EMBARGOED AND NOT FOR PUBLICATION IN ANY FORM BEFORE 11:00 ON 15.09.14

Christina Edkins family statement.

Re: NHS Birmingham CrossCity Clinical Commissioning Group,
homicide investigation report, September 2014 (STEIS reference 2013/7122).

Christina's family acknowledge the consideration shown to us by Dr Alison Reed and the committee investigating circumstances leading up to the tragic death of Christina.

The report clearly shows that long-term failings by members of the police, prison-service and medical staff effectively to deal with and treat P Simelane (PS) during eleven years of a developing mental illness, culminated in a series of mis-managed opportunities throughout the fourteen months leading up to Christina's death on a bus in Birmingham on 7 March 2013

The facts detailed in the investigation into PS's behaviour during this time record his escalating acute paranoid psychotic disorder and show clearly that he was becoming increasingly dangerous to the public at large.

We agree with the investigation panel findings that the fatal attack on Christina could have been prevented had he received appropriate treatment and that there were many missed opportunities for the provision of mental health treatment and follow-up.

We believe that it was predictable that, without treatment, PS would eventually resort to a knife attack on another person and it was only a matter of time before he carried out his threats to kill.

Documented indications of his growing mental instability coupled with authorities' failures include:

a) his previous attacks on family members, including holding a knife to his mother's stomach whilst threatening to kill her;
b) his declared intent whilst on oath in a Magistrates' Court to stab and kill his mother;
c) assaulting a police officer;
d) the "near miss" situation when PS was at large having failed to surrender to custody after he was granted bail on 11 July 2012 because there was no transport to take him from the Court to prison on remand;
e) the concerns raised by medical experts that he should receive treatment in a secure hospital. That this was not carried out was due to continued failings by many individuals, and systems which perpetuated those failings, in the Birmingham and Solihull Mental Health Foundation Trust, HMP Hewell and latterly HMP Birmingham.

As a result, a paranoid psychotic was left to his own devices, without continued medication, a vagrant living on buses without help or supervision from our public services: this is the person who killed Christina on one of those buses.

We are hopeful that the many recommendations contained in Dr Reed's report are implemented and the learnings are "embedded" in the organisations so that no other family has to experience the heartache of such a meaningless and avoidable death of a loved one.

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15.09.14

We request that in twelve months time the Birmingham Safeguarding Children Board and NHS England will review the extent of change effected as a result of the recommendations in this report and publish a progress report.

Statement ends.

N.B. Mr Chris Melia, on behalf of the family of Christina, will be available to respond to related questions on Monday 15 September 2014 between 12:00 and 13:00 at 54 Hagley Road, Birmingham. B16 8PE.