North East London
Health Authority
NHS

REPORT OF AN INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF SH

Report commissioned by North East London Health Authority and published July 2002

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Panel Membership

Mr Derek Holwill.	Barrister and Chairman of the Inquiry panel
Mr Angus Cameron.	Mental Health Manager with the National Probation Service, London Probation Area
Dr Chandra Ghosh.	Consultant Forensic Psychiatrist
Mr Mike Lindsey.	Retired, formerly Deputy Director of Social Services

Acknowledgements

We would like to thank everyone who gave up time to give evidence to the Inquiry panel and who spoke so freely to us. We would also like to acknowledge the co-operation of the police whose assistance has been valuable in helping the Inquiry panel to complete its task. All of the witnesses who gave evidence to the Inquiry panel are listed in Appendix 1 to this Report.

We are also grateful to Dr A. Polmear of the University of Sussex for his assistance to the Inquiry panel and his expert advice in relation to those aspects of this Inquiry which concern General Practice.

We would also like to thank Miss Dulara Khatun, Project Manager, Independent Inquiries with the East London and The City Health Authority, who managed the Inquiry for us with great diligence; as well as looking after all of our needs whilst we took evidence at the offices of East London and The City Health Authority.

Terms of Reference

1. To examine all the circumstances surrounding the treatment and care of SH, and in particular:

   1.1. The quality and scope of his health and social care and any assessment of risk.

   1.2. The appropriateness and quality of any assessment, care plan, treatment or supervision provided, having regard to

   - 1.2.1. His past history
   - 1.2.2. His assessed health and social care needs
   - 1.2.3. His ethnic origin, religion and culture
   - 1.2.4. Any risk to his wife, his children and other family members
   - 1.2.5. The support needs of his wife, his children and other family members
   - 1.2.6. The interaction with the Metropolitan Police
   - 1.2.7. The role of forensic mental health services

   1.3. The extent to which his 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.

   1.4. The extent to which his care and treatment plans

   - 1.4.1. Reflected an assessment of risk
   - 1.4.2. Were effectively drawn up, communicated and monitored
   - 1.4.3. Were complied with by SH

2. To examine the adequacy of the co-ordination, collaboration, communication and organisational understanding between the various agencies involved in the care of SH or in the provision of services to him, 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.

3. To examine the adequacy of the communication and collaboration between the statutory agencies and the family of SH.

4. To prepare an independent report and make such recommendations as may be appropriate to the North East London Health Authority.

Introduction

On 4 June 2000, SH killed his wife, AK. The sympathy of all of us goes out to AK's family and friends. On 27 October 2000, SH was convicted of manslaughter on the basis of diminished responsibility and subsequently, a Hospital Order was made under section 37 of the Mental Health Act 1983, together with a Restriction Order, without limit of time, under section 41. SH is at present an in-patient in the Medium Secure Unit at the John Howard Centre, Hackney. The *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* provides a definition of a "Mental Illness Homicide" as one where the person convicted *"had symptoms of mental illness at the time of the offence."* From the evidence we have heard, set out at length in our report, there is no doubt that the killing of AK was a "Mental Illness Homicide" within this definition. We note that neither alcohol nor drugs appear to have contributed to the offence.

In this instance, the consent of the person convicted, for the release of his case notes, could not be secured unless he was given an assurance that he would not be named in this Report. In order for the Inquiry panel to proceed with its task, it was, therefore, decided to write this Report referring to that individual and his family only by initials. The patient is, accordingly, referred to throughout this report simply as SH.

Mental Health Services in Newham

The London Borough of Newham is part of London's "East End". It is one of the most deprived and diverse boroughs in the United Kingdom.

Over 50% of the population of Newham are non-white, with some 55 different ethnicities and a large number of refugees and asylum seekers. These communities cover the whole spectrum of the major world religions. It is a major task for services in this area to respond appropriately to such diversity. This has wide ranging implications, not least for ensuring a personnel base which reflects this diversity, and for training, working in partnership and ensuring sufficient resources to deliver effective services.

In addition, East London has historically suffered from under investment in its mental health services and particularly so in the provision of forensic mental health services.

During the course of this Inquiry, we have heard of plans for re-organisation and service development within the National Service Framework. We have been encouraged by the attention given to diversity, and to work with the Local Authority to take account of issues raised by service users and their carers.

The task of "modernising" mental health services in this area is considerable and the challenge of matching need to investment must not be underestimated.

At the time of this incident the principal mental health services for the London Borough of Newham were provided by The East London And The City Mental Health NHS Trust which formed on 1 April 2000. Together with Newham Social Services, the Trust was developing a single point of entry to mental health services with all assessments being provided by one of three Community Mental Health teams: the East team ("CMHT-E" catchment area population 90,000 approximately), the West team (CMHT-W" catchment area population 60,000 approximately) and the South team ("CMHT-S" catchment area population 90,000 approximately).

At the time of the incident, the Trust provided the following statutory services for people with mental health problems:

- Primary care (at the time each GP had an identified linkworker in the CMHT, and plans were in place for a primary care liaison team).

- Community Mental Health Teams ("CMHTs"), serving people with severe and enduring mental health problems.

The CMHTs are jointly funded and managed by the Trust and Social Services, with a jointly-appointed head of adult mental health. The catchment areas for CMHTs are coterminous with those of the adult wards.

- **Acute Adult Wards**
  Purcell Ward, East Ham Memorial Hospital, linked with CMHT-S and had three consultant psychiatrists. Elgar Ward, East Ham Memorial Hospital, linked with CMHT-E and had three consultant psychiatrists. Rosemary Ward, Goodmayes Hospital, linked with CMHT-W and had two consultant psychiatrists. The Psychiatric Intensive Care Unit (PICU), containing eight beds, was based at the Newham Centre, Runwell (under the South Essex Partnership NHS Trust). The Handel Ward, East Ham Memorial Hospital, was an acute elderly assessment ward divided into two parts, one for those with functional illness, and one for those with dementia.

- **Child and Family Consultation Service**
  Individual and family therapy, counselling and support for young people (i.e. those of eighteen years of age or less) with emotional problems.

- **Acute Day Hospital for adults, East Ham Memorial Hospital**
  Francis House Day Hospital provided activity and talking based therapy and group therapy for adults. It was staffed by occupational therapists, psychiatric nurses, and medical staff.

- **The Rehabilitation Team**
  Newham had a significant number of supported houses for people with severe and enduring mental health needs, and this team supported those people and others living in the community.

- **The Community Team for People with Learning Disabilities**
  A multi-disciplinary health team which included (amongst others) a consultant psychiatrist, a Community Psychiatric Nurse ("CPN") and clinical psychologists.

- **Forensic CPNs**
  At the time, there were three forensic CPN posts located in the borough, two of whom were

linked to the forensic CPN team managed by the John Howard Centre.

- **Elderly Community CPN Team at Francis House**

- **Clinical Psychology**
  The Direct Referral Therapy Service was staffed by two clinical psychologists.

There were, in addition, a number of services for people with mental health problems provided by Newham Social Services including day care, family support, respite and home care services, adult placement scheme, community support team, homeless outreach support team, combined arrest referral scheme, psychotherapy counselling service, and an out of hours Emergency Duty Social Work Team. There was also an effective network of support services provided by independent and voluntary sector organisations.

The Facts

A chronology of events is set out in Appendix 2.

SH's Family Background

SH was born in Bangladesh in 1969. He was raised by his biological parents, both of whom were from Bangladesh. He came with his family to the UK at the age of three years, but when SH was aged 10, he returned with his family to Bangladesh for four years. He grew up in the Hounslow area and subsequently moved to East London.

SH's father had previously been a factory worker. He lived in East London and received a state pension. He married his second wife when SH was around 14 years old. During SH's childhood, his father spent a lot of time in Bangladesh but he has recently returned to the UK. It is understood that he has not suffered from any mental illness.

SH's mother is now in her 60's and lived with his father until his second marriage. She is described as a woman who was caring of her children, but who worried a lot about her family. She has been diagnosed as suffering from schizophrenia, a condition from which she has suffered for a long time - it is believed that she may first have become mentally ill shortly after SH's birth. At the times relevant for the purposes of this Inquiry, she was receiving support from the mental health services.

SH has four siblings, three brothers and one sister. The oldest brother, S, is aged 36 and is married with four children. He works as a grocer in East London. He has no history of mental or physical illness and we understand that SH had a reasonable relationship with him.

SH's oldest sister is 34, married with five children and lives in East London. She is in regular contact with SH. She does not have any history of mental illness.

SH has two younger brothers. The elder of these two brothers, JH, is in his late 20's, and is married with one child. The wife and child live in Bangladesh. JH has a seven year history of mental illness, diagnosed as schizophrenia, with repeated relapses needing admission to East Ham Memorial Hospital. It is also understood that JH becomes violent when he is unwell. He too was receiving support from the mental health services, and we heard evidence from his social worker, Jennifer Lewis.

SH's youngest brother is aged 23 years old, is single with no children and has suffered from life long physical disabilities related to his neck. He also suffers from thyroid problems and is understood to have learning disabilities.

There is therefore significant pathology within the family, including schizophrenia, and one member of the immediate family, the brother, JH, has a history of significant violence associated with his mental illness.

The accounts of SH's childhood are varied. The family did not suffer from any financial hardships and the children were adequately provided for at all times. Some reports record simply that SH got on well with all his siblings and that he was raised in a reasonably happy and supportive environment. This is however, at odds with a later report which suggests that his father, who was spending a lot of time in Bangladesh, was not very caring of his family.

It is in any event clear that SH's mother suffered from mental illness throughout SH's childhood and that she therefore found it difficult to manage her children. SH denies any significant disruption in his upbringing, despite his father's second marriage and his mother's illness. He was not subjected to harsh or excessive discipline and he was not sexually, physically or emotionally abused or neglected. As far as he is aware, his birth and early development were normal. There were no behavioural problems and there is nothing in the GP's notes that would suggest that he had any behavioural or emotional problems prior to 1997.

SH attended primary school in the UK and also school in Bangladesh. He left school at the age of 16 in the UK without any qualifications. He does not have any learning disability, but his schooling was disrupted by the move to Bangladesh and back again and this has led to him not being able to write well in English. He can speak English very adequately and was well able to communicate with the Inquiry panel when we saw him for an interview for the purposes of this report.

SH worked for the first six or seven years after leaving school as a waiter in various restaurants. He worked with his elder brother when they opened a take away Indian restaurant and managed the business on his own when his brother gave control to him after his marriage. However, the business collapsed, an event which we understand occurred shortly before the time when SH first became mentally ill.

SH's Medical History

SH was first seen by his GP in 1984 when he had a positive HEAF test. This was an indicator of possible tuberculosis but he was found, on examination, not to have any of the symptoms, and was allowed to return to school.

SH was subsequently seen on 27 February 1985 for hearing problems, mainly affecting his left ear. He complained of ear-aches and discharges and was found to have a small central perforation of the tympanic membrane, which was scarred. There was evidence of tympano-sclerosis. It is believed that he continues to have some hearing disability of the high tone in his left ear.

His only other physical illness was appendicitis, which was diagnosed and an appendectomy carried out on 16 May 1995. He made a good recovery from that operation.

SH's Marital History

SH first met his wife, AK, when she was 17 and he was 24 years old. It was an arranged marriage and they had met once prior to the wedding. They had been married for nearly five and a half years at the time of the Index Offence.

AK and her family came from Birmingham and she grew up in this country. The evidence given to the Inquiry panel indicates that her command of the English language was better than SH's. She has consistently been described in the documentary and oral evidence before the Inquiry panel as a very competent young woman.

She was SH's main carer and he claimed that they had a very happy sexual relationship, which was enjoyable and fulfilling. He always described his wife as a very good-looking young woman. He has also described himself as an attractive man and described themselves as a beautiful couple, loving and well matched. In his initial interviews after the Index Offence SH denied any serious arguments, let alone any physical violence or fights, with AK. He also denied ever making direct or indirect threats towards her and he said that he could not remember being upset with her or even raising his voice towards her. He described themselves as being humble towards each other and he spoke of how they talked together about trying to make each other very happy.

However, other evidence before the Inquiry panel suggests that the marital picture set out above is not an accurate or complete one. There was evidence from SH himself of two incidents when he behaved in a violent manner towards AK. More importantly, in witness statements given to the police by AK's sister, it was asserted that AK had told her that SH had been violent, particularly in the months immediately prior to the Index Offence. Details of what AK's sister said to the police are set out below. Unfortunately, it was not possible for the Inquiry panel to make contact with her and interview her for the purposes of this Report.

Forensic History

In August 1991, SH was convicted of an offence of gross indecency for which he was fined £15. Details of the circumstances of this conviction are not relevant for the purposes of this report. There is no suggestion that this offence was a consequence of any mental illness.

On 23 July 1997, SH assaulted a police officer. In summary, SH attended at his local police station apparently in an attempt to have his address verified so that he could obtain access to computer data of some sort. He was asked to produce his driving licence. This showed a different address and he was told by the police officer that, in those circumstances, there was a doubt about his true address and that failing to notify the change of address to the licensing authorities rendered him liable to a fine of £400. SH thereupon left the station, but returned a few moments later and then refused to leave. A police officer laid hands upon him, whereupon SH punched the officer and a short struggle ensued. SH was arrested and placed in custody. On 17 December 1997, SH pleaded not guilty to the charge, but was convicted of the offence of assaulting a police officer. The sentencing hearing was adjourned pending provision of a psychiatric report. The Inquiry panel has not seen a copy of this Report, but it was written by a Dr Selvaratnum who had become involved in SH's care in August 1997. In early 1998, SH was given a conditional discharge, a sentence which reflects the relatively minor nature of the offence.

Comment:

Whilst this can be categorised as an offence of violence, the offence itself was a relatively trivial one, and the Inquiry panel do not consider that it was something which, in itself, gave any indication that SH was someone capable of the acts which led to his wife's death. It was, however, out of character and it may in fact have been related to a deterioration in SH's mental state at around this time.

SH's Breakdown in August 1997

Around the beginning of August 1997, SH apparently had a disagreement with a close friend and business partner; and this seems to have provoked a serious deterioration in his mental health with increasingly bizarre behaviour.

On 8 August, a Friday, AK accordingly attended upon the family GP, Dr Bhadra. Dr Bhadra's note of this attendance referred to a family history of schizophrenia and he told the Inquiry panel in evidence that he was aware of this history, having been involved in the treatment of other family members' mental problems. His note also recorded that AK had reported that SH was shouting "most of the time" although he had become "calmer". In his evidence to the Inquiry panel, Dr Bhadra expanded upon this, saying that AK had told him that SH was behaving in a bizarre manner, shouting and screaming. She did not report that SH was displaying any physical violence towards others. It is significant, in the light of what happened subsequently, that Dr Bhadra said in his evidence to the Inquiry panel that AK did not at this time - or indeed on any other occasion - report or make any suggestion that SH had ever been violent towards her.

Dr Bhadra's recollection when giving evidence to the Inquiry panel was that there was no suggestion made by AK at this stage that SH was even threatening to harm himself, but it may be that Dr Bhadra's recollection was imperfect in this respect. There are a number of references in the medical records which follow (for example, the summary of reasons given for SH's subsequent admission to East Ham Memorial Hospital a few days later) to the effect that SH was at this stage threatening to harm himself with knives.

Although Dr Bhadra did not see SH himself, the GP took the view that, on the basis of what was reported to him by AK, there was a depressive element in SH's behaviour. He accordingly concluded that it was appropriate immediately to prescribe anti-depressants for SH, and he prescribed Paroxetine. There is nothing in Dr Bhadra's note of this attendance - apart from the prescription of Paroxetine itself - which actually records that Dr Bhadra had reached the view that SH was, or might be, depressed, or which records the basis upon which Dr Bhadra reached that conclusion.

Dr Bhadra also prescribed largactil. His notes record that SH "may take Largactil 25 mg 1-2 nocte for next 2/3 night total 10".

Comment:

Whilst this drug is appropriate treatment for acute psychosis the dosage actually prescribed was small. The dosage recommended by the British National Formulary is an initial dose of 25 mgs three times a day or 75 mgs at night.

Dr Bhadra regarded AK as a reliable and articulate source of information, such that he was prepared to give this prescription as a matter of urgency in reliance upon what she said and without seeing SH. Dr Bhadra did, however, arrange to make a home visit to see SH the following day, Saturday 9 August. He was anxious to ensure that the prescription which he had given on the basis of AK's report to him was appropriate and seeing SH as soon as possible was a necessity.

Comment:

Dr Bhadra's response to AK's attendance at his surgery on 8 August was meant to be helpful. We are concerned, however, that he took the unusual step of prescribing anti-depressants on the basis simply of a history provided by SH's wife and it is regrettable that he did not make any record of the information from AK which had led him to the conclusion that there was a depressive element to SH's condition. It should be noted that it is possible that the administration of anti-depressants to an individual with psychosis may have had a deleterious effect on that individual's mental state, and the necessity for an emergency prescription of Paroxetine, given without even the benefit of an examination of the patient, was not clear to the Inquiry panel. Dr Bhadra did, however, decide to follow up the situation by a home visit the following day, a Saturday.

On Saturday 9 August, it appeared that SH's condition had worsened. He was behaving in an agitated manner and the family, it is assumed AK, made the decision to call for an ambulance. This duly attended, but SH was unwilling to go to hospital with the ambulance. The ambulance crew accordingly contacted Dr Bhadra who attended at the family home as a matter of urgency, bringing forward the routine visit, which he had planned to make in any event. Dr Bhadra prescribed further medication for SH which SH said he would be willing to take. Dr Bhadra made a note to contact a social worker and a psychiatrist on Monday.

The local CMHT then became involved. As mentioned above, there were two teams associated

with East Ham Memorial Hospital, CMHT-E and CMHT-S. Insofar as SH had any contact with a CMHT, he was dealt with by CMHT-E. On Monday 11 August, the notes kept by CMHT-E record that SH had been referred to the CMHT by Dr Bhadra. No record was made by Dr Bhadra of this contact, other than the note referred to above recording his intention to get in touch with a social worker.

The CMHT-E made contact with AK by way of the telephone, and she is recorded as having said that SH was threatening suicide, although again she did not suggest that there was any violent behaviour being exhibited towards herself or others.

The CMHT-E attempted to contact Dr Bhadra by telephone, but it was apparently only possible to speak to Dr Bhadra's wife. She works as Dr Bhadra's Practice Manager. She was able to explain the steps which Dr Bhadra had taken over the previous days. The view was communicated to the CMHT-E that Dr Bhadra thought that if SH took the prescribed medication he would probably be all right. In any event, after an assessment by Ross Lange, an Approved Social Worker with the CMHT-E, SH agreed to be informally admitted to East Ham Memorial Hospital. Later records state that SH was referred by the CMHT-E because of "bizarre behaviour" - specifically, it was noted that he had stopped eating and drinking and was experiencing difficulty in sleeping. It was also recorded that SH had expressed a desire to harm himself and was experiencing auditory hallucinations.

Comment:

Once SH's condition worsened, the CMHT-E and the other services responded quickly and appropriately to the situation, with the result that SH was promptly admitted to East Ham Memorial Hospital. SH's admission to East Ham Memorial Hospital was handled appropriately by all concerned. The absence of any record in the GP's notes of the contact which was actually made with the CMHT is regrettable.

Although SH had originally agreed to be informally admitted to East Ham Memorial Hospital, he then decided he wanted to leave. Staff there considered that this was not in his best interests so he was detained, initially under section 5(2) of the Mental Health Act 1983. Ross Lange then arranged a formal Mental Health Act assessment. In his Report, Ross Lange recorded that he had been told that SH's problems had started after an argument with a friend. SH spoke of something having been a "mistake" and wanting to say "thank you" to this friend for help given over the

years, but that he could not now say this himself to the friend. Mr Lange also noted that SH had asked family members to kill him with knives. He also added in his conclusions that it would be of value if someone who SH could trust, probably from the same culture, could provide an environment in which SH could say what was troubling him.

In due course, a Medical Recommendation under Section 2 was made by Dr Amin Elhihi (a psychiatrist attached to the CMHT-E) and by Dr Bhadra. Dr Elhihi's Medical Recommendation stated:

> "The patient is psychotic, there is a history of one week duration of poor sleep and verbal argumentative behaviour, is paranoid about others, asking his relatives to kill him with a knife, he is perplexed in his affect, vague and lacks insight into his condition, wife is extremely concerned about him, currently he is on section 5(2). He is in need for hospital assessment."

Dr Bhadra's Medical Recommendation stated:

> "He is suicidal, has loss of sleep, loss of appetite, still hears voices and refuses to stay in the hospital for treatment. He lacks insight into his condition and is in need of treatment."

SH was thereupon formally detained at East Ham Memorial Hospital.

Dr Bhadra did not recall if any information which was new to him emerged during this assessment. His own records do not even refer to the fact that he had made a Medical Recommendation under section 2 of the Mental Health Act 1983, and do not therefore contain any details of the relevant examination.

Comment:

It is regrettable that Dr Bhadra did not retain any record of his examination of SH, and detailing the circumstances which led to him making the Medical Recommendation under Section 2 of the Mental Health Act 1983. The only record of his examination is the Medical Recommendation itself which was located in the records obtained by the Inquiry panel from East Ham Memorial Hospital. Dr Bhadra's record keeping in this respect is less than satisfactory.

Dr Elhihi was also unable to recall anything other than that which was recorded in such notes as remained available. There were, in the records obtained by the Inquiry panel, no details of his examination of SH or of the basis for his Medical Recommendation other than those contained within the Medical Recommendation itself. Dr Elhihi's evidence to the Inquiry Panel was, however, that he had kept medical notes over and above the documentation which had been retained by the CMHT-E and which the Inquiry panel was able to make available to him. He told the Inquiry panel that at the time his own medical notes were kept in a file of papers separately from the social worker's notes. Regrettably, however, no further documentation could be traced.

Comment:

Dr Elhihi was sure that he would have made notes of his attendance upon SH. In the event, the loss of such notes probably matters little for the purpose of this Inquiry, but it is obvious that systems should exist to ensure that all medical notes remain available and accessible to those involved in the subsequent care of a patient.

What is significant for present purposes is that, when completing the standard form Medical Recommendation for admission for assessment under section 2 of the Mental Health Act 1983, both Dr Elhihi and Dr Bhadra stated that they considered that SH ought to be detained:

> *"(i) in the interests of the patient's own health*
> *(ii) in the interests of the patient's own safety"*

Both chose, however, to delete the other offered option, namely:

> *"(iii) with a view to the protection of other persons".*

It can be inferred that there was no indication at this stage that SH might pose a threat to anyone other than himself.

Comment:

All of the evidence indicates that, at this stage, there was no basis upon which anyone could have taken the view that SH was, or was likely to be, a danger to others. It does not appear to be the case that anyone was aware at this stage of the outstanding criminal proceedings

against SH, in connection with the assault on the police officer on 23 July. There is however no reason why this information should have been elicited at this stage, nor do we think that it would have made any significant difference to SH's treatment had details of this relatively minor incident been known to all concerned.

Following admission, SH came under the care of a locum consultant, Dr Selvaratnum. However, SH was initially examined not by Dr Selvaratnum but by a Dr Heath Springer who was at that time on what he described as a self-constructed GP training scheme, conducting a six-month detachment in psychiatry at East Ham Memorial Hospital. Dr Springer was attached to Dr Coleman, the other psychiatric consultant employed at East Ham Memorial Hospital at the time and a permanent member of staff. Under the rota system in operation at the time, it fell to Dr Springer to deal with SH's admission. As recorded below, Dr Springer also saw SH subsequently during his time as an in-patient at East Ham Memorial Hospital.

Dr Springer gave evidence to the Inquiry panel. He was an impressive and careful witness. He had made a very full and helpful note on SH's admission and he told the Inquiry panel that, after having admitted a patient who was to be under the care of Dr Selvaratnum, he, Dr Springer would have made sure that he discussed that patient with Dr Selvaratnum's Senior House Officer, a Dr Patel. Such discussions were not generally recorded in the medical records, but were a regular part of the routine at the hospital. Dr Springer said that he did not usually have such discussions with Dr Selvaratnum himself. He explained that because Dr Patel, as the Senior House Officer, would have been on the ward on a daily basis, and because the consultants generally were not, information would usually be communicated to the Senior House Officer or the Registrar who would then pass it on to the consultant.

Dr Springer's admission notes referred, amongst other things, to the recent closure of SH's restaurant business, and to the fact that SH had had long periods of unemployment. No record was made of the financial or other implications for SH and his family, and this aspect of SH's history is not amplified anywhere else in the medical records.

On 13 August 1997 SH was seen and examined by Dr Patel, who was also a GP trainee. He had started in his position as Dr Selvaratnum's Senior House Officer only in August 1997 and this attachment was his first experience working in a psychiatric context. It follows that SH would have been one of the first patients with whom Dr Patel dealt.

Dr Patel also gave evidence to the Inquiry panel. He was also an impressive witness. He too had taken a long and careful note recording his examination. Amongst other things, he recorded that one of SH's brothers suffered from mental illness, but he did not record any further details of this family history. No further information about the family history appears elsewhere in the clinical notes. Dr Selvaratnum, in his evidence to the Inquiry panel, was not able, so long after events, to recall what he knew of the family history, and he was understandably concerned about the absence from the clinical notes of any record of what the family history noted by Dr Patel might have been. He agreed with the Inquiry panel that information about the family history would certainly have been very useful to a full understanding of SH's condition, and that it would have been routine for him to obtain such information. He told the Inquiry panel that he was surprised that the clinical notes did not disclose details of the family history. He also agreed that this would have been an appropriate case to interview SH's wife, AK.

The documentary evidence suggests, therefore, that there may have been a failure by the clinical staff to appreciate the potential significance of the family history to an understanding of SH's condition and to obtain full details. However, Dr Patel said in evidence to the Inquiry panel that he was aware at least of the fact that SH's brother had a history of serious mental illness - specifically, a long history of illness with associated violence and repeated relapses needing admission to East Ham Memorial Hospital, and a diagnosis of schizophrenia. Dr Patel told the Inquiry panel that, before he saw SH, the nurses on the ward had told him about SH's brother, JH, and that he had regularly been admitted to the ward. Dr Patel was therefore aware of at least this aspect of the family history of mental illness, although details were not recorded in the notes.

Dr Patel also said that he believed that Dr Selvaratnum also knew of JH's history of mental illness, because the nurses had briefed him as well. Dr Patel recalled that, as soon as he mentioned SH to Dr Selvaratnum, Dr Selvaratnum asked Dr Patel if SH was the brother of JH and was told that this was indeed the case. Dr Patel's evidence about this matter, accordingly, significantly supplemented what Dr Selvaratnum had been able to tell the Inquiry panel.

Dr Patel also explained the way in which the ward round had operated, describing it as a round table conference at which the nurses, the consultant, the Senior House Officer, and any other person involved with the patient, such as a care-worker, attended. He explained that patients were discussed one at a time, and that, with each case, a nurse would fetch the patient concerned.

Accordingly, and notwithstanding the absence of any formal note in SH's clinical notes recording full details of the family history of mental illness, those concerned in SH's care were aware at least of the serious mental illness affecting his brother, JH. This is confirmed by a passing reference to JH's history in the Discharge Summary subsequently prepared by Dr Patel.

What is not clear however, is whether the remainder of the family history was fully appreciated - certainly there is no reference in the notes to, for example, the mother's mental illness. Dr Selvaratnum did not seek to involve the CMHT-E in his assessment of SH notwithstanding their involvement in the care of SH's brother. He did not therefore, have access to the knowledge of the family which had been accumulated by that team in the course of their dealings with the brother. It is also clear that there was never any formal interview of AK, although she was seen from time to time at the hospital.

Comment:

Although we are pleased to record that the evidence of Dr Patel established that the clinicians at East Ham Memorial Hospital were aware throughout the treatment of SH of the important fact that his brother, JH, had a long history of serious mental illness, it is nevertheless a concern that this information was never properly documented. It is also a cause for concern that other details of the family history were not recorded anywhere, and that no attempt was made to interview AK. In addition, although the admission notes had included a reference to the recent closure of SH's restaurant business, and to the fact that SH had had long periods of unemployment, no enquiries were apparently made by Dr Selvaratnum about the financial or other implications for SH and his family of these events. The importance of a comprehensive assessment, with consideration of environmental factors as well as the patient's presentation, should not need to be re-emphasised. It may be that the clinicians at the time were aware, or thought that they were aware, of full details of the family history, but it is nevertheless obvious that any relevant information in this regard ought to have been recorded within SH's notes. We regret that the responsibility for these shortcomings must lie with Dr Selvaratnum.

Returning to Dr Patel's discussions with SH on 13 August, some of the personal details disclosed by SH to Dr Patel were, in the view of the Inquiry panel, relevant to a full understanding of SH's condition and of what had led to his mental breakdown. It is not necessary for the purposes of this Report to record what those personal details were. What is important is to note that the

information disclosed by SH and recorded by Dr Patel would, in the view of the Inquiry panel, have proved useful information for those involved in SH's subsequent care following his discharge from East Ham Memorial Hospital. It would have assisted them in reaching a fuller understanding of SH's condition, and in particular his feelings of guilt, the content of his paranoid delusional system, and the concerns and pressures which had led to, or at least contributed to, his initial breakdown.

On 14 August 1997, Dr Patel made a note that he would discuss SH's case with Dr Selvaratnum the following day. He and Dr Selvaratnum saw SH on the ward on 15 August. SH was described as looking worried and being preoccupied with thoughts about his loss of dignity. He is recorded as saying: "I am shocked with something in my life and I am totally broken." The notes of this attendance, signed by Dr Patel, conclude:

"Imp[ression]: Psychosis - Paranoid delusions, catatonia."

Comment:

Dr Selvaratnum himself did not, at any time, make and sign any of the notes in the clinical records. He told the Inquiry panel that if he saw a patient with a Senior House Officer, he would, reasonably enough, have left the note taking or record keeping to that Senior House Officer. However, the Inquiry panel was left with the overall impression that Dr Selvaratnum may not have had a very close involvement with this patient, and may perhaps have delegated much to his Senior House Officer, Dr Patel. This impression was reinforced by Dr Selvaratnum's own uncertainty about the occasions when he himself had actually seen SH in the hospital - it was eventually agreed that the first time that Dr Selvaratnum himself had seen SH was probably on 15 August.

On 16 August, SH made an attempt at suicide, or at least an attempt to injure himself. During a fire alarm at the hospital, SH was taken out on to a fire escape and he apparently tried to jump off, stating that he had sinned and that he deserved to be punished.

This incident led to the further involvement of Dr Springer, who again made a detailed and careful note. He concluded that SH was suffering from a paranoid psychotic depression, and remained a moderate suicide risk. Dr Springer noted that SH was now anxious to return home and accordingly placed SH on Level 2 Observations with "Doorstop" - so that SH was to be

prevented from leaving the ward. Dr Springer also elicited on this occasion personal information similar to that which had earlier been noted by Dr Patel - the information which the Inquiry panel feels would have been useful to a full understanding of SH's feelings of guilt, of the content of his paranoid delusional system and of the concerns and pressures which had led to, or at least contributed to, his initial breakdown.

Dr Springer decided to maintain the doorstop policy and this is recorded in a note in the clinical records on 16 August. No note was made the following day (a Sunday) but on 18 August, Dr Patel again saw SH. Dr Patel's note records that he subsequently discussed SH with Dr Selvaratnum, and a decision was made that they would, the following day, consider allowing SH to return home for 24 hours leave, with a view to extending that period if things went well. This was discussed with AK who was reported as being happy that her husband was considered well enough to return home, although she did ask that SH be kept under close observations on 18 August to prevent him running away.

Comment:

It is surprising that a decision was made to consider home leave so soon after the episode of 16 August and the need for Level 2 Observations. We would have thought that Dr Selvaratnum would have liked to have a longer period of observed stability before considering home leave, whatever the patient's own wishes. It is also of interest that AK herself was still concerned at this stage about the risk of SH running away.

In any event, the plan was to maintain a doorstop policy overnight, but this was ineffective. Shortly after midnight on the 18/19 August a note was made that SH was absent without leave. SH was contacted at his home, and AK said she was happy for him to be there. The hospital accordingly decided to let him stay at home, and to review matters in the morning.

SH came back to the hospital the following morning and he, together with one of his brothers, was seen on a ward round by Dr Selvaratnum. The history from the brother suggested that SH's condition was improved, at least from what it had been prior to admission, and Dr Selvaratnum accordingly decided to allow SH to go home on leave until Friday 22 August.

Comment

The Inquiry panel considers it surprising that, notwithstanding the fact that SH had left the ward without permission, and contrary to the doorstop policy then in force, the decision was nevertheless made retrospectively to endorse his departure by granting him extended home leave. The Inquiry panel considers that the fact that SH had absented himself from the ward without permission ought, in itself, to have been perceived as non-compliance and therefore as a risk factor indicating that SH was not ready for discharge.

On 21 August, SH returned to the ward in the belief that he had to see a Dr Amin there. This seems to have been a mistake by SH, but AK, who came with him, reported that his behaviour had been fine for the previous two days, with no paranoia or aggression.

Later on that day, however, a report was received from the CMHT-E and from Dr Amin concerning an argument or dispute between SH and one of his brothers. The report recorded in the clinical notes was that there had been "tensions between two brothers to the point of pulling out knives"; that the police had been called on five separate occasions; and that the CMHT did not want SH in the same house as his brother. No one who gave evidence to the Inquiry panel was able to recall more detail than this about this incident - the only member of the family who responded to the Inquiry panel's invitation to give evidence was SH's elder brother who was not present at this incident. Dr Amin Elhihi recalled nothing of this incident either.

Following this report, Dr Patel made a note indicating that he had spoken to Dr Selvaratnum and that it was agreed between them that contact should be made with the wife, AK.

On 22 August, SH returned to the ward with AK and with his mother. He was seen on the ward round by Dr Selvaratnum and Dr Patel. Notwithstanding the events of the previous day, the notes made record that SH "Was OK over the leave period". SH was described as appearing vague but saying that he was better.

Dr Patel's evidence to the Inquiry panel, having looked through the clinical notes, was that the incident of 21 August would certainly have been discussed on this occasion, and that when it was discussed the family blamed the episode upon JH. He said that the note that SH was "OK over the leave period" reflected what had been reported by SH's mother and by AK and that they had said that the incident was all JH's fault.

In any event, a decision was made to reduce SH's medication and to allow him to continue his home leave.

Comment:

Bearing in mind that SH's younger brother, JH, was known to have a predisposition to violent behaviour, it is certainly possible, indeed very likely, that the incident of 21 August was provoked by JH. Nevertheless, the Inquiry panel does consider it surprising that further details of what seems to have been a serious incident, involving knives and repeated attendances by the police, were not recorded in the notes with, at the very least, an explanation of why, despite SH's involvement in an incident of this kind, the clinicians did not alter their approach to SH's care - and indeed actually reduced his medication. Dr Selvaratnum's response to this when giving evidence to the Inquiry panel was:

> ***"The only comment I could make on the notes is that I would not start reducing his medication if his mental state was of serious concern."***

In the light of Dr Patel's evidence, it is likely that Dr Selvaratnum did inquire into this incident and did receive reassuring replies from both SH and AK. However, he was unable to confirm that this was the case, and it is regrettable that there are no notes covering this issue. SH's apparent involvement in a violent incident could surely have been very relevant information so far as any subsequent risk assessment was concerned.

SH returned to East Ham Memorial Hospital on 26 August, where he was seen on the ward round by Dr Selvaratnum and Dr Patel. He was said to be feeling better. AK confirmed that he was behaving well, with no bizarre behaviour. SH asked for assistance with his housing arrangements on this occasion and consideration was given to refer him to a social worker. It was decided that SH did not qualify for a social worker referral and he was told he would have to make the necessary application to the housing authorities himself.

Comment:

This response was not helpful for a man who was still, at this stage, the subject of an Order under section 2 of the Mental Health Act 1983. Furthermore, it is difficult to see how this

decision could properly have been reached unless and until there had been an assessment of the home circumstances and a carer's assessment.

On 1 September 1997, SH saw Dr Bhadra. The GP's records contain the following short entry:

"E mc 3/12 Schizophrenia"

Dr Bhadra explained that this meant he had issued a Medical Certificate certifying SH as unfit to work for a period of three months on the basis of a diagnosis of schizophrenia. The "E" indicated that an examination had been carried out although no details were recorded. The diagnosis of schizophrenia was no doubt based in large measure upon his knowledge of the family history, but it represented a rather different view of SH's condition to that being taken at East Ham Memorial Hospital.

SH returned to East Ham Memorial Hospital again on 2 September. He was again seen on the ward round by Dr Selvaratnum and Dr Patel. SH said he was feeling much better. A history from the wife did not disclose any real cause for concern and SH was discharged from East Ham Memorial Hospital with an Out-Patient Appointment for two weeks' time.

Comment:

So far as the treatment afforded to SH on and following his admission to East Ham Memorial Hospital, the Inquiry panel was impressed by the quality of the history taken and the notes made by both Dr Springer and Dr Patel. There are however, concerns about the degree of consultant involvement.

Dr Selvaratnum was responsible for the care of SH. It is perhaps a little odd that he did not himself ever make any clinical notes concerning SH, but this was presumably because he only ever saw SH on his twice weekly ward rounds, when he was accompanied by Dr Patel to whom note-taking was delegated.

Of more concern, however, is the possibility that Dr Selvaratnum's review of the notes which had been taken by Dr Patel and Dr Springer may not have been as thorough as it might have been. We have already commented above upon the absence of any proper record in SH's notes of the family history of mental illness, and the fact that the relevant information may

in any event have been confined to knowledge of JH's illness. We have also mentioned the absence of any formal interview of AK, notwithstanding her close involvement in the events leading up to SH's admission. In addition, there were decisions which appear somewhat surprising - the decision to consider allowing SH home leave a very short time after an apparent suicide attempt; the fact that the decision to allow home leave was made notwithstanding that SH was exhibiting serious non-compliance by absconding from the ward, a factor which seems to have been ignored; and the decision, in effect, to disregard SH's involvement in the incident on 21 August. It may be that each of these decisions was justified clinically, but the notes do not properly disclose the basis upon which they were reached and do not disclose any in-depth consideration by Dr Selvaratnum of the possible implications of these matters.

A number of documents had to be completed upon discharge. In addition to the Discharge Summary itself, there was a document entitled Discharge Liaison Form, dated 2 September 1997, which was sent to Dr Bhadra. This referred to the diagnosis of a brief psychotic episode, and gave details of the medication prescribed. However, whilst the document includes a block entitled "Aftercare Arrangements", and whilst it was recorded in this block that there was an Out Patient appointment made for two weeks time, the rest of the "Aftercare Arrangements" block was left blank, including the section which specified the level of Care Programme Approach ("CPA"), Level 1, 2 or 3, which was to be applicable to SH.

A CPA Registration Form also appears in the East Ham Memorial Hospital notes, although it is not clear whether this was actually sent to anyone - it does not appear, for example, on CMHT-E's file of papers. This form also had boxes to be ticked to indicate the allocated CPA level (as they were defined at that time). In SH's case, he was designated as "Level 1 (All Clients)". [Level 2 was described as "All 117, Long term needs clients, Multi-disciplinary and old CPA"; and Level 3 as "Supervision Register".]

Dr Bhadra commented that the absence of details of the "Aftercare Arrangements" from the Discharge Liaison Form did not surprise him, at least with a patient who was not giving any particular cause for concern. Dr Selvaratnum agreed that in theory every patient should have been given a CPA level. He also said that he recalled difficulties at around this time with liaison with the CMHTs as a result, he said, of problems with staffing, resulting in difficulties with the CMHT representatives attending the ward rounds, and, accordingly, difficulties in the effective implementation of the CPA. Specifically Dr Selvaratnum said:

"Occasionally [the CMHT representatives] came but as a routine they did not come, not due to their fault; it was due partly to the organisation and partly to staffing problems."

Frank Harrington was managing the CMHT-E at the material times in 1997. He worked there from October 1996 through to 2000. He gave evidence to the Inquiry panel after Dr Selvaratnum, and he disagreed with the picture which had been painted by Dr Selvaratnum. He accepted that there were occasions when a social worker may have been called away on some emergency, and when, therefore, there was no representation at ward rounds from the CMHT, but otherwise, he said, attendance at ward rounds was perceived as an important part of the social worker's role and was certainly not routinely missed. He also said that there had been a good continuity of personnel within his team throughout his tenure.

He did also agree that at one point there had been problems because a ward round might commence at 09.30 hrs and go on until 13.30 hrs and there were practical difficulties with having a social worker there all of that time; but he explained that this problem was eventually resolved by a formal agreement that the social workers, or other representatives from the CMHT, would spend a total of an hour and a half at the ward round, and that during this period, the needs of any person about whom the ward or the Responsible Medical Officer had concerns would be discussed.

There was no other evidence presented to the Inquiry panel which suggested that the CMHTs were under-staffed at this time or that they were so stretched that patients requiring care could not be catered for. The Inquiry panel did hear evidence from Mr Peter Horn, who was, from 1995 till April 2000, the Chief Executive of Newham Community Health Trust Services and who was from April 2000 till May 2002 the Chief Executive of the East London And The City Mental Health NHS Trust. He told the Inquiry panel that the process of setting up CMHTs in Newham had only begun in 1996, with the first team, CMHT-S, being set up in May 1996. The community mental health services in Newham were, accordingly, relatively immature at the time when SH first came to the attention of the mental health services - as Mr Horn put it, it was "early days in terms of trying to establish a different model of service".

Diane Ball, who was the Ward Manager on Purcell Ward in 1997, provided the Inquiry panel with some interesting insight into the position at that time. She described differences between the degree of integration and communication with the CMHT which had been achieved by Purcell Ward - which worked with the CMHT-S - as compared with Elgar Ward, where SH was and which worked with the CMHT-E.

Purcell Ward's principal advantage was probably the fact that the CMHT-S had been the first CMHT to be established the previous year; but it also had the benefit of greater consultant continuity. Dr Coleman, who worked in Purcell Ward, was the only permanent consultant psychiatrist working at East Ham Memorial Hospital at the time, and whilst Dr Selvaratnum had worked at the hospital for some time, it probably right to say, as Dr Selvaratnum himself acknowledged, that he had more difficulty in building up contacts and establishing working relationships as a locum than might have been the case had he been a permanent consultant.

Mr Harrington agreed with the assessment that the interaction between the CMHT and the consultant worked better on Purcell Ward than was the case on Elgar Ward. He also described difficulties in establishing a good working relationship with Dr Selvaratnum. Whilst he told the Inquiry panel that Dr Selvaratnum was always thoughtful about and attentive to his patients and their needs, Mr Harrington felt that Dr Selvaratnum had a tendency to make decisions without reference to the team and also that, especially towards the end of his tenure as a locum consultant, he was not, perhaps, as much of a "team player" as might have been the case.

Comment:

It is trite to say that sometimes individuals can have difficulties in fitting comfortably into a team framework. Personalities do not always match well and this may have implications for the effective operation of a team. Two observations can however, be made here. The first is that the impression received by the Inquiry panel was that this situation, where CMHT-E was having difficulties with the liaison with Elgar Ward, appears to have been a well-recognised problem which continued for a lengthy period. The second is that it is clear that a locum consultant, even one who has been in place for a number of years, is inevitably less likely to invest time and energy into establishing the working relationships necessary for the effective running of a team. We understand that although Dr Selvaratnum was, for all practical purposes, doing the work of a permanent consultant, he was not, at the relevant times, on the Specialist Register. He could not accordingly apply for a position as a permanent consultant. However, the situation was an unfortunate one for all concerned, and may perhaps have contributed to some of the failings which are identified in this Report.

Returning to the details of SH's discharge, however, in none of the documentation which has been seen by the Inquiry panel is there anything purporting to be a formal risk assessment of SH by Dr

Selvaratnum. It was clear that Dr Selvaratnum's view, at the time of discharge, was that SH was not one of the cases which merited referral back to CMHT-E and accordingly, he made no attempt to implement the CPA. The basis for this judgment is not evident from the documentation. Furthermore, notwithstanding that SH had been referred to East Ham Memorial Hospital through CMHT-E it is not clear that CMHT-E was actually notified, at the time, of SH's discharge back into the community.

Comment:

The decision not to refer SH to CMHT-E was, in the view of the Inquiry panel, an error of judgment by Dr Selvaratnum. Dr Selvaratnum must have taken the view that the degree of risk which SH posed, either to others or to himself, was insufficiently high to trigger the need for follow-up in the community. The view of the Inquiry panel is that this was wrong. There were significant life events recorded in the notes made by Dr Patel and Dr Springer that should have alerted Dr Selvaratnum. Particularly relevant here is the fact that SH was part of a family in which there was a history of significant mental health problems, such that one brother and SH's mother were already receiving support from the mental health services. SH may well have benefited from psychological work, as well as the involvement of a social worker, particularly in view of his employment position.

It may be that Dr Selvaratnum's failure to ascertain full details of SH's family history contributed towards this error of judgement. We do not know whether or not fuller information about the incident on 21 August 1997 would also have pointed towards the appropriateness of follow-up in the community - in the absence of any proper record of what SH and AK had had to say about that incident, we cannot assess its significance so far as a risk assessment of SH was concerned.

The *Report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People* had been published in April 1996 and identified the following, amongst others, as risk factors:

- **Self harm as an indicator of future violence towards others**
- **Serious mental illness in a relative**
- **Problems at work.**

The significance of the fact that self harm should be an indicator of future violence towards

others was all the greater here, given the content of SH's persecutory delusions and the link with his self harming behaviour. Dr Selvaratnum should therefore also have appreciated the potential significance of the fact that SH had recently lost his business, and had had long periods of unemployment. Unemployment is known to impair physical and mental health and is associated with an increased risk of suicide and self harm. As mentioned above, a comprehensive assessment must encompass not just the patient's presentation, but also a full consideration of all environmental factors.

Dr Selvaratnum should have carried out and documented a formal risk assessment of SH. In a case where we have taken the view that the decision made on discharge was erroneous, the absence of documentation is doubly unfortunate, since it leaves open the possibility that Dr Selvaratnum did not, in fact, carry out a complete or proper risk assessment.

Dr Selvaratnum did say in evidence to the Inquiry panel that he felt that if he had had more support, by which we think he meant more time, to consider individual patients, his risk assessment in this case would have been different. He agreed that there was information available to him in the medical records which, if only he had had more time to consider the records, could have led to the conclusion that there were risks relating to SH which merited follow-up in the community.

We regret to say, therefore, that we do consider that Dr Selvaratnum failed properly to identify and/or to appreciate the significance of the various risk factors which existed here which might, and the Inquiry panel feels should, have led him to recommend follow-up in the community by the CMHT-E for SH after discharge.

A discharge summary, signed by Dr Patel, was sent to Dr Bhadra on 8 September 1997. Dr Patel's evidence about discharge summaries was that the practice which he and Dr Selvaratnum followed was that Dr Patel would prepare a draft, but that draft would then be edited by Dr Selvaratnum.

As finally sent out to Dr Bhadra, the discharge summary recorded that the diagnosis on discharge was a "brief psychotic episode". Reference was also made to the initial formulation having been a depressive illness with paranoid delusions and suicidal intent. The discharge summary did not, however, refer to the content of those paranoid delusions. It made reference to the argument with SH's friend and business partner, and to SH being pre-occupied with thoughts about this person. It also referred to the younger brother, JH, and his history of mental illness. It recorded that SH

had no previous forensic history. Whilst it referred to a possible attempt at self harm, in the view of the Inquiry panel, it rather understated the episode where SH had tried to jump from the fire escape. It contained no reference to the incident on 21 August 1997. It contained no reference to the personal details which had been elicited from SH by Dr Patel on 13 August and again by Dr Springer on 16 August.

Dr Patel said in evidence that his first draft of the discharge summary contained a fuller history, extracted from all of the clinical notes. He said that it would, in particular, have contained reference to the personal circumstances which he had elicited on 13 August which in his view had played an important part in triggering SH's psychotic episode - a view which the Inquiry panel shares - and reference also to the incident on 21 August. He also said, however, that Dr Selvaratnum favoured a more concise type of discharge summary and would often edit down the original draft. In addition to this, he said that Dr Selvaratnum had not shared his views as to the significance of the personal circumstances recorded in the notes, and that this was why any reference to these matters was ultimately edited out of the discharge summary by Dr Selvaratnum. In his evidence, Dr Selvaratnum initially indicated to the Inquiry panel that he was still not sure whether he should have referred to these personal circumstances in the discharge summary, although he ultimately accepted that the information was potentially relevant, because of its significance in SH's paranoid delusional system, and that it should have been communicated to the GP.

Comment

The fact that the discharge summary contained no reference to the personal details which had been elicited from SH by Dr Patel on 13 August and again by Dr Springer on 16 August concerns the Inquiry panel, as does the absence of any reference to the incident of 21 August. So far as the personal details are concerned, as recorded above, the nature of those details is of secondary importance so far as this Report is concerned. What matters is that information in the possession of the staff at East Ham Memorial Hospital - information which was, in the view of the Inquiry panel, relevant to a proper understanding of SH's condition, the content of his paranoid delusional system, and the feelings of guilt which had triggered his mental breakdown - was not shared with those responsible for his care following his discharge. The evidence from Dr Patel was that Dr Selvaratnum had taken the view that these personal details were not relevant to an understanding of SH's condition, and that he therefore chose not to include any reference to them in the discharge summary.

We recognise that the content of a discharge summary must to some extent be a matter of judgment - it is not feasible for every last detail of an admission to be recorded. The Inquiry panel's view is, however, that this was an erroneous judgment by Dr Selvaratnum and that any subsequent risk assessment was therefore jeopardised.

On 2 September 1997, Dr Bhadra was asked by solicitors acting for SH in relation to the charge of assaulting a police officer on 23 July 1997 whether SH was well enough to be able to attend Court. Dr Bhadra could not recall what happened in this regard. There is no letter from him responding to this question on his files.

Comment:

Dr Bhadra became aware, as a result of this letter, that SH had been involved in an offence of violence. Although the facts surrounding that offence were not, it now transpires, indicative of any serious problems or tendency to violence by SH, it is nevertheless surprising that Dr Bhadra did not follow up this letter, so as at least to ascertain what it was alleged SH had done.

On 5 September 1997, Dr Bhadra received a letter from Newham Council arising out of an approach which SH had made to them as a homeless person seeking accommodation. Dr Bhadra was asked to complete a questionnaire and he did so on 15 September. He described SH's diagnosis as schizophrenia - notwithstanding the views expressed in the discharge summary of 8 September - and he described the main illness as of "moderate" severity. Dr Bhadra did not seek to discuss his diagnosis with Dr Selvaratnum, even though it was a diagnosis which differed significantly from that reached by Dr Selvaratnum. He did not take the view that it was appropriate to involve the CMHT in dealing with SH, even though he, unlike Dr Selvaratnum, had formed the view that SH was suffering from an ongoing condition, not merely a "brief psychotic episode".

Comment:

It is surprising that Dr Selvaratnum on the one hand was advising that SH had undergone a brief psychotic episode whilst Dr Bhadra on the other was forming or had formed the view that SH had schizophrenia. Dr Bhadra had the advantage of more detailed information about SH's family background, and the family history of mental health. Whilst Dr Selvaratnum did have the advantage of such information as had been elicited from

SH during his short stay in hospital, the Inquiry panel considers it unlikely that further information from the hospital would have caused Dr Bhadra to take the view that his diagnosis of schizophrenia was less tenable.

Unfortunately, Dr Bhadra made this diagnosis of schizophrenia without making any detailed notes of the reasoning which had led him to that conclusion, notwithstanding that he was taking a different view from that taken at East Ham Memorial Hospital. As the chronology set out above shows, his diagnosis of schizophrenia was repeated on 15 September, after his receipt of the discharge summary from the hospital (which referred only to a brief psychotic episode). The view which the Inquiry panel has reached is that Dr Bhadra was probably correct in his conclusion that SH was suffering from a chronic condition, but the basis for his conclusion cannot be said to be fully recorded in his notes. We do consider it surprising that Dr Bhadra did not try to discuss with Dr Selvaratnum the fact that he was making a diagnosis which differed significantly from that reached by Dr Selvaratnum. SH was still under the hospital's care, and if Dr Bhadra thought, as he apparently did, that the view taken by the consultant was wrong, we feel that he ought to have discussed the matter with Dr Selvaratnum.

In any event, having made his diagnosis of schizophrenia, Dr Bhadra thereafter took the view that the appropriate approach to SH's schizophrenia was to prescribe medication as and when SH came to ask for it.

On 25 September and 24 October, the GP's Notes record a prescription having been provided to SH. Dr Bhadra said that he would not necessarily have seen or examined SH on this occasion. His evidence was that the procedure whereby SH, or other mentally ill patients, obtained repeat prescriptions was straightforward. At the relevant times, the position at Dr Bhadra's practice was that it was felt necessary to re-examine a mentally ill patient seeking a repeat prescription only once every four months or so. It would, therefore, have been possible for a patient to receive up to three repeat prescriptions without an examination. There was a practice of examining the patient before providing a certificate to the effect that the patient was unfit to work, but this could mean, in practice, examinations only every six months. Dr Bhadra described the type of examination which would occur on these occasions in the following terms:

> *"A general examination of the patient, the general appearance of the patient. How he talks, his mood and any aberration of the thoughts."*

Comment:

The Inquiry panel was concerned by the lack of controls built into the procedures described above for the prescription of medication for mentally ill patients - allowing up to three repeat prescriptions without there being any mental state examination by the GP. Dr Bhadra told the Inquiry panel, however, that the systems had since been changed and that the procedure now was that a patient could only get a single repeat prescription before being re-examined.

On 6 November 1997, SH attended his first outpatient appointment with Dr Selvaratnum. It was recorded that he was *"Improved but not better - taking Haloperidol and Procyclidine"*. In a letter to Dr Bhadra dated 10 November, Dr Selvaratnum referred to the fact that AK had attended this appointment and said:

> *"According to his wife, SH tends to stop his medication. He tends to be withdrawn and preoccupied with thought and his sleep gets disturbed and his wife has difficulty in coping with this behaviour."*

The implication was that SH became withdrawn and depressed rather than violent and aggressive, when he stopped his medication.

Dr Selvaratnum also informed Dr Bhadra that SH had started taking Haloperidol about two days before his outpatient appointment and that his mental state had consequently improved. It was recorded that SH said that he was hearing banging noises and that his thoughts were muddled and confused. Dr Selvaratnum advised SH to continue with Haloperidol 5 mg at night and Procyclidine 5 mg at night and arranged to see him in one month's time.

Comment

Whilst Dr Selvaratnum's plan had been for SH to be seen two weeks after discharge (i.e. by mid-September 1997), in the event SH was not seen until 6 November, over two months after discharge. Bearing in mind that SH was admitted with concerns about the possibility of self harm and bearing in mind also that there was an attempted suicide whilst SH was an in-patient, we are surprised that the follow-up appointment was planned for as long as two weeks after his discharge. As recorded in the Royal College of Psychiatrists' National

Confidential Inquiry into Suicide and Homicide by people with Mental Illness (1997), 40% of suicides occur before the first follow-up appointment. As SH ought to have been perceived as at increased risk of suicide or self harm following discharge, we consider that an earlier appointment than two weeks would have been advisable and that leaving that appointment was unacceptable. National Service Framework, Standard One now requires that those who at some time during their admission were detained under the Mental Health Act 1983 because of high risk of suicide must be followed up by face to face contact with a mental health professional within seven days of discharge from in-patient hospital care.

In the event, fortunately, the delay here appears to have been of no significance.

However, as recorded by Dr Selvaratnum, SH did not take his medication on a regular basis and this had, unsurprisingly, adverse effects on his mental state. SH's tendency to stop taking his medication was an important risk factor. It demonstrated another aspect of SH's non-compliance and was, in the opinion of the Inquiry panel, a further indication that some follow-up in the community would have been appropriate. It is disappointing that Dr Selvaratnum did not take this opportunity to reconsider his earlier decision not to involve the CMHT in SH's care. The fact that SH's mental health was adversely affected in the absence of the prescribed medication was, at the very least, an indication that Dr Selvaratnum's earlier diagnosis of a brief psychotic episode needed to be reconsidered.

Dr Selvaratnum could also have looked into the reasons why SH tended not to take his medication. SH's evidence to the Inquiry panel was that he did not like to take the medication prescribed because of its side effects. Continuing SH on Haloperidol when SH tended to default because of its side effects was potentially problematic. The new neuroleptics which were available on the market at that time are known to have fewer side effects, and Dr Selvaratnum could therefore have considered altering the prescription in an attempt to ensure better compliance by SH by prescribing drugs likely to have fewer side effects. His evidence to the Inquiry panel was, however, that he was not encouraged to prescribe these newer drugs because of their higher costs.

There appears again therefore to have been a failure to recognise further risk factors, including non-compliance with medication and disengagement from psychiatric services.

In any event, and with the benefits of hindsight, it would have been appropriate for Dr Bhadra to have emphasised to SH, and also to AK, the importance of SH taking his medication on a regular basis. As is commented below, the pattern which subsequently developed was that SH attended at the GP's practice on increasingly irregular occasions for repeat prescriptions, making it apparent that he cannot have been taking the medication regularly.

On 25 November 1997 SH attended at the GP's surgery for a further repeat prescription. The GP's notes recorded this as follows:

> *"Rpt 1,2"*

On 1 December 1997 the following short entry was made in the GP's notes:

> *"E mc 6/12 Schizophrenia"*

Dr Bhadra explained to the Inquiry panel that *"mc 6/12"* recorded the renewal of the Medical Certificate which had previously been provided to SH certifying that he was unfit to work for a further period of 6 months. Dr Bhadra said in evidence to the Inquiry panel that he would on this occasion have conducted an examination of SH, keeping an eye out for any abnormalities. Dr Bhadra again recorded his diagnosis of schizophrenia on this occasion, but without any details being recorded of the basis upon which he reached that conclusion.

Comment:

The notes made by Dr Bhadra on the occasions referred to above, and indeed on most subsequent attendances by SH, were extremely brief with few, if any, details being recorded of examinations carried out or of any management plans which may have been formulated. There are no notes which record information or advice being given to SH by Dr Bhadra about the medication being prescribed, or about any other aspect of his condition. Dr Bhadra's record keeping was, we regret, less than satisfactory.

On 12 December, SH was due to attend another outpatient appointment with Dr Selvaratnum. He did not attend. Dr Bhadra was duly notified of this by Dr Selvaratnum.

Comment:

Neither Dr Selvaratnum nor Dr Bhadra took any pro-active steps in the light of this non-attendance, notwithstanding that it represented another failure by SH to comply with what his doctors wanted, and notwithstanding that it was known that SH's condition could deteriorate if he failed to take his medication regularly. No doubt both relied in large measure upon AK to notify the mental health services of any further deterioration in SH's mental state, but this was a heavy burden to place upon AK. She was never offered any formal advice or assistance in this role, or asked whether she would value the involvement of the CMHT in the care of SH. There was a history of SH not taking his medication as required, and it was acknowledged that this could result in a deterioration in his mental state, yet nowhere in either the documentation which we have seen is there any suggestion that AK was advised about the necessity for SH to take his medication regularly or told what she should do if he refused to take it.

So far as we can tell, the pattern that subsequently developed was that SH would only take his medication if he thought he needed to do so. SH's evidence indicated that AK attempted, on occasion, to persuade him to take medication, sometimes with success, sometimes without. However, AK was not, so far as we can tell, ever advised that the type of medication which SH was taking was medication which was intended to be taken continuously, and not merely as a response to an acute episode. It may perhaps be that, had she appreciated this, AK would not thereafter have acquiesced in SH's policy of taking the medication only as and when he felt he needed to take it.

On 16 December 1997 and 14 January 1998 the GP's notes record repeat prescriptions for SH.

Also on 14 January, SH was due to attend an appointment at the Probation Services. He did not attend, but on 15 January he did go the Probation Services offices. He explained that he had been unable to attend the previous day, as he had had to take an injured child to Hospital. The probation report subsequently referred to SH's youngest child having had an injured shoulder and having needed to go to hospital. Probation Services brought this to the attention of Westminster Social Services who then contacted Newham Social Services.

On 16 January 1998, Paul Rimley of the Transition team was approached by Westminster Social Services. SH and family had moved to temporary accommodation in Westminster, pending

provision of more permanent accommodation in Newham. Westminster Social Services were asking for more information about SH's children. The reasons for this enquiry are not clear. Although the Inquiry panel has attempted to find more out the involvement of Westminster Social Services with SH's children, we have been told by Westminster Social and Community Services Department that no file on SH's children or family can be found.

Jennifer Lewis of CMHT-E agreed that she would obtain SH's discharge summary from East Ham Memorial Hospital - it seems it had not been provided to CMHT-E prior to this time, notwithstanding the CMHT-E's involvement in the admission of SH to East Ham Memorial Hospital.

It is relevant to record that Jennifer Lewis, who gave evidence to the Inquiry panel, was the social worker who was appointed to deal with SH's younger brother, JH, who had also been diagnosed as having schizophrenia. She said in evidence that SH's condition had simply never come up in her dealings with JH.

Comment:

Whilst the Inquiry panel were told that communications between East Ham Memorial Hospital and the CMHTs have improved greatly since 1997, it is disappointing that East Ham Memorial Hospital did not, apparently, let CMHT-E know of SH's discharge at the time of discharge.

In any event, the CMHT-E Notes show that Jennifer Lewis had a discussion with Dr Selvaratnum on 16 January 1998. She explained Westminster Social Services' involvement arose because of the children, and was not directly related to SH. Dr Selvaratnum told Jennifer Lewis that he would forward the discharge summary to her and that it could then be passed on to Westminster Social Services. He confirmed to her that he had taken the view that there was no need for SH to be referred back to the CMHT-E upon his discharge on 2 September 1997.

On 21 January, SH appeared in Court in connection with the assault upon the police officer of 23 July 1997. The Court sought a psychiatric report and on 10 February SH was seen by Dr Selvaratnum at East Ham Memorial Hospital for the purposes of preparing that report. Dr Selvaratnum did not communicate the results of his examination on this occasion to Dr Bhadra.

Comment:

This appears to be another disappointing failure by Dr Selvaratnum to communicate relevant information to SH's GP. Furthermore, he was by now in possession of additional worrying information about SH, namely his involvement in criminal proceedings, and the fact that Social Services were expressing concerns about his children. Although the offence itself was relatively trivial, it was apparently out of character for SH, and, as an offence of violence, was relevant to any risk assessment. This was, therefore, another occasion when we consider that Dr Selvaratnum should have reconsidered his earlier decision that SH did not need to be referred to the CMHT.

The CMHT-E notes show that on 17 February 1998 they reviewed the question of whether or not it was appropriate for them to have any further involvement with SH. It was decided to discuss the matter with Jennifer Lewis, who was at that time on leave.

On 23 February, the records of the CMHT-E show that, following a discussion with Jennifer Lewis, a decision was made by Frank Harrington to close SH's case.

Comment:

No specific reason for this decision was recorded in the CMHT-E notes. Whilst a formal record would have been good practice, this decision was no doubt based upon Dr Selvaratnum's assessment that SH did not need to be followed up by a CMHT after discharge. It is difficult to see how the CMHT could have reached a different decision in the light of the views expressed by the consultant who had had care of SH. Perhaps if, before making this decision, the CMHT had made contact with Dr Bhadra a different approach might have been adopted, but it is difficult to see why the CMHT should have chosen to go down that route.

On 27 February and 8 April the GP's notes record further repeat prescriptions for SH.

On 25 April, Dr Bhadra filled in a Disability Living Allowance form for SH in which Dr Bhadra stated that he last saw SH on 1 December 1997 when he had formed the view that SH had schizophrenia. He stated that SH's condition was under control with the use of regular medication and that SH still receiving treatment from the hospital. Dr Bhadra said that there was

some uncertainty about SH's ability to self-medicate. He also said, in response to the question: *"Is there a history of self-harm or danger to others?": "Possibilities are always there."*

Comment:

Dr Bhadra's remarks show that he had taken on board Dr Selvaratnum's comments about SH's failure always to take prescribed medication; and that he did have safety concerns about SH.

On 14 May, SH again failed to attend a scheduled outpatient appointment with Dr Selvaratnum. Dr Selvaratnum accordingly decided to discharge SH from care at East Ham Memorial Hospital and he duly informed Dr Bhadra of this decision in a letter on 15 May. The letter stated:

> *"Your patient has not kept the Psychiatric Outpatients Appointment again on 14 May 1998. He was admitted to East Ham Memorial Hospital for three weeks from 12 August 1997 with a diagnosis of Brief Psychotic Episode. He has been taking Haloperidol 5 mgs at night since discharge from the hospital. I hope he is well now. I am taking his name from the Clinic list but we will be pleased to see him again if necessary at your request."*

Coincidentally, on 15 May SH sought a further repeat prescription from Dr Bhadra - presumably this was before Dr Bhadra received the letter of this date from Dr Selvaratnum.

Comment:

If the diagnosis of a brief psychotic episode (which would, by its nature, be transitory) had been accurate, then Dr Selvaratnum's decision to discharge SH from further care following his non-attendance, and in the absence of any indication of ongoing problems, might, taken in isolation, be considered reasonable, even though it is recognised that disengagement from psychiatric aftercare is, in itself, a risk factor.

For the reasons set out above, however, we do not consider that Dr Selvaratnum was right to take the view that there was no need for SH to be followed up in the community. Furthermore, Dr Selvaratnum had, in his earlier letter to Dr Bhadra of 10 November 1997, commented that SH's mental state was affected if he failed to take the medication prescribed. In this context, a decision to discharge SH from the outpatient list because of

his non-attendance seems contradictory, or at the very least risky. We consider that SH's non-attendance should have been recognised by Dr Selvaratnum as a point of concern and not something which justified his discharge from further follow-up.

In any event, however, from this date onwards Dr Bhadra knew that he was left with the responsibility for the care of a patient he perceived to be schizophrenic - indeed, the only medical care subsequently received by SH was provided by Dr Bhadra's surgery. This makes it particularly regrettable that Dr Bhadra had not been given all the information which might have been relevant to an understanding of SH's condition. Notwithstanding this, it is a little surprising that Dr Bhadra, left with the responsibility for the care of a patient he considered to be schizophrenic, did not seek to involve a CMHT in assisting him with the care and management of SH.

Even in the absence of full information, however, we have concerns about the subsequent management by Dr Bhadra. He had reached a diagnosis of schizophrenia, i.e. a chronic mental illness. He knew that there had been problems with SH failing to take medication and his condition deteriorating as a result. Yet, as described below, he followed, in effect, an entirely passive management plan which involved relying solely upon SH (or possibly AK) to determine if and when help and/or further medication was needed.

On 21 May 1998, Dr Bhadra was contacted by the Benefits Agency. In response to their queries, Dr Bhadra again stated that SH was suffering from schizophrenia. On 29 May, Dr Bhadra saw SH again. The GP's notes simply record:

> *"E mc 6/12 Schizophrenia"*

indicating that an examination had been carried out, and that Dr Bhadra had again renewed SH's Medical Certificate, certifying him as unable to work for a further six months on the basis of a diagnosis of schizophrenia.

On 26 June, the GP's notes record that SH took to Dr Bhadra a Benefits Agency form for completion. A repeat prescription was not given to SH on this occasion so it must have been apparent that SH was not now taking his medication on a regular basis. In the event, no further prescription was given until 9 November 1998.

Comment:

Dr Bhadra was aware of the possibility of a deterioration in SH's condition as a result of him not taking his medication regularly. He nevertheless adopted an approach which was dependent upon SH and/or AK accessing him or the mental health services. He explained to the Inquiry panel that his view was that SH was someone who would ask for medication as and when he, SH, felt the need - or, more accurately, that AK would ensure that he, Dr Bhadra, was contacted if and insofar as she felt that there was a need for assistance with SH.

We do not consider this approach to be an appropriate management plan for a patient considered to be schizophrenic (and sufficiently ill to be certified off work for periods of six months at a time). Expecting someone with a serious mental illness to have the capacity to recognise the need for medication and to manage it effectively is unrealistic. To the extent that Dr Bhadra expected AK to manage SH's medication, that placed an undue burden upon her. This was even more so in this case as no assessment was ever made of her needs and no support ever offered to her.

On 28 September 1998, Dr Bhadra saw SH for the purpose of signing a Disability Living Allowance form. The GP's notes record that SH was "Still the same", but it does not seem that any medication was prescribed. It is relevant to point out that SH was not on regular medication at this point so if SH's condition had not deteriorated, it might reasonably be thought that SH's stability was a sign that his condition was improving to the extent that he did not now need regular medication.

On 9 November, the GP's records show that a further repeat prescription was given to SH. He was seen on this occasion by Dr Bhadra's colleague, Dr Sahu. Dr Bhadra suggested in his evidence that this attendance suggested that SH felt he had experienced something of a deterioration in his mental health and that he had taken the view, therefore, that he needed to resume his medication.

On 1 April 1998, the GP's records show a further repeat prescription being given to SH. The relevant entry is made in the handwriting of Dr Bhadra's receptionist and Dr Bhadra said in evidence that the prescription may have been provided by the receptionist, without any formal assessment or examination by either of the doctors at the surgery. Dr Bhadra was sure, however, that SH would have been told to return in a month's time to see a doctor and that he would not be

given a further repeat prescription unless he saw a doctor.

Comment:

The practice of a receptionist providing patients with a repeat prescription (which would presumably be signed by a doctor at the receptionist's request) without the patient actually seeing a doctor at all, let alone being examined, is far from ideal. There may be circumstances where there is no need for a full formal examination - where for example, the patient has been receiving the same prescription on a regular basis for many months - but that was not the case here. SH had not been prescribed any medication for some five months and the Inquiry panel is therefore concerned to see that a decision was made to resume that medication without any examination of SH by one of the doctors at the practice.

On 26 July 1999, SH re-attended at the GP's surgery seeking assistance with regard to his wish formally to change his name and to get some documentation signed or witnessed. He saw Dr Sahu. Dr Bhadra told the Inquiry panel that this change of name was linked with a pilgrimage which SH was preparing to undertake to Saudi Arabia to a site holy to Moslems, and the evidence from other witnesses confirmed that this was the case. SH was unhappy with the response he got from Dr Sahu, who was unwilling to sign the formal documentation required.

In any event, on 7 September, following his pilgrimage, SH paid a further visit to Dr Bhadra. The GP's notes simply record that SH was "well". It seems that this was more in the way of a social visit by SH, but it is of note that Dr Bhadra observed nothing amiss on this occasion. Dr Bhadra told the Inquiry panel that it was not uncommon in his experience for Moslems who have made a pilgrimage to come and visit him afterwards - not for medical reasons but simply to talk about the experience.

SH did attend his GP again on 1 December, but only in connection with a cold. No further entries appear in the GP's records, or indeed elsewhere in connection with SH's mental health, until after the homicide. There is, accordingly, an absence of any clinical record of SH's mental state from 7 July 1999 (when he was described as "well") through to the date of the homicide.

The evidence which the Inquiry panel was able to gather from other sources about SH's mental health in the months prior to the homicide was sketchy.

One point of significance, however, was that, following the episode of August 1997, SH turned to religion. He had always been a Moslem and, following his discharge from East Ham Memorial Hospital in September 1997, his elder brother, S, suggested that he should visit an individual called Mohammed Sufi Khan (referred to by other witnesses to the Inquiry as Sufi Sherle), who offered a form of general spiritual guidance. Mohammed Sufi Khan gave evidence to the Inquiry panel and it appears that he offers a service akin in some ways to psychotherapy. He said that he was willing to see persons of any religion to offer spiritual guidance, but clearly his teachings are based on the Koran.

SH became a very close follower of Mohammed Sufi Khan, and began to take his Islamic faith very seriously. He grew his beard, and began to wear traditional Islamic dress. He went with Mohammed Sufi Khan on a pilgrimage to Saudi Arabia and changed his name. He encouraged his wife, AK, to adhere to Islamic customs. He met with Mohammed Sufi Khan increasingly regularly, until they were meeting on a daily basis. Mohammed Sufi Khan encouraged SH to believe that he had special qualities and that he too could become a spiritual guide. SH's brother, S, described SH developing grandiose ideas about his importance as a result of his relationship with Mohammed Sufi Khan, and this grandiosity is to some extent reflected in SH's behaviour following the homicide.

What is not clear is the extent to which Mohammed Sufi Khan was aware of the existence of problems in the relationship between SH and AK.

The evidence which the Inquiry panel heard about SH's relationship with his wife in the months prior to the homicide was sparse. From SH's family, only SH's elder brother, S, responded to our invitation to give evidence. His evidence was that, prior to the homicide, he never saw, or heard of, any problems between SH and his wife. He also said that his own wife had seen nothing amiss. The picture which S had was that SH and AK had loved each other very much, and that the homicide had come completely out of the blue.

A rather different picture may have been presented had the Inquiry panel been able to make contact with AK's younger sister, A. There are a number of references in the documentation which has been made available to the Inquiry panel, principally A's witness statement to the police following the homicide, but also a report from SH's present social worker, Tony West, which indicate clearly that A's evidence would be that AK had told A that she, AK, had been the subject of domestic violence prior to the homicide. A's witness statement to the police refers, in

particular, to an episode at Christmas 1999 when A noted bruising on AK's throat which she was concealing with a scarf and which A believed to have been inflicted by SH. The basis for that belief was not spelt out in the witness statement. There is also reference in the witness statement to a telephone call from AK in the months prior to the homicide in which AK had apparently told A that SH had assaulted her badly. A's evidence to the police was that AK told her that SH had got hold of her hair and dragged her from one end of the bedroom to the other; that he had kicked her in the back such that she could not move; that he had squeezed her cheeks so much that she could not chew her food properly; and that he had taken off his belt and struck her with it. A's witness statement also records that AK had said that the reason for the assault was that SH suspected her of being unfaithful - evidence which seems very credible in the light of what SH himself told the Inquiry panel - and further that similar incidents had happened before.

There is also a suggestion contained in documentation put before the Inquiry panel that Mohammed Sufi Khan had been approached by AK on a number of occasions in the weeks before the homicide, reporting that SH had been violent towards her. Mohammed Sufi Khan denied that there had been any such contact with AK, but the view of the Inquiry panel was that, notwithstanding this denial, there is a real possibility that AK had indeed approached Mohammed Sufi Khan for help in the weeks prior to her death.

SH's own evidence to the Inquiry panel was that there had been a couple of occasions when he had been violent towards AK. He said that on one occasion he had thrown a shoe at her; on a second occasion he had pulled her hair. He said that these incidents occurred because he was unwell. He said that he had suspected his wife of being unfaithful to him - a suspicion he again now attributes to his mental illness and his failure to take his medication - and that that was the reason why he had killed her.

He also described how he had asked Mohammed Sufi Khan to perform a ceremony to make or declare his wife, AK, "clean". This apparently occurred some four or five weeks prior to the homicide. SH said that Mohammed Sufi Khan tried to make him understand that AK was faithful and a good woman, but that notwithstanding this, his suspicions about her fidelity had recurred, and that ultimately led to the homicide. Mohammed Sufi Khan said that he recalled something along these lines but said that he was never told by SH of any suspicions that AK might not have been faithful. His evidence was that SH's suspicions were related to the disappearance of a pair of his glasses (which Mohammed Sufi Khan said SH had loved) and some of his clothes.

The Inquiry panel regrets that Mohammed Sufi Khan may not have been wholly accurate in his recollections about this "cleansing" event; unfortunately, his evidence means that it is not now possible to get any sort of objective insight into what may have been in SH's mind at this time.

Comment:

We can understand that Mohammed Sufi Khan, as a spiritual adviser, might regard discussions between SH and himself as confidential. When giving evidence to the Inquiry panel, however, he did not state that he did not feel able to disclose matters which had been reported to him in confidence; and the firm impression which the Inquiry panel had was that, in giving evidence, he was unwilling to say anything which might cast either himself or SH in a bad light.

So far as we can tell, however, (and notwithstanding the evidence of Mohammed Sufi Khan) the overall picture in the months leading up to the homicide was that SH was becoming violent towards his wife. It is likely that this was a result of a deterioration in his mental state, with an expansion of his previously expressed paranoid delusional system, combined with or possibly consequent upon an unwillingness to take medication. Even though he had not received a fresh prescription for his medication since April 1999, the police still found unused pills at the house following the homicide. He can therefore, have taken very little medication at all in the weeks or months immediately preceding the homicide.

SH said, when asked about his medication, that he did not like to take the prescribed medication because it gave him side effects and made him feel poorly. He agreed that he was regularly asked by his wife and family to take his medication, when they thought that he was getting unwell, but that he did not always do so when asked. He said that he had taken medication two weeks prior to the homicide at his wife's request, and because he was feeling strange and getting strange thoughts. He described these as including feeling anxious, restless, with thoughts such as that the world was ending and that he was worthless, as well as suspecting his wife of being unfaithful. Although AK asked him to take further medication, he did not do so.

Comment:

SH was a mentally ill patient, diagnosed with schizophrenia, who was probably becoming increasingly violent towards AK, but who was unwilling to take medication because it gave

him side effects. We still do not know why AK, faced with this situation, did not do what she had done in August 1997 and contact her GP. It may be that she was fearful of SH's reaction if she followed this course. It may be that she regarded Mohammed Sufi Khan as the appropriate person to whom to turn - if she did, we regret that that was a mistaken view. It may perhaps be that she had lost faith in the mental health services, although it is not easy to see why she should have reached that conclusion. Whilst we have taken the view that there were shortcomings in the service which was provided to SH, that would not, we think, have been obvious from AK's standpoint. From her standpoint, the system had responded promptly to the crisis in August 1997. SH's admission to hospital had quickly led to a significant improvement in his condition. AK would not have known of or had concerns about the absence of a proper risk assessment at that time. Nor would she have known that steps could and should have been taken to help her in her role as SH's carer.

The Homicide and Subsequent Events

On 4 June 2000, an ambulance crew was called to SH's house by members of his family because AK had been found dead. The ambulance crew found suspicious marks on AK's neck and called the police. SH was arrested and taken to the police station.

Concerns were then felt by the police as to whether or not SH was mentally well enough to be interviewed and for samples to be taken from him for forensic purposes. Police officers appeared to have no difficulty getting a forensic medical examiner ("FME") to see SH at Forest Green Police Station. A request was made quickly to the Emergency Duty Team (EDT) for an Approved Social Worker/Appropriate Adult. Angela Ayre, a member of the Emergency Duty Team, was called to the station. In the event, she acted as an Approved Social Worker for SH, and arranged to act as an Appropriate Adult when police interviewed SH's mother.

Angela Ayre recorded in some detail the difficulties experienced by all the professionals in interviewing SH due to his distressed state. Indeed, he was considered so unwell by the police that samples of blood, fingernail clippings and the like were not taken, notwithstanding the perceived need for such evidence to enable SH to be charged. SH was not formally interviewed and was not charged before he was sectioned.

Angela Ayre and the FME both formed the view that it was necessary for an assessment of SH's mental state to be carried out. Angela Ayre accordingly contacted Dr Frank Rohricht, the

consultant psychiatrist on call, and informed him of the need for such an assessment. Dr Rohricht duly attended at the station. He told the Inquiry panel in evidence that this was only the second time that he had been called upon to carry out a Mental Health Act assessment at a police station. Dr Rohricht's view was that SH was not fit for interview and that he should not be in custody. Dr Rohricht took the view, therefore, that SH should be detained under section 2 of the Mental Health Act 1983. No forensic psychiatric advice was available to either Angela Ayre or Dr Rohricht.

After a discussion with Dr Rohricht and a Duty Nurse, Angela Ayre made the section papers out to East Ham Memorial Hospital. It is difficult to see what other options were open to her at this time. Her evidence to the Inquiry panel was that, although theoretically it was the psychiatrist who was responsible for finding a patient a bed, in practice it was usually the Approved Social Worker who contacted a hospital in order to identify a bed. Similarly, Dr Rohricht, whilst acknowledging that the Code of Practice places this responsibility on the doctor [Department of Health Code of Practice 2.18(d)], told the Inquiry panel that doctors are usually heavily pressed for time. He said that if they actually undertook the task of locating an inpatient bed whenever a decision was made to admit a patient to hospital, the job would be impossible. In practice, therefore, so he told the Inquiry panel, it normally came down to the Inpatient Manager to locate an appropriate bed.

On this occasion, however, there was no liaison with the Inpatient Services Manager, Mr Vijay Sonnar, and the section papers were, accordingly, made out to East Ham Memorial Hospital without his input. Mr Sonnar's evidence was that he was the on-call manager at this time, available 24 hours a day, and Dr Rohricht said, very frankly, that the failure to contact Mr Sonnar was an oversight on his part, largely contributed to by the pressure which he felt he was under from the police to have a decision as to whether or not SH was fit to be interviewed and to provide samples for forensic purposes.

Having formed the view that SH was not fit to give informed consent to the taking of samples or to be interviewed, Dr Rohricht was in a very difficult position. The police were not prepared, on the state of the evidence then available to them to charge SH so that he would be processed through the judicial system. However, Dr Rohricht was aware that placing a patient who was suspected of homicide in an appropriately secure place, for practical purposes a Medium Secure Unit, was an impossibility - the Inquiry panel was told by more than one witness that it usually takes between three and six months to obtain a medium secure bed.

Comment:

It is not possible to fault Dr Rohricht for reaching the conclusions that he did reach about SH's condition. If his medical opinion was that SH was not fit to provide informed consent or to be interviewed, then he was obliged to act on that opinion. However, the practical problems which arise in such circumstances are formidable. It was agreed by the witnesses involved in this episode who gave evidence to the Inquiry panel that advice from a forensic psychiatrist, even if only by way of the telephone, might perhaps have helped to avoid the difficulties which then ensued in trying to deal appropriately with a mentally ill patient in a police cell, who was suspected of a homicide, but who the police were unwilling or unable to charge. We deal with this difficult question in the Discussion section of the Report below.

In the event, with the section papers made out to East Ham Memorial Hospital, enormous practical problems arose. East Ham Memorial Hospital, understandably enough, refused to accept SH. He was a man suspected of a homicide and East Ham Memorial Hospital had only open beds for acute psychiatric patients. It was perceived that SH would present a real risk to other patients on the ward and, quite correctly, Mr Sonnar refused to allow SH to be admitted.

The police custody staff grew increasingly concerned about SH’s continued presence in the police cells and involved senior officers to try to resolve the situation. Police officers believed they were acting only as a ‘Place of Safety’ under Sections 135/136 of the Mental Health Act 1983. The police custody records show that they were concerned that SH's continued detention, once he had been sectioned, might well infringe his human rights.

Following a meeting on morning of 5 June attended by Mr Sonnar, Dr Rohricht, and Kevin Mullins (the Newham Locality Director of Mental Health for the East London and The City Mental Health NHS Trust), Dr Rohricht attempted on the morning of 6 June to rescind the Section 2. However, the police, understandably enough, refused to accept this.

Eventually, however, Mr Sonnar, after making considerable efforts to locate a bed somewhere, and in the face of increasing pressure from the police who were most unhappy, again understandably, about having SH in their cells when he had been sectioned under section 2 of the Mental Health Act 1983, was able to persuade his colleagues at the Psychiatric Intensive Care

Unit ("PICU") at Runwell to agree to take SH. Mr Sonnar said in evidence that it was only as a result of a very good working arrangement which he had with his PICU colleagues at Runwell that he was able to make this arrangement. As part of the arrangement, Mr Sonnar agreed to take back two patients who were currently at the PICU in Runwell. He told the Inquiry panel that these patients were not considered ready to return but he took the view that the risk involved in their return was lower than the risk faced with SH if he could not be moved to the PICU. Not only did Mr Sonnar agree to take back these two patients, so as to create capacity at Runwell, he also agreed that East Ham Memorial Hospital would close the empty bed and be responsible for SH's supervision until alternative arrangements could be made.

This did not, however, end Mr Sonnar's problems. Because the Section 2 papers were made out to East Ham Memorial Hospital, Mr Sonnar himself went to Runwell to accept papers on behalf of East Ham Memorial Hospital before formally transferring SH to Runwell.

Comment:

It was fortunate indeed that Mr Sonnar, who struck the Inquiry panel as a most competent individual, was able to take advantage of his personal contacts to sort out a potentially intractable problem here.

Overall, the position following the arrest can be summarised as follows. SH was sectioned at 08.45 on Sunday 4 June, but it was not until 13.45 on Tuesday 6 June that he was removed from police premises. As SH had been arrested at 02.15 hrs on 4 June (arriving at Forest Gate Police Station at 02.30 hrs) he had therefore been in continuous police custody for 59 hours 30 minutes.

Comment:

As has been recognised by all relevant witnesses to the Inquiry panel, this situation was highly unsatisfactory.

On 7 June, SH was interviewed by Dr Bartlett, Specialist Registrar from Hackney Medium Secure Unit ("MSU") who agreed to accept SH when a bed became available. On 11 June, SH was transferred to the John Howard Centre (the MSU for East London and The City Health Authority).

He has since remained at this MSU. We understand that on 12 November 2001 a decision was made by the Mental Health Review Tribunal that SH should remain detained.

Discussion

The quality of care provided to SH

Diagnosis and discharge

As will be apparent from the foregoing, the Inquiry panel feels that there were serious shortcomings in the care afforded to SH during his time as an inpatient at East Ham Memorial Hospital.

Most importantly, there was, on discharge, no formal risk assessment at all, at least none which has been documented. There were at least two points in the management of SH when Dr Selvaratnum should, we think, have made a formal written risk assessment, firstly before discharging SH to the community in September 1997 and secondly when reporting to the Court in connection with SH's assault on a police officer.

We are not suggesting, even with hindsight, that Dr Selvaratnum could, in September 1997, have been able to predict the events of 4 June 2000. However, Dr Selvaratnum should have been informed by the guidance available to him on the issue of risk assessment from the Department of Health and the Royal College of Psychiatrists. In 1994 the Department of Health published *Guidance on the Discharge of Mentally Disordered Offenders* and, in 1995, *"Building Bridges.* More importantly, the Royal College of Psychiatrists published, in April 1996, two documents, *The Report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People,* and Council Report 53 *Assessment and clinical management of risk of harm to other people.* Under "General Principles" this Council Report notes that:

> "Risk cannot be eliminated; it can be rigorously assessed and managed, but outcomes cannot be guaranteed."

It continues:

> "Interventions can increase risk as well as decrease it. The interaction between the clinician and the patient is crucial in the assessment and management of risk. Good relationships make assessment easier and more accurate and may reduce risk. Risk may be increased if the doctor/patient relationship is poor."

We feel that Dr Selvaratnum's management of SH would have been more robust had he followed

these principles and produced a written risk assessment. There is, unfortunately, little evidence of Dr Selvaratnum establishing any relationship with SH. On his own admission, he had very limited face-to-face contact with SH during the in-patient episode. He also failed to take properly into account all of the information recorded by his junior staff about the nature, degree and context of SH's illness. The importance of a comprehensive assessment, with clinicians eliciting and taking full account of all environmental factors, including a full family history, and not focusing solely upon the patient's presentation, cannot be over-emphasised.

The Inquiry panel's view is that if all the relevant information which was available had been gathered, then a properly considered risk assessment would have led to the conclusion that SH was a patient who merited follow-up in the community. Almost every witness to whom the Inquiry panel posed the question (including Dr Selvaratnum himself) took the view that, with what was known about SH at the time in September 1997, the CPA should have been implemented and SH should have been the subject of a referral to a CMHT. There was a family history of serious mental illness; there was an attempted suicide whilst SH was an in-patient; and SH displayed a tendency not to comply with the requirements of his doctors - not least in absconding from the hospital without leave, whilst the subject of a "doorstop" policy.

However, as a result of an inadequate and undocumented risk assessment which unhappily reached the wrong conclusion, Dr Selvaratnum did not refer SH to CMHT-E following SH's discharge on 2 September 1997.

We also consider that, for similar reasons, the diagnosis recorded in the discharge summary of a brief psychotic episode was probably incorrect - albeit it does not appear to have influenced Dr Bhadra's own diagnosis.

Further, whether the decision made by Dr Selvaratnum that SH did not need to be referred to a CMHT was or was not a reasonable decision, we consider that the information which was included within the discharge summary was inadequate. In the first place, it omitted any reference to the personal details, elicited by Dr Patel and Dr Springer, including the content of the paranoid delusional system, which the Inquiry panel considers would have provided a useful insight into and a fuller understanding of SH's condition and of the feelings of guilt which had triggered his mental breakdown. The fact that this information was not shared with those responsible for his

care following his discharge, meant that those carers were handicapped in forming a proper risk assessment of SH. Secondly, the discharge summary contained no reference to the incident of 21 August 1997. An incident of violence, or threatened violence, involving SH would surely have been relevant to any future risk assessment, and this information ought also to have been passed on to the GP.

So far as post-discharge care is concerned, there was regrettably a further failure by Dr Selvaratnum to pass on relevant information when he failed to pass on to Dr Bhadra details of the report which he had been asked to prepare in connection with SH's conviction for assaulting a police officer. This occurred only a month after he had been informed that Social Services had concerns about SH's children.

By this time, Dr Selvaratnum should have appreciated that his patient was withdrawing from treatment, was failing to comply with medication, and was involved in the criminal justice system, albeit in relation to a relatively trivial matter. He was aware that there was no clear care plan and that there had been no real contact between the clinicians and the main carer, AK.

We feel that if Dr Selvaratnum had followed the advice from the Royal College of Psychiatrists at this point (his last face to face meeting with SH) he would have appreciated the need to have the CPA implemented, and would have given a more detailed consideration to what community supports were in place and what access those carers had to appropriate support and help. He would also have ensured that this information was available to the GP.

We cannot, therefore, avoid making direct criticism of Dr Selvaratnum here. There is no documentary evidence confirming that he acquainted himself sufficiently with SH's history and family background. He failed to interview AK. He failed to ensure that all relevant material about SH's condition was included in the discharge summary; and he failed to carry out, and record, a formal risk assessment prior to discharge. Had a proper risk assessment been done, with the benefit of all available information, we think that it is very likely that Dr Selvaratnum would have recommended that SH should be followed up in the community and should therefore be referred back to a CMHT on discharge.

There was some evidence presented to the Inquiry panel to the effect that Dr Selvaratnum's continuing position as a locum consultant, and his relationship with his employers, may have

affected his attitude to his work. It is not possible for this Inquiry panel to take a view on this question, which would require investigations going beyond our Terms of Reference. Whether or nor this was the case, (and it seems that he was employed as a locum for a surprisingly long time), there was certainly evidence suggesting that he did not work within the multi-disciplinary team with the same vigour as the permanent consultant. We have been told that since his departure, there has been a permanent consultant in post, and that there has been, or is perceived as being, considerable improvement in the communications between Elgar Ward and the associated CMHT.

This case therefore, illustrates once again the value of making strenuous efforts to appoint and to retain permanent consultants. The advantages of such a policy are largely self-evident. The presence of permanent consultants allows continuity of care; it allows for the proper development of policies and procedures; and it helps to ensure the necessary degree of commitment on the part of the consultant psychiatrists which is vital to take forward the delivery of care to vulnerable individuals.

We note that the National Service Framework for Mental Health sees "Partnership working" as the model for future developments. This proposes a key leadership role for consultant psychiatrists and it is critical that substantive posts are filled in order to discharge this responsibility. The East London and The City Mental Health NHS Trust should be aware that making these permanent appointments is an important element in the structure of clinical governance.

On a related issue, we note that the East London and City Mental Health NHS Trust has introduced a Care Programme Approach Policy in March 2001, which incorporates guidance on the assessment and management of risk.

It is particularly important that the Trust develops an approach to training and continuing professional development, which includes assessment and management of risk. Within such training there should be an emphasis on teamwork and communication.

It is, therefore, our recommendation that the Trust should develop a systematic approach to the assessment of clinicians' training needs; and should have in place a training programme that addresses risk assessment and management. Bearing in mind what we perceive as the failure, in this specific case, to take proper account of the family history and other environmental factors,

such training should also seek to ensure that full recognition is given to these factors in any assessment.

The Care Programme Approach

It was apparent to the Inquiry panel that the CPA was not being implemented with all necessary vigour in 1997. Many witnesses to the Inquiry panel spoke of improvement which had occurred since that time and it is unfortunate that the slow start to the implementation of the CPA may have created, or allowed, a culture where full and proper consideration may perhaps not always have been given in each case to the question of whether or not there should be CMHT involvement following discharge.

Since 1997, East London and The City Mental Health NHS Trust has produced a CPA policy document (March 2001). We have considered this document and it appears largely satisfactory, although links with Primary Care Teams and the role of GPs may have to be reviewed. If the Trust is to ensure that all operational staff implement this latest guidance in full, it will need to ensure that all operational staff, including senior clinicians, are adequately trained in the requirements of the policy.

It will be important to ensure that there is Trust-wide guidance on the implementation of this policy and that care co-ordinators are in place. We were disappointed to learn that despite the more thorough approach to CPA set out in this policy document, at present people are being identified on CPA who are unallocated and held on a duty basis as a result of staff shortages. It has been drawn to our attention that in a report to the East London and The City Health Authority and to the London Borough of Hackney by the Independent Inquiry into the care and treatment of Feza M, dated September 1999, the following recommendation was made:

> *"1(i) East London and The City Health Authority, City and Hackney Community Services NHS Trust and the London Borough of Hackney should jointly review the existing CPA policy to ensure Keyworker arrangements are in place for all patients subject to CPA."*

It is therefore disappointing that, almost 3 years later, it is necessary again to comment upon shortcomings in the implementation of the CPA. The Trust needs to address this issue and develop clear standards for the monitoring of this policy.

We were surprised in this connection to hear evidence from Mr Horn (who was, as mentioned above, formerly the Chief Executive of Newham Community Health Trust Services and subsequently the Chief Executive of the East London And The City Mental Health NHS Trust) to the effect that, because the Independent Inquiry into the care and treatment of Feza M related to a homicide in a neighbouring Trust, City and Hackney Community Services NHS Trust, it was questionable whether anyone in Newham would ever actually have considered its recommendations at all.

We welcome the plan for the CPA audit indicated in Phase 3 of the Local Implementation Plan for the National Service Framework for Mental Health, and particularly welcome the involvement of users in this audit. Consideration might also be given to the involvement of carers.

We therefore recommend that the Trust consider the role of Primary Care Teams and GPs in the CPA policies and procedures; that there is Trust-wide guidance on the implementation of the policy; that carers should be involved in the audit of CPA; and that training for operational staff including senior consultants should be available.

The GP's care

We now turn to consider the role played by SH's GP, Dr Bhadra. In the absence of a Panel member with direct experience of general practice, the Inquiry panel asked Dr Andrew Polmear FRCP FRCGP to assist with those parts of this Report which address the involvement of general practitioners in SH's care and treatment. Dr Polmear is the Senior Research Fellow at the Academic Unit of Primary Care, at The Trafford Centre for Graduate Medical Education and Research at the University of Sussex. He is Clinical Adviser to the East Sussex, Brighton & Hove Medical Audit Advisory Group. He practised for 17 years as a GP in Hove and during that time was a GP Trainer and course organiser of the Brighton GP Training Scheme. From 1997 to 1998 he worked as the Acting Associate Dean of Postgraduate GP Education for East Sussex and he remains involved in the training of GPs. He is the co-author of *Practical General Practice*, a book for GPs on the management of clinical problems, including management of acute psychosis and schizophrenia. The Inquiry panel is most grateful to Dr Polmear for his assistance in the preparation of this Report. The comments about the role of Dr Bhadra which follow are the views of the Inquiry panel, but we have been greatly assisted in forming those views by the input provided by Dr Polmear.

We have commented above upon our concerns about Dr Bhadra's initial response to AK's attendance at his surgery on 8 August 1997, and in particular, his decision to prescribe anti-depressants to a patient who he had not seen and who was clearly potentially psychotic. It is not possible to know whether or not the prescription of anti-depressants contributed towards the increase in SH's agitation which manifested itself the following day.

We have also commented upon what we consider to be the less than satisfactory standard of record keeping by Dr Bhadra over the time in which he was involved in the care and treatment of SH. At the material times, the General Medical Council's guidance to practitioners as to good practice advised that a practitioner should:

> *"Keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to the patients and the drugs or other treatment prescribed."* [Source: *Good Medical Practice. Guidance from the General Medical Council* October 1995]

Dr Bhadra's notes do not meet this standard. On each of the occasions when he told the Inquiry panel that he had conducted an examination of SH (for example 1 September 1997, 1 December 1997 and 29 May 1998) the notes simply record the issue of a medical certificate, the length of time for which SH was certified as unfit to work, and the single word "Schizophrenia". Whilst Dr Bhadra carried out an examination of SH on these occasions, he did not record any details of his findings, merely his conclusion, namely that the diagnosis was schizophrenia. It is relevant in this context to record that Dr Bhadra's evidence was that he was an extremely hard-pressed practitioner, seeing as many as 50 patients a day with only part-time support from Dr Sahu. He also pointed out that many of those patients were from ethnic minorities, and we accept that this may well have made increased the pressure on his time since taking a full history when there are language difficulties cannot be easy. Dr Bhadra also pointed out that the local psychiatric services were somewhat stretched and that at the material times he did not as a General Practitioner have direct access to a community psychiatric nursing service. There was no out-of hours CMHT, and if he required an out-of-hours psychiatric assessment he would have to refer the patient in question to the casualty department of Newham General Hospital or to Goodmayes Psychiatric Hospital in Goodmayes, Essex.

The absence of any record of Dr Bhadra's clinical examinations and of the basis for his diagnosis of schizophrenia is important because that diagnosis, first made in September 1997, and

Dr Bhadra's subsequent willingness to certify SH as unfit for work for lengthy periods, must be contrasted with the discharge summary which set out a different analysis of SH's problems - namely, a diagnosis of a brief psychotic episode. We think, with the benefits of hindsight, that Dr Bhadra was right in his diagnosis and that SH does have a severe and enduring mental illness. We are, however, concerned that he did not seek to discuss his differing diagnosis with Dr Selvaratnum, who was and remained unaware of the diagnosis reached by Dr Bhadra.

It must be possible for GPs to be able to feel free to pick up the telephone and speak to a consultant if, as here, they reach somewhat different conclusions about the appropriate diagnosis of a mutual patient. We recommend that steps be taken to put in place shared care protocols for the clinical management of people with severe mental illness; those protocols should encourage informal liaison between GPs and consultants as and when necessary.

We are also concerned that Dr Bhadra was left, or left himself, with the responsibility for monitoring and managing a patient whom he had diagnosed as schizophrenic. The National Service Framework envisages that patients with enduring mental illnesses, including schizophrenia, will be managed within the psychiatric services. The National Service Framework had not been published in 1998, but it would, in our view, still have been best practice for Dr Bhadra to have sought to involve the CMHT in the care and management of SH from May 1998 onwards when SH was formally discharged from Dr Selvaratnum's care. We believe, therefore, that much stronger links need to be developed between GPs and the CMHTs so a GP has the opportunity to discuss diagnosis and management of a patient, even one who has not been referred to the CMHT, particularly when the GP otherwise has the sole responsibility for monitoring the mental state of a patient.

Consultants should also be encouraged to consider the option of discussing a patient with his/her GP directly before making a decision upon whether or not to implement the CPA. It is, therefore, our recommendation that CPA arrangements should, where possible, be planned in conjunction with the GP as well as the CMHT, particularly where it is the GP who is expected to monitor the patient's mental state.

We heard from Caroline Godleman, Mental Health Manager for East London and The City Mental Health NHS Trust and the London Borough of Newham, that links with the GPs have improved quite significantly. There are three primary care liaison nurses who work

specifically on the interface around primary/secondary care. Each GP has a link worker. It should now be possible for the GPs to seek help if they are concerned about the mental health of one of their patients.

There is also a proposal being put forward by Ms Godleman that CMHTs should be linked with individual General Practices. This is a proposal which we support.

We have considered carefully Dr Bhadra's approach of waiting to be approached by SH (or by AK) rather than adopting a more proactive role. In the event, neither SH nor AK did come back to him about SH's mental health, notwithstanding a serious deterioration in SH's mental health. It cannot be said that Dr Bhadra's decision to adopt a "wait and see" approach in May 1998 was based upon a belief that SH was fully recovered. Dr Bhadra was still certifying SH as unfit to work for extended periods; and in his report of 25 April 1998 to the Benefits Agency, Dr Bhadra recorded his reservations about SH's ability to self-medicate, saying, in answer to a question as to whether SH could administer his own medication:

> *"Yes, when he is better, other times another person has to administer the medicines."*

In retrospect, it would clearly have been better if Dr Bhadra had taken steps to involve the CMHT in the care of SH. His decision not to do so is understandable, particularly in light of the fact that Dr Selvaratnum had decided against a referral to the CMHT. There was little in SH's past history, as known to Dr Bhadra, which would lead him to take the view that SH might be a risk to others. There was the family history of mental illness, but only the younger brother, JH, was known to have violent tendencies. Dr Bhadra also told the Inquiry panel that he had seen AK herself, and her children, on a number of occasions from 1998 onwards. He said that SH routinely accompanied AK on her visits to his surgery; and his evidence was that nothing that he saw in any of these contacts with the family caused him to suspect that SH's condition was deteriorating.

Dr Bhadra might perhaps have taken a different view about seeking to involve the CMHT if he had been given additional information about SH. It may be, for example, that full knowledge of the circumstances of the incident of 21 August 1997 would have led to a different risk assessment by Dr Bhadra, but we simply do not know enough about that incident to take a view on this. In the light of the circumstances known to Dr Bhadra, and in the light of his assessment of AK and her demonstrated willingness to access the mental health services if SH

needed help, we can see why he adopted the approach which he did.

However, the care of a patient with schizophrenia should never just be seen as involving simply the prescription of medication as and when sought by the patient. If a patient is not under the care of specialist services, a GP should seek to initiate discussions with the patient and his family about the diagnosis, what the future holds, and what should be done in the event of a relapse. He should seek to discuss with the patient the impact of the illness upon that patient's social and family life, and upon his ability to work. He should try to build up a relationship with the patient by regular contact, sending for the patient if he fails to attend on a regular basis, and making home visits if necessary. Where appropriate, a GP should ensure that a patient receives the benefit of contact with specialist services.

In this case, the evidence is that SH was only infrequently examined by Dr Bhadra after September 1997. There must have been an examination on 1 September 1997, when Dr Bhadra first made his diagnosis of schizophrenia - as noted above, the letter "E" appears in the notes, indicating an examination was carried out, although no details of the findings are recorded. There was a further examination on 1 December 1997, when the diagnosis of schizophrenia was confirmed - notwithstanding the contents of the discharge summary from East Ham Memorial Hospital - and when Dr Bhadra certified SH off work for a period of six months. There was another examination on 29 May 1998, when Dr Bhadra again certified SH off work for a period of six months.

The Inquiry panel's view is that it must be very difficult for a GP, however experienced, to form a fully informed picture of a patient's mental state based only on short examinations of the type described above, separated by many months. The panel further believes that in the early stages of an illness, before the diagnosis has been confirmed, and before a care plan has been established with which the patient is compliant, there should be regular mental state examinations, ideally on a monthly basis. We recognise that the demands on the time of a GP are such that this may be an unattainable objective, but we are advised by Dr Polmear that reviews as infrequently as six monthly are only appropriate for a patient with an established record of well controlled schizophrenia. We are further advised that, bearing in mind that SH was in the early stages of his illness (and was soon recognised as being non-compliant with his medication), he should have been seen by Dr Bhadra monthly, until a record of at least six months stability had been established.

This issue is directly related to the question of issuing repeat prescriptions of anti-psychotic medication without mental state examinations. Guidance from the General Medical Council, set out in Good Medical Practice (3rd edition - May 2001), states in relation to repeat prescriptions:

"Doctors in many GP practices are making increasing use of pre-printed scripts, to simplify the work involved in issuing large numbers of repeat prescriptions. Getting scripts prepared by practice staff or generated by computer can be an efficient way of meeting patients' needs, while reducing demands on doctors' time. It is important, however, that any system for issuing repeat prescriptions takes full account of doctors' obligations to prescribe responsibly and safely. Before signing a repeat prescription, a doctor must be satisfied that it is safe and appropriate to do so. Arrangements for issuing repeat prescriptions should include suitable provision for monitoring each patient's condition; and for ensuring that patients who need a further examination or assessment do not receive repeat prescriptions without being seen by a doctor. This is particularly important in the case of drugs with potentially serious side effects, for example steroid preparations, where safe management must be a priority."

The view of this Inquiry panel is that the repeat prescription of anti-psychotic medication should be accompanied by regular mental state examinations, ideally on a monthly basis at least in the early stages of the illness. It is therefore our recommendation that Newham Primary Care Trust should review its clinical governance protocols regarding repeat prescriptions to ensure that arrangements for issuing repeat prescriptions include suitable provision for regular and appropriate monitoring of each patient's condition, and for ensuring that patients who need a further examination or assessment do not receive such prescriptions without being seen by a doctor. Clear guidance should be made available to GPs.

Furthermore, and on a more technical level, we consider that more consideration should have been given to the continued use of Haloperidol. The new neuroleptics on the market have fewer side effects, and, in view of SH's irregular compliance with his medication, it would have been more appropriate to have considered using one of these new neuroleptic medications rather than Haloperidol. We believe that the inconsistent use of Haloperidol by SH over the months and years following his discharge may have contributed to the serious deterioration in his mental state and the resultant violence which led to the index offence.

We would, therefore, recommend that advice should be issued to GPs regarding best practice in the prescription of anti-psychotic medication. That advice should be regularly updated. Prescribing patterns should also be monitored and further support provided to GPs if and when inconsistency with modern practice is identified.

Furthermore, as we have commented, the pattern which developed here was that SH attended at his GP's practice on increasingly irregular occasions for repeat prescriptions, making it apparent that he cannot have been taking the medication regularly and appropriately. There are practical difficulties for a GP in identifying occasions when patients do not re-attend to collect a repeat prescription which may indicate non-compliance by that patient with his medication. We are aware that action is already being taken nationally to improve both management and clinical control of repeat prescribing to ensure that patients' treatment is monitored and altered according to their changing needs. With the technology now available, it ought to be possible to set up systems which are capable of flagging up instances where a patient who is on repeat prescriptions (of whatever nature) fails to re-attend for that prescription at the appropriate time, and who is likely therefore to be defaulting.

We therefore recommend that Primary Care Trusts should devise and implement systems to monitor repeat prescriptions which are sensitive enough to pick up instances of non-compliance with, or inappropriate under-using of, medication, so as to flag up for GPs the necessity for consultation with a patient before a further prescription is issued.

The position of AK as SH's carer

Dr Bhadra's passive approach to the management of SH placed, intentionally or otherwise, a great responsibility upon AK. She was described by Dr Bhadra as a reliable and articulate source of information; and she was clearly relied upon by him to report back on SH's progress. It was anticipated that she would notify the mental health services in the event of a deterioration in SH's condition. Dr Bhadra also considered her as a reliable person to supervise, albeit in an informal sense, the administration of SH's medication - she was the major carer of SH (and indeed of other members of this family) in the sense that she provided a substantial amount of care on a regular basis.

Tragically, AK, the carer, ended up as the victim. There is statistical evidence available now that a large number of carers become victims of homicide and this is also reflected in the statistics on

domestic violence - the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, for example, found that 82% of mental illness homicides have a family member as victim. The risk assessment in this particular case was, as we have said above, inadequate, but one lesson which can be learnt for the future is that there are very real dangers in assuming that a wife, or other relative, acting as carer for the patient concerned can and will be able to access the mental health services if and when further problems arise. We do not know whether domestic violence and consequent fear of reprisals played a part in AK's decision not to re-engage the mental health services even when SH's condition deteriorated and she had difficulty getting him to take his medication; but it is very possible that this was a factor, and domestic violence may be a factor in many other cases, making it difficult or impossible for a carer to seek assistance when it is needed most.

Considerable care needs, therefore, to be exercised by clinicians before following a course similar to that adopted here, leaving it up to a patient or his/her carer to identify a deterioration in condition and to access the mental health services. There will still be many cases where continuing active involvement by the mental health services is neither necessary nor practical, and where, accordingly, it must be left to the patient or his relatives/carers to contact the mental health services. However, we feel that greater emphasis needs to be given to the position of the carer, and, in particular, consideration needs to be given to the possibility that a situation may develop where the carer is either unable or unwilling to access the mental health services.

If, notwithstanding the dangers, such reliance is to be placed upon a carer, it must be done explicitly, so that the person concerned knows and understands what responsibilities are being placed upon him or her. It is significant that there is no reference in any of the documentation available to this Inquiry panel to any assessment of AK's needs as a carer and that there was no reference to such an assessment in the evidence of any of the mental health professionals who gave evidence to the Inquiry panel. In particular, despite AK being clearly considered the main carer and despite the fact that the medical practitioners were dependent on her reporting on SH's need for medication, there is no record in the notes of her ever being given any information about his medication. She could, for example, usefully have been told of the likely consequences of SH ceasing to take that medication, and of any side effects of the medication which could have been expected or predicted. This was a clear failure by those concerned to support AK in her carer's role.

It is also of concern that at no point in the management of SH did AK's views appear to be taken into account in the care planning. As mentioned above, during SH's period as an in-patient at East Ham Memorial Hospital she was never interviewed by the consultant despite his being aware that there was a family history of mental illness. The only occasion on which she appears to have been contacted was when a period of home leave was being considered and she unsurprisingly reported that she was happy that her husband was well enough to return home. No assessment appears to have been made of the home circumstances. Before SH was discharged from this in-patient episode, he requested assistance with his housing arrangements and consideration was given to him being referred to a social worker. However, as it was decided that he did not qualify for a social work referral, he was told he would have to make the necessary application to the housing authorities himself. This was in itself unhelpful, and the Inquiry panel considers that it is a decision which could not properly have been made unless and until there had been an assessment of the home circumstances and a carer's assessment.

The role of carer is complex and requires a sensitive approach from mental health professionals. The evidence that we have heard suggests that AK had to cope with crises, acute distress and difficult behaviour from SH. As a carer she also had to cope with the long-term effects of mental health problems of other members of the family and had to shoulder the responsibilities for the parenting of her two young children and the management of the household. At the very least, some form of assessment of AK should have taken place to determine what supports were necessary to sustain her in her carer's role and to consider if any services could have been available through the Social Services Department. Such an assessment might well have picked up the significance of the various environmental factors which we feel Dr Selvaratnum, in his assessment of SH, under-estimated or overlooked, and might well have led to a reconsideration of the decision that SH should not be referred back to CMHT-E. AK should also have been advised of any carers’ support group or other appropriate support networks to have enabled her to address issues of her own health and well-being. If such a service had been in place it is possible AK may have had an outlet, other than or additional to Mohammed Sufi Khan, when she began to experience difficulties in the marriage.

Our recommendation is that there needs to be a close link between the CMHT, the carers and also the local police Domestic Violence Unit so that the CMHT can be proactive in putting people who they consider to be at risk in touch with the Domestic Violence Unit. More information also needs to be made available to carers, particularly women carers, of the existence of not only the local Domestic Violence Unit but also voluntary sector organisations which help victims of domestic

violence. This link between the carers of people who are mentally ill, the CMHT and the voluntary sector should be initiated and monitored by the managers of the CMHT.

The Carers and Disabled Children Act 2000 should ensure that non-professional carers who provide regular and substantial care receive an assessment of their own needs. However, it is essential that CPA procedures be adhered to so that people like AK are not excluded from such assessments. It is also imperative that mental health professionals are aware that the starting point of a Carer's Assessment should be the carer's views and what the carer thinks are the most important issues.

In this context, the Inquiry panel considers that it is important that training be made available to all mental health professionals and GPs in the operation of The Carers and Disabled Children Act 2000. Steps should also be taken to ensure that carers are involved in assessment and treatment processes as early as possible in accordance with Standard 6 of the National Service Framework. Furthermore, we consider that the London Borough of Newham should publish a directory containing an "A-Z" of local carer organisations and other sources of support for carers of persons with a mental illness, and that such a directory should be readily available to carers throughout all areas of mental health services.

There was no contact between SH and his GP about mental health issues at all between April 1999 and June 2000. We can only speculate about what might have emerged had a more pro-active approach been adopted during this period. The involvement of a social worker with SH over this period may well have provided AK with a route whereby she could convey her concerns about the violence to which she was apparently being subjected (assuming that the account which we have seen was given by the younger sister, A, in her witness statement to the police is accurate). Such contact would have provided AK with an opportunity to express her concerns about SH directly to the mental health services. Professionals may also have appreciated the dangers of SH's attitude towards his medication - being reluctant to take it at all, but in any event only taking it as and when he felt it was required - and warned AK of the possible implications of this.

Spiritual and religious care

We have commented above upon the role of Mohammed Sufi Khan in the this tragedy. A vulnerable and mentally ill man was taken under the wing of this spiritual adviser, and ended up

seeing him on a daily basis. Regrettably, and surprisingly, a serious deterioration in his mental health apparently went either unnoticed by Mohammed Sufi Khan, or, if it was noticed, no attempt was made to get SH to seek medical help. There is no reason to expect Mohammed Sufi Khan to have any particular insight into mental health issues, but we find it difficult to accept that a man whom SH followed and trusted implicitly, and who saw SH on a daily basis, had no appreciation of the increasing mental health problems which SH was experiencing. If, as some evidence suggests, he was aware of increasing violence being exhibited by SH to AK and of the deterioration in SH's mental state, it is very sad that he did not seek to obtain help and advice for SH and AK, and did not in particular advise them to seek further assistance from the mental health services.

In a multi-cultural context such as East London, where there is a such a range of ethnic and religious groups, the local population may well choose to first access spiritual leaders rather than the mental health services. This type of problem, where a mentally ill patient seeks advice and guidance from a spiritual leader rather than from the mental health professionals, is therefore likely to recur.

Traditional healers and spiritual leaders have their place in the treatment of the mentally ill, and the mental health services must be careful to respect the traditions and belief systems of other cultures. However, if and when the mental health services become aware of contact between a mentally ill patient and religious leaders or guides who can perhaps best be described as outside of the mainstream, attempts should be made to consider carefully the implications of that contact. It should be recognised that there are risks as well as benefits of the involvement of religious or spiritual advisors in supporting a person with a mental illness. Furthermore, efforts should be made to engage religious and spiritual advisors in the CPA process so as to ensure the closest compatibility possible between the care provided by mental health services and that provided by a religious or spiritual advisor.

More generally, however, in the culturally diverse context of East London, where there are communities whose first recourse, faced with mental illness, may well be to traditional healers or spiritual leaders, rather than to the mental health services, it is important that spiritual and community leaders are given as much insight, education and information as is possible into the role of the mental health services. The objective must be to reach a position such that if and when such leaders are faced with a situation involving mental illness, they have the knowledge to enable them to make appropriate suggestions to the individual or family concerned as to the

assistance which can be obtained from the mental health services. The objective must also be to try to change, by education and information, the type of situation illustrated by the case of SH and AK, where individuals chose to seek solutions for mental illness otherwise than by accessing the mental health services.

It is not realistic to expect that liaison with local spiritual leaders could or should target the type of informal spiritual guide which Mohammed Sufi Khan apparently represents. There are already so many religions and ethnic groups represented in East London (evidence presented to the Inquiry panel suggests 294 religious organisations in Newham alone) that it is probably impossible at the moment to expect effective liaison even with the more formal spiritual leaders, let alone individuals such as Mohammed Sufi Khan. However, the scale of the problem should not deflect the mental health services from the continued pursuit of a policy to educate and inform religious and ethnic groups about the role of the mental health services, particularly on issues of risk and public protection (in particular, relapse, violence, domestic violence and child protection issues).

Work is already being done in East London to make the mental health services more sensitive to the cultural needs of its users - work described in the evidence given to the Inquiry panel by Mr Nigel Copsey, who has initiated an ambitious project designed to build bridges between ethnic communities and the mental health services. This work is commendable - the more sensitive the mental health services are to the religious and cultural needs of its users, the more likely it is that those users will be prepared to access the services when there is a need. However, in an area as culturally diverse as East London, there will surely be enormous difficulties in seeking to accommodate the needs of each and every group. The view of the Inquiry panel is that it is at least as important to focus on seeking to inform and educate those minority communities about the role of the mental health services, as it is to sensitise the mental health services to the needs of users from minority communities.

We believe that health organisations and local authorities should engage in this educative role with a wider range of community organisations, including self-help groups, like the Newham Women's Advisory Group, and minority ethnic organisations. The objective should be to develop a programme of education and information on mental health policies, care and treatments, aimed at reaching faith communities and influential community groups.

These improved links will be necessary for the new roles envisaged in the *Mental Health in*

London: Strategy for Action, which highlights the role of the local authority as community leader; and the Local Government Act 2000 which gives local authorities powers *"to improve economic, social and environmental well-being"* in their community.

Under the National Service Framework, health authorities, and now primary care trusts, are to act to improve the *"health and well-being"* of their populations. These roles require a dialogue with all sections of the community, including faith communities, in engaging on the wider issues of risk and public protection in relation to people with mental health problems. We recommend that the health organisations and local authorities initiate a dialogue with faith communities and other groups on issues of risk and public protection in the management of people with mental health problems.

Domestic violence

It seems that AK told no one, apart from her sister and perhaps Mohammed Sufi Khan, about the violence which SH was exhibiting towards her. We are not in a position to form a firm view as to the extent of the violence which she faced, save to say that there were, even on SH's account, at least two such episodes of uncertain severity.

It is always important that women subject to domestic violence should have some place to which they can turn for advice, but the view of this Inquiry panel, which has the benefit of Dr Chandra Ghosh's knowledge of the Bengali culture and community, is that the availability of such a place is of still greater importance where cultural issues may make it even more difficult for a woman to acknowledge and report that she is the victim of domestic violence.

The scale of the problem with domestic violence is enormous and some of the statistics bear repetition. About 44% of all incidents reported by women to the *British Crime Survey* were domestic violence incidents. Since 1981, the largest increase in violent crimes has been in incidents of domestic violence. A number of local surveys in the UK show that about one in three to one in four women report having suffered domestic violence at some time in their adult life. A household survey of 430 women in a London borough found that one in three women had experienced domestic violence at some time in their lives. 12% have been victims of domestic violence within the last year. A survey of 281 women attending GP surgeries in West London found that one in three reported suffering abuse from a male partner. A survey carried out in 1997, of 129 women attending GP surgeries in North London, found that one in nine reported

experience of domestic violence serious enough to require medical attention in the last twelve months.

We are aware that AK did not seek help from her GP in connection with any domestic violence against her. We have to see that in the context of what happens to women who are subjected to domestic violence. It is known that, each year, 45% of female homicide victims are killed by present or former male partners, compared to 8% of male victims by female partners. On average, about two women per week are killed in England and Wales by their partners or ex-partners. We are aware that repeat victimisation is common and that half of all victims of domestic violence are involved in incidents more than once. We know that women who are subjected to physical violence often do not report the crime to the police - domestic violence is the least likely violent crime to be reported to the police. Domestic violence is a factor in one in four suicide attempts by women, and it seems to be a particular factor for women from the Indian sub-continent. It must not be forgotten either that children of families where the mother is subjected to domestic violence also suffer psychological effects; and although it does not arise directly out of the facts surrounding this Inquiry, we do recommend that Child Protection Agencies should consider the possible co-existence of domestic violence against adult family members when investigating cases of suspected child abuse. Mental health professionals should reciprocate by checking with the Child Protection Agencies whenever domestic violence is suspected in families with whom they are working.

In the case of this homicide, there is evidence that AK reported the physical abuse to her sister. She may also have reported it to Mohammed Sufi Khan, although we reiterate that he has denied all knowledge of any physical violence by SH towards AK. If AK did go along with SH in seeking help from Mohammed Sufi Khan, rather than going to the mental health professionals, this situation would not be unique to this Inquiry. We are aware that there are a number of cases of domestic violence where the individual has sought help from religious organisations or religious individuals, rather than seeking help from the mental health professionals, and the comments set out above in relation to the need to build links between the mental health services and local communities and faiths should encompass information and education about domestic violence issues as well as purely mental health issues.

Other Inquiries have noted that assessment for domestic violence needs to be integrated into the process of risk assessment and risk management. Whilst there is evidence here which suggests that AK was subjected to physical abuse by SH during a period of deterioration in his mental state

prior to the homicide, it is unlikely that any domestic violence would have been identified in any risk assessment of SH - there is certainly no suggestion of any domestic violence in 1997 or 1998. However, if a Carer's Assessment had been carried out, as we consider should have been the case, looking at AK's role in the family context - in this case a family with considerable psychiatric morbidity - it may perhaps have elicited information and/or created an environment which could have reduced the risks for AK here.

Evidence to the Inquiry panel was to the effect that staff in hospitals and CMHTs have little, if any, training around recognising the signs of domestic violence; and that it would be a matter of pure good fortune if staff recognised that a patient or carer was a victim of domestic violence.

We therefore recommend that all operational staff receive training in the recognition of domestic violence, its relevance to risk assessment and its appropriate management.

We would like also to register our concern regarding the management of SH's children. The statistics available suggest that children are affected both psychologically and developmentally when they are exposed to domestic violence against a parent by another parent. We think it is very important that this should be kept in mind and we would recommend that the children's needs should be assessed, keeping in mind that their father killed their mother following what was possibly considerable domestic violence over a period of a year or thereabouts.

Post-homicide events

So far as the events following the homicide are concerned, the principal point of concern is the difficulty which was encountered in getting SH to an appropriate bed once he had been assessed by Dr Rohricht.

We should comment, however, that, in spite of police anxieties, the holding of Mr SH in police custody for nearly 60 hours was legal. The early part of SH's period of detention was following his arrest on suspicion of murder. This would have been covered by the Police and Criminal Evidence Act 1984 and custody documentation reflects this.

Once SH had been examined by the doctors and the Approved Social Worker, and after they had decided to place him on Section, he became subject to the regulations issued under the Mental

Health Act 1983. Section 137 of that Act details:

(1) Any person required or authorised by or by virtue of this Act to be conveyed to any place or to be kept in custody or detained in a place of safety or at any place to which he is taken under section 42[6] above shall, while being so conveyed, detained or kept, as the case may be, be deemed to be in legal custody.

As to the time limits imposed by the legislation, Section 6(1)(a) provides:

(1) An application for the admission of a patient to a hospital under this Part of this Act, duly completed in accordance with the provisions of this Part of this Act, shall be sufficient authority for the applicant, or any person authorised by the applicant, to take the patient and convey him to the hospital at any time within the following period, that is to say

in the case of an application other than an emergency application, the period of 14 days beginning with the date on which the patient was last examined by a registered medical practitioner before giving a medical recommendation for the purposes of the application;

It would appear that, as SH was kept in a place of safety for 43 hours before hospital admission, this detention was legal. The fact that it was legal does not mean that it was ideal, or good practice; it was not.

The root cause of the problem here was the combination of two factors. Firstly, the view taken by the police that they could not properly charge SH, at least without forensic evidence in the form of samples and fingerprints. This view cannot be criticised - no one would consider it appropriate for the police to charge someone when the police did not consider that they had the necessary evidence. However, this view meant that it was simply not possible for SH to be processed by the judicial system at an early stage. The second factor was the view taken by Dr Rohricht that SH was not fit for interview; that he should not be in custody but should be detained under section 2 of the Mental Health Act 1983. This meant that there was a mentally ill individual, suspected of a very serious offence, but who could not be processed through the judicial system because he could not be charged. In view of the seriousness of the offence which it was suspected SH had committed, he could not possibly be admitted to East Ham Memorial Hospital which does not have any form of secure facility. Admission would have posed a

wholly unacceptable risk to other patients at the hospital. However, there was simply no appropriately secure bed to which SH could be admitted, unless he went through the judicial system.

We heard from a number of witnesses that they regarded the problem here as, in effect, a result of the police's intransigence in not charging SH. The view was expressed that this would have been the correct solution, and that there was, therefore, no real need to be concerned about a possible repetition of the problem, because next time the police would behave more sensibly. We strongly disagree with this view.

The police's decision whether or not to charge can only ever be based upon the evidence available to them. It is not acceptable for the mental health services to expect the police to charge a mentally ill suspect, regardless of the state of the evidence against that suspect, in order to enable that suspect then to be processed through the judicial system and, accordingly, to enable him or her to have access to an appropriately secure bed through the forensic psychiatric services.

The situation which occurred here, where a mentally ill individual was arrested and held in a police cell, suspected of a serious offence, but with the police having insufficient evidence to charge him, is unlikely to be a unique situation. Regrettably it does not appear that, if this situation were to recur, finding a solution would be any easier. It is necessary for the mental health services to be able to cater for this situation, and that means that if a person is regarded as mentally ill and needing to be sectioned, but is also potentially a danger to others, an appropriately secure bed needs to be made available without the patient having to enter the judicial system so as to be able to access the forensic psychiatric services. This is the problem which needs to be addressed and, to date, notwithstanding universal acceptance that what happened to SH was unacceptable, it is a problem which does not appear to the Inquiry panel to have been addressed.

It was also recognised that it was unsatisfactory that Dr Rohricht, a general psychiatrist, was put in a position where he was having to deal with a situation more suited to an appropriately qualified and experienced forensic psychiatrist. It may perhaps have been that a robust forensic psychiatrist might have taken the view that SH could be interviewed and samples could be taken (appreciating the practical problems which would arise if any other view was reached), but that would have been an entirely pragmatic approach. As we have mentioned above, we cannot fault

Dr Rohricht for reaching the conclusions which he did reach about SH. Having concluded that it was his medical opinion that SH was not fit to provide informed consent or to be interviewed, then Dr Rohricht had no option but to act in accordance with that opinion. We do not see that advice from a forensic psychiatrist would have changed the situation, but we do endorse the general view expressed to the Inquiry panel that it would be valuable if the Emergency Duty Team, and people in the position of Dr Rohricht, could have at least telephone access to advice from a forensic psychiatrist to assist with the situations which can arise when, as here, a patient is seen in a police cell.

The fact that East Ham Memorial Hospital was inserted on the section 2 papers without steps first being taken to ensure that a bed was available there, created a real problem. The Approved Social Worker is required to convey the patient to the named hospital and to deliver the documentation in order to make the admission legal - see The Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, paragraph 3(2).

We note that in the annotated *Mental Health Act 1983* edited by Richard M Jones, (a widely used publication by Approved Social Workers), it is observed that:

> *"Every application for admission shall be addressed to the managers of the hospital to which admission is sought and every guardianship application shall be forwarded to the local social services authority named in the application as guardian, or, as the case may be, to the local social services authority for the area in which the person so named resides. ... As the application does not authorise the applicant to take the patient to any other hospital than the hospital specified in the application, it is suggested that the name of the hospital should not be written on the application form until the recommending doctor has confirmed that a hospital bed has been arranged for the patient."*

We comment that the practice of only writing on the name of the hospital after a bed has been confirmed would have avoided at least some of the problems which arose here. It is, therefore, our recommendation that such a practice be adopted whenever sectioning a patient under the Mental Health Act 1983.

It is interesting to note that similar issues have arisen before in the Metropolitan Police Area. In the Inquiry on DJ (another Mental Health Homicide; MSWHA, 2000) a near parallel experience was described:

"We have also been disturbed to realise that the police do not have direct access to a secure unit in a situation where they find themselves having to decide what to do with someone they are holding who is clearly mentally disturbed and a risk to himself and others, and who should not - for his own safety and the safety of the police officers – be kept in a police cell overnight.

At present, if there is not a local forensic psychiatrist available who can arrange admission to a secure unit, the only alternative to keeping the person in a police cell until the morning when they can be brought before a court and a Hospital Order made, is to admit the person to a local acute psychiatric ward, which puts the other patients and the hospital staff at considerable risk."

This produced the following recommendations :

"Every police station should have available a standard protocol to initiate a mental health assessment. (In most services this starts with the police contacting the local Approved Social Worker). There should be a collaborative audit between the police and their local mental health services to identify problems with this - such as excessive waiting or the availability of sign language interpreters. In London this should be dealt with by the Metropolitan Police on a pan-London basis within a jointly agreed framework for London.

Every psychiatric catchment area should have a consultant forensic psychiatrist available on call to deal with people who are in police custody and are very disturbed, and protocols should be developed jointly by general and forensic psychiatry services to allow direct access to forensic inpatient facilities where this is judged to be clinically appropriate."

There was, in the event here, no input from the forensic psychiatric services. This placed both Dr Rohricht and Angela Ayre in a very difficult position. We would recommend much better liaison between forensic psychiatric services and general psychiatry. It is unacceptable that an individual with mental illness, who may have committed a serious offence, only has access to the forensic psychiatric services through the Criminal Justice system.

A number of developments are proposed for improvements in local services. There will be the introduction of an electronic CPA system, overlaid on a number of existing local systems which would allow for access to information held in those various systems throughout the area. This

should greatly assist the work of out-of-hours duty staff in situations such as undertaking assessments at police stations.

It is also proposed that there will an expansion of the Medium Secure service to provide a "community-based" service, which will provide expert advice and support to local community services. This will involve forensic psychiatric services in both providing care and advising general psychiatrists, and we regard this is an important step forward. There will also be available, within Newham, a new facility at a lower level of security, but still within the secure system. In addition, there will be an assertive outreach service which will develop expertise in managing hard-to-engage individuals.

However, we must express considerable concern that the evidence to the Inquiry panel suggested that anticipated pressure on these services will be such that if a situation such as is described above were to be repeated, it would remain unlikely that immediate access to a secure bed would be available other than through the criminal justice system. This is unacceptable. We recommend that a protocol be developed jointly between general and forensic psychiatric services so that direct access to secure inpatient facilities is available when it is judged to be clinically appropriate, and not just through the criminal justice system.

We also endorse and adopt the recommendation referred to above that every psychiatric catchment area should have a forensic psychiatrist available on call to deal with people who are in police custody and who are very disturbed.

We note that Angela Ayre of the EDT was approached for "Approved Social Worker/Appropriate Adult" intervention. As the Approved Social Worker she, after joint deliberation with two doctors, made an Application for Admission to Hospital under the Mental Health Act 1983 for SH. She later responded as an Appropriate Adult under the Police and Criminal Evidence Act when the police wished to interview SH's mother. We understand that there was no other social worker available to discharge this function in this "out of hours" situation.

However, we believe that there is role conflict in expecting the same person to discharge these separate functions in the same case. It is our recommendation that the roles of the Approved Social Worker and the Appropriate Adult need to be separated. Many authorities, including Newham's near neighbours, have systems whereby a number of lay persons trained in the role of Appropriate Adult are available to Social Services departments.

We recommend that the Local Authority and the Metropolitan Police develop such a scheme, taking the opportunity to design into it the cultural and communication needs of an ethnically diverse population. Access could be via Social Services' duty teams or directly by police station.

Conclusion

We believe, having examined all the evidence available to us surrounding SH's care and treatment, that this homicide could not have been reliably predicted.

It could, perhaps, have been prevented had the mental health services been approached in 2000, as they had been in 1997, by SH or his family, when SH's mental health deteriorated at home in the months prior to the homicide.

In 1997, the CMHT-E acted promptly to hospitalise SH when his wife expressed concerns to their GP. They would no doubt have responded again in early 2000, had they been asked. The decision that contact with the CMHT be discontinued, on discharge from hospital in September 1997, unfortunately removed an important safety net.

Recommendations

1. East London and The City Mental Health NHS Trust should make every effort to secure permanent appointments to consultant psychiatrist posts so as to enable continuity in care, the consistent development of policies and procedures, and consistent implementation of the National Service Framework for Mental Health.

2. East London and The City Mental Health NHS Trust should institute a system for the assessment of clinicians' training needs; and should have in place a training programme that addresses risk assessment and management.

3. East London and The City Mental Health NHS Trust and Newham Primary Care Trust should put in place shared care protocols for the clinical management of people with severe mental illness; the protocols should allow for the availability of informal advice to GPs from consultant psychiatrists.

4. East London and The City Mental Health NHS Trust, the London Borough of Newham and Newham Primary Care Trust should review Care Programme Approach policies and procedures to ensure they reflect the importance of full participation by GPs in care planning, particularly where the GP will carry responsibility for monitoring the patient's mental state and managing his/her medical treatment for mental illness.

5. East London and The City Mental Health NHS Trust, the London Borough of Newham and Newham Primary Care Trust should institute a rolling programme of training to ensure that all staff delivering mental health services and all primary care teams are fully conversant with the operation of The Carers and Disabled Children Act 2000.

6. East London and The City Mental Health NHS Trust and the London Borough of Newham should ensure their compliance at the earliest date with the involvement of carers in CPA assessment, care and treatment plans, in accordance with Standard 6 of the National Service Framework for Mental Health.

7. The London Borough of Newham should publish, in the principal community languages, a directory of local carers' services and other sources of support for carers, which should be provided to all identified carers of people with severe and enduring mental illness, and available readily at all mental health service sites.

8. The London Borough of Newham should ensure that the Carers' Directory contains information and contact details on the Domestic Violence Unit within the police service and on voluntary sector organisations providing advice and support to victims of domestic violence.

9. East London and The City Mental Health NHS Trust and the London Borough of Newham should institute a rolling programme of training to ensure that all staff delivering mental health services are trained in the recognition of the signs of possible domestic violence and its relevance to risk assessment, and that they receive clear guidance on action to take where domestic violence is suspected.

10. East London and The City Mental Health NHS Trust should develop links between CMHTs and the Domestic Violence Unit within the police service, so that persons (whether service users, carers or other members of the family) identified as at risk of domestic violence can be put in touch with the Domestic Violence Unit. CMHT managers should be responsible for initiating and sustaining these links, and those with voluntary sector organisations providing support to victims of domestic violence.

11. East London and The City Mental Health NHS Trust and the London Borough of Newham should introduce protocols into CMHT management which direct that where domestic violence is suspected in a family with which a CMHT is working, a routine check shall be made with child protection agencies.

12. The London Borough of Newham and the Metropolitan Police should ensure that child protection teams and agencies assess the possible co-existence of domestic violence against adult family members when investigating cases of suspected child abuse.

13. East London and The City Mental Health NHS Trust should establish at the earliest date a duty roster for consultant forensic psychiatrists which makes forensic psychiatric advice available on call where a mentally disordered person is held in police custody.

14. East London and The City Mental Health NHS Trust and the North East London Strategic Health Authority should review capacity in secure inpatient mental health facilities to permit direct access to a secure bed when appropriate on clinical and risk grounds, without the necessity for access through the criminal justice system.

15. East London and The City Mental Health NHS Trust and Newham Social Services Department should issue advice to their staff that, when completing applications under the Mental Health Act 1983, the name of the hospital should be inserted on the application form by the Approved Social Worker only once the availability of a bed has been confirmed by the psychiatrist making the medical recommendation.

16. Newham Primary Care Trust should review its clinical governance protocols regarding repeat prescriptions to ensure that arrangements for issuing repeat prescriptions include suitable provision for monitoring each patient's condition, and for ensuring that patients who need a further examination or assessment do not receive such prescriptions without being seen by a doctor. Clear guidance should be made available to GPs.

17. Newham Primary Care Trust, having consulted with the Medical Director of East London and The City Mental Health NHS Trust, should issue advice to GPs through its clinical governance arrangements regarding best practice in the prescription of anti-psychotic medication, updating the advice from time to time. Prescribing patterns should be monitored and further support provided to GPs when inconsistency with modern practice is identified.

18. Newham Primary Care Trust should introduce computer systems to monitor repeat prescriptions; these should be sufficiently sensitive to identify irregularities suggestive of poor compliance or of significant under- or over-use of prescribed medication, and should flag to GPs the necessity for consultation with a patient before a further prescription is issued.

19. East London and The City Mental Health NHS Trust should review its policy on spiritual care so as to recognise the possible risks, as well as benefits, of the involvement of religious or spiritual advisors in supporting a person with a mental illness; every effort should be made to engage religious and spiritual advisors in the CPA process so as to negotiate the closest compatibility available between the care provided by mental health services and that provided by a religious or spiritual advisor.

20. East London and The City Mental Health NHS Trust and Newham Primary Care Trust should develop a programme of education and information on mental health policies, care and treatments, to reach faith communities and influential community groups; this should aim to foster a balanced appreciation of the issues of stigma and of risk and public protection.

21. East London and The City Mental Health NHS Trust must audit CPA performance regarding the involvement of CMHTs in pre-discharge planning from inpatient units, the notification of CMHTs when a patient is discharged, and the prompt communication of a discharge summary.

22. East London and The City Mental Health NHS Trust should review CPA policies and procedures with the involvement of Primary Care Trust representatives in order that the role of primary care teams and GPs should be reflected throughout; the revised policies and procedures should be implemented Trust-wide; routine audit of CPA should involve carers; and full training in CPA should be provided to all mental health service operational staff including consultant psychiatrists, and repeated at specified intervals.

23. The London Borough of Newham and the Metropolitan Police in Newham should establish a programme to train a number of lay persons in the role of Appropriate Adult, so that the Social Services department has available a number of Appropriate Adults reflecting the cultural and communication needs of an ethnically diverse population.

Appendix 1 - Witnesses Interviewed

SH	Subject of Independent Inquiry
S	SH's brother
Dr Selvaratnum	Locum Consultant Psychiatrist
Dr Patel	Senior House Officer to Dr Selvaratnum
Dr H Springer	Senior House Officer to Dr Selvaratnum
Dr Rohricht	Consultant Psychiatrist and Clinical Director
Mr V Sonnar	Acute Inpatient Services Manager
Ms D Ball	Ward Manager, Purcell Ward
Dr Bhadra	SH’s General Practitioner
Mr F Harrington	Community Mental Health Team Manager (East Team)
Ms J Lewis	Social Worker of SH’s brother S
Ms A Ayre	Approved Social Worker
Mr. T West	Forensic Social Worker, John Howard Centre (Medium Secure Unit)
Mr J Wilkinson	Head of Mental Health, North East London Health Authority
Mr K Mullins	Director of Services, Newham Locality
Ms C Godleman	Head of Mental Health, Drug and Alcohol Integrated Services
Mohammed Sufi Khan	Spiritual advisor to SH
DCI Bob Davidge	Edmonton Police Station
DI Langley	Forest Gate Police Station
Mr P Horn	Chief Executive, East London And The City Mental Health NHS Trust

Appendix 2 - Chronology of Main Events in the Care and Treatment of SH

23.07.97	SH assaulted a police officer.
08.08.97	AK attended the family GP, Dr Bhadra, and expressed concerns about SH's mental state. Dr Bhadra prescribed Paroxetine and Largactil, and made arrangements to visit the following day, a Saturday.
09.08.97	Following a deterioration in SH's mental state, an ambulance was called. Dr Bhadra was called to the house, and he prescribed further medication. He made a note to contact a social worker and a psychiatrist on Monday, 11.8.97.
11.08.97	CMHT-E was contacted by or on behalf of Dr Bhadra about SH.
12.08.97	Ross Lange, an Approved Social Worker, visited SH's home. SH agreed to be informally admitted to East Ham Memorial Hospital. Following fears that SH would then chose to leave the hospital, SH was detained, initially under section 5(2) of the Mental Health Act 1983. Following a formal assessment by Dr Elhihi and Dr Bhadra, and on the application of Ross Lange, SH was admitted for assessment under section 2 of the Mental Health Act 1983. SH was under the care of Dr Selvaratnum, but was actually admitted by Dr Springer.
13.08.97	SH was interviewed by Dr Patel, Dr Selvaratnum's Senior House Officer.
16.08.97	Whilst still an in-patient, SH tried to jump off a fire escape. He was then placed on Level 2 Observation and a "door stop" policy was imposed.
18.08.97	Notwithstanding that the door stop policy was still in force, SH left the hospital and returned home.
19.08.97	SH returned to the hospital. His condition was noted to be improved and he was allowed to go back home, on leave, until Friday, 22.8.97.
21.08.97	An incident occurred at SH's home involving knives and repeated attendances by the police. The incident was probably provoked by SH's brother, JH.

22.08.97	Following review at the hospital by Dr Selvaratnum, SH's home leave was extended to 26.8.97, and his medication reduced.
26.08.97	SH returned to the hospital for a further review. His home leave was extended to 2.9.97 with a view to possible discharge.
02.09.97	SH was discharged from East Ham Memorial Hospital. The diagnosis recorded on the Discharge Summary was a brief psychotic episode and the plan was for SH to be followed up as an outpatient two weeks later. There was no referral back to CMHT-E.
15.09.97	Dr Bhadra completed a questionnaire in connection with SH's application for accommodation in which he stated that the diagnosis was schizophrenia, and that the illness was of moderate severity.
25.09.97	SH received a repeat prescription from Dr Bhadra's surgery.
24.10.97	SH received a repeat prescription from Dr Bhadra's surgery.
06.11.97	SH attended his first outpatient appointment with Dr Selvaratnum.
10.11.97	Dr Selvaratnum wrote to Dr Bhadra in connection with the outpatient appointment of 6.11.97.
25.11.97	SH received a repeat prescription from Dr Bhadra's surgery.
01.12.97	Dr Bhadra provided SH with a medical certificate certifying that SH was unfit to work for a period of six months. The diagnosis was schizophrenia.
12.12.97	SH failed to attend an outpatient appointment with Dr Selvaratnum. Dr Bhadra was informed of this.
16.12.97	SH received a repeat prescription from Dr Bhadra's surgery.

17.12.97	SH convicted of assaulting a police officer on 23.7.97. He and his family have, by this stage, moved to temporary accommodation, a hotel in Westminster, pending the provision of more permanent accommodation in Newham.
14.01.98	SH received a repeat prescription from Dr Bhadra's surgery. SH failed to attend an appointment with the Probation Services in connection with his recent conviction.
15.01.98	SH attended at the Probation Services offices and explained his non-attendance the previous day was because he had had to attend hospital in connection with an injury to one of his children. This information is passed to Westminster Social Services.
16.01.98	Westminster Social Services seek information about SH. Jennifer Lewis of CMHT-E obtains a copy of SH's Discharge Summary from Dr Selvaratnum, and secures his permission to pass this onto Westminster Social Services. Dr Selvaratnum confirmed to Ms Lewis his view that there was no need for SH to be referred to a CMHT for follow-up.
21.01.98	SH's sentencing for assaulting a police officer was adjourned pending the provision of a psychiatric report.
10.02.98	Dr Selvaratnum saw SH for the purpose of preparing a psychiatric report for the court.
17.02.98	CMHT-E reviewed SH's file and concluded that a decision whether or not to close that file should only be made after discussion with Ms Lewis.
23.02.98	CMHT-E closed its file on SH.
27.02.98	SH received a repeat prescription from Dr Bhadra's surgery.
08.04.98	SH received a repeat prescription from Dr Bhadra's surgery.
25.04.98	Dr Bhadra completes a Disability Living Allowance form for SH recording that he had last seen SH on 1.12.97, and that the diagnosis was schizophrenia.

14.05.98	SH failed to attend an outpatient appointment with Dr Selvaratnum, who removed SH from his list. Dr Bhadra was informed of this.
15.05.98	SH received a repeat prescription from Dr Bhadra's surgery.
29.05.98	SH was seen by Dr Bhadra, who provided him with a medical certificate certifying that SH was unfit to work for a period of six months. The diagnosis was again schizophrenia.
26.06.98	SH received a repeat prescription from Dr Bhadra's surgery.
28.09.98	SH was seen by Dr Bhadra who recorded that SH was *"still the same"*.
09.11.98	SH was seen by Dr Sahu, who provided SH with a repeat prescription.
01.04.99	SH received a repeat prescription from Dr Bhadra's surgery.
26.07.99	SH was seen by Dr Sahu in connection with documentation formally to change SH's name. SH made a pilgrimage to Saudi Arabia.
07.09.99	SH was seen by Dr Bhadra who recorded that SH was *"well"*.
01.12.99	SH attended t Dr Bhadra's surgery in connection with a cold.
04.06.00	SH killed AK. SH was arrested at 02.15 hrs and taken to Forest Green Police Station. The police requested the attendance of an Approved Social Worker/Appropriate Adult, and Angela Ayre of the Emergency Duty Team duly attended. Dr Rohricht was then called to carry out an assessment of SH's mental state at the police station. He took the view that SH was not fit to be interviewed and that he should be detained under section 2 of the Mental Health Act 1983. The application for admission named East Ham Memorial Hospital. However, staff at East Ham Memorial Hospital refused to accept SH for safety reasons.

05.06.00	Attempts were made, unsuccessfully, to find an appropriate bed for SH.
06.06.00	Negotiations resulted in a bed being found for SH at the PICU at Runwell. At 13.45 hrs SH was taken from police custody to the PICU at Runwell.
11.06.00	SH was transferred from Runwell to the John Howard Centre.
27.10.00	SH was convicted of manslaughter on the basis of diminished responsibility. Subsequently, a Hospital Order was made under section 37 of the Mental Health Act 1983, together with a Restriction Order, without limit of time, under section 41.
12.11.01	A Mental Health Review Tribunal concluded that SH should remain detained.

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