Birmingham City Council

OFFENSIVE WEAPON HOMICIDE REVIEW

REF 007
APRIL 2024

Author- Debra Clothier-Commissioned by Birmingham Community Safety Partnership as part of a Pilot.

RESET RESHAPE RESTART

Birmingham City Council

Contents

Name of Relevant Review Partners *(where an Offensive Weapons Homicide has occurred).*

Birmingham City Council- Community Safety Team
West Midlands Police
Coventry and Warwickshire Integrated Care Board

Case Reference Number: 007

PSEUDONYMS

Victim- Mr A

Perpetrator- Mr B

It was agreed that the same names were to be used in the Mental Health Review running alongside this review.

Date of incident/death which led to the Review: July 2023

Review's start date (commissioned): 06/12/2023

Review completion date (approved and signed off): 10/09/2025

Publication date: 30/09/2025

The review experienced some delays during the initial stages due to challenges around information sharing.

The consultant in care had not been made aware of the Offensive Weapon Homicide Review and, citing GDPR concerns, was initially unwilling to share information. Following several meetings, this matter was resolved, enabling the review team to access the necessary information, as well as the Mental Health Reviewer to work together and provide it to the Chair. However, there were also delays later in the process when NHS England suspended publications of their mental health reviews whilst they reviewed their processes.

Additional delays occurred due to changes in management and staffing within some of the agencies involved. This required the review team to establish new contacts and update them on the case, which extended timelines.

Further delays arose from missing information from the housing provider, as well as the need to confirm updated information during the recommendations stage.

While these issues were not significant in nature, they did contribute to an overall delay in the completion of the review. The review process was part of a pilot and therefore on occasions, some processes took longer to establish even after the draft report was completed.

Outline of circumstances resulting in the Review:

Notification

1. Brief summary of incident leading to review-

The brief circumstances were that in July 2023 officers were called to an address in Birmingham (exempt supported housing) to a report from a witness that a deceased male was in the garden. He had been stabbed by a knife which was found at the scene.

The victim is Mr A and was aged 43 at the time of his death. The address was his current address.

A suspect, Mr B, aged 32 at the time of the homicide, was arrested at the scene (he had been a resident of the same property until shortly before) and was consequently assessed and sectioned under the Mental Health Act 1961. At the time of writing this, he has been found guilty of manslaughter and remains sectioned.

An OWHR was commissioned by Birmingham Community Safety Partnership the Relevant Review Partners for the death, in accordance with the OWHR Statutory Guidance. The criteria for this Review are met under:

2. Legislation for Review

Section 24(6) of the Police, Crime, Sentencing and Courts Act 2022, the homicide of a person is a qualifying homicide if:
a. the person was aged 18 or over, and
b. the death, or the events surrounding it, involved the use of an offensive weapon
The criteria set out in the legislation confirms that for a homicide to be considered for an OWHR the victim must be over 18. An alleged perpetrator can be included in a review at any age, including under 18.
An offensive weapon is defined, for the purposes of an OWHR, in section 1 of the Prevention of Crime Act 1953 as:
“Any article made or adapted for use for causing injury to the person, or intended by the person having it with him for such use by him, or by some other person.”

The Relevant Review Partners and supporting agencies are;

Head of Reviews, West Midlands Police– Force Review Team, West Midlands Police
Community Safety Team (CST), Coventry City Council
Designated Nurse Safeguarding Adults and Children, Coventry and Warwickshire Integrated Care Board (ICB)
Violence Prevention Programme Manager, Coventry City Council
Community Safety Partnership Manager, Birmingham Council
Designated Nurse for Safeguarding Adults and Children (Lead for Adults), Birmingham and Solihull ICB
Director, Violence Reduction Partnership (VRP)
Deputy Designated Nurse Safeguarding Adults and Children, Coventry and Warwickshire Integrated Care Board (ICB).

The relevant review partner/s, are under a duty to arrange for there to be a review of the person's death, as set out in section 24 of the Police, Crime, Sentencing and Courts Act 2022 ('the Act').

The decision around this OWHR has been made by all RRP'S at the steering group on 8th August 2023 and it was agreed that Birmingham would be the lead agency that will send notifications on OWHR decisions.

4. **Who was the Victim? -** It is important that we remember the victim of this homicide as a person beyond the records of agencies alone. On request, his ex-partner, who knew him well, has written about him, from their perspective. I am grateful that they agreed to do this, and recognise this must have been difficult.

Mr A (Victim) as known by a previous partner and mother of two of his children

'……..(Mr A) had a deep heart, hidden in a life riddled with drug use, which unfortunately for us, took its toll on our family life and relationship. He tried for many years to become drug free and whilst living with us, he stayed out of prison and didn't have many dealings with the police.

When he first told me about his drug addiction, I was about to give birth to our first daughter. I knew there was a problem but totally unaware of how serious - he always dressed well, showered twice a day, kept his hair tidy, shaved, polished shoes, clean teeth, aftershave, I've never seen a drug addict look so well presented. He kept our home immaculate. Never shared needles, disposed of his needles at the chemist, got new needles from the chemist. We went to the GP who said they could help, but there was a 6 month long waiting list- waiting lists were always so long. Those 6 months were hell. He tried a number of times to go cold turkey, but it never worked. He did eventually get the methadone prescription, which he did take.

Him retaining a job was hard, he was great at interviews always looked the part and was so happy to get work, but he always ended up mixing with drug users and would fall back to bad habits, his prescription eventually cancelled and we were back to square one. He once looked into joining the Fire Service but he wouldn't have passed

the fitness tests, that was a shame as at that point he was in good health. (For him) It was the methadone usage that they obviously couldn't accept, but he couldn't be without it. He found that hard. We eventually parted and this is where he really suffered.

He used to send letters from prison, always positive about his release, he mentioned once that he would be doing a course and was hoping to become a probation officer. He completed first aid courses and health & safety courses; happy he could use this knowledge outside of prison. He had dreams of becoming clean and making something of himself, to make his parents proud. It seemed that when he left prison all those dreams he had, were impossible to make come true. The bad times would come back to haunt him, it turned into a cycle. He lived to survive.

I always thought he would be at his daughters' weddings to give them away. He loved them a huge amount, they were his Angels. They were always the first people he would ask me about and mention in his prison letters. He used to say that when he was able to get a house, there would always be a room for them so they could visit. It is incredibly sad that this hope I had for him has been snatched away by another person. ……..(Mr A) wasn't a bad person, I know he was no Saint, but he had hopes, dreams and wanted a happy peaceful life. Drugs just overpowered him every single time.

I'm so sad that his life ended the way it did. He didn't deserve his life to end like that, we always had hope that he would call and say he was clean and had a roof over his head. But now the hope is gone forever.'

5. Summary of circumstances

Both victim and alleged perpetrator had been living in the same 'exempt accommodation' up until the date of the homicide and both had extensive contact with agencies for a number of years prior to this date.

The victim had told someone close to him that, he had suffered some traumatic childhood experiences and had struggled with substance misuse issues for a number of years. A significant event for him in his final year, was in February 2023, when he had walked into a main road and been hit by a vehicle, suffering serious injuries including a brain injury, facial injuries and broken bones. This required hospital treatment as an inpatient until May of the same year.

He had been discharged from hospital in May 2023 to a shared house[1] following a referral from the homelessness team, (he could not return to previous accommodation as he required a ground floor room due to his injuries) based at the same hospital, with one hour a week of support from the housing support provider. He raised with support staff, the

[1] 'Supported accommodation is a broad term which describes a range of housing types. Exempt accommodation is supported housing which is exempt from certain Housing Benefit provisions. It is defined as: a resettlement place; or accommodation provided by a county council, housing association, registered charity or voluntary organisation where that body or person acting on their behalf provides the claimant with care, support or supervision.' https://commonslibrary.parliament.uk/research-briefings/cbp-9362/ Supported exempt accommodation (England). Research Briefing. Sept 2023.

occupational therapist and the mental health team, that he felt the accommodation inappropriate to his needs and, that he was struggling to cope. He needed to use crutches and at times, a wheelchair. During this time, he was readmitted to hospital twice, once for a fall and the other for a seizure. He was discharged each time, back to the same accommodation and was refused further support. The last discharge was the day before the homicide took place.

The perpetrator had self-referred to the same exempt accommodation after a previous house he was living in, similar in status, had closed. He had a significant mental health history including periods as an inpatient under section, the last time being earlier in 2023 (Under Section 2). He had told staff previously that he had suffered sexual abuse as a child, his mother had left and he was brought up by his father. He has been diagnosed with paranoid schizophrenia and poly-substance misuse. He had a history of causing damage to his accommodation and making threats to previous residents of that previous accommodation. He was under the care of the community mental health team but had not been seen in person by them, since May 2023. The housing provider was aware of his diagnosis and that he wasn't taking his medication and had referenced in his support notes, a number of things which, to someone trained in mental health would have recognised as a, deterioration in his mental health leading up to the day of the homicide.

The day before the homicide, he had damaged his room and had been transported by a staff member to the emergency department (due to delays in ambulance service), as his behaviour was causing concern, but he left the department before being seen by health staff. It is believed that, he returned to the accommodation during the early hours of the following day, where the homicide took place (in the garden). The weapon used was found on the scene and was believed to have been taken from the kitchen of the house.

Information taken after the homicide report that, 'Mr B would take Mr A's food and money at times without replacing them, would bully him if others not present and, had tried to fight Mr A in the garden around two weeks prior to the homicide' [2]. Mr A had described himself as the 'weak one' which was why he felt that Mr B 'was aggressive to him'. Mr A was said to be 'kind but very forgetful' at the time, this may have been due to his brain injury.

6. First Panel Meeting

The First Panel Meeting was held on the 21st November 2023 and was attended by: the Independent Chair, West Midlands Police, Probation, Birmingham and Solihull Integrated Care Board, Concept Housing, NHS England, Birmingham City Council -Housing, Provident Housing, Birmingham City Council – Adult Social Care, Psychological Approaches, Birmingham City Council- Offensive Weapon Homicide Review Team.
A request for Individual Management Reviews (IMR's) were sent out to a number of agencies who it was believed had contact with either the victim or perpetrator, or both within the previous 3 years of the homicide (from July 2020 to July 2023) but with the request of further information if felt relevant to the review, outside of that timeline. A deadline was given to agencies to return their completed IMR's for the 22nd December 2023.

[2] A resident of the same property reported this to Police as part of their witness statement.

7. Following the initial scoping the key lines of enquiry building on the Terms of Reference (Appendix 1) were:

A. Mr A when registering at a GP surgery in December 2022, reported having been in a road traffic incident where he was left with significant injuries including a traumatic brain injury:

- What were the circumstances of this and what injuries resulted?
- Where was he previously registered for a GP prior to December 2022?
- What services were offered following the road traffic incident? If there was a lack of engagement by Mr A in accessing services for example- 'rehabilitation', what follow ups were carried out?
- Had this incident resulted in longer term effects on mental/physical health of victim that you were aware of prior to the homicide?
- He was seen in January 2023 by a health professional and prescribed sertraline for anxiety and depression, were any other services offered?
- Mr A was seen in February 2023 and suspected by health professional of having psychosis, and prescribed further medication, what date was this? Drug and alcohol use was noted, were further referrals to services offered/referred to?
- On 24.02.23 Mr A apparently 'walked into the road' resulting in hospital admission for 'multi-trauma' and was assessed in March 2023 by Liaison Psychiatry. Noted to be a 'Vulnerable adult male in crises. What referrals made at this time, with what outcomes?
- It appears Mr A was not seen by Osborn House for more than a 2 months at least (6th June 2023). Was there further support in the intervening time?

B. Both Mr A and Mr B were living in a shared house (exempt accommodation) at the time of the homicide, which took place on that property (in the back garden)-

- Mr A had presented as homeless on the 21st April 2023, what were the circumstances of this, what assessments were carried out and what actions were taken?
- On 06/07/23 Mr A was seen at Osborn House and said that his accommodation issues are 'driving him mad'. In what way? Did he elaborate? What action, if any, was taken?
- Was he receiving any form of support other than mental health, at the time of death? He reported he had support through the Housing Provider, what did this consist of, what referrals, outcomes etc?
- Does the Housing Provider do any type of assessment before housing someone in this type of accommodation?
- Do they (Housing Provider) liaise with other service providers, or vice versa to manage risk/safeguarding?
- Mr B was apparently evicted the day before the homicide and had returned to the property. What were the circumstances of that eviction? If they involved Mr A, what risk assessments/actions/referrals were carried out at the time, if any, to safeguard Mr A?
- Mr B returned to the property on the day of the homicide, was this pre-arranged/known about in advance?
- Do we know where the knife used in the attack came from? How did the perpetrator access this?

- How had Mr B come to be living in the property and what support was he receiving, given he was known by health professionals to be 'noncompliant with his medication' previously and be 'a risk of violence to others'? Where had he lived in the previous 2 years?
- The day before murder took place, how long had the alleged perpetrator waited in ED before leaving? Why wasn't it recorded what he presented with? Do reception ED take names and basic details of why presenting?
- More information as to Mental Health history, housing and monitoring and support etc of Mr B required, going back 3 years?

C. What contacts had both Mr A and Mr B had with Probation services (noted that …….Probation recall a 'fleeting' contact with the victim on 04/12/2014 when completing an oral Pre-Sentence Report) and what records are available re any time in prison for either/both?

D. Re Police-

- Mr A was known to Police over a number of years, were any mental health assessments carried out during any recent periods of custody and what actions followed, if any?
- Mr B was known to Police, please provide details.

E. Any involvement/referrals/assessments over the last 2-3 years to/from drug and alcohol services?

These key lines of enquiry and terms of reference were agreed at the panel meeting dated 21st November 2023.

Agencies were asked to provide chronology of contact with both Mr A and Mr B.

Agency timeline/Chronologies – see Appendix 2

8. Second Panel

The second panel meeting was held on the 15th January 2024 and was attended by: the Independent Chair, Psychological Approaches, Birmingham and Solihull Mental Health Foundation Trust, Probation, Coventry City Council – Housing, Concept Housing, West Midlands Police, Provident Housing, Birmingham City Council- Housing, Birmingham City Council – Adult Social Care, Birmingham City Council – Offensive Weapon Homicide Referral Team

9. Further requests for information

Where there were gaps or outstanding questions, further information was sought and were sent out following the second panel in January 24. These questions focussed on: -

a. Treatment whilst in hospital, what if any referrals and/or follow up appointments were made with Mr A.
b. Details about the referral to the Housing provider.
c. Why the requests for further support for Mr A were refused.
d. Were additional housing assessments carried out following the two further admissions to hospital?
e. Allocation and risk assessment policies and procedures of Housing provider.
f. Training and supervision of Housing provider staff.

g. Emergency department procedures when someone presents with a mental health crisis.
h. Information sharing more generally across different agencies.

10. Family engagement

Initial contact was made with Mr A's ex-partner in December 2023, she is mother to two of his children, both teenagers, and Mr A's mother who currently lives abroad.

The mother made it known through the Police Family Liaison Officer that they did not wish to be involved in the review. Mr A's ex-partner agreed to engage with both this review and the mental health review. A joint on-line meeting was held with them and, it was agreed that they would write something to reflect Mr A's life from a family perspective rather than an agency perspective. They explained the impact of the homicide on the family and some background information on Mr A, which was helpful in understanding him as a person. They were given further information on support organisations for the family, should they need them in the future. They also agreed to have the draft report sent to them before publication.

It is believed that, Mr A may have adult children who were not in contact with him before his death.

Contact with the family of Mr B was made after charging had taken place. West Midlands Police made contact with the sister of Mr B in January 2024, and delivered a letter from the report author. They declined to be involved in either this Review or the Mental Health Review.

No contact was made with Mr B due to his mental health, (he is currently still sectioned at the time of writing this report) his 'No Comment' interview with Police and the ongoing court process.

11. Criminal Justice Process and Coroner

At the time of writing, the trial took place in 2024 and Mr B was found guilty of manslaughter and the Coroner has adjourned the case. They have been made aware of this review taking place.

12. Protected Characteristics/Equality and Diversity:

- **Age**: Not applicable
- **Disability**: This is applicable.

Victim-Mr A had significant physical needs following his road traffic incident, and he had raised his concerns over the inappropriateness of his accommodation and location, because of these needs. Prior to this incident he had a history of substance misuse, although there is no evidence received by the report author to suggest any Class A substance misuse following the car incident.

Perpetrator- Mr B was known to be schizophrenic and had periods in hospital within the reviews scope. He was being provided with mental health services at the time of the homicide but had not had face to face contact with his Care Coordinator for some months. He has a history of substance abuse. He is currently under section.

- **Gender reassignment**: Not applicable
- **Marriage and civil partnership**: Not applicable
- **Pregnancy and maternity**: Not applicable

- **Race**: It is noted that Mr A was White British but Mr B has been recorded both as White British and Mixed White/Asian, it is not known why this is.
- **Sex**: Both Mr A and Mr B recorded as male
- **Sexual orientation**: Not applicable to this case.
- **Socio-economic disadvantage**: Both Mr A and Mr B unable to work due to health problems and were on benefits and living in a shared house (exempt accommodation). They both had been living in these circumstances for some time, although the physical needs of Mr A had changed significantly for the worse, when he was involved a road traffic incident in February 2023. They both were said to have aspirations to be able to work and change their circumstances.

13. The 'Offensive Weapon'

It is believed that the weapon used, was a kitchen knife. Police believe that it was probably accessed from the kitchen of the house where the homicide took place. The Housing Provider has said that their houses are not provided with sharp knives as part of the inventory, so it's possible that a resident or previous resident brought it into the kitchen for use, but this is not known at this time.

14. Practice, Organisational Learning and Recommendations

Although both Mr A and Mr B had numerous contacts with a variety of agencies, over a number of years, this review looked in more detail at the previous 3 years to the homicide date of the 11th July 2023, and once that information had been analysed by the author and further questions asked, the majority of the opportunities for agency learning are mainly focussed on the 6 months leading up to the homicide for Mr A and the 2-3 years prior, for the Mr B and how those two individuals came into contact at that time, and in those circumstances.

For Mr A, a significant event was when he walked into the road on the 24th February 2023 and was seriously injured, his injuries included a brain injury (for which he was in an induced coma for some time) and a number of broken bones, as well as facial injuries. There was some concern at the time that, he may have tried to commit suicide on that day, but he denied this (when he was seen whilst at the hospital by Liaison Psychiatry) and it looks more likely that, based on the information we have, that he had been under the influence of drugs and/ or alcohol that day. He was taken to the Queen Elizabeth (QE) hospital in Birmingham and remained there until the 4th of May 2023.

He was seen and assessed by 'Homeless Pathways' service at the hospital on the 17th April 2023, which is operated by Claremont Living (a private company), who are commissioned by Birmingham City Council to provide the service, based at the QE Hospital. They referred Mr A to Concept[3] (a Community Interest Company)/Provident (a Private company) Housing [4] to live at……., a house with 3 other residents, which was classed as 'exempt accommodation'. Mr A was unable to return to his previous accommodation as he needed a ground floor room, he had to use crutches and, at times, a wheelchair.

[3] 'Concept Housing (a CIC) were the landlords of ……and have details of the start dates, support plans and licensing. Concept work with a number of providers including Managing Agents and the Managing Agent of ……..was Provident Housing who manage the day-to-day, support planning and risk assessments etc.' Taken from the minutes of the first panel- 2nd November 2023.

[4] Provident Housing Group

The reviewer recognises the impact that this homicide may have had on all the individuals who had recent contact with both Mr A and/or Mr B in the lead up to this homicide and hopes that they are able to access the support that they need. These conclusions and recommendations are for the agencies involved with the purpose of reducing the likelihood of a similar incident taking place in the future.

Mr A was particularly vulnerable at the time of the homicide, due to having significant physical injuries and being placed in shared 'exempt accommodation', which was assessed by the Occupational therapist as suitable due to having a ground floor room and access for someone on crutches. The victim had identified that he felt the accommodation did not meet his needs at that time and had said to the hospital that there 'should be accommodation for people like me just leaving hospital'. He had a brain injury as well as other physical injuries for which he had not fully recovered.

Recommendation 1. *The Homelessness Teams (Claremont Living) may wish to look at whether the physicality of accommodation should not be the only basis for these decisions on suitability, to be made. Any housing referrals from hospital need to consider the possibility of vulnerability and safeguarding, and consider if there are more appropriate accommodation available which might better meet the health needs of patients at that time.****(See NB on recommendation 5)***

Recommendation 2. *Housing Commissioners need to review what accommodation is available to those coming out of hospital to ensure it best meets their health needs at that time, recognising safeguarding and vulnerability.*

It appears that the referral to Concept Housing was the only accommodation referral Claremont Living made,(even though there is accommodation nearby for those with head injuries which potentially could have been suitable) the accommodation involved sharing with others with unknown backgrounds, their own vulnerabilities and, the support was restricted to one hour a week by those with limited knowledge or qualifications on health needs. The support staff at the address had made enquiries about further health support for him as had he, on a number of occasions, but this was refused. He believed it was because he had not 'engaged in rehabilitation', the records state however, it was because he already had an hour a week of support from the housing provider. The support he was receiving was very different to the type he had identified as needing, which was, a change of accommodation and help with his mobility and other injuries. This does not seem to have been acknowledged, and his statement about having things stolen from him was dismissed. Others in the house confirmed this was happening to him. He was told that his GP in the community would need to make a referral if different accommodation was required, there is no record of that happening or any referral being made.

Recommendation 3. *Hospital staff and Homelessness staff based in the QE Hospital should ensure that appropriate follow up appointments and referrals are in place to minimise the chance of readmittance or incidents in the community, before discharge.*

Whilst in hospital Mr A was seen by Liaison psychiatry who saw no signs of a mental health illness. The ward staff referred back to Liaison Psychiatry whilst he was in hospital and he was seen promptly. It was identified after he was seen on one occasion, to require 'bereavement support', there are no records showing whether this was offered or arranged for him. He had been referred to the Community Mental Health Team (CMHT) on discharge and attended 2 appointments before his death. On both occasions he told them that he was not coping in his accommodation. Although they did consider further support this was turned down, no other referrals were made though, to address his needs.

Recommendation 4. *The Community Mental Health Team need to address those occasions where someone has requested support and this need is not suitable for the CMHT to address, that they then look at referring to other more appropriate organisations who may be able to offer that help.*

The referral from the Homeless Pathways at the Hospital ((Claremont Living) was incomplete and lacking in key information about Mr A, his history and health needs at that time[5]. No other referrals to accommodation had been made. In the 3 months he was at the accommodation, he had suffered 2 further re-admissions and the accommodation was assessed each time, as suitable. Claremont Living have not identified any learning from this homicide and their contacts with the Victim. However, they said 'there is already an existing list for the frequent fliers, but we can further investigate with a professional to understand why this occurs as often as it does.'

Recommendation 5. *The Commissioner from this service, which is Birmingham City Council should discuss with any provider how service delivery can be improved to better meet the needs of vulnerable people coming out of hospital, Claremont Living describing those that are re-referred as 'frequent flyers' is disappointing.*

NB. The author has been advised that Claremont Living was de-commissioned from this contract in September 2023.

The admissions/allocation process (Concept Housing/Provident Housing) meant that very little verified information was required on residents before being offered a place, some were admitted the same day as referral (as in Mr B's case). There were gaps in the referral form which Claremont/QA Hospital had completed as to Mr A's health and background. There was no evidence produced to suggest that, there is regard to the safeguarding of residents when allocating rooms or, making enquiries with other agencies when there are potential gaps in information. Concept Housing have recognised some changes are required (see Learning).

I support the proposed learning and would also like to see some additional learning/changes. The emphasis/culture needs to be on- meeting the needs and the supporting of residents. This includes improving the training and supervision of staff and looking at their 'sub-contracting' arrangements. Concerns were raised about Concept

[5] Received by author following request to Housing organisation.

Housing by the Housing Regulator in 2021[6]. They said that '*It has failed to ensure that it has effective governance arrangements in place that deliver its aims, objectives and intended outcomes for tenants in an effective, transparent and accountable manner.'*

Recommendation 6- *To have regard to the safeguarding of residents and staff when allocating places and on day-to-day management and supporting residents and, for staff to be empowered to say No to referrals when deemed unsafe or not enough information. The Allocations Policy and processes need to reflect the different types of tenancies and the safeguarding policy reviewed to reflect this.*

Recommendation 7- *The risk assessments for both Mr A and especially Mr B, were inaccurate and were not reviewed when Mr B's behaviour deteriorated (He had been assessed under 'Risk of Harm to others' as 1 out of 10 and, 'Risk of deterioration in mental health' as 4 out of 10 even though he was known to have schizophrenia and not taking medication). Risk assessments should be reflective of actual risk, this would require staff to have knowledge on risk assessments and other areas of vulnerability- drugs, alcohol, mental health, offending etc and be dynamic, rather than reviewed after a certain period. The current form encourages low scores, which according to their policy, means no additional work is required by staff.*

Recommendation 8 - *Although staff rightly transported Mr B to the emergency department at the hospital, when an ambulance was unavailable, the Housing Provider should consider a change in their policy to state that any transportation in similar circumstances (mental health crisis), should involve at least 2 members of staff and should be risk assessed, to protect staff and ensure that the resident is accompanied at all times until admittance or discharge from the ED.*

Recommendation 9. *If a resident is ill enough to require an emergency admission, he perhaps should have been reported 'missing' when having left the hospital. On this occasion by the Housing provider, as they were aware of his state of mind, rather than the hospital who had not had the opportunity to triage at that stage. There was a missed opportunity for him to have been returned to hospital.*

The Hospital emergency department at City Hospital where Mr B was taken to, have said that if he'd been reported missing, they could have taken some action to assist in finding him.

Recommendation 10. *Concept Housing should ensure that all staff (who engage with residents, including sub-contractors) are adequately trained by someone qualified to deliver the training. This training should include Mental Health, Offending, Drugs and alcohol, safeguarding and risk assessments as a minimum.*

[6] https://www.gov.uk/government/publications/regulatory-judgement-concept-housing-association-cic/regulatory-notice-concept-housing-association-cic-23-july-2021

The Housing provider staff did not identify the deteriorating mental health of Mr B and the potential risk to other residents or the community. There were strong clues to this in the support records which were not picked up on. This is likely due to a lack of appropriate training in mental health, not a lack of contact. Any current training delivered appears to be 'in-house' and an emphasis on knowing the policies rather than providing skills and knowledge to staff.

Recommendation 11. *Concept Housing should ensure all staff are supervised, supported and appraised on a regular basis and details of those meetings are recorded and kept.*

There current system of weekly staff meetings for which no records are kept is not sufficient.

Recommendation 12. *Concept Housing should review the record keeping, specifically ensuring that it is done as quickly as is possible after contacts or incidents and that there is external training for all staff on those subjects enabling good decisions to be made and the safety of staff, residents and the public as a priority within its culture.*

Mr A was lacking in rehabilitative care for his injuries, the referral was not made to the Moseley Hospital (although recorded that it was made, by the Occupational Therapist) for his brain injury. Apparently, it may not have been sent due to him 'not having a permanent address' recorded. The Queen Elizabeth Hospital have recognised some learning points (see Learning). In addition, if referrals are not made, and not recorded that they weren't made on the basis of no permanent accommodation, this potentially can affect a number of those people, who are most vulnerable, and this should be reviewed.

Recommendation 13. *The QE Hospital should review their referral procedures to ensure that vulnerable patients are not excluded from treatment.*

The author has spoken (be email) to the Moseley Hospital who confirmed that 'not having a permanent address' does not affect a referral and they do in fact have patients who are of 'no fixed abode'. The author has suggested that contact be made with the QE Hospital by the Moseley to clarify the referral procedure for them.

However, it was reported that, 'if the referral had been sent, the waiting time for an appointment of three months, would still have meant he did not receive the support'. At the time of this report, information on the actual waiting time had not been made available to the author.

The delay in getting his medication to address his seizures, may have led to further admissions to hospital. This appears to have been because, there had been confusion around him having 2 NHS numbers and some paperwork being sent to the wrong surgery in Bristol. Birmingham and Solihull Integrated Care Board have already addressed this in the Learning Points (see Learning). This may also be a reason why Mr A did not attend some of his out-patients appointments, as he may not have been aware of them.

Recommendation 14. *This confusion may have been avoided and Mr A receive the on-going treatment he needed, if checks had been done prior to his hospital discharge to the accuracy of information on file. The Queen Elizabeth Hospital should review this process and ensure their recording is accurate.*

Mr B had self-referred to the same housing provider and had declared that he was diagnosed with schizophrenia and was not taking his medication, but not his full history or, that he was being monitored by the Community Mental Health Team. The Community Mental Health Team had not made contact with the Housing provider during his stay there, although they were aware of the address, even when the Care Coordinator was having difficulties since May 2023, in having any face-to-face contact and, there were noted concerns about his drug use and, not taking medication.

This report fully supports the findings and recommendations from the Independent Mental Health Investigation[7] re Mr B, see below-

PLEASE NOTE: The Independent Mental Health Investigation has taken place alongside this review, and will be published separately. The recommendations have been included in this report, see below.

This Reviewer took part in some joint meetings with the Mental Health Reviewer with regards to Mr B's mental health treatment and was very concerned by the lack of face to face contact that Mr B had with adequately skilled and experienced Trust staff, despite them being aware of Mr B not taking his medication, where he lived and, his history. They made no contact with the accommodation provider to engage with them to make contact with Mr B and this, may have given the accommodation provider further information to better manage the risk within the property for Mr A and other residents.

His most recent time as an mental health inpatient had been for a relatively short time (28 days), which had not allowed/made it more unlikely, for further work to be done or proper future planning for care in the community to be carried out, to the extent it could have been done.

Mental Health Review Findings-:

'1. Mr B needed the structure and containment provided within a predictable, in person and secure relationship with a care co-ordinator. The CMHT did not recognise this need. Indeed, for a short period, his support in the community was provided by a Support Time Recovery Worker who could not have been expected to have the requisite level of skills. Overall, there were deficits in staff supervision, skills and capability.

2. The usual procedures for recognising and managing risk, and for engaging service users with their own care – specifically, risk assessment and care planning protocols – were not followed.

3. There was a lack of communication between the CMHT and other parts of the service. Mr B's level of disorder was not highlighted to services which could have provided him with increased support. There was a lack of liaison with the housing provider and with the family, so opportunities to share information and to obtain collateral information were

[7] AN INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF Mr B (OWHR 007) 3 April 2024- Psychological Approaches CIC

missed. Similarly, there was a lack of a two-way liaison between the in-patient service and the CMHT.

Recommendations-:

1. For individual practitioners, the Trust[8] should implement clinical supervision, as separate from managerial supervision, so that each care co-ordinator has the opportunity to reflect on the issues raised during their work with service users under the supervision of a more senior clinician.

2. Multi-disciplinary teams should address deficits in communication with housing workers and family members. Staff have a duty to satisfy themselves that, where service users are placed in supported accommodation, their needs are being met and risks are assessed and managed.

3. The Trust should monitor the provision of clinical supervision to care coordinators.

4. The Trust should continue to address structural issues with service provision, characterized by 'silo thinking' which leads to a failure to request increased levels of care from other parts of the service.

5. The Trust should ensure that appropriate processes are in place to agree contingency arrangements for staffing shortages.'

15. Some Further Observations

National Housing Issues- The author recognises the shortage of housing provision and this can mean that, those who are often most adversely affected are those with significant vulnerabilities, in need of specific support. The use of 'exempt accommodation', particularly within the Birmingham city area has been raised nationally[9] and legislation[10] has been put in place to address some of the concerns and lack of standards and monitoring of those standards nationally. This legislation is yet to be 'rolled out' across the country and this author hopes that this is done without any further delay.

In the authors view, this accommodation was not suitable at that time for the victim due to his vulnerability, not just in practical terms of self-care but, in terms of how he was seen by other more high-risk residents. The victim needed a more 'rehabilitative' environment to support his on-going recovery from his significant injuries with staff on site potentially, to monitor and assist with that.

[8] Birmingham and Solihull Mental Health NHS Foundation Trust
[9] House of Commons Levelling Up, Housing and Communities Committee Exempt Accommodation Third Report of Session 2022–23. 19 October 2022
[10] Supported Housing (Regulatory Oversight) Act 2023

Information sharing- Information sharing between agencies was raised as part of this review and some felt that there was on occasions, and over-reliance of GDPR legislation[11] to not share information with some other agencies. However, there was no specific evidence that this was relevant to this review. The lack of communication between agencies, appear to be as a result of:

- 'silo' working and therefore no one person taking an overall view of the risk factors and,
- a lack of understanding around risk and, a culture of not considering 'safeguarding' as something all agencies have a responsibility for.

Some of the agencies involved in this review may wish to review their policies and procedures with this in mind.

Traumatic childhood experiences- Both Mr and Mr B had reported in the past that they had been abused as children, and although their experiences as children were outside of the scope of this review, it still should not be dismissed as not relevant to the outcomes for both and, their on-going difficulties in adulthood. Any improvement to the accessibility of help and awareness, for those who have been victims of this as children, should be a funding priority.

Best Practice examples-

- West Midlands Police had involvement over a number of years with both Mr A and Mr B. Their records and actions during these contacts, whether as victims or perpetrators, were, as hoped for in the circumstances.

- The Mental Health Review identified that the care and treatment of Mr B whilst involved with the e Forensic Intensive Recovery Support Team (forensic community team, 'FIRST') until October 2020 was an example of best practice and this author supports this conclusion. They provided a stability and intensity of support, which Mr B required to maintain his mental health and keep himself and others safe.

[11] General Data Protection Regulation. Data Protection Act 2018.

16. Learning and Recommendations identified from Agencies

The Housing Provider Concept/Provident have identified the need for further learning as detailed in the table below-

Recommendation	Action to take	Lead Agency
Additional training in mental health awareness for staff and managers of Provident Housing.	Support workers to have up to date mental health awareness training. Managers to have up to date mental health awareness training	Provident Housing Provident Housing
Additional training in assessing and managing client risk	Retrain all support staff and managers on assessing and managing client risk, particularly where the client perceives a lower risk that the worker and how to manage this. Review the risk assessment process and guidance to ensure providers have greater clarity and understanding	Provident Housing Concept Housing Association.
Enhance data sharing and checks especially where residents are self-referring and no agencies to provide further information to support accuracy of risk assessment.	Review letting process to ensure a balance between supporting housing people who need immediate housing whilst ensuring sufficient information is collated and reviewed to assess risk and make an informed decision.	Concept Housing Association

Birmingham and Solihull Integrated Care Board-

Recommendation	Action to take	Lead Agency	Target Date	Impact Monitoring
Increase GP's understanding as to how to manage those patients that present with complex history and the importance of previous clinical notes.	Develop Communication briefing and cascade via staff briefings, newsletters, safeguarding meetings	BSOL ICB	April 2024	Increased awareness & understanding of resources and agencies that are available.

Increase awareness within Primary care and across the Integrated care System (ICS) regarding the importance of information sharing especially out of area	Develop Communication briefing and cascade via staff briefings, newsletters, safeguarding meetings. Work with communications teams	BSOL ICB	April 2024	Increased awareness & understanding of resources and agencies that are available
Escalate the concerns identified across BSOL footprint	Communication with IG colleagues	BSOL ICB	Jan 2024	Any IG breaches can be addressed

Birmingham & Solihull Mental Health Foundation Trust- Re Alleged Perpetrator

Learning from this have been identified as follows:

- Less than optimal frequency and modality of contact with him.

- Curiosity in relation to no clear follow-up or escalation process when there are concerns in changes to mental health.

- Communication of concerns to MDT or medical staff.

The Reviewer understands that further work was carried out by the Trust following the homicide and a Care Quality Commission visit, which they believe will also improve services. These are detailed in the Mental Health Review Report, which will hopefully be published in due course.

	Recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Impact Monitoring
Less than optimal frequency and modality of contact with him.	A case note review of patients on CPA to take place in order to review both frequency and methods of contact for these patients	The team will be looking at the caseload of people on CPA to look at the appropriateness of frequency/ modality of contact.	BSMHFT	A process map to then be developed for use in individual's caseload supervisions.		Clear process map and follow-up audit planned.
Curiosity in relation to no clear follow-up or	A case note review of patients on CPA to take	Following the gathering of data for the first action	BSMHFT		Safety alert to all staff was	

escalation process when there are concerns in changes to mental health.	place to review for changes to mental state. Reminder to staff regarding curiosity and escalation to be cascaded. Accountability and individual professional practice for greater supervision.	point, the team will complete a deeper dive into notes. Practice alert to be issued as a reminder to staff, this is to come from Director of Nursing & Medical Director. Discussion in supervision with clinician: Professional accountability : frequency of visits as per policy, escalation to MDT, modality of visit - Evidence in RMS and caseload supervision records			publish ed on 25/07/2 3	
Communicati on of concerns to MDT or medical staff.	Medical review process in relation to communicatio n with medic when requested timeframes cannot be met. It was also highlighted that when timeframes are agreed in MDT it is not always filtered through to the booking system.	Urgent contact with medical secretaries to ensure there is a process in place and a clear escalation point. Clinical Services Manager to look at booking system and ensure there is a robust system in place	BSMHF T	Clear process map		Follow-up audit for assuran ce

University Hospitals Birmingham have stated that their 'process on retaining referrals' has been updated since Mr A's admission.

Sandwell and West Birmingham Hospitals NHS Trust (City Hospital re the emergency department) reported that they have improved systems over the previous 12 months

including putting in place a Mental Health Triage tool which 'highlights risk and suggested response based on presentation'. They have reported that 'If the team had information to suggest risk, then we may look to conduct a search of the immediate hospital grounds and register as missing' In this case no risk was reported.

17. Methodology

On-line Meetings: -

- The Independent Chair regularly met with the Mental Health Reviewer to discuss findings. A joint meeting with the family member (ex- partner and mother of 2 of his children) of the victim was held.
- Attended a meeting with the Mental Health Reviewer with Dr P, Psychiatrist for the CMHT. At the interview, Dr P was supported by Dr T, Consultant Psychiatrist in Acute Care and Clinical Director for Adult CMHTs in the Integrated Community Care and Recovery Directorate.
- It was not possible to meet with the alleged perpetrators family as they declined involvement in with either review.
- It was not possible to meet with the Housing Support Worker involved with both victim and alleged perpetrator as they had left their employment only days before the request was made and refused a meeting.
- Further liaison and meetings took place with the investigator of the Mental Health review with regards to the alleged perpetrators contact with mental health services in the lead up to the homicide.
- There were delays with some agency's responses to the report author and a couple of requests for extensions, and one agency did not respond until after the 2nd panel meeting. I am aware that the Mental Health Review Investigator also had similar delays in getting the information they required. Following the 2nd panel meeting based on the information received, it was necessary to contact other agencies, who had not been involved previously to answer some of the gaps in information. This involved the Queen Elizabeth Hospital in Birmingham, City Hospital and the Moseley Hospital as well as, Claremont Living, a private housing provider[12].
- An information request was made a number of times to the Chief Executive of Claremont Living. A Personal Assistant responded to the enquiries with regards to the referral made to Concept Housing for Mr A.
- Further information was requested from Police about the relationship between residents prior to the death and the police record of calls in the previous year, to that address, these enquiries were responded to promptly.
- Further questions were asked about the knife used and where this might have originated from, there was no definitive answer on this.
- Concept Housing sub-contracted the support of tenants to Provident Housing (a private company), although they attended the panel meetings, they did not respond to the request for information, Concept did. The Reviewer was told staff had to have regard to both the policies and procedures for both Concept and Provident in this instant.
- **A third panel** meeting was held on the 6th June 2024 to review the first draft of the report and its recommendations, a follow up email was sent to those not attending

[12] Claremont Living, a private company, operate the Homeless Pathways service from the QE Hospital on behalf of Birmingham City Council.

the meeting, who may wish to comment of the recommendations, no comments received.

The following documents were contributed to the Review: -

- Initial scoping from Housing, BCC, BSOL ICB, West Midlands Ambulance Service (WMAS), Probation Service, West Midlands Police, Coventry City Council Housing and Homelessness Team, The Supported Exempt Accommodation Team (SEA).
- Individual Management Reports were submitted by Concept Housing (re Mr A and Mr B), Birmingham and Solihull Mental Health Foundation Trust (Mr A and Mr B), West Midlands Police (Mr A and Mr B), Birmingham and Solihull Integrated Care Board (re Mr A), Birmingham City Council, Housing (re Mr A), Coventry City Council, Housing (re Mr A).
- Further documentation was requested from Concept Housing and Provident Housing which were supplied by Concept. Referral form from Claremont Living re Mr A, Referral form re Mr B, which was a self- referral. Risk assessments on both Mr A and Mr B, contact sheets for both Mr A and Mr B with Housing Support person, Needs Assessment Forms for both Mr A and Mr B, and an Incident form stated as being completed on the 10th July 2023. The Allocations Policy. Termination Notice letter to Mr B, dated 11th July 2023.
- Supervision notes for staff were requested but were not supplied as no notes are taken at meetings.
- Further documentation was requested for the referral from the QE Hospital to Moseley Hospital re Mr A's brain injury which was recorded as completed, but this was not found and probably wasn't made or sent.

Dissemination

List of recipients who will receive copies of the Review Report (in line with guidance and due to the recommendations of this Report): Please copy and paste the appropriate number of instances.

Date circulated to relevant policy leads: 01/06/2025

Organisation	Yes	No	Reason
Single Competent Authority	☐	☒	No involvement
West Midlands Police	☒	☐	Click or tap here to enter text.
NHS Birmingham and Solihull Trust/ Sandwell and Birmingham NHS Trust	☒	☐	Click or tap here to enter text.
Change Grow Live	☐	☒	Click or tap here to enter text.
Birmingham City Housing/ Sustain Housing	☒	☐	Click or tap here to enter text.

Final confidence check

This Report has been checked to ensure that the OWHR process has been followed correctly and the Report completed as set out in the statutory guidance.

I can confirm that this Report section is at a standard ready for publication ☒

Once completed this report needs to be sent to the Secretary of State for the Home Office. Tick to confirm this has been completed. ☒

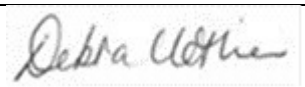
Statement of Independence by Chair:

Statement of independence from the case

I make the following statement that prior to my involvement with this review:

- I have not been directly involved in the case or any management or oversight of the case.
- I have the appropriate recognised knowledge, experience and training to undertake the review. Therefore, I have met the criteria of an Independent Chair.
- The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference. I recognise that the purpose of this is to identify learning from the case, not to attribute blame to practitioners or agencies.
- I have read and understood the equality and diversity considerations and will apply accordingly.

The Chair and author of this report has worked within the criminal justice and other associated fields for over 40 years in a number of roles, in practice, policy and management. She has worked extensively with victims of serious crimes and their families, and was a criminal justice expert for the European Commission. They are independent and, have no recent connection with the relevant review partners or the local oversight agencies, they live out of the review area.

Signature: 

Name: Debra Clothier
Date: 10/09/2025

To be completed by the Home Office:

Please tick here to confirm that the Chair was appointed from the Independent Chairs List held by the Home Office: ☒

Appendix 1-Terms of Reference

1. Referral and assessment

a. How did the individual come into contact with your service? Did the individual self-refer, were they referred by another service?

b. How was the individual assessed by your service? Who was involved in this assessment?

c. Did the practitioners take action once the assessment and any relevant decisions were made in relation to the individual? Were practitioners clear on what actions they should take and which services they should refer to?

d. Did the organisation have policies, assessment criteria and procedures in place for dealing with concerns about the emotional wellbeing of the victim and re the alleged perpetrator, their violent behaviour and vulnerability? Were these policies, assessments and procedures put to use?

e. Were practitioners knowledgeable about the potential indicators of emotional wellbeing, violence or vulnerability that the individual may have demonstrated? If so, were practitioners aware of how to act if they had concerns?

f. Were practitioners aware that, the individual (alleged Perpetrator) had previously had access to a weapon in their possession at any point prior to the homicide occurring?

g. What were the key opportunities for assessment and decision making in relation to the individual prior to the homicide? Does it appear that practitioners took advantage of these opportunities for assessment and decision making?

h. Do practitioners feel that there were any missed opportunities for assessment and decision making? If so, when?

i. Please provide a complete chronology of contact and actions taken, which cover all known interactions.

2. Services offered

a. What services provided by your organisation did the individual access?

b. Did the individual access all of the relevant services that your organisation provides? Please explain the services that the individual accessed. If there are relevant services that were not accessed by the individual, please explain why not.

c. Did your organisation make a formal referral to another service for the individual? Specifically, did your agency make any referrals to agencies of physical or wellbeing support or assessment, financial support to housing related support etc.

d. To your knowledge, was the individual accessing any other services?

e. To your knowledge, was the individual in contact with a number of practitioners? If so, do you think the individual could have benefited from a single support person?

f. How accessible were the relevant services you provided to the individual?

g. Do practitioners feel that your organisation provided relevant services to the individual? Could your organisation have provided any additional services to the individual? If yes, what would they have been?

h. How was the organisation and practitioners sensitive to the intersectionality, wider vulnerabilities and protected characteristics of the individual?

3. Outcomes and outputs

a. What was the outcome of the initial assessment carried out by your organisation?

b. Were practitioners' content with this outcome? Please explain.

c. If the individual was subsequently referred to another organisation or service, are you aware of the outcome of this referral? Please provide details.

d. Did your organisation monitor and audit the outcomes and outputs associated with the individual in this case? Please provide details.

e. Does your organisation have in place a means of monitoring and auditing the outcomes? Please provide details.

f. Do practitioners feel that this monitoring process is effective in practice? Please explain in what ways, with reference to this case and past experience where applicable.

g. Could an adjustment in policy, assessment or procedure have secured a better outcome for the individual? If so, please give details of the adjustments you would suggest.

4. Information sharing

a. Did the organisation share information with other partners where necessary? Please include any information shared with any enforcement agency, health-based providers, financial, housing or wellbeing support.

b. Were there any challenges in relation to data and information sharing between partners in this case?

c. Could an adjustment in the approach to information sharing with partners have improved the outcome in this case?

d. Are there any necessary changes to your organisations or the system-wide approach to information sharing in order to achieve better outcomes for individuals in future?

5. Potential learning

a. What are the best practice examples and lessons to be learned from this case regarding the way in which your organisation and practitioners identify, assess and manage the risks posed by individuals?

b. In what ways could policies, assessments and procedures be improved to safeguard individuals more effectively in the future? Please consider changes within your organisation, within other organisations and system-wide.

c. Are there any system-wide lessons or best practice examples to be learned/shared from this case? Please explain.

d. If you were to go through this journey with the individual again, what changes would you like to see? These changes can be relevant to the service that your organisation provided, or they could be system-wide.

Relevant documentation-Please share any relevant documentation related to the victim and/or alleged perpetrator and/or other persons connected to the death.

Appendix 2- Chronologies

Following receipt of the IMR's, the report author compiled chronologies with regards to agency contacts and actions on both Mr A and Mr B.

Although those chronologies went back about 3 years prior to the homicide date and beyond in some cases, as requested by the author for this report, the last 5 months have been highlighted re Mr A. Following the 2nd panel meeting and further investigations being carried out and requests for further information, additional information has been added to the report chronology. See below-

Chronology Mr A- Victim	**OWHR007** Some of this information has been paraphrased and identifying features removed.		
DATE	**CONTACT**	**AGENCY SOURCE**	**ACTIONS TAKEN**
01/01/23	Mr A received an out of court disposal for an incident of robbery	West Midlands Police	Arrest, charge and out of court disposal
05/01/23	GP Consultation-was told on sertraline for anxiety and depression and diazepam but no previous notes available so only prescribed sertraline.	BSOL ICB	Prescribed sertraline but no diazepam and given 'not fit for work' statement. GP to follow up change of surgeries
07/02/23	GP consultation. Noted to be keeping off cocaine and heroin and is very anxious and seeing what he attributes to his mind creating encounters and situations	BSOL ICB	GP to review in two weeks query psychosis – prescribed diazepam

	that he can't believe are coincidences, drinking 4 strong cans of lager.		
24/02/23	GP Consultation-substantial consultation within the surgery – history noted to be previously taking 6mg of diazepam but when he ran out, he started to drink alcohol again. Appears to have ideas of reference from the television with delusional intensity	BSOL ICB	Plan was to see again and refrain from drinking alcohol.
24/02/23	18.48pm Road Traffic Incident, all witness stated that 'the male had walked out in front the of the vehicle'. Mr A identified as Victim. Serious injuries, taken to hospital. No offences reported.	West Midlands Police	Mr A taken to hospital by ambulance
24/02/23	Admitted multiple injuries (including brain.	University Hospitals Birmingham (UHB)	1 month on ITU (ventilated). Input from Speech and Language Therapy, Physio, OT, Liaison Psych, Vulnerabilities team, Neurology, Dietician, Orthopaedics, Ophthalmology, Major Trauma Service, Homeless Pathway Team. Brain injury, ICP bolt (temporarily), Collar, Sling, NG feeding, Surgery to ankle, rehab on ward. Referred to Brain Injury Specialist Clinic @Moseley Hall. He had DoLS during this admission.
09/03/23	GP appointment-Did not attend appointment	BSOL ICB	– text message sent to …… (Mr A)
16/03/23	First contact with BSMHFT was a referral following road traffic incident, Mr A 'Patient stepped into road'	Birmingham and Solihull Mental Health Foundation Trust	
17/03/23	Consultant Psychiatrist	Birmingham and Solihull Mental Health Foundation Trust	Consultant Psych attempted to see Mr A. He was unable to assess due to being asleep. He spoke with the nurse who was looking after. From information available at this time, CP-A's impression was that there was nothing to suggest this was an intentional suicide attempt and

			history available suggested the collision was an accident when Mr A was intoxicated. Was discharged from liaison psychiatry with advice to the hospital to refer back if further information found, or requiring assessment.
21/03/23	Re-referral received to liaison psychiatry. From referral information, there appeared to be intermittent episodes of agitation and concerns that he might have been hallucinating. The reason for referral was stated as "How much are elements of psychosis / delirium / personality issues. Does he need inpatient psych bed?"	Birmingham and Solihull Mental Health Foundation Trust	Referral to Psychiatrist.
23/03/23	GP contact attempted by phone	BSOL ICB	None noted
23/03/23	Consultant psychiatrist, (CP-B) attempted to see Mr A. Mr A requested for the doctor to see him at a different time.	Birmingham and Solihull Mental Health Foundation Trust	
24/03/23	Assessment by CP-B. The consultant reviewed the hospital documentation, referral reason and circumstances of current admission. (Paraphrased) No obvious evidence of flight of ideas. Recalls the incident, resulting in this admission. Reported to have run over, while he was heading to a shop, month ago, next thing he recalls is waking up in the hospital. Mr A acknowledged drinking almost on a daily basis, few cans of lager, getting drunk, some cannabis. Remarked experiencing low mood, weeks prior, was not suicidal. Was noted at times to be agitated and loud and expressed annoyance at waiting for a wheelchair. Sleep had improved. Eating	Birmingham and Solihull Mental Health Foundation Trust	As an outcome of the assessment, CP-B requested for hospital neuropsychology team to re-review, for therapy support with mobility and activities of daily living and for hospital rehabilitation. History of substances was discussed with Mr A with suggestion for service support (CGL) with this. Mr A declined a referral, so it was suggested that Mr A consider this further and self-refer should he choose so. Was discharged from liaison psychiatry with a plan for onward referral to CMHT once discharged from hospital and advice to the ward to contact the team if there is a change in his circumstances, or any new concerns.

	and drinking was “alright”. He denied any suicidal thoughts or intent. He denied perceptual disturbances. He advised that he had experienced religious voices in the past and coped by reading, psychology and meditation. He advised of a history of poly drug misuse, including injecting heroin. There was a degree of confabulation and grandiosity. His capacity appeared to be fluctuating.		
27/03/23	OP Clinic Ophthalmology	UHB	
04/04/23	OP Clinic Ophthalmology	UHB	
06/04/23	OP Clinic Ophthalmology	UHB	
12/04/23	Re-referral received to liaison psychiatry re supporting 'bad news (death of Aunt) and discharge planning	Birmingham and Solihull Mental Health Foundation Trust	13/04/23: Re-referral screened by Registrar, (SPR-A). This was determined to not be the remit of liaison psychiatry. As previous, the plan on discharge was for referral to CMHT
17/04/23	Referral form from Homeless Pathways Officer (HPO) (Claremont Living)	Concept Housing Association	
17/04/23	OP Clinic Ophthalmology	UHB	
21/04/23	Mr A approached the Council and started to complete a housing application but it 'never reached the stage where it was assessed'	Birmingham City Council	Case closed 9/10/23
21/04/23	OP Clinic Ophthalmology	UHB	
28/04/23	OP Clinic Ophthalmology	UHB	
04/05/23	Mr A moved in having been referred from Homeless Pathways after being discharged from hospital. He was brought to the house by ambulance. An initial risk assessment and needs	Concept Housing Association	Initial assessment was completed (by Provident Housing) which identified the following- No drug or alcohol concerns, physical health conditions arising from a car accident listed as broken neck,

	assessment was completed and, it was identified that due to poor mobility following a road accident he required a ground floor room with access to a downstairs bathroom.		leg and pelvis with nerve damage in the right side of his face. He cited the impact of these conditions as being he used crutches and sometimes a wheelchair and that his sight is impacted in right eye. He also advised he had been diagnosed with depression and anxiety and advised he found day to day living very stressful but advised he had not self-harmed previously and did not have any suicidal ideations. He advised he had been prescribed Sertraline, Diazepam and Codeine. License agreement commenced
05/05/23	Referral to CMHT made via single point of access as Mr A now discharged from QE.	Birmingham and Solihull Mental Health Foundation Trust	Referral to CMHT
09/05/23 – 24/05/23	Referral being screened by CMHT for allocation	Birmingham and Solihull Mental Health Foundation Trust	screening
09/05/23	Welfare check conducted by support worker (Provident Housing)- no issues	Concept Housing Association	
11/05/23	Weekly support session	Concept Housing Association	supported to open a bank account and make contact with job centre regarding benefits
15/05/23	Welfare check done- no issues reported	Concept Housing Association	None noted
16/05/23	Ent Appointment	UHB	Did not attend
17/05/23	T&O Appointment	UHB	Did not attend
18/05/23	Weekly support session- focussed on mobility issues and physical health issues and frustrations with limitations in comparison to his previous active lifestyle	Concept Housing Association	None noted
22/05/23	welfare check done- no issues reported	Concept Housing Association	None noted

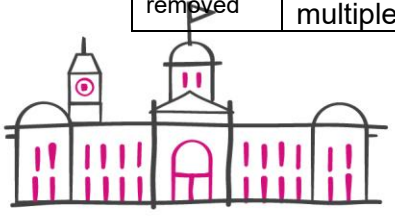
23/05/23	Pelvic Trauma Clinic	UHB	Did not attend
25/05/23	Weekly support session – covered mental health and the impact of his mobility issues and increased dependency on others is having on his mental health, agreed he had been so focussed on physical recovery may have neglected his mental well-being.	Concept Housing Association	Provided information on waiting room app for access to services and encouraged booking an appointment with the GP.
29/05/23	welfare check done- no issues raised	Concept Housing Association	None noted
30/05/23	Fracture Clinic (neck)	UHB	Attended and discharged
31/05/23	Attended emergency dept.	UHB	Feeling dizzy- 3 episodes of syncope since OPA previous day. Stated unable to cope at home, admitted until 4.6.23
01/06/23	Support session completed on phone as Mr A was back in hospital following a fall. he has a fall and goes back into hospital. He advised that his aunt and NOK had passed away and nobody in his family had advised him of this. Spoke to Mr A about possible need to consider alternative higher support housing options due to the risk of falls.	Concept Housing Association	None noted
02.06.23	Referral made to Homeless Pathway Officer (Claremont Living) by telephone.	University Hospital Birmingham	This was because he was medically fit. Homeless pathway services note that they placed him in accommodation with Provident Housing the previous month having been assessed by OT as being suitable for crutches but also lent a wheelchair for long distances. It is noted he had issues with wheelchair access and theft at the property. The HPO enquired about thefts (with Provident), there had been none reported. Nurses reported he was mobile and self-caring, and he is noted to state he felt better on his anti-seizure medication. The HPO liaised with OPAL to explain his situation. They ascertained with

			nursing staff that he was mobile and did not require reassessment. The HPO spoke with …. (Mr A) directly to explain he would need to go home. He stated he was disappointed there was no accommodation for others like him just discharged from hospital. The HPO informed him that the OTs on his previous admission had assessed him, and that the accommodation was suitable. Other options were not considered as he was deemed suitable for that accommodation.
04/06/23	discharged back to previous address	UHB	Letter addressed to Tudor practice, Birmingham
05/06/23	Welfare Check done – Mr A out of hospital	Concept Housing Association	None noted
08/06/23	weekly support session completed- discussed the negative impact alcohol is having on Mr A recovery.	Concept Housing Association	None noted
08/06/23	Initial assessment by CMHT. At this appointment, reference was made to the Mr A's previous assessment by liaison psychiatry, the injuries he had sustained following the RTC and the impact of this on Mr A's current mental state. At this time, Mr A voiced dissatisfaction with his accommodation, he advised that he felt his accommodation was unsuitable. He said this was due to there being lots of hills around and he struggled with this due to his mobility. He reported that he didn't have any support, but his accommodation was referred to as "supported" and he had raised this with the staff there. There was also exploration into his use of substances; it was noted that he had a history of Class A	Birmingham and Solihull Mental Health Foundation Trust	Following assessment, there were no signs of acute risks or mental illness, rather the impression was of adjustment disorder related to his road traffic accident. A plan was agreed to review him again and, in the meantime, he was given crisis details should he have concerns before next appointment.

	drug use, but he denied using these for years. He reported that he used alcohol, but this was less than once a week. He also admitted to using cannabis but this was infrequent, the last time being 5 days prior, this was not something he raised as a concern or something he wanted to address.		
12/06/23	Welfare check completed	Concept Housing Association	None noted
15/06/23	Weekly support session- discussed housing at 28 Ashwin Road and discussed if a higher support provision would be more suitable. Mr A advised he did not want to move however the support worker spoke about making a referral for possible accommodation with support onsite. Mr A agreed for this to be explored	Concept Housing Association	A call was made to Homeless Pathways who advised they considered the existing 1-hour support to be sufficient and advised the alternative option would be a referral to SAFA Fireside. Which Mr A advised he did not want. Mr A asked for assistance with filling in forms for his solicitor who was supporting a compensation claim and with completing PIP applications.
19/06/23	Welfare check completed	Concept Housing Association	None noted
22/06/23	Weekly support session	Concept Housing Association	assisted Mr A to completed compensation forms for solicitor spoke to them and helped complete
26/06/23	Welfare check done- no issues raised	Concept Housing Association	None noted
29/06/23	Weekly support session completed. Talked about incidents in hospital and how much he wants to avoid readmission and discussed reading and other social activities	Concept Housing Association	None noted
03/07/23	Welfare check completed no issues	Concept Housing Association	None noted
04/07/23	ENT appointment	UHB	Did not attend-discharged. Letter to Tudor practice, Birmingham

06/07/23	Weekly support session completed		Mr A has registered at the local GP but the new surgery had not received his files yet so-called old GP to get prescription sorted. Some confusion over Mr A having been given two different NHS numbers. Prescription written up and Mr A advised he wanted to pick this up from his old GP surgery
06/07/23	Review appointment by CMHT. Mr A spoke of his ongoing frustrations in relation to his physical health and the unsuitability of his accommodation	Birmingham and Solihull Mental Health Foundation Trust	He reported that he had a support worker from Provident Housing and had asked to be referred back to hospital housing group but had been told this wasn't possible because he didn't engage properly with rehabilitation. There was no change to the impression in relation to his mental health or risk profile, however the concerns in relation to his accommodation were documented and consideration was given to request for an STR worker to support his accommodation needs. This was taken to MDT discussion the following day, but it was noted that Mr A had advised that he already had a support worker for his accommodation and so referral for an STR worker was not indicated as there was already support in place.
06/07/23	admitted following increasing seizures.	UHB	Reviewed- nil acute. Also reviewed by Major Trauma Service to ensure was getting follow up following previous admission- looking to arrange peripheral nerve studies and ophthalmology. Reviewed by homeless team who stated could go back to current accommodation. He did state he found area hilly which affected his mobility- but this was agreed to be sorted in community as OT had assessed. He had also expressed that his things had been stolen from the accommodation and had been advised to talk to the support work and report to police. His increasing seizure activity was

			due to difficulty getting medications. A Dr contacted his GP in Bham (Tudor) to send discharge letter to ensure could get regular medication (NB June letter had gone there).
06/07/23	Referred to OPAL Social care as stated he felt unsafe to return to his accommodation.		Social worker advised seeing Homeless Team. He was seen by Homeless Pathways Officer (Claremont Living). He told them he felt accommodation unsuitable due to having things stolen and mobility issues. Housing Manager (Provident) did not substantiate theft issues. Mr A was advised later that day that they had completed their checks and he hadn't reported thefts to provider or Police. He said that area hilly affecting his mobility, ward nurse said to HPO that this could be sorted by an assessment in the community arranged by GP.
07/07/23	Discussed in CMHT MDT – discharge being considered.	Birmingham and Solihull Mental Health Foundation Trust	None
07/07/23	Mr A was admitted to hospital due to a seizure; he was discharged on Monday 10th July 2023	Concept Housing Association	
….07/23 (Date removed for anonymity	Mr A found deceased at the property by Provident Housing- Branch Manager – Handsworth, who attended to visit Mr B to give eviction order.	Concept Housing Association	
07/23 (Date removed	At 14:34hr WMP were called (priority 1) to a house of multiple occupancy where	West Midlands Police	Investigation followed



for anonymity	there was a report of a dead male (Mr A).		

Chronology Mr B Alleged Perpetrator	**OWHR007** Some of the text has been paraphrased and identifying text removed.		
DATE	**CONTACT**	**AGENCY SOURCE**	**ACTIONS TAKEN**
2013 (Before Review Timeline)	Mr B known to BSMHFT since 2013, and open to services since 2014. K2 has a formal diagnosis of paranoid schizophrenia and mental and behavioural disorders due to use of cannabinoids. In 2013, he was seen by liaison psychiatry after presenting with suicidal thoughts, and thoughts of wanting to kill his mother's boyfriend.	Birmingham and Solihull Mental Health Foundation Trust	Following assessment, he was referred to CMHT. He was offered a psychological appointment in August 2013, but did not attend and he was discharged back to his GP.
2014 (Before Review Timeline)	In 2014, Mr B was arrested after there was a report of a male in the street with a knife. A search of a communal doorway resulted in the recovery of a kitchen knife. Whilst speaking with officers, Mr B stated he wanted to kill a neighbour. In interview, Mr B displayed signs of poor mental health, was assessed by the medical staff in custody.	West Midlands police	It was subsequently determined that he was fit to be interviewed with an appropriate adult. He charged with this offence and possession of a knife and received a hospital order
01/11/14 (Before Review Timeline)	Mr B was seen by Street Triage – he was making threats to kill his neighbour and had a knife.	Birmingham and Solihull Mental Health Foundation Trust	He was detained under Section 136 of the Mental Health Act and was later assessed but deemed not detainable as there was no evidence to suggest he was presenting with any mental illness of a nature or

			degree warranting admission into hospital. His presentation was secondary to cannabis abuse. He was therefore discharged into police custody.
01/10/15 (Before Review Timeline)	He was assessed by Forensic Services staff from the Tamarind Centre at HMP Birmingham due to staff reporting he was paranoid, guarded, psychotic, with fluctuating mood elevation and low mood, and displaying impulsivity in relation to behaviours and violence	Birmingham and Solihull Mental Health Foundation Trust	Following assessment, he was transferred to Tamarind under Section 38.
01/02/17 (Before Review Timeline)	He was discharged from Tamarind inpatients in February 2017 to the care of the FIRST Team. Therapy.	Birmingham and Solihull Mental Health Foundation Trust	Whilst under the care of the FIRST team he was supported with his benefits, housing, social activities and by Occupational health. Mr B reported periods of not using cannabis however declined to provide a urine sample when he was asked.
Oct-20	In October 2020, Mr B was transferred to Ladywood and Handsworth CMHT and remained open to them up until the time of the incident.	Birmingham and Solihull Mental Health Foundation Trust	With CMHT, he had regular medical reviews and was allocated a community psychiatric nurse (CPN). From these reviews, he was settled in his mental health and denied any cannabis use.
22/01/20	address registered as ……	Birmingham and Solihull Mental Health Foundation Trust	
01/07/20 at 20:28hrs	Call from victim stating that a male (Mr B) was at her back door, had opened it and said "I'M COMING IN." …. attempted to block his path but ….. pushed past her. ….. managed to push …. out of the door and ran off but was detained by officers and arrested.	West Midlands Police	Call correctly graded as a 'Priority 1'. Officers arrived within eight minutes, in line with P1 grading (danger to life/risk of imminent harm, officers must attend within 15 minutes of receiving the call). The victim gave a description to officers and conducted an area search in a bid to find him. Mr B was located and arrested on suspicion of burglary. Whilst in custody he stated that he used anti-psychotic medication and was seen by the Liaison and Diversion team. He underwent a mental health

			assessment and was deemed fit for detention and interview but with an appropriate adult present for interview. During interview, Mr B confirmed that he had been at the property but denied using any force in trying to push the door open. The case was reviewed by the Detective Sergeant and it was identified that there was insufficient evidence to charge the offence of burglary. There was; however, sufficient evidence to prove the offence of 'Using or Threatening Violence to Secure Entry to a Premises' and Mr B was charged and convicted of this offence. He was sentenced to imprisonment for three months.
20/08/20 at 22:40hrs	Mr B flagged officers down and reported that he had been assaulted on a bus by three Asian males; they were said to have taken offence to something he said. He had substantial injuries to his face and was very intoxicated but refused an ambulance and refused to attend hospital. He finally agreed that officers could take him home.	West Midlands Police	Given that Mr B flagged officers down, the incident was correctly graded as 'Priority 8' (Internally Generated Task – the creating officer addresses the needs of the incident). Mr B was taken home and left in the care of his neighbour, a nurse. He informed officers that he did not wish to make a complaint and would not consent to officers taking photographs of his injuries. He was not asked to sign a pocket note book entry as he had a large quantity of blood on his hands. Officers attempted to give Victims' Code advice; however, Mr B's intoxication led the officers to doubt whether he accepted the advice. The investigation could not progress as no details of the bus route were known for CCTV and witness enquiries to commence. Also, there was no statement or support from Mr B. The investigation was filed due to evidential difficulties and a lack of victim engagement. Mr B's intoxication was not subject of any referrals as this was the first recorded incident within this timeframe where he was publicly intoxicated. There was nothing to suggest in the circumstances that Mr B had a problem with alcohol.
January 2021 – February 2021	Custodial sentence	Birmingham and Solihull Mental Health	His CPN attempted to engage with him the day after his release however this was unsuccessful. CPN offered face to face

		Foundation Trust	appointments to him however he declined. He had telephone contact instead in March, April and May 2021
Jun-21	Was medically reviewed by the consultant	Birmingham and Solihull Mental Health Foundation Trust	No changes were made to his medication, Mr B attended medical reviews and it was felt that he remained stable in his mental state and reported he was taking his medication
Oct-21	He was commenced on Aripiprazole as he reported ongoing auditory hallucinations.	Birmingham and Solihull Mental Health Foundation Trust	
Nov-21	When reviewed, he reported that he had stopped taking the Aripiprazole due to side effects. He reported that he continued to hear voices and was started on Quetiapine instead.	Birmingham and Solihull Mental Health Foundation Trust	When Mr B was contacted by his CPN later the same month he reported he had not taken the prescription the doctor had given him because he didn't want to take more medication.
Jan-22	He was medically reviewed where he continued to hear voices which are command in nature asking him to kill "Abud".	Birmingham and Solihull Mental Health Foundation Trust	A mental state examination was completed where he presented as restless at times. His speech was of normal rate with no pressure of speech. Ongoing abnormal perceptual experiences in the form of auditory hallucinations. No formal thought disorder. No thoughts of harm to self. No imminent plans reported of harming others. Insight is limited. The plan following the review was to continue olanzapine, mirtazapine and start lorazepam and quetiapine and for the CPN to follow up. He was reviewed by his CPN following this monthly, where at times he reported not hearing voices and other times reported he was managing the voices and didn't want the CPN to explore this further. He reported he was taking his medication. Occasional cannabis and alcohol use was reported. His attendance for appointments was sporadic and he would miss CPN and medical appointments.

May-22	Mr B reported people coming into his flat when he is out, and that people were messing with his phone.	Birmingham and Solihull Mental Health Foundation Trust	These reports were followed up by the consultant who reviewed the service user and restarted Olanzapine and Mirtazapine. He was medically reviewed again in June 2022 where no evidence of any change in risks and no evidence of any acute drug intoxication or withdrawal were noted at the time of the consultation.
Jul-22	He reported to his CPN he had stopped taking his medication	Birmingham and Solihull Mental Health Foundation Trust	Attempts the following week to contact the service user were unsuccessful.
Sep-22	Family of Mr B contacted the CMHT to report he had damaged his flat.	Birmingham and Solihull Mental Health Foundation Trust	In response he was medically reviewed and reported he was taking his medication, and the damage was caused as he was frustrated as nothing gets fixed in the accommodation
middle of October 2022	An 'Allied Professional' who was supporting Mr B in the absence of his allocated CPN spoke with Mr B at his home. They explained his CPN was off work and Mr B said he didn't need services and wanted to be discharged.	Birmingham and Solihull Mental Health Foundation Trust	The plan was to discuss this in the MDT
early Nov 22	Mr B was discussed in the team's MDT due to the reported property damage and his CPN off work.	Birmingham and Solihull Mental Health Foundation Trust	He was medically reviewed later in the month and reported he was not taking his Olanzapine and only takes the Mirtazapine occasionally. However, after discussion with the doctor he agreed to restart Olanzapine. The plan was for the 'Allied Professional' to follow up.
early December 2022	The housing provider had contact with a CMHT duty worker after Mr B had caused damage to the property	Birmingham and Solihull Mental Health Foundation Trust	The housing provider was advised if they have any concerns for his and others safety then they should contact the police. The housing provider were also made aware of the member of staff who was supporting Mr B in the absence of his CPN and agreed to contact them the following day. There is no clinical record of the housing provider contacting the following day. However, the 'Allied Professional' did

			attempt to contact the housing provider and left a voice message and also spoke to Mr B.
15.12.22	A wellbeing telephone call was attempted by unqualified nursing staff to Mr B	Birmingham and Solihull Mental Health Foundation Trust	However, Mr B didn't engage and ended the telephone call
20.12.22	Family of Mr B contacted the CMHT duty worker reporting Mr B was carrying a knife and would stab anyone who came to the door	Birmingham and Solihull Mental Health Foundation Trust	The plan following this contact was to discuss with the consultant. The following day the housing provider contacted the CMHT and advised they had persuaded him to take his medication. Mr B was also discussed in the team's MDT where it was agreed for him to be medically reviewed the following day. The same day CMHT staff attempted to contact Mr B and his support worker and messages were left on their telephones. When Mr B telephoned the CMHT regarding his medication on the 22 December 2022 and spoke to a CMHT administrator he was verbally aggressive and terminated the telephone call.
18/02/23 at 15:03hrs	Call was made to WMP stating that Mr B was smashing up his bedroom within shared accommodation. He had entered two other resident's rooms and threatened to smash them up with a wrench	West Midlands Police	Officers arrived at the location (delayed) Mr B was arrested but required a mental health assessment before interview. He was detained under Section 2 of the Mental Health Act and taken to Highcroft Hospital. He was bailed with the condition to report to Lloyd House police station every Wednesday upon release from Highcroft. The OIC encountered obstacles when attempting to obtain a statement from the housing company for the criminal damage. The company felt that the incident was as a result of Mr B's poor mental health and wanted to get him the help he needed. However, one of the other managers did eventually provide a statement. The three reports were filed. The OIC was unable to interview Mr B as a result of his mental health. The two assaults were filed due to lack of victim support; both of the victims refused to provide statements. The criminal damage was filed following a detailed discussion between the

			OIC and their supervisor. A statement was obtained in respect of the damage; however, the OIC spent months chasing medical records in relation to Mr B's mental health but they were not provided.
19/01/23	The CMHT were informed by the Mr B's housing provider he had caused damage to the property, and he attempted to assault 2 people	Birmingham and Solihull Mental Health Foundation Trust	He was taken to hospital due to his injuries and later taken to custody. Following a Mental Health Act Assessment in custody he was admitted to acute psychiatric inpatients under Section 2 MHA. He remained as an inpatient until 28 February 2023
28/02/23	He was discharged initially to home treatment and then back to CMHT.	Birmingham and Solihull Mental Health Foundation Trust	
13/03/23	address registered as ……, …….	Birmingham and Solihull Mental Health Foundation Trust	
14/03/23	Mr B was medically reviewed by a consultant after his inpatient admission. A mental state examination was completed where he presented as impatient at times, though engaged with the interview very well. His speech was of normal rate with no pressure of speech. No evidence of any abnormal perceptual experiences evident or reported by the patient at the time of the appointment. No formal thought disorder. Insight is partial.	Birmingham and Solihull Mental Health Foundation Trust	The plan following the review was to reduce Olanzapine 15mg once daily. GP to take over prescribing in 4 weeks.
01/05/23 at 18:23hrs	Mr B telephoned WMP to say he had been approached by three males, who had threatened to stab	West Midlands police	Given the delay in the reporting of the incident, the log was initially graded as a 'Priority 5' (An appointment should be made for investigation officers to complete an

	him unless he gave them his wallet. He handed it over as he believed the threats to be real. He could not recall the date, time or location of where this occurred. He believed that it occurred on the previous Thursday or Friday but could not be sure; he finally stated that it occurred on Friday 28th April 2023.		investigation within three days). This was amended very quickly to 'Priority 3' (We should arrive on scene as soon as possible and within 24 hours of receiving the call). Attempts were made to speak with Mr B between 1st May and 5th May but contact could not be made as Mr B would not answer the phone or respond to messages. The incident was recorded as robbery on 5th May. The OIC attempted to contact him 11 days later but there was no reply. The investigation was filed due to lack of victim engagement, lack of witnesses, CCTV or forensic opportunities. Safeguarding consideration and referrals were noted on the investigation log; however, due to Mr B's lack of engagement the OIC was unable to provide advice or know which referrals were needed as well as obtaining permission from Mr B to make any necessary referrals. Ultimately, a text message was sent to Mr B with details of how he could contact Victim Support and details of other support agencies available to him
beginning of May 2023	CPN attempted to contact Mr B without success	Birmingham and Solihull Mental Health Foundation Trust	
05/05/23	Mr B moved into ……., having self-referred from his previous supported accommodation property which had been closed down. He moved in that day.	Concept Housing Association	The initial needs and risk assessment was completed with Mr B and he advised he smoked cannabis and has a beer now and again. He advised he did not require assistance with this as it was recreational only. Mr B disclosed that he has schizophrenia, depression and anxiety and advised he had good days and bad days but it was affecting his ability to look for work. Mr B advised he was not taking his medication presently. Mr B advised he had a previous conviction for carrying a blade 2013 which had resulted in him going to prison and hospital until 2017. Mr B advised he was not subject to any supervision or

			orders and advised there was no CMHT involvement.
08.05.03	Welfare Check conducted- no issued	Concept Housing Association	None noted
11.05.23	Weekly support session- discussed how Mr B was settling in, advised he was feeling a little anxious about getting to know his new housemates, discussed some ways to assist him with this transition	Concept Housing Association	None noted
12/05/23	He notified CMHT that he moved address as the previous landlord had sold the property and new address was ……..He was medically reviewed by a consultant he reported he has stopped taking his medication and believes that he had difficulty getting this, therefore had stopped it. He was dismissive of the recent admission and the incidents leading up to this.	Birmingham and Solihull Mental Health Foundation Trust	A mental state examination was completed, and he presented as irritable at times and restless. His speech was of normal rate with no pressure of speech. He was not distracted during the interview and no thoughts of harm to self or others. He also gave the consultant his new address. The plan following the review was outpatients' appointment in 4 months but an earlier appointment to be booked, if any symptoms of relapse.
15/05/23	Welfare check done- no issues reported. Stated he was getting on with the other residents	Concept Housing Association	None noted
18/05/23	Weekly support session- focussed on the importance of taking his medication as he advised he was not taking it for his mental health. Discussed the importance of discussing any	Concept Housing Association	None noted

	concerns about medication with his GP. He advised he would think about booking an appointment with his GP to discuss.		
22/05/23	welfare check done- asked Mr B about if he had followed up following conversation about GP and medication. - He disclosed he would book at GP appointment if he felt he needed it but stated he felt ok at the time.	Concept Housing Association	None noted
24/05/23	The CPN continued to attempt to contact Mr B after his medical review and following an MDT discussion an unannounced home visit was attempted without success and further unsuccessful attempts to contact the service user following this were made by the CPN	Birmingham and Solihull Mental Health Foundation Trust	
25/05/23	Weekly support session – discussed personal hygiene and self-care with Mr B as appeared to be wearing the same clothes continuously.	Concept Housing Association	None noted
29/05/23	welfare check done- Mr B advised he was bored at home, discussed helping him get involved in some activities and agreed to discuss further at next support session.	Concept Housing Association	None noted
01/06/23	Support session completed discussed accessing gyms and looked at memberships	Concept Housing Association	None noted

	available. Mr B had stated he would like to be a football coach but did not feel he was fit enough.		
05/06/23	Welfare Check done – Mr B said he was fine and no issues reported	Concept Housing Association	None noted
08/06/23	weekly support session completed- discussed housekeeping and cleaning skills	Concept Housing Association	None noted
12/06/23	Welfare check completed	Concept Housing Association	None noted
14/06/23	CPN spoke with Mr B and documented his voice sounded as if he had taken some form of drugs/alcohol.	Birmingham and Solihull Mental Health Foundation Trust	An appointment was agreed for the following week however he didn't attend
15/06/23	Weekly support session- discussed budgeting	Concept Housing Association	
19/06/23	welfare check completed- Mr B had no issues to report	Concept Housing Association	
22/06/23	Mr B attended the office of Provident and said he had lost his bank card	Concept Housing Association	Called the bank. Mr B became very frustrated but calmed down and was assisted to order a new bank card.
26/06/23	Welfare check done- Mr B advised he was able to resolve his issue with the bank and explained they would be sending him a new card.	Concept Housing Association	
29/06/23	Weekly support session completed. Discussed the terms of Mr B's license agreement and the importance of following this in order to maintain his current accommodation	Concept Housing Association	
03/07/23	Welfare check completed. Mr B seemed 'a little on edge' and advised	Concept Housing Association	

	that his mental health was not great. Had a conversation with him about coping strategies.		
03/07/23	The CPN attempted to contact Mr B, however there was no reply, and a voice message was left	Birmingham and Solihull Mental Health Foundation Trust	This was the last attempted contact with Mr B prior to the incident by BSMHFT
06/07/23	Weekly support session completed – Discussed contact his GP and OH for assistance with mental health and why this is important. He advised he had not, as he did not want to engage and he was again encouraged to seek help. Offered a lift to the GP and he declined and said he would decide if he wanted to do this himself. He advised he would get in touch if his mental health deteriorated further.	Concept Housing Association	
../07/23	Mr B attended the Provident Housing office on 10.07.23 with cuts to his left hand and was bleeding stating 'you are not going to be happy with me, I need a new yard, I've smashed my room up, I've lost it.'	Concept Housing Association	Staff asked why he had 'lost it' and he advised he needed to get in touch with the bank as an ATM in ……had swallowed his bank card. Members of staff attended his address to review the damage and took video footage of the damage to the room. Contact was made with the bank with Mr B. He was agitated and talking fast stating 'everyone is trying to confuse me, 'nuff people are trying to following me, I take nonces away and put them off street and yet no one respects me.' Mr B kept stating everyone is trying to confuse me. Staff talked with Mr B and asked him if it was ok to call the mental health crisis team, call made at 3.31pm. Mr B remained calm on the call however ended the call stating 'you can't help me'. Staff continued to talk to Mr B and asked permission

			to call paramedics to assist with both the cuts to his hands and his mental health. Mr B initially stated no. After speaking with him for some time he agreed for the support worker to call 999 for the ambulance service, this call was made at 16.55 and the call lasted 17 minutes. Towards the end of the call, it was explained that ambulance could take several hours to attend due to shortages and asked if it was possible for staff to support him to attend A&E. This was discussed with him and he agreed to attend. .....the Branch Manager for Provident Housing advised he would take him to City Hospital. Prior to leaving, he was asked for his keys back to the room as it was not safe due to the damage done. He advised he was hungry and, had a cup of tea and some toast prior to be driven to hospital. He was driven to City Hospital and temporarily parked just outside in order to get him booked in. Once he was booked in, Mr …..advised he needed to move his car to the car park and would be just a few minutes. In the time it took to move the car Mr B left the hospital. There is and was, no indication that the incident leading up to the notice being served involved or identified any potential risk to the victim.
...07.23 (Date removed for anonymity)	Provident Housing- Branch Manager – Handsworth, attended the address to visit Mr B (about 2.30pm) and serve him an immediate termination notice as, he had been alerted by another resident that Mr B had regained access to the property (at about 2.30am).	Concept Housing Association	Mr B asked ..... to go through to the garden and showed him the victim's body ..... …..... .....He remained at the property with Mr B until the police arrived. And notified Concept Housing Association of the incident.

…. /07/23 14:34hrs (Date removed for anonymity)	WMP were called by .....of a house of multiple occupancy (exempt accommodation), reporting a .... dead male in the garden at the address. When the call was received by police it was correctly graded as a 'Priority 1'. Officers arrived within six minutes, in line with P1 grading (danger to life/risk of imminent harm, officers must attend within 15 minutes of receiving the call).	West Midlands Police	He further advised that the suspect lived at the property and had told him that he had 'killed a man' and was still present (Mr B). On arrival officers found the victim …… (Mr A) lying face down in the back garden. A knife believed to be the murder weapon was recovered from the garden. Mr B was arrested at the scene and taken into custody. He was subsequently sectioned.

Appendix 3

Abbreviations	
Appropriate Bodies	Those appropriate to contribute to a review. These will be in addition to the relevant review partners/review partners and are those that may have had contact or could reasonably be expected to have had contact with either the victim, or alleged perpetrator/s, and could include those in the community with wider expertise of serious violence, criminality, exploitation, and societal and economic risk factors.
Care Coordinator	The care coordinator is often the single most important role involved in the care of any individual patient. Supervising interdisciplinary care by bringing together the different specialists whose help the patient may need, the coordinator is also responsible for monitoring and evaluating the care delivered.
CPA	Care Programme Approach The CPA process and CPA care plans are the basis of supporting recovery and ensuring that the process is structured and recorded. 'Modernising the CPA' and subsequent policy and practice advice states that care plans should include action and outcomes in all aspects of an individual's life. Psychological and physical needs, social functioning, occupational activity as well as housing and welfare benefits should all be assessed and planned for. Inpatient CPA systems should record and collate the information and share it with the community care coordinator so there is an agreed plan that is shared between all parties to ensure safe passage into the community. A review date should be recorded.
CPN	Community Psychiatric Nurse
DoLS	The Deprivation of Liberty Safeguards
ED	Emergency Department at a hospital
FIRST	The Trust's community forensic team

GP	General Practitioner
ICB	Integrated Care Boards are NHS organisations responsible for planning health services for their local population. There is one ICB in each ICS area. They manage the NHS budget and work with local providers of NHS services, such as hospitals and GP practices, to agree a joint five-year plan which says how the NHS will contribute to the ICP's integrated care strategy.
ICS	Integrated Care System
IG	Information governance
IMR	Individual Management Review- A person from an agency (not previously associated with an individual will review all contact that agency has had with that person.
Panel	A meeting of a group of agencies made up of the Relevant Review Partners and Appropriate bodies
Relevant Review Partners	Review partners are defined in section 36 of the Act as: a chief officer of police and a local authority in England and Wales, and an Integrated Care Board (ICB) in England or a Local Heath Board (LHB) in Wales. A local authority is defined in England as a county council, a district council, a London borough council, the Common Council of the City of London in this capacity as a local authority or the Council of the Isles of Scilly.
STR	Support Time and Recovery worker – a member of the team who offers support with community engagement.
The Trust	Birmingham and Solihull Mental Health NHS Foundation Trust