	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** (1) [redacted], Chief Executive NHS England. (2) [redacted], Chief Executive Birmingham and Solihull Mental Health Trust. (3) [redacted] MP, Home Secretary. (4) [redacted], Chief Constable West Midlands Police.
1	**CORONER** I am Mr James Bennett, HM Area Coroner for Birmingham and Solihull.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 17 January 2018 I commenced an investigation into the death of **Khalid Seneen Yousef**. The investigation concluded at the end of the inquest on 8-17 June 2022.
4	**CIRCUMSTANCES OF THE DEATH** After a post-mortem the cause of death was determined to be: 1a Decapitation. On 4/1/18 Khalid was at Paddy Power on Rookery Road, Handsworth, Birmingham. At around 12:45hrs the perpetrator arrived in possession of four knives and commenced a sustained assault. Khalid's main injuries were decapitation, [redacted]. Alerted by staff the police arrived and the perpetrator was arrested on suspicion of murder. Within 24 hours he was detained under the Mental Health Act. He was severely delusional reporting he and Khalid were shapeshifting superheroes in a competition to find treasure at the behest of the Queen as part of a league of extraordinary gentleman. He had transformed into various beings and followed Khalid and decided to 'end the devil'. He was not previously known to the mental health services. It was established his family had a strong history of schizophrenia due to consanguinity. He was diagnosed with paranoid schizophrenia which responded well to medication. He stood trial for murder between 10-13/9/18 and was found not-guilty by reason of insanity and made the subject of a mandatory hospital order under the Mental Health Act. The background is as follows.

	In 2007 the perpetrator completed a 5-year Medicine and Surgery degree in Sudan followed by extra training in the USA achieving an exceptional score. There is no evidence he ever worked as a doctor after arriving in the UK in 2013. Khalid's port-mortem examination revealed his injuries had been carried out with skill. On 3/11/17 the perpetrator's relatives were concerned as he was reporting an irrational fear of foxes in the garden that no one else could see. This was not reported to the authorities. On 9/12/17 he was stopped by police near his flat and was in the possession of nun-chucks and a wheel-brace. He was released and told he would be informed later if any action was to be taken. There were no obvious signs of any mental illness. On 12/12/17 he was challenged and restrained by workers when found breaking into commercial premises. He was arrested on suspicion of burglary and taken to Perry Barr Custody Suite. A Force Medical Examiner noted no mental health concerns. On 13/12/17 he was interviewed and stated the Queen was responsible for a league of extraordinary gentleman and left clues that led to prizes. He had previously won prizes and had followed clues that led him inside the building. The detective constable was concerned that his beliefs appeared genuine and therefore referred him to Liaison and Diversion (L&D) located in the custody suite. The purpose of L&D was to screen patients for vulnerability and refer them onto appropriate secondary services. He was seen by a band 6 mental health nurse in his cell for a maximum of 45 minutes. He repeated his belief he was part of the league of extraordinary gentleman. The nurse did not recognise he was floridly psychotic and incorrectly decided he did not meet the threshold for a formal Mental Health Act assessment and could not be referred to mental health services. The nurse gave him a leaflet and advised him to contact a GP if he felt the league of extraordinary gentleman was affecting his day-to-day life. The detective constable did not want him to be released as she felt his beliefs would cause him to commit further offences, albeit similar offences, but she considered L&D as the experts and did not challenge the decision. The perpetrator was released from custody on bail under further investigation. On 18/12/17 he was stopped and arrested after trying to evade the police when in possession of a crowbar and detained until released on 19/12/17. There was no evidence to charge him with an offence and he was released. There were no obvious signs of any mental illness. Khalid and the perpetrator were known to each other. There is evidence they were friendly but on occasion the perpetrator had dragged and pushed Khalid around. On 31/12/17 the perpetrator visited Khalid at home and they left together seemingly on good terms. There is no evidence the authorities were aware of their relationship or of any direct risk to Khalid. The coroner’s conclusion as to the death was: Khalid was killed by another person who was severely mentally ill and acted upon his delusional beliefs. The significance of the perpetrator's presentation on 13/12/17 was not appreciated and it meant he was not referred to mental health services when he should have been. Had he been referred he would have received treatment and/or been detained and the death would not have occurred. The decision to not refer him for treatment was a very serious failure and occurred because of the L&D clinician's inexperience, inadequate training and supervision, and the absence of psychiatrists within L&D to provide advice.

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: The L&D police custody suite model is a nationally commissioned service. It is a broad service designed to identify persons in custody (PICs) with vulnerabilities and is generally successful at signposting them to a variety of different secondary services. In relation to mental health L&D is not intended to replace or duplicate secondary mental health services. It was originally intended to commission psychiatrists within this L&D model but they were removed from the final commissioned service. The expert evidence explained this decision is a very serious flaw in commissioning. The reality is a small number of PICs will be seriously mentally unwell or be developing a serious mental illness, in particular first episode psychosis. Such people are complex and L&D practitioners, who are generally junior staff, are not sufficiently trained or experienced enough to guarantee they will always recognise the significance of symptoms and take appropriate action, as happened with the perpetuator in this case. Therefore, L&D practitioners (who will include social workers, disability nurses, speech and language therapists, and band 6 mental health nurses) need readably available advice, support and reassurance from a Consultant Psychiatrist within L&D, even if only available via a phone call. Having indirect, and often difficult, access to psychiatrists as part of extended or secondary services is inadequate. The expert evidence explained that the most comparable L&D model is in prison custody where psychiatrists are commissioned, and there is no logical rationale for why L&D services in prisons have commissioned psychiatrists but L&D services in police custody suites do not. More widely, GPs (who are better trained and more experienced than L&D practitioners) have access to Consultant Psychiatrists working for secondary mental health services who have it written into their contracts to provide advice. The expert evidence explained the risks arising from the "gap" in commissioning is compounded by (1) police officers wrongly see L&D as mental health experts when they are not (there was direct evidence of that in this case). The Clinical Director for BSMHFT also gave evidence that some clinicians within BSMHFT also get confused about L&D's role. It follows whilst L&D is not there to replace or duplicate secondary mental health services there is evidence police officers and clinicians do not fully understand L&D's role and purpose and do wrongly view them as experts; And (2) there has been a material reduction in both (a) the number of Forensic Medical Examiners (FMEs) (commissioned by individual Chief Constables) working in police custody suites generally, but also (b) the number of Forensic Medical Examiners that are section 12 MHA 1984 approved. This reduction reduces the ability of L&D practitioners to seek advice from FMEs. There is an overlap between FMEs and L&D practitioners who both feed into police custody sergeants who have ultimate responsibility for the health and safety of PICs. In reality there are two health care systems working in parallel, however, multiple higher level local meetings have revealed a lack of clarity around who is responsible for what.

	BSMHFT's serious incident investigation (via the Root Cause Analysis (RCA) process) identified the lesson learnt was that there was no psychiatrist in the L&D model and reported this to NHS England. The evidence did not reveal the response. Generally, the evidence revealed BSMHFT's RCA process was unsatisfactory. An outside Trust agreed to undertake the RCA investigation but returned it incomplete and the paperwork has been lost. The circumstances were later reviewed by a Consultant Forensic Psychiatrist who identified no care and service delivery issues were identified. However, the evidence at the inquest did reveal matters of concern. BSMHFT had lost the relevant L&D practitioner's records which would have confirmed her training. The inquest evidence revealed concerns around her experience, training and supervision in this case. Two senior BSMHFT witnesses gave evidence there is now an intention to review induction and training of L&D clinicians. It follows I am not satisfied appropriate lessons have at the time of writing been learned. In summary, despite the death being 4 ½ years ago no changes have been made despite it being identified the absence of psychiatrists is a flaw in the commissioning of the L&D police custody suite model, compounded by the reduction in FMEs generally/section 12 approved FMEs, and more generally the experience, training and supervision of L&D practitioners needs to be reviewed by BSMHFT. In my view, there is nothing to suggest the same failures that occurred on 13 December 2017 in this case will not happen again. My specific concerns: 1. The L&D police custody suite model has not commissioned psychiatrists. 2. Liaison and clarity is needed between Chief Constables and the Trusts providing L&D services on who has responsibility for mentally unwell persons in custody. 3. West Midlands Police officers and BSMHFT staff do not sufficiently understand the role and limitations of the L&D police custody suite model. 4. BSMHFT have not learnt sufficient lessons from the incident and need to review experience, training and supervision of L&D practitioners.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 18 August 2022. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner of England and Wales, and to the following Interested Persons: (1) Khalid Yousef's family, (2) Birmingham and Solihull Mental Health Trust, (3) West Midlands Police, and (4) [redacted].

	I have also sent it to the following who may find it useful or of interest: (1) [redacted] – Consultant Forensic Psychiatrist, and [redacted] – Consultant Psychiatrist with Special Responsibility for Forensic Psychiatry. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Date:** 23 June 2022 **Signature**:  **Mr James Bennett, HM Area Coroner for Birmingham and Solihull**