass, consultant psychiatrist at St Clements Hospital, made similar points in some detail. He said that the South Asian community in the area is mainly Bangladeshi. There are not many Pakistani people and they are not really part of (or do not feel that they are part of) a

larger South Asian community. He said that the Trust had made efforts to address the needs of the Bangladeshi population. In the mid-1990s a Bangladeshi community mental health team was set up by the local authority on a borough-wide basis. It trained a number of social workers from a Bangladeshi background who were bilingual, so that they would become approved social workers and then join local community mental health teams. Although this was, in Doctor Bass' opinion, a very promising project, the local authority did not manage to retain the social workers in the borough once they had been trained. He said that there are surprisingly few mental health workers drawn from the community and that the Trust struggles to get translation services let alone trained mental health workers. Doctor Bass thought that the problem arose because there was a certain stigma in the community about working in mental health services. He said that the Trust has never been able to find Bengali-speaking psychiatrists, and very rarely gets Bengali-speaking nurses or social workers. There are a few health care assistants from that background. The result, he told us, is that the mental health service relies heavily on the large networks of families and friends that exist within the Bengali community. This is an established community, with a lot of English speakers, which is familiar with British society. The same cannot be said of many other ethnic groups and so the Trust does not have similar networks to rely on in respect of people from other groups.

17. Mr Dave Hill, the head of Children and Families Services in the London Borough of Tower Hamlets, was speaking for the local authority rather than the Trust when he told us that he considered that that authority is very good at specialist interventions to reflect the cultural diversity of the population, telling us that cultural diversity training and awareness is "the lifeblood of our organisation". He described a Multi-Agency Project, working with children in the Bangladeshi community, schools and mosques on issues of child protection, and an African Families project.

18. In its Clinical Governance Review of the Trust in February 2003, the Commission for Health Improvement ("CHI") commented on the lack of any kind of credible arrangements with community voluntary service organisations in the provision of mental health care. The Social Services Department (London Borough of Tower Hamlets) contracts for social care services in mental health with a wide range of voluntary community sector organisations, with particular emphasis on ensuring that there are services in place which are appropriate for the needs of the diverse local community. The Department has specialists working in the Bangladeshi and Somali communities and the voluntary sector provides a wide range of support activities including drop-in centres, employment-based projects and counselling projects. Mr Goldup, Head of Adult Services in London Borough of Tower Hamlets Social Services Department, told us that the local authority funds more groups and services run directly by their users than any other local authority in London. Although he was speaking for the local authority rather than the Trust, he also told us that there is now an Adult Mental Health Partnership Board in which the voluntary sector and users are well represented. The local authority's community partnership arrangements are integrated into the strategic development and delivery of mental health services in Tower Hamlets. The Terms of Reference of the Partnership Board include addressing the needs of the diverse community in Tower Hamlets, equality and social inclusion. The fact that none of the witnesses from the Trust mentioned this Board to us suggests that it might not have as high a priority within the Trust as within the local authority.

19. The reports of both CHI[40] and HASCAS[41], to which we refer in more detail in the next chapter, made recommendations about ways to

[40] Commission for Health Improvement, February 2003

[41] Health and Social Care Advisory Service, April 2003

improve the quality of the services to people from a wider diversity of backgrounds:

19.1 CHI recommended the following:

19.1.1 To develop a strategy for service user and public involvement

19.1.2 To implement “structured interpretation” services

19.2 HASCAS recommended that the Trust should :

19.2.1 examine the possibility of employing staff from the local black and minority ethnic population within CMHTs, perhaps by creating link worker posts with different communities and community organisations

19.2.2 ensure that people from local community organisations are involved in Acute Care Forums and in other service development initiatives

19.2.3 develop links between the inpatient wards and the local community organisations.

20. The Trust has more recently been developing a number of strategies to address the diversity of its population. The Trust has established a Department of Religious, Spiritual and Cultural Care. It has representation from the major faiths and aims to secure support for users, carers and staff. It assists staff to work with patients from ethnic groups that the staff are not familiar with. It has trained key individuals who then work with the teams to promote better understanding of the issues. In addition, the Trust is sponsoring a number of places on an MSc in Transcultural Care. Those who participate in the MSc will then work within the Trust on improving awareness of diversity and ethnicity issues.

21. Ms Foley (Chief Executive), Ms Hunt (Director of Nursing) and Doctor Dolan (Medical Director) have taken a number of steps to address some of these issues, including the latter two personally working with the teams in Tower Hamlets to improve the functioning of their clinical multi-disciplinary teams.

22. We recognise that this is "work in progress" and that there is a commitment within the Trust to improving the services that it delivers to patients from all backgrounds in a manner that is culturally sensitive to them.

The Trust's Equality and Diversity Scheme and Action Plan

23. We consider that it is important that the Trust develops effective approaches to addressing the diverse needs of the population it serves. The deficiencies of the approach to Mrs Miles' treatment arose critically from a failure to understand her as a person and this in turn appears (as Ms Lynn Hunt said) to stem from an underlying approach which fails to value the patient as an individual or to understand the patient's present concerns and his/her hopes and desires for the future. Ms Hunt suggested that the service needs to engage in a therapeutic way with patients. We agree. Yet the recent review of adult mental health services in the Trust, already referred to in the previous chapter[42], found that there was very limited expertise in psychological treatments available within community teams and on the wards and that the community teams do not have the capacity to meet NICE[43] guidance in that field.

24. The new Equality and Diversity Action Plan lists a number of important developments: commissioning language support services according to local needs; developing a more balanced range of effective therapies such as peer support services, psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective; involving local people and staff in developing culturally appropriate services; training and development for staff including in cultural competence. We heard no evidence that any such changes have been implemented at the time that the draft Action Plan was presented to us (early February 2006), though many of the action

[42] Chapter Two para 40

[43] National Institute for Clinical Excellence

plan proposals are not new. The CHI and HASCAS reviews made their recommendations in February and July 2003 respectively.

25. We have three main concerns about whether the present commitments of the Trust contained in this document will be implemented effectively.

26. First, the Action Plan lacks concrete proposals for ensuring implementation of a number of the action points. For instance, the key action point regarding provision of a range of effective therapies is

> "A more balanced range of effective therapies such as peer support services, psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective"

27. The Plan is silent as to how this will be achieved. There are no concrete programmes identified in order to achieve the goal, nor any clear measures of successful outcome save that of "Care plans show a greater use of talking therapies", nor is there any provision for auditing this action point.

28. Under the heading "Patient and Public Involvement Consultation" the Plan includes the following Action Point:

> "Involve local people and staff in developing culturally appropriate services and in our work to promote racial equality"

29. In respect of this point, the plan is to "work with representative groups", and all directors are to lead on this. Under the heading "Evidence" the Plan states

> " – Involvement of external stakeholders from diversity groups on Trust boards, planning and service groups
>
> - Involvement of external stakeholders from diversity groups on trust equality and diversity groups
>
> - Involvement of external stakeholders from diversity groups in training and development
>
> - Involvement of external stakeholders from diversity groups on interview and appointment panels

30. The Plan is silent as to how these objectives will be achieved, and does not identify how "culturally appropriate services" will be developed through these involvements.

31. Similar comments can be made with regard to other aspects of the Action Plan.

32. Second it is vital that the Trust invests adequate resources to enable equality and diversity issues to be addressed effectively.

33. Third, neither the Scheme nor the Plan identifies any individual with responsibility for ensuring that the action points are carried out. We have been informed that in fact the Director of Partnership has this responsibility but this is not set out in the documentation. We note that the Department of Health publication, "Delivering race equality in mental health care"[44] states:

> "3.23…each organisation…must now have an active race equality and cultural capability framework and plans for action. These should be managed at a senior level – not left to subgroups that are too poorly resourced and weakly positioned to have an impact on the organisation. Chief executives are directly accountable for progress, and the plans should be integral to organisations' governance frameworks."

34. While responsibility for the various action points in the Trust's Plan has been allocated to different senior personnel at director and board level, the Plan does not give explicit responsibility for delivering it to any single person. The Plan should provide for overall responsibility to be given to one individual at director level, providing strong leadership and effective accountability. Without allocating responsibility clearly in this way, there is a danger that responsibility may in the future be distributed more widely which could weaken the impact of the Plan on the functioning of the Trust. This risk is illustrated by the following. The Action Plan commits the Trust to integrating diversity and equality into its corporate planning process. Yet the Trust's recent "Proposal for the Development of an Integrated Healthcare Governance Framework" (August 2005), with which we were provided as an example of the Trust's improved approach to healthcare governance, does not once mention ethnicity, diversity or equality. This proposal predates the

[44] January 2005

Action Plan but the example illustrates the importance of clear overall responsibility for equality and diversity.

Cultural competence

35. Although we consider that the above steps should be taken in order to achieve the Trust's present commitments, we are concerned that the approach taken to date may be too narrow and could have unintended consequences. For example, we agree that staff composition, at all levels of the organisation, is very important. The position in February 2006 was that only one Board member was from a black or ethnic minority. Few senior management staff and just over 20% of consultants have such a background. The efforts being made to address the composition of the workforce are welcome. However, focussing too much on the ethnicity of staff and Board members can be problematic as the evidence before us in this case has illustrated. First, there is a tendency to focus on reflecting the local population's major ethnic groups within the work force so that some parts of the population remain unrepresented or inadequately represented. Second, there is a risk of ignoring the more important challenge which is to ensure that staff have the skills to understand the specific issues facing each individual within the service. Each service user is different. Each worker is different. Mental health workers need to be able to recognise their own biases and be able to transcend those in their communications with each unique service user. Generalisations related to ethnicity are often unhelpful.

36. Similarly, employing specialist workers can discourage the rest of the workforce from taking responsibility for diversity issues. Focusing on building links with local community organisations can have the unintended consequence of making the organisation less able to respond to the "one offs". Building links with community organisations and employing staff from the local black and ethnic minority communities are of course a vital part of any equality and diversity strategy, and is a requirement for NHS organisations following "Delivering Race Equality in Mental Health Care". However the work

has to be conducted in the certain knowledge that each patient is a unique person and will not fit the stereo-type. The danger can be that individual workers or the organisation can assume that they know about a person because they know about their cultural heritage. Trying to address the needs of the diverse local community by adopting ethnic stereotypes will not only fail in respect of those ethnic groups that are embraced by such an approach but will also entirely neglect the "one-offs", as Mrs Miles was neglected. The point was well made by Doctor Joanna Bennett in her evidence to the Independent Inquiry into the Death of David Bennett"[45], which is summarised in that Inquiry report as follows:

> "Rather than mental health services focussing on cultural matching, whatever that was supposed to mean, we should be focusing more on how we enable practitioners to deal with people as people, with some humanity, because that was how you were going to find out what really matters to that person. If we took time to respect and individual and say to him, "What is it that is troubling you, what are your needs?" we were more likely to get it right than if we started to talk about culture, ethnicity and cultural competence. We also need to understand about the ideology of racism and how that creates stereotypes, assumptions and values. That had nothing to do with culture."

37. Doctor Bennett has advised the East London and City Mental Health Trust on one of its programmes designed to improve race awareness in its staff. She recently pointed out:

> "There is no agreed definition of cultural competence and no evidence that it works in producing better services for black and minority ethnic users. We should be looking at structural processes and power relationships in the way services are delivered."[46]

38. The research published in "Between Worlds: Interpreting conflict between black patients and their clinicians"[47] is relevant in this respect, in particular the analysis of the value of anthropological approaches in seeing people in their context so as to avoid patients "constantly…battling against a reduction of their problems and

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[45] Norfolk, Suffolk and Cambridgeshire Strategic Health Authority (December 2003)

[46] "The Struggle for Cultural Competence", The Guardian, 12 April 2006

[47] Kilshaw, Ndwgwa and Curran, May 2002

experiences", the critique of "insight" as a valid assessment tool for many patients, the analysis of explanatory models and conflict between clinicians and patients.

39. We consider that the Trust should invest in training for all clinical staff to address these issues, and in developing advocacy and mediation services with a view to bridging the gap between the perceptions and explanatory models of clinicians and of patients. We do not consider that we should be prescriptive as to how the Trust should approach these issues. It is for the Trust to explore this and identify its preferred solution.

CHAPTER FOUR

THEME 3: ORGANISATIONAL ISSUES

Introduction

1. The purpose of this section of the report is to consider any organisational issues which may have contributed to the seemingly narrow perspectives, poor decision-making and poor partnership-working across the health and social care services in respect of the care and treatment of Mrs. Miles. A number of organisations were involved in her care and treatment (principally the East London and City Mental Health Trust, Tower Hamlets Primary Care Trust and London Borough of Tower Hamlets Social Services Department) but the focus of this section is on the organisational issues prevailing at the time for the East London and City Mental Health Trust. This section concludes with an assessment of progress achieved by the Trust in the ensuing period to rectify the perceived problems.

2. We have identified a number of problems and failings in the care and treatment of Mrs Miles, as outlined in Chapters One, Two and Three. It is plain that not all of these problems were unique to her case. It is important to understand the institutional causes of the dramatic failure of her care and treatment, to identify what has already been done to address these and to advise on what remains to be done.

The perspectives of Mrs Miles, her husband and family on the Trust

3. As part of our conversations with the family members we sought to establish how things might have been different from their point of view. From Peter Miles we heard that there was a need for the services to find ways of understanding better the effect of Mrs. Miles' behaviour on her family and how risks and dangers were perceived by family members. This was confirmed by Sally Miles who felt that no one understood the very detrimental impact of Mrs. Miles' behaviour on her husband and the family. She said that Mrs Miles' mental health care seemed "haphazard and inadequate". Mrs. Miles' medication was not acceptable to her. She took it sporadically and had some weight gain, was zombie-like and had

disturbed sleep pattern as a result. Despite the medication being unacceptable to Mrs. Miles (it was not part of her personal/cultural construct that she was suffering from a mental illness) no other treatment was pursued with any degree of success. Sally Miles said that Mr Miles had noted more than once that, where a person in Pakistan was not functioning mentally or emotionally in an appropriate manner, treatment with medicine, by a doctor or in hospital was not seen as the appropriate response. She felt that the approach to Mrs Miles' illness was particularly questionable as the medication she received did not alleviate her evident distress. Sally Miles reported that Mr Miles also felt that the services did not have a handle on the situation and that he had never been given a clear diagnosis, despite many conversations with doctors. Crucially, in Sally Miles' view, the services should have consulted the family before releasing Mrs. Miles from section.

4. Peter Miles was also concerned about the circumstances of Mrs Miles' discharge from hospital. He felt that Mrs Miles' case was not a one-off and that professionals who have the responsibility for making decisions about releasing people in to the community ought to be more careful. In Mrs Miles' case they did not ensure that she took her medication even though it was known that the problems arose when she was not doing so.

5. The Panel was pleased that Mr. and Mrs. Miles' daughter, Laila Miles, chose to speak to us. Her view was that the hospital was not a nice place to visit and that her mother always wanted to run away from it. Her mother's stays in hospital did not help her take her medication at home and made her unhappy and depressed. Miss Miles remembers visiting the hospital and not being able to tell who was a patient and who was a nurse because it was "all a mess". She said that the hospital let her mother discharge herself when she was obviously ill but she wouldn't go back. For herself, she always found it awkward talking to the hospital nurses and still finds the visits to her mother in the John Howard Centre difficult because of the nursing presence.

6. Miss Miles said an explanation to the family of what exactly was wrong with her mother and what her illness made her do or say would have been helpful. She said

> "I knew that not everything she was saying or doing was her, but it was hard to pinpoint what was her and what was the illness."

7. She did not think that the family social work or support services helped. She said that when Ms Loshak or social workers visited the family it was always very awkward having to talk in front of everyone. She felt it was really difficult talking about her mother when she was in the room. She said her mother easily got "wound up" and the social workers would then turn their attention to her and nothing would get resolved.

8. Our conversation with Mrs. Miles herself left us with a strong impression that what she most wanted from services was help in social inclusion – within her own marriage and family as well as more broadly with Muslim, Urdu-speaking people in the area. Her assessment was that she needed to talk with her husband and friends and to be with her children when she was depressed, and not be in hospital, with "mental people", which was a depressing place where life was awful. We discuss this in more detail in Chapter Three.

Partner agency perspectives on the Trust

9. The Trust did not pursue any form of inter-agency working that had an impact on the direct clinical care of Mrs Miles. There was no involvement from black and ethnic minority communities, from the voluntary sector or from any person or agency involved in spiritual care. As we have already described, Mrs Miles refused to make contact with a community group but the professionals engaged with Mrs Miles did not appear to have considered any alternative plan. Our interviews with outside agencies were therefore limited to the GP and London Borough of Tower Hamlets social services department.

10. Doctor Pollen was the GP for Mrs Miles and the whole family. She had concerns ranged across both community and inpatient services. She was particularly concerned about her experience of the absence of any integrated role for the GP in the

community treatment of mental health patients. She explained that in her view the GP's role in prescribing drugs and signing section papers was a "utilitarian" one. She thought that there was little collaboration between the inpatient psychiatrists and GPs in respect of medication, and she felt that the psychiatrists did not see the GPs as part of a patient's mental health care because they "did not have a mental health care label".

11. Her specific concerns about the Trust and its services included the lack of basic administrative systems in the Pritchard's Road CMHT during the time when Mrs Miles was under its care. This resulted in delays in or complete absence of follow-up letters and phones not being answered. The Team was so overworked that it was extremely reluctant to take new referrals.

> "you would refer a patient and several weeks or months later you might get a letter or a phone call saying that it was thought that this person was not suitable on paper for their team work and so they had been rejected. So, we became progressively turned off from the idea of referring direct to the mental health team. So, on the whole in our practice we referred direct to the consultant psychiatrist at St Clements and if they involved the mental health team, then our patients would fall into the mental health team."

12. Doctor Pollen's impression was that the Bethnal Green CMHT seemed simply to follow the patient's illness but had no strategies for managing or caring for patients who were not ill enough to detain in hospital but were not well enough to manage their medication alone. Because of her lack of faith in the system, Doctor Pollen stated that she preferred to make referrals directly to consultants because they were obliged to respond, whereas other routes did not seem to get a result. Referral through other agencies could result in rejection without seeing the patient.

13. Communication between the CMHT and the GP was poor. There was no routine system for the CMHT to keep the GP up-to-date with a patient's circumstances, although Doctor Pollen acknowledged that Ms Semper did in fact communicate with her about Mrs Miles.

14. Doctor Pollen participated in an audit review which demonstrated that, of the caseload at the Bethnal Green CMHT recorded as live, around 50% were wrongly registered: patients were either dead, had gone away or had been recorded more than once. In Doctor Pollen's view there was a similar number of people being looked after solely in primary care who would have benefited from access to secondary care from which they had been discharged for non-clinical reasons, such as failing to attend outpatient's clinics.

15. Doctor Pollen proposed a number of practical suggestions which, based on her experiences, would improve the partnership working between GP and ELCMHT. These include:

    a) after every meeting between the CMHT and the patient, notes are copied to the GP (and vice versa);

    b) improving the systems of community mental health teams so that staff are able to clarify their workload and no longer feel over worked;

    c) consultants replying to letters (she said that both she and her colleagues had had problems in this respect);

    d) ensuring that patients are followed up when required;

    e) including GPs in community mental health team meetings, particularly in respect of the sectioning process.

16. Even though the above describes the experience of one GP, it is a sad reflection of the state of mental health services in Tower Hamlets at the time that she spoke to us that any GP felt the need to make such suggestions for improvements, many of which constitute examples of good practice which should have been happening as a matter of course.

17. Mrs Miles' case illustrated the operation by the consultants of a strict medical model. Doctor Pollen was content to work in this way, if the GP was able to contribute the "holistic" role that complements the psychiatrists' role. This did not happen, however. The psychiatrists' treatment strategy depended upon Mrs Miles taking her medication. The

central failure was that they did not ensure compliance. Whilst Mrs. Miles was difficult to assess in both symptoms and presentation, her pattern of non-compliance made it perfectly clear when she was or was not well.

18. A more interventionist approach was required if the strict medical model was to be effective. We discuss this in more detail in Chapters Two and Three.

Some internal perspectives

19. The East London and City Mental Health Trust ("ELCMHT") was formed on 1st April 2000 from the disaggregation of three community services trusts and the merger of their mental health departments to create a new organisation. One of these was Tower Hamlets Healthcare NHS Trust. Peter Horn, the Chief Executive of one of the predecessor organisations (Newham Community Services Trust), was appointed as Chief Executive of the newly created ELCMHT. Mr Horn explained that much energy was put into sorting out the financial problems following disaggregation and to resolving the chronic under funding of the NHS in East London (and particularly mental health) resulting in the, then, biggest budget increase known of around 10% (overall) in 2002/03.

20. Mr. Horn's assessment of the different components which comprised the new organisation was that each of the component community services trusts brought a very different approach to the provision of mental health services. The Trust did not have its own culture: its culture was a "conglomeration" of the three different component organisations which were brought together at that time.

21. He felt that Tower Hamlets still carried the ill-effects of service reductions dating back to the early 1990s, and operated an "entrenched medical model" with the psychiatrists very much in control. That the medical model dominated in Tower Hamlets at the time was confirmed to us by a number of witnesses from whom we heard.

22. Mr Horn described the initiatives that he put in place to develop and improve the new organisation with the aim of creating a more "inclusive,

empowering approach". It clearly was an unusually complex task since he had to create one body out of the mental health sections alone of the three former organisations (as opposed to merging together whole organisations).

23. It is hard to judge how much change and improvement one could expect to have seen by 2003. Mr. Horn clearly did not expect to see them during his time in office.

24. Cath Gaskell was Nursing Director in the Trust until 2 May 2003. Given her role, she felt a strong sense of responsibility for the organisation as a whole. She felt the lack of a strong corporate centre or a corporate culture. After its creation, the Trust continued to operate as three separate organisations with each borough director operating, effectively, as a chief executive of his/her patch. She described the poor communication between tiers in the hierarchy and "silos" in the system and spoke of the difficulty in getting agreement to Trust-wide policies. Even once agreed, the policies would be implemented differently in the three 'mini Trusts'.

25. On the day of Mr Horn's leaving party she found out that CHI (the Commission for Health Improvement) was to review the clinical governance of the Trust, in order to assess how well the trust ensured high standards of care and what it was doing to improve services. The Review and the interim arrangements to cover Mr Horn's departure pushed her and the system to its limit.

> "It just seemed that [the CHI Review] would not be the right thing …because we were just consolidating, making sure everything was safe, rather than have to go through this huge process without additional support."

26. CHI published the review in February 2003. It found very significant failings. Relevant comments include:

> "CHI has serious concerns about the trust's ability to deliver safe quality care for its service users."
>
> "CHI has serious concerns about clinical risk management within the trust, in particular the trust's ability to manage serious untoward incidents. The trust does not have adequate processes and systems in place to provide effective risk management at all levels of the organisation and no direction from the trust board. "

27. In respect of the experiences of service users, CHI found:

> "The care in the trust is managed very much using a traditional medical model, particularly in Tower Hamlets, with other professions only being involved in therapy at the doctor's request. This has caused problems due to the way some consultants sometimes approach service users' needs and a dependency on drug treatment rather than a holistic approach. As the trust does not routinely monitor outcomes of care it is difficult to determine the success or otherwise of this approach….
>
> Individuals felt that they were often treated with drug therapy when other alternatives were not explored."

28. Sheila Foley, Chief Executive from November 2002, called in HASCAS (the Health and Social Care Advisory Service) for an independent review as a consequence of the CHI Review and other misgivings that she had about the system. Tony Bamber, Service Director in Tower Hamlets, described the culture in Tower Hamlets at that time:

> "People were working very hard …. But they seemed to be working in silos….
>
> Certainly the CHI report had happened and I think, as often happens in those circumstances, a little bit of bunker mentality had emerged. People kept their heads down, became risk averse, and not really getting on with the day job. I think there was a concern that people would become victims. I think there is something peculiar about Tower Hamlets…
>
> "Tower Hamlets is a very deprived borough….: high unemployment, young population, overcrowding, all of those things. … some people tended to glory in that and very much said: we cannot do anything about changing it, this is what we have, this is what we work with."

29. The HASCAS review report was published in July 2003. Its findings and recommendations covered a range of issues including staff management and supervision, review of the care programme approach, closer integration of psychiatrists and CMHTs, involvement of black and ethnic minorities and developing links with local community organisations.

30. Tracey Upex, Sector Manager for Tower Hamlets, felt the key task facing the Trust after CHI and HASCAS was to break down the barriers between the community teams and the inpatient wards. She described a "siege mentality" in the early period, with people feeling "a bit overwhelmed". Some people viewed inpatient services as the main focus, with community work being a little peripheral, but this was changing. In the original structure the consultant was responsible for building the relationship with the ward manager and the community mental health team manager in order to ensure coherent care for a patient. Following the restructuring a single manager was responsible

for both inpatient care and CMHT-based care, and this helped to ensure that the consultant related to both.

31. Mr Bamber was clear that many changes and improvements had been put in place following the HASCAS Review. He highlighted the importance of enabling GPs to refer directly to CMHTs rather than having to refer a patient to a consultant first. Nonetheless, he considered that established practices by some consultants could be an obstacle to effective change and that the introduction of new psychiatrists with different approaches was important.

32. From John Goldup, Head of Adult Services in the Social Services Department of the London Borough of Tower Hamlets, we got the perspective of someone who was both 'inside and outside'. He is responsible for the development, commissioning and delivery of all social care services to adults. He exercises his responsibility for mental health social care services through the Trust, to which the local authority has formally delegated its provider functions. These integrated services are accountable to a Joint Management Board which meets monthly. Mr Goldup told us about a number of concerns including the poor implementation of the CPA. The Joint Board also had concerns about the poor relationships between primary and secondary care and the rigid medical model of care which was being operated. He thought that unifying the management structure for inpatient and community service was particularly helpful, resulting in more consistent and continuous care planning between the two branches of secondary care.

33. The Joint Board was concerned about referral pathways. Although the Trust is committed to achieving a single point of entry to mental health services through the community mental health teams, Mr Goldup told us that

> "There are still some consultant psychiatrists…who are not fully convinced that they should accept referrals from anybody other than a GP."

34. Indeed, Doctor Nick Bass told us that he continued to see patients who were not referred through the CMHT and considered that he was justified

in doing so as he thought there were organisational problems in the single point of entry.

35. Doctor Bass' evidence gave us an insight into what appeared to us to be a divided organisational culture. As a senior consultant within the Trust he seemed to be at odds with the stated policy direction, vehemently expressing his opposition to the implementation of policies on the centralisation of notes and sectorisation (realigning Trust services around GP practices). We acknowledge that Doctor Bass was not alone in his views, particularly among consultants.
36. We got the impression from a number of witnesses that clinicians in Tower Hamlets saw themselves as very much a service under siege. As one consultant said to us:

> "But I would not say that morale has necessarily been low… although there are some people that would not consider touching the place with a barge pole because of the level of morbidity, I think that draws and attracts certain other types and it is part of the challenge"

37. Dr Bass thought that there was a surprisingly low rate of serious untoward incidents given the high levels of morbidity in the area, prevailing violent culture and low level of resources.
38. Doctor Tim Read's comments about the community mental health team, already cited, demonstrated the 'them and us' climate that existed between the community mental health teams and the doctors. He made a number of critical remarks about the competence of the community mental health teams to administer systems and felt no accountability for their performance.
39. He described how one consultant in Tower Hamlets had to be "brisk and businesslike" in his clinical care with time only to squeeze patients in between his management duties. He said that that consultant had no time to develop therapeutic relationships with patients and had to focus on the high risk issues
40. Alan Mountain, the manager of the Bethnal Green CMHT, gave us evidence of the sense of high caseloads and overwork in the team at that time. The lack of consultant involvement in the CMHT was an issue for

him at that time and he felt the relationship between consultants and the community team was unequal. Consultants could tell him what to do but he had no authority to do likewise. His view was that, for community services to work effectively, consultants should be based in the teams, rather than the more traditional model operated at St Clements in which the consultants worked very much from hospital. Although he raised these concerns at management meetings, nothing was done about them at the time.

41. Mr Mountain's evidence illustrated the purely medical model which applied in Tower Hamlets, which resulted in little, if any, effective social care intervention in the case of Mrs Miles. Thus, he thought that, if Mrs Miles would not take her medication, there was no possibility of recovery:

> "Yes, it was difficult to get Mariam to comply with medication because she did not have, from my recollection, any insight. She did not see there was anything wrong."
>
> "I am not sure we could have got her better…. in all my years of working in mental health, my experience was the patients tended to fall into two or three groups; some could have an episode, recover and never have another episode; others, who had some insight, were compliant with their medication because it frightened them what they were like when they were ill. But there were some who never had any insight and would come back again refusing medication and refusing to comply."

42. The danger of having these sorts of categories in mind is that low expectations can be held about patients who it is perceived fit one of the stereotypes. In Mrs. Miles' case "refusing medication and refusing to comply" seemed to justify the clinical team having no other expectations of her or hopes that she might recover and thus failing to adopt other strategies to enable her to get better. By placing her in the third category, it was assumed that she would not get better.

43. Tony Bamber told us that doctors didn't trust managers and that the key consultants in Tower Hamlets operated to the same medical model. In respect of two of the consultants working in St Clements at the time, he said

> It was very much: I go down and I will tell you what is going on, I will tell you what is going to happen, you go on and carry out my instructions."

44. This description is not accepted by all consultants. However, there is a striking resemblance to the description by Alan Mountain of the approach of the psychiatrists to the CPA[48].

45. Jan Murray, who was Lead Nurse in Tower Hamlets at the time, also gave us insights into the culture then prevailing in the Trust. Taking us through the process that was used to compile the Serious Untoward Incident 28 Day Report after Mr Miles was killed, she explained that within Tower Hamlets (but not elsewhere in the Trust) there was a culture that inhibited nurses from questioning doctors about their practices: the doctors regulated themselves. This meant that she (as the Lead Nurse) interviewed the care co-ordinator, CMHT manager and ward staff and shared this with the consultant (Doctor Trevor Turner) who co-wrote the review report with her. Doctor Turner interviewed Doctor Falkowski but did not share the information with her.

Recent organisational developments and plans for change

46. From the evidence we heard it was clear that the culture of the ELCMHT has not historically been conducive to good patient care. What happened to Mrs Miles, which Lynne Hunt (the present Director of Nursing) characterised as "not care and treatment but a series of visits", with much recording of what was happening but insufficient focus on action, was in part a product of this. The particular problems and unhelpful approaches in Tower Hamlets were well known, with external reports from CHI and HASCAS confirming the detail. There appears to have been little learning across the Trust, from one borough area to another. A beleaguered, bunker mentality prevailed in Tower Hamlets. We have outlined what has been done since 2000 to identify and address the problems in the Trust but wanted to know if this had resulted in effective change. We were therefore concerned to learn from the Trust senior management their views as to what, if anything, has been achieved so far and what remains to be done.

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[48] see paragraph 23, Chapter Two

47. We interviewed three key people from the current Management Team: Sheila Foley, the Chief Executive since November 2002; Doctor Dolan, the Medical Director since 1st April 2003; and Lynne Hunt, the Director of Nursing from November 2004. This gave the Panel the opportunity to come to a view on whether the ingredients are in place to secure the necessary improvements which would make it less likely that service users and their families will be let down as badly as the Miles family was in the future.

48. In between Mr Horn's departure and Ms Foley's arrival at the Trust there had been an acting chief executive and deputy chief executive. Ms Foley described the situation in the Trust as "a nightmare" when she took up post. She explained the key areas of concern that she had at that time:

    a) The trust was being run as three separate organisations and there had been no attempt to pull them together as one organisation, so that each of the areas was working on the policies they had been working to before it became an integrated Trust.

    b) Within the Trust, Tower Hamlets was the most problematic. Those working there did not identify with the Trust as a whole.

    c) Apathy at St. Clements meant a very poor physical environment was tolerated.

    d) Leadership was ineffective. People did what they wanted to do and there was an atmosphere, as highlighted by the CHI Review, of complacency.

    e) There were problems of poor patient care, poor communication with GPs, and patients being discharged without proper follow up.

    f) The systems for dealing with serious untoward incidents were inadequate.

    g) Record keeping was haphazard.

49. As has been seen, CHI reported shortly after Ms Foley's arrival. An action plan was produced to address the issues raised and, on a Trust-wide basis, CHI was subsequently satisfied that the big issues around systems failures had been tackled and that the action plan was largely complete. The action plan was signed off by the Trust and the Strategic Health Authority, after a meeting with members of the Healthcare Commission in October 2005. The reforms included:

    a) Establishment of an Assurance Framework incorporating a new system for handling Serious Untoward Incidents

    b) Auditing processes to check the extent to which policies were being implemented.

    c) A standard format for integrated mental health notes was introduced.

    d) There was a quarterly performance management system for each directorate

    e) A Child Protection Policy was implemented and responsibility for ensuring its implementation was given to clearly identified individuals in each sector.

50. In addition to the Trust-wide issues, Ms Foley was so concerned about the situation in Tower Hamlets and St. Clements Hospital that she commissioned the HASCAS Review. This focussed on inpatient services in particular and resulted in the production of a separate action plan. Some of the key issues that arose were:

    a) Tower Hamlets was less well resourced than other comparable boroughs in London and compared to the other two boroughs within the Trust. Within Tower Hamlets, some patches were better resourced and more manageable than others. Bethnal Green was amongst the unmanageable ones.

    b) Generally speaking, the consultants did not work well with the community teams. In Bethnal Green, consultants ran their own outpatients clinics and did not have day-to-day integration with

the community team. Although relationships worked well in some cases, there were not the infrastructure and processes to ensure that this happened consistently.

c) There was no agreement that there should be a single point of entry for referrals and referral processes were unwieldy. A referral by a consultant to the community mental health team could result in rejection by the team.

d) The poor inter-agency coordination in Mrs. Miles' case was found in a number of other serious incident reviews at the time.

e) The CPA policy was very detailed, ill-focussed and was not patient-centred. CPA paperwork was cumbersome and as a consequence was not completed appropriately.

51. She told us that the Trust leadership had decided to use the HASCAS report to raise key issues with doctors and to shape a challenging agenda for change. There had been a lot of resistance to change, in the beginning, but Ms Foley and Doctor Dolan felt that was diminishing. They acknowledged there was still much to be done.

52. We were told by senior management that there was a hard core of consultants in Tower Hamlets that was resistant to change including to attempts to manage their performance. Other clinicians have been much more positive: they want to change and are being given a lot of support by management. Doctor Dolan spoke of using the Consultants Contract as another lever for change because, for example, it would enable him to ensure that doctors spent specified amounts of time (Programmed Activities) in the CMHTs through the annual appraisal process.

53. A number of structural and procedural changes have since taken place or are now underway to secure the necessary improvements. The Trust is now promoting strong clinical direction and a focus on patient care. Three new consultant posts were created with locums in place since late 2004. This had brought in doctors who were enthusiastic to work in the community. Steps were being taken to increase the amount of

consultant time spent in the community teams. Once the locums were in post it had been possible to implement sectorisation around GP practices and community mental health teams. They had started implementing a single point of entry, and measures were being taken to integrate psychiatrists and CMHTs. This included increasing the amount of consultant time spent in the community teams. Doctor Dolan and Ms. Hunt were working personally with multi-disciplinary teams in Tower Hamlets. Over a recent period of ten months, the nursing vacancies had dropped from 216 to 5. A programme was underway to improve training and development at all levels of the workforce. We also heard about the plans for the development of an Assertive Outreach Team and a Home Treatment Team in Tower Hamlets.

54. There remains work to be done. For instance, Doctor Dolan acknowledged that, notwithstanding that Directors were receiving positive audits in relation to the CPA, the recent patients' surveys indicated that patients were not aware of their care plans and reported that they had not had copies of them. Doctor Dolan explained that formal performance management arrangements were in place and were improving but that further work was required by the Board to improve its governance arrangements. In addition, Doctor Dolan acknowledged that there was limited expertise in psychological treatments both on the wards and in the community, and that the community teams did not have the capacity to meet NICE[49] Guidance in that field. Earlier this year he recommended to the Board that this should be addressed as a priority.

55. Ms Hunt's assessment also was that Tower Hamlets had made great strides particularly in the involvement of service users and their carers, and that working relationships with the Primary Care Trust and with the Social Services Department had improved. The Bethnal Green area still had its problems, not least in clinical leadership, but she felt that it was benefiting now from a very different management style approach, which

[49] National Institute for Clinical Excellence

she described as much more proactive, and a much more cohesive approach with the local authority.

56. The Panel put to both Doctor Dolan and Ms Hunt the apparent mismatch between their upbeat accounts and the impressions that we had gained from other witnesses. For example, Doctor Pollen did not appear to feel that there had been substantial changes in Bethnal Green. She felt that the system was still not adequate to the needs of many of her patients and that major tensions remained on the ground between the CMHT, the consultants and primary care centre. Some consultants expressed the view that the CMHT remained poorly functioning and that resources was a major issue. In addition, the fact that not all consultants are cooperating fully with the single point of entry and the scepticism that exists about the sectorisation project all present obstacles to achieving effective change. Most strikingly of all, none of the clinicians interviewed had mentioned the HASCAS Review nor the change process that had been outlined to us.

57. Ms. Hunt acknowledged that was the reality but thought that it was important to remain upbeat. The critical thing in her view was that the Trust now had a vision and knew where it was heading. She confirmed that in her view Tower Hamlets was the part of the organisation that struggled the most with the concept of change. Its CMHTs were not meeting the needs of patients, GPs or the local population. Doctor Dolan explained that in fact three of the seven consultants in Tower Hamlets were not working as part of the community mental health team and he acknowledged that not all doctors were cooperating with the drive towards a single set of notes. Indeed, Doctor Dolan's view was that a few doctors in Tower Hamlets did not relate well to either the CMHTs or management and that they were not involved in the running of the organisation. Ms Hunt also described the tension between management and clinical staff. She described the "silos" that still exist in the Trust, for example between community psychiatric nurses, social workers and doctors, and the poor functioning of the multi-disciplinary teams. She said that some doctors still did not view themselves as "community

psychiatrists with some beds", but rather the other way round, and that the Trust was behind in connecting with local communities.

58. We were not wholly reassured, therefore, as to the success of the programme for improving services in Tower Hamlets. Doctor Dolan told us that he considered that the treatment of Mrs Miles was typical of the service at that time and that, although he hoped that things were not moving on, he would not have been surprised to see further evidence showing that there is still a major problem of that kind.

Serious Untoward Incidents

59. The Trust's approach to serious untoward incidents deserves to be addressed specifically, because a number of issues in that regard have emerged during the course of this Inquiry. The Trust instigated its Serious Untoward Incident (SUI) procedure after Mr Miles was killed. Doctor Trevor Turner and Ms Jan Murray carried out the investigation and wrote the report which is dated 11 September 2003 (very much later than the required period of 28 days from the date of the incident). The conclusions and recommendations of that report are set out in the Introduction to this report.

60. Although we heard that an action plan had been produced following this report, none of the witnesses to whom we spoke who had been involved in the care and treatment of Mrs Miles nor in the production of the SUI report was aware of this. They could tell us only of some informal discussion amongst those who were aware of the incident.

61. Ms Semper was interviewed for the purposes of that investigation. She was never shown the final transcript of her evidence. She said that what she has since seen (in preparing for her evidence to the Inquiry) appears to be a draft only and is not wholly accurate. She was not sent a copy of the SUI report nor informed of the outcome of that investigation. She was never offered an explanation as to the role of this Inquiry so that she was under the impression, when she came to give evidence to us, that our Inquiry may have been a continuation of the internal investigations. It does not appear that any of the Miles family was interviewed for the SUI

investigation, and they were not sent a copy of the report. Even Doctor Turner and Ms Murray were not informed of the fate of their report after they handed it over to the Trust.

62. This approach to the incident indicates that, by May 2003, little had been done to respond to the findings of the Commission for Health Improvement's Clinical Governance Review into the Trust which was published in February 2003. This found:

> "There is no systematic approach to managing and investigating incidents. In particular CHI has serious concerns about the systems and processes in place to manage serious untoward incidents. There is an atmosphere of complacency amongst managers, clinicians and the trust board to investigate homicides, suicides and other serious untoward incidents. The trust continually fails to meet the requirement to investigate and report on SUIs within 28 days.
>
> CHI is concerned about the lack of information on the progress of investigations and how any action plans are implemented. CHI is also concerned about the lack of direction from the trust board and lack of discussion at trust board meetings regarding serious untoward incidents.
>
> There is little or no learning across the organisation from the outcomes of these investigations and further incidents continue to occur. There is no analysis of for example, the homicide reports to identify common themes, identify risks and implement changes to reduce recurrence."

63. It is particularly surprising that, as this SUI followed so closely upon the CHI report, the Trust did not at least ensure that the "28 day report" was produced within 28 days.

64. We also note that in January 2002 the Report of the Independent Inquiry into the Care and Treatment of Mathew Raymond Hotston[50] commented on the inadequacy of the approach to the serious untoward incident that was the subject of that inquiry. That Inquiry Report included recommendations that the East London and City Health Authority (the predecessor body to North East London Strategic Health Authority) take specified steps to address the problems identified. It appears that, by the time of the CHI review, no or no adequate steps had been taken to implement those recommendations.

65. Since this incident, the Trust has adopted an Incident Policy. This includes guidance as to responsibility for ensuring implementation and

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[50] East London and The City Health Authority (January 2002)

monitoring of recommendations, and communication of the outcome of an SUI investigation to all those who provided information, all those involved in the service user's care and the senior managers and clinicians of the relevant service areas.

66. We also heard from Sheila Foley, the present Chief Executive of the Trust, that all the Trust's senior managers and a number of other people have received root cause analysis training, and it is these people who will carry out SUI investigations in the future. There is now in place a system for quarterly reporting of SUIs to the board.

67. We note that in December 2004 the Trust achieved level one accreditation under the NHS Litigation Authority Risk Pooling Scheme for Trusts.

68. Nonetheless, the appalling difficulties that we experienced in obtaining copies of the relevant documentation for this Inquiry (as set out in the Introduction) indicate to us that, by late 2004 and early 2005, the Trust still had a long way to go in terms of its approach to SUIs. While much of the documentation had already gone astray before the Trust's current incident policy was produced, our experience was that there was in practice no effective mechanism for finding and obtaining records when they were required. The present Incident Policy should prevent such fiascos in the future, if it is adhered to.

Achieving change

69. We appreciate that we spoke with a limited number of people, some of whom were no longer in relevant posts within the Trust when we finished taking evidence in February 2006. Nevertheless the evidence causes us to question how much effective change had been achieved by that time. The medical culture remains dominant in that a medical approach has dominance in the treatment and care regimes. Consultants remain poorly integrated within CMHTs, Psychological and other non-medical treatment is limited. The evidence that we heard indicted that some clinicians are not cooperating with (and in some cases are actively

obstructing) the change programme. Patient survey results do not show that the CPA policies have translated into improved practice.

70. The Board needs to take responsibility for managing the performance of its leadership structure, both managerial and clinical, to ensure that effective change is in fact taking place. The most important measure of effective action is the delivery of good quality services in accordance with the criteria set for them.

POST SCRIPT

1. We visited Mrs Miles at the John Howard Centre where she was transferred from HMP Holloway on 30 December 2003 and has since been detained first under section 48 Mental Health Act 1983, and subsequently under a hospital order made on 9 July 2004 following her conviction. She is subject to the special restrictions set out in section 41 Mental Health Act 1983. We talked at some length to her and to her consultant psychiatrist, Doctor Ratnam. Some of what Mrs Miles reported to us about her present circumstances, and the comment on that provided by Doctor Ratnam, is helpful in shedding light on Mrs Miles' condition prior to May 2003.

2. Mrs Miles described herself as being very depressed. She told us that she wants to be among Asian people but that there are neither Asian patients nor staff in hospital and that nobody speaks her language, Urdu. She said that she feels very homesick. Her only contact with Asian people is with an Imam who comes on Fridays to pray. She said that she misses Asian food. Although the food in hospital is Halal, it is English and is tasteless. She has asked for Asian food but said that the hospital takes no notice.

3. When asked how she spends her time, Mrs Miles said that she smokes because she is depressed. She said that she wants to go out shopping but only gets to go outside, in the courtyard, for 15 minutes each day. She said that there are not enough activities for her. She goes to everything that she can: a discussion group, sewing class and sports class.

4. Mention of her children immediately triggered pleasure. Mrs Miles sees them every two weeks and can phone them. However, she has no other visitors.

5. Doctor Ratnam told us that not all of this description was accurate. It was true that there were no other Asian women patients on the ward but Mrs Miles' primary nurse spoke Urdu and bought Asian food for her. Mrs

Miles had to be stopped from cooking because she would not comply with health and safety requirements, but the occupational therapist was, at the time of our visit, reinstituting her self-catering. The hospital was buying Urdu newspapers. The hospital had been trying to get a befriender to visit Mrs Miles but had not managed to find anyone of the same cultural background to do this. The complaints about food seemed to be well founded: the hospital did not provide Asian food each day and, though there were a lot of curries and rice, they were not authentic.

6. What we saw was a woman with an intense sense of personal isolation which pervaded her daily life, as it seems to have done throughout the seven years, or more, preceding Mr Miles' death.

RECOMMENDATIONS

Context

This Trust has been the subject of two important external reviews and several independent inquiries over the five years of its existence. We are conscious that both the CHI and HASCAS Reviews were detailed exercises including some time on site meeting a wide range of people. Our Inquiry was necessarily more constrained than those Reviews but we have interviewed some of the same people. We are concerned that, by spring and summer 2005 (the period during which we received most of our evidence, the CHI and HASCAS recommendations continued to strike a cord with us as relevant. By February 2006 it was plain that some further progress had been made, but more work remains to be done. Of course it is possible that the CHI recommendations have been implemented fully in other parts of the Trust, but the focus of our Inquiry was Tower Hamlets where they do not appear to have been.

We are concerned that we should not make recommendations which have already been made, but that we should contribute to ensuring that the changes which others have already recommended are actually implemented as well as adding our own new recommendations where appropriate.

We make the following recommendations:

1. **Clinical practice and culture**

1.1 The Trust Board must immediately ensure the effectiveness of clinical and managerial leadership of the Tower Hamlets area, including putting in place appropriate remedies.

1.2 The Trust should ensure that there is an increased amount of consultant time spent within the community mental health teams, the assertive outreach team, home treatment team and other community teams. This should include:

1.2.1 implementing the proposals for consultant time spent in community teams proposed by the Medical Director in “The

Review of Teams in Adult Mental Health Services in Newham, Tower Hamlets and City and Hackney";

1.2.2 once those proposals have been implemented, further increasing consultant time spent within the community teams with a view to doctors moving their offices from the hospitals and into community mental health team premises;

1.2.3 holding medical outpatient clinics on community mental health team premises

1.3 The Trust should undertake a full investigation into Doctor Falkowski's work within the Trust and review his position. The investigation should encompass

1.3.1 his clinical practice;

1.3.2 whether and, if so, the extent to which his practice in relation to Mrs Miles is symptomatic of his practice more generally.

2. **Therapeutic options**

2.1 The Trust should increase the availability of psychological and other therapeutic interventions across the community mental health teams and on the wards.

2.2 The Trust should ensure that the NICE[51] guidelines on schizophrenia as to the allocation of resources between medical and other forms of treatment are implemented

3. **Care Programme Approach**

3.1 The team manager should have responsibility for ensuring that the Care Programme Approach is fully implemented in respect of every patient, including those treated only as outpatients. The Trust should ensure that this function is performed effectively through appropriate supervision and audit.

[51] National Association for Clinical Excellence

3.2 Every patient in an acute admission ward should have a ward round on a weekly basis, as a minimum, attended by all relevant clinical staff including consultants and patients' care co-ordinators. Carers and others involved in patients' care should be invited to attend.

3.3 In respect of every patient on the enhanced CPA there should be a systematic assessment of the needs of any children associated with the patient and a plan for meeting their needs in accordance with the Trust's child care policies. Such assessment should not be limited to child protection issues but should embrace the full range of the children's needs in accordance with the Framework for the Assessment of Children in Need and Their Families[52].

3.4 Regular clinical audits of the work of CMHTs should include their effectiveness with regard to child protection and welfare.

4. **Serious Untoward Incidents**

The Trust must establish procedures for ensuring that learning arising from each serious untoward incident is translated into effective change, in particular in service delivery. The Trust must be able to demonstrate such change with concrete evidence.

5. **Equality and Diversity**

5.1 The Trust should explore and support the development of cultural mediation services to be deployed in the most effective way.

5.2 The Trust should ensure that the Equality and Diversity Action Plan includes concrete, measurable actions and that it is implemented within the set timescales, with sufficient resources allocated in order to do so. The Trust should ensure that a Board level director's post has explicit overall responsibility for ensuring the implementation of the Plan throughout the Trust.

[52] Department of Health, Department for Education and Employment, Home Office (2000)

5.3 The Trust must monitor on a regular basis whether and how the Action Plan affects the nature, quality and effectiveness of services to patients.

5.4 The Trust should ensure appropriate representation at every level of the organisation to reflect the diversity of the community that it serves, including at Board and top management level.

ACTION PLAN

Recommendation	Action taken to date	Further action	Responsible	Date
Clinical Practice and Culture				
The Trust Board must immediately ensure the effectiveness of clinical and managerial leadership of the Tower Hamlets area, including putting in place appropriate remedies	Implementation of sectorisation across Tower Hamlets. Increased consultant psychiatrist input to all community services. Substantive Clinical Director and Borough Director in post Review of Community Services conducted in 2005, action plan implementation underway	Revised management and clinical nurse leadership structure to be implemented	Borough Director/Associate Director Nursing	Dec 06
The Trust should ensure that there is an increased amount of consultant time spent within the community mental health teams, the assertive outreach team, home treatment teams and other community teams. This should include • Implementing the proposals for consultant time spent in the community teams proposed by the Medical Director in The Review of Teams in Adult Mental Health Services in Tower hamlets, Newham and City & Hackney • Once those proposals have been implemented, further increasing consultant time spent with community teams with a view to doctors moving their offices to from hospitals into community mental health team premises • Holding medical outpatient clinics on community mental health team premises	Consultant time within CMHTs, Home Treatment and Assertive Outreach services across the Trust has significantly increased in 2005/06. Monitored through annual job plan and appraisal by Clinical Director One consultant based within CMHT. Existing community team bases preclude basing consultants there due to lack of space.	Continue to monitor consultant time through job plan reviews and Multi Disciplinary Team feedback All future capital and service developments need to consider this issue and make allowance for consultant office space. In Tower Hamlets the Assertive Outreach Team consultant psychiatrist will be based in the team following the move to the new hospital at Mile End in 2006/07	Clinical Directors Clinical Director/ Director of Estates and Facilities	Ongoing Ongoing

Recommendation	Action taken to date	Further action	Responsible	Date
The Trust should undertake a full investigation into Doctor Falkowski's work within the Trust and review his position. The investigation should encompass • His clinical practice • Whether, and if so, the extent to which his practice in relation to Mrs Miles is symptomatic of his practice more generally	An independent investigation has been commissioned by the Trust with the support of NHS London	To be determined based on the outcome of the investigation	ELCMHT Chief Executive	January 2007
Therapeutic options				
The Trust should increase the availability of psychological and other therapeutic interventions across the community mental health teams and on the wards	Occupational Therapy (OT) recruitment has significantly improved within the Trust and all CMHTs have a full establishment of staff. OT staff provide generic and specialist input to the teams. All CMHTs have part-time psychology input. A senior psychologist provides supervision and support to all CMHTs The majority of care coordinators have undertaken motivational interview training A number of care coordinators have undertaken THORN training	Maintain recruitment and retention and links with colleges and employment schemes such as Routes To Employment All Care coordinators to complete MI training to be monitored through Personal Development Plan	Director of Therapies Service Managers	Ongoing Ongoing

Recommendation	Action taken to date	Further action	Responsible	Date
The Trust should ensure that NICE guidelines on schizophrenia as to the allocation of resources between medical and other forms of treatment are implemented	A senior psychologist is undertaking consultancy and some direct clinical work with all CMHTs to further implement the NICE guidelines	Funding has been allocated to this work but is subject to review due to financial constraints across the Trust	Borough Director	Ongoing
Care Programme Approach				
The Team Manager should have responsibility for ensuring the Care Programme Approach is fully implemented in respect of every patient, including those treated as outpatients. The Trust should ensure that this function is performed effectively through appropriate supervision and audit	The Trust has developed a robust and clear CPA policy that is supported by a defined training programme. The CPA policy, guidance and documentation have been reviewed in 2006 in consultation with the Trust's partners and its' service users. Compliance with key targets is subject to monitoring as part of the Annual Health Check conducted by the Healthcare Commission. Monthly reports are submitted to the Trust Board.	Completion of Trust-wide review of CPA policies and procedures. Trust Board to approve revised policy. Achieve 100% compliance for all patients including crisis planning and allocation of dedicated care coordinator. Continue routine audits, patient surveys and rolling training programme for all staff	ELCMHT ELCMHT ELCMHT	Oct 06 March 07 Ongoing
Every patient in an acute admission ward should have a ward round on a weekly basis, as a minimum, attended by all clinical staff including consultants and care coordinators. Carers and others involved in the patient's care should be invited to attend.	Every patient in an acute ward has a weekly 'ward round' through the clinical review process which has consultant input and attended by the relevant staff. The patient's care coordinator attends when a CPA review is undertaken. Carers and significant other are invited where appropriate.	Weekly ward rounds will be audited through the clinical audit department. Full discussion around discharge planning will be undertaken as part of the CPA process and will involve all relevant carers/support providers	Clinical/Borough Director Clinical teams	Immediate Immediate

Recommendation	Action taken to date	Further action	Responsible	Date
In respect of every patient on enhanced CPA there should be a systematic assessment of the needs of any children associated with the patient and a plan for meeting their needs in accordance with the Trust's child care policies. Such assessment should not be limited to child protection issues but should embrace the full range of children's needs in accordance with the Framework for the Assessment of Children in Need and their Families.	1. The Trust's Safeguarding and Promoting the Welfare of Children Policy has a full section on Minimising Risk and Promoting Welfare of children as part of the CPA process 2. Monthly Safeguarding Children training for new and existing staff covers the use of the assessment triangle 3. Support for teams is available in each borough from specialist parental and perinatal mental health staff and the Safeguarding Children Team. The Team attend team and ward based meetings as well as providing specific training 4. The CPA forms include details about children 5. Children's Social Care Services notify the Trust's Safeguarding Children Team of all Child Protection Conferences to ensure appropriate and effective mental health involvement and input is available 6. A pilot scheme introducing the use of a Child Protection Conference Report proforma in adult services has been launched	1. ELCMHT and Children's Social Services to agree thresholds for intervention and assessment protocols for children of adult patients 2. New Trust-wide risk assessment training to include child welfare 3. ELCMHT to work with partner agencies to agree model for conducting assessments using the Common Assessment Framework 4. Implement rollout of Child Protection Conference Proforma following evaluation of pilot scheme 5. Continue programme of bespoke training for all wards and teams	Dec 06 Oct 06 Dec 06 Nov 06 Ongoing	

Recommendation	Action taken to date	Further action	Responsible	Date
Regular clinical audits of the work of Community Mental Health Teams should include their effectiveness with regard to child protection and welfare	Past audits have included checking information on patients files regarding children	1. Include child protection and welfare audit in Trust Audit Priorities for 2006/07 2. Specialist audit tool for Community Mental Health Teams to be developed and implemented 3. Audit Community Mental Health Teams	Safeguarding Children Team/ Assurance Department/Borough audit leads	Mar 07 Dec 06 Mar 07
Serious Untoward Incidents				
The Trust must establish procedures for ensuring that learning arising from each serious untoward incident is translated into effective change, in particular in service delivery. The Trust must be able to demonstrate such change with concrete evidence	The Trust has invested in Root Cause Analysis training in order that staff are trained to undertake investigations and implement learning from them. Serious Untoward Incidents are reviewed quarterly through the Trust's Clinical Governance structures and feedback provided through line management systems	Continue to provide training to staff Establish borough-based Serious Untoward Incidents groups and incorporate learning into professional development programme for staff	ELCMHT	Ongoing Dec 06

Recommendation	Action taken to date	Further action	Responsible	Date
Equality and Diversity				
The Trust should explore and support the development of cultural mediation services to be deployed in the most effective way	The Trust is focussed on becoming a culturally competent organisation. A range of a advocacy and mediation services may be part of this and will be developed by locality/service directors with partners on the basis of local needs and resources	Implement the Equality and Diversity Action Plan across the Trust	Service and Borough Directors	Ongoing
	The Trust is an implementation site for the Department of Health's national programme Delivering Race Equality in Mental Health. The Trust is one of four trusts specifically piloting the Race Equality Cultural Capability programme. Upon its successful completion it will be rolled out across the Trust	Complete Cultural Capability pilot including evaluation and agree options for taking forward across the Trust	Director of Partnership/Service & Borough Directors	Mar 07
	Over 500 staff in the Trust have participated in the 4site development consultation and training programme. Tower Hamlets will take the programme forward in 2007	Implement Tower Hamlets programme	Borough Director	2007
The Trust should ensure that the Equality and Diversity Action Plan includes concrete, measurable actions and that it is implemented within the set timescales, with sufficient resources allocated in order to do so. The Trust should ensure that Board level director's post has explicit responsibility for ensuring the implementation of the plan in the Trust	The Action Plan agreed in April 2006 is a long term plan, it is reviewed 6 monthly with progress reported to the Trust Board. The Trust has a specific director post responsible for Equality and Diversity. The Board has a designated Non-Executive Director responsible for this area of work	Continue to review and assess progress biannually	Director of Partnerships	ongoing

Recommendation	Action taken to date	Further action	Responsible	Date
The Trust must monitor on a regular basis whether and how the Action Plan affects the nature, quality and effectiveness of services to patients	Performance on Equality and Diversity is monitored via the quarterly performance reviews in each Borough. Information gathered through the national Patient Survey and local surveys is also used to inform the Trust's actions	Continue quarterly monitoring process	Service and Borough Directors	Ongoing
The Trust should ensure appropriate representation at every level of the organisation to reflect the diversity of the community that it serves, including at Board and top management level.	The Trust continues to support and encourage applicants from all under represented groups at Board and senior management level The Trust is fully committed to ensuring the Board and senior managers reflect the diversity of the communities served	Implement Quality and Diversity Action Plan Appoint Associate Director Equality and Diversity	All Directors Director of Partnerships	Ongoing 2007

APPENDIX A

North East London NHS
Strategic Health Authority

INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF MARIAM MILES (MM)

Terms of Reference

1. The Inquiry has been set up in accordance with the Department of Health Guidance HSG (94) 27: Guidance on Discharge of Mentally Disordered People and their continuing care in the community, in order to inquire into the care and treatment of Mariam Miles following her conviction for the manslaughter of Edward Miles in May 2003.

2. The Inquiry will be conducted by:

   Kate Markus, barrister and Inquiry Chair

   Professor Sashidharan, University of Warwick

   Zoe Reed, South London and Maudsley NHS Trust

3. The Inquiry will

   3.1. examine all the circumstances surrounding MM's health and social care and treatment.

3.2. present a first draft of its report to the North East London Strategic Health Authority by 31 July 2005, or as soon as possible thereafter, designed to reduce the likelihood of such an event recurring.

3.3. the commissioners must be given fair notice and explanation by the Inquiry team of any expected delay in their concluding their work.

4. The Inquiry will in particular examine:

4.1. the quality and scope of her health and social care

4.2. the appropriateness and quality of any risk assessment, care plan, treatment or supervision provided, having particular regard to:

4.2.1. any risk to her children, her husband or others

4.2.2. her past history

4.2.3. her psychiatric diagnosis and her past psychiatric history

4.2.4. her ethnicity

4.2.5. her religious and or spiritual beliefs

4.2.6. her assessed health and social care needs

4.2.7. any inter-agency issues arising, including communication between primary care, mental health and social services.

4.2.8. any carers' assessment and carers' needs

4.2.9. the extent to which her care and treatment corresponded to statutory obligations, relevant guidance from the Department of Health (including the Care Programme Approach HC (90)23/LASSL (90)11 and the Discharge Guidance HSG (94)27) and local operational policies.

5. The extent to which her care plans and treatment

5.1. reflected an assessment of risk

5.2. were effectively drawn up, communicated within and beyond mental health services, implemented and monitored

5.3. were complied with by MM.

6. The Inquiry will examine the adequacy of the co-ordination, collaboration, communication and organisational understanding between the various agencies involved in the care of MM or in the provision of services to her or to her family, in particular whether all relevant information was effectively passed between the agencies involved and other relevant agencies, and whether such information as was communicated was acted upon adequately.

7. The Inquiry will examine the adequacy of the communication and collaboration between the statutory agencies and any family or informal carers of MM.

8. Consideration of the management of risk should consider with equivalent attention the risk to herself and the risk to others represented by MM, and whether her treatment and care were proportionate.

9. The Inquiry will consider any other matters relating to the issues arising in the course of the Inquiry as the public interest may require.

10. The Inquiry will prepare a report and make recommendations as appropriate to the North East London Strategic Health Authority.

The following documents will be used by the Inquiry Panel in undertaking this Inquiry:

1. All medical notes of or relating to MM, including all hospital records whether as an in-patient or an out-patient, GP records and all records prepared by any other doctor or nurse.
2. All documents relating to MM and her children in the possession of the Social Services Department.

3. All documents in the possession of the police relating to the prosecution of MM.
4. All policies and procedures effective in local services at the time of the events in question.
5. The NELSHA Board report on action plans arising from previous inquiries.
6. Any other documents that the Panel identifies as necessary for the proper conduct of the Inquiry

APPENDIX B

INQUIRY PROCEDURE

Introduction

1. The Inquiry is independent of its commissioners
2. The Inquiry will be known as “The independent inquiry into the care and treatment of Mariam Miles”.
3. The terms of reference will be agreed by the Inquiry panel

Evidence generally

4. The Inquiry panel will determine from whom it wishes to receive evidence and which witnesses to invite to give oral evidence.
5. Factual evidence will be sought from a) those working for the agencies/services involved with MM at the relevant time, b) “lay” witnesses, being family, friends or others with direct knowledge of MM and not within the identified agencies/services
6. Advice may be sought from relevant experts on practice issues.
7. Witnesses will be given an opportunity to comment on the evidence of others where relevant and necessary and as provided for below by way of written representations (see paragraphs 11, 19 and 20).

Written evidence

8. Each factual witness will receive letters informing them:
    a) of the terms of reference, the membership of and the procedure adopted by the Inquiry;
    b) of the proposed timetable for the Inquiry;

c) of specific areas and matters on which the Inquiry wishes them to provide evidence in addition to anything the witness him or herself wishes to raise;

d) of the method of accessing records relevant to their own role in the care of MM for the limited purpose of responding to the Inquiry.

9. The Inquiry panel may require witness evidence is to be provided in writing in the first instance.

10. Not every witness written to will automatically be invited to give oral evidence unless this is specifically requested by the witness with reasons.

11. All witnesses asked to provide written evidence will be provided with a list of factual witnesses written to so that they may i) indicate whether in their opinion any material witness has been omitted and ii) suggest areas of inquiry with any of the proposed witnesses.

Hearings and oral evidence

12. All hearings of the Inquiry will be held in private: this means that the press and other media will not be allowed to attend hearings. There will be no cross examination of witnesses except by members of the Inquiry panel.

13. The Inquiry hearings will be conducted as informally as possible. Questioning will be lead by the Panel members and aim to ensure that the views of all those participating in the inquiry process, and in particular the victim's family, are properly and fully canvassed in evidence.

14. Details of venue and recoverable expenses incurred in attending to give oral evidence will be provided at the time a factual witness is notified by the Inquiry panel of the need for such evidence. Witnesses will be offered an opportunity to familiarise themselves with the venue in advance of giving evidence.

15. Witnesses attending in person to provide evidence may raise any matter they feel might be relevant to the Inquiry.

16. Witnesses may bring with them, at their own personal cost, a lawyer or a member of a defence organisation, friend, relative, colleague or member of a trade union, provided that no such person is also a witness to the Inquiry: it is

the invited witness who will be expected to answer questions. It is expected that if required agencies/services will provide legal assistance to staff/officers from whom evidence is requested by the Inquiry.

17. Factual witnesses will be asked to affirm that their evidence is true.

18. Questions asked will take into account representations made by the family and other factual witnesses or agencies or professional bodies and any advice received from experts.

19. Oral evidence will be recorded and a transcript sent to the relevant witness to check for accuracy.

20. Any points of potential criticism concerning a witness of fact which may be material to the Inquiry's findings will be raised with that witness either directly at the time they first attend to give evidence to the Inquiry in person or in writing at a later time. They will be given a full opportunity to respond (usually in writing). A summary of any relevant evidence or, if appropriate an extract of the same, will be provided by the Inquiry for that purpose.

21. Paragraph 20 above will also apply to any matter which falls short of a criticism but where the evidence of one witness may be material to that of another.

22. The commissioners have reserved the right to refer individual practitioners to the relevant professional bodies where negligence or incompetence are identified.

Other evidence

23. A public statement inviting anyone with relevant information to contact the Inquiry will be issued, through local media or community organisations, or such other channels as the Inquiry panel considers appropriate, and the Inquiry may invite such persons to make written or oral representations.

24. Representations may be invited from relevant professional bodies, agencies and individuals as to their views and any recommendations on the issues arising.

25. Any other person who feels that they may have something useful to contribute to the Inquiry may make written submissions for the Inquiry's consideration.

Victim's family

26. The families of MM and EM will be given a full opportunity to contribute to the Inquiry process and to consult with the Inquiry. In particular, family members will:

    a) be provided with copies of the terms of reference and procedure

    b) meet informally with the panel members, counsel and/or the inquiry manager

    c) be asked to provide a list of potential witnesses together with issues/questions they consider to be relevant

    d) be provided with a list of proposed witnesses prior to hearings for their comments and questions

    e) give formal evidence to the inquiry

    f) be provided with a copy of the final Inquiry report.

Publication of report

27. Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments that appear within the narrative of the report, and any recommendations will be based on those findings.

28. The evidence which is submitted to the Inquiry either orally or in writing will not be made public by the Inquiry, save as disclosed within the body of the Inquiry's final report.

29. The findings and any recommendations of the Inquiry will be presented in a report to North East London Strategic Health Authority and made public by the Health Authority.

30. The Health Authority will make public any ensuing action plans.

APPENDIX C

LIST OF WITNESSES

Witnesses interviewed

(Note: A number of the professional witnesses have since left the posts that they occupied at the relevant time. Descriptions here apply to the posts occupied at the relevant times)

Mariam Miles	
Peter Miles	Brother of Edward Miles
Sally Miles	Sister of Edward Miles
Laila Miles	Daughter of Mariam and Edward Miles
Doctor Pollen	GP for Miles family
Doctor Kandeth	Senior House Officer, 2002/3, St Clements Hospital
Doctor Jan Falkowski	Consultant Psychiatrist, St Clements Hospital
Doctor Tim Read	Consultant Psychiatrist and former Clinical Director, East London and City Mental Health Trust
Doctor Nick Bass	Consultant Psychiatrist, St Clements Hospital
Doctor Trevor Turner	Consultant Psychiatrist, East London and City Mental Health Trust
Doctor Suni Ratnam	Consultant Psychiatrist, John Howard Centre
Doctor Johnson Agbodo	Specialist Registrar, St Clements Hospital

Stephanie Garrett	Ward Manager, Lansbury Ward, St Clements Hospital (2000-2003)
Mary Harris	Health Visitor for Mrs Miles and her family (1989 to 2003)
Gerrie Semper	Care Co-ordinator for Mrs Miles (February 2000 – May 2003)
Rosemary Loshak	Psychiatric Social Worker, Children and Families Consultation Service (to February 2002) Coordinator for Children in Families with Mental Illness (from February 2002)
Alan Mountain	Social Worker; Manager, Bethnal Green Community Mental Health Team (2001-2003)
Peter Horn	Chief Executive, East London and City Mental Health Trust, 2000-2002
Sheila Foley	Chief Executive, East London and City Mental Health Trust (from November 2002)
Catherine Gaskell	Director of Nursing (May 2000-May 2003), East London and City Mental Health Trust
Lynne Hunt	Director of Nursing, East London and City Mental Health Trust (from June 2004)
Doctor Robert Dolan	Medical Director, East London and City Mental Health Trust (from April 2003)
Jan Murray	Lead Nurse, East London and City Mental Health Trust
Tracey Upex	Sector Manager, East London and City Mental Health Trust

Tony Bamber	Service Director, Tower Hamlets, East London and City Mental Health Trust (from April 2003)
Dave Hill	Family and Children's Services Manager, London Borough of Tower Hamlets
Ian Williamson	Head of Social Care, London Borough of Tower Hamlets Social Services Department
John Goldup	Head of Adult Services, London Borough of Tower Hamlets Social Services Department

Witnesses providing written evidence only

Kevin McDonnell	Headteacher, Stormont House School, Hackney
Professor Jeremy Coid	Consultant Psychiatrist, St Bartholomews Hospital
Anthony Stevens	Friend and neighbour of Edward Miles
Alison Beam	Welfare benefits advice worker, MIND, Tower Hamlets
Bernadette Hoyte (formerly Healy)	Care co-ordinator for Mariam Miles, August 1996-March 1999