INDEPENDENT INQUIRY
INTO THE CARE AND TREATMENT OF MR GLAISTER EARLE BUTLER

STATEMENT OF CHAIR OF INQUIRY ROBERT FRANCIS QC

On 21st May 2004 on a canal towpath in Birmingham, Glaister Earle Butler, a man with a longstanding diagnosis of paranoid schizophrenia in receipt of care and treatment from the Small Heath Assertive Outreach Team ("the AOT"), lethally stabbed a police officer, Detective Constable Swindells. That this occurred is a tragedy affecting a number of people. First and foremost Mr Swindells= family have lost a much loved relative and I would like to repeat our deepest sympathy for them. Secondly the community has lost a brave and respected police officer. But thirdly Mr Butler, a man with real achievements to his name, was left in a position to commit such a terrible act under the influence of his mental disorder as a result of which he is now indefinitely detained in a high secure hospital.

This inquiry was commissioned by the Strategic Health Authority to inquire into the care and treatment provided by the NHS to Mr Butler. As is clear from the report concerns were expressed to us about other organisations, but we could not inquire into their part in these sad events and our report should not be taken as expressing views on such matters.

The spirit in which we sought to conduct this inquiry very much echoed something Mr Swindells' mother and step-father said to us: A... as well as [Mr Swindells], Mr Butler was let down by the system. Both were let down by the system in different areas... we are here not to condemn anything... just to try to stop these things happening.@

We found significant areas of unsatisfactory practice which we concluded were due to the culture and practice of the Assertive Outreach Team as a whole, abetted by a failure in management at all levels, team supervision and review. We decided it would be unfair to single out individuals and counterproductive in terms of ensuring that the proper lessons are learned for the future.

We found that a number of factors came together on 21st May which, unpredicted by any of those who had responsibility for Mr Butler' care and treatment, made the terrible events of that date more likely. Many of those factors could have been avoided by good practice which was conspicuously absent. Among the matters of concern we discovered were the following:

- Undetected by the team Mr Butler had not been taking the medication prescribed for his mental disorder: 432 doses of it were to be discovered in his flat.
- He had allowed himself to get into financial difficulty by not renewing his application for housing benefit and owed back rent to the housing authority. This was not known to mental health services.
- Only weeks before the incident mental health workers, including a consultant psychiatrist, had visited Mr Butler in his flat and observed a large knife on the sofa and damage to the flat door. They accepted an explanation that this was due to martial arts practice and concluded wrongly that there was no cause for concern.
- The housing authority decided to serve an eviction notice on Mr Butler on the day of the killing without consulting with or notifying the AOT. The authority retained no record that he was a service user of mental health services..
- Neighbours had become concerned about his behaviour but this was also unknown to the AOT.
- A Council carpenter attended at Mr Butler's home for routine repair work to a garden gate