REPORT TO YORKSHIRE AND THE HUMBER STRATEGIC HEALTH AUTHORITY OF THE INDEPENDENT INVESTIGATION INTO THE HEALTH CARE AND TREATMENT OF JD

REFERENCE: SUI 2004/3403

December 2008

The Panel

Malcolm Rae OBE FRCN
Formerly Nursing Advisor (Mental Health and Forensic), Department of Health 1997 - 2002

Dr Stephen Colgan
Consultant Psychiatrist and Medical Director Greater Manchester West Foundation Trust

Elsa Conway RMN
Associate Director Clinical Governance Northumberland, Tyne and Wear NHS Trust

Acknowledgements

We are conscious that the death of Mr D has deeply affected the lives of his family. We wish to offer our sincere condolences to Mrs D and also her son and his family in their tragic loss.

We realise that engaging in this investigation must have been extremely difficult and distressing and we are very grateful to them.

The investigation team wish to express their gratitude to Kay Morgan for her skills and efforts in co-ordinating the administration and the organisation of the investigation. Also to Janet Blackburn for her diligent and expert note taking, and the transcribing of interviews. We very much appreciate the time given by them to these activities.

We also wish to acknowledge the contribution of the clinical staff, managers, and the partner agencies for the open and appropriate way in which they responded to our questions and challenges. We appreciate the distress felt by those involved in the care of Mr JD and the subsequent scrutiny of their performance.

Contents

1 General Introduction

This independent investigation into the care and treatment of JD was commissioned by NHS Yorkshire and Humber SHA in accordance with the Department of Health (DH) circular HSG 94 (27) the discharge of mentally disordered people and their continuing care in the community, and the updated paragraphs 33-36 issued in June 2005. The Terms of Reference for the investigation are given in section two of the report.

On the 7 November 2004 following their usual Sunday lunch at Mr D's home JD attacked and killed his father. He was subsequently charged with the murder of his father. On the 31 January 2006 following a hearing at Sheffield Crown Court, JD was considered unfit to plead. A hospital order under Section 37 of the Mental Health Act was imposed, together with a restriction order (Section 41) without time limit. He remains detained in a High Security Hospital.

BACKGROUND TO THE HOMICIDE

At the time of the incident JD was receiving care and treatment from the Barnsley PCT Community Mental Health Services.

He had been referred to the Mental Health Services on a small number of occasions since 1992 with problems of depression, associated with drugs and alcohol misuse. In 1996 he was re-referred after expressing paranoid ideas and displaying violent behaviour.

On the 5 January 1997, he was arrested for the attempted murder of his mother after stabbing her three times in the throat. His mother declined to press charges and as a result he was not convicted. Instead he was managed through the Mental Health system and was detained at the Wathwood Regional Secure Unit until 2000 when he was transferred to the Department of Psychological Medicine (DPM) in Barnsley. He was discharged from the DPM in November 2000 on Section 25 (community supervision order) of the Mental Health Act. He continued to receive care and support from the Community Mental Health Team up to the incident and this is described in considerable detail later in the report.

The Trust established an internal review which started to examine the circumstances of the critical incident in March 2005 and the report was made available to the Primary Care Trust Board on 14 August 2006. The internal review report was never published as there were concerns in respect of confidentiality. The family told us they only received limited feedback as there was to be an Independent Inquiry.

INVESTIGATION APPROACH

In January 2008 we started the investigation and after obtaining and studying clinical records and a range of documents identifying key issues and questions, we commenced interviews of key individuals. We considered the complete psychiatric history of JD since he was first involved with the Mental Health Services. There are often important pointers from an individual's history which have relevance to future risk concerns and management. This was most certainly a feature of this case. We have been conscious of our advantaged position in being able to consider all the information without the day to day pressures of managing a large number of service users and liaising with their families for whom professionals have responsibility. The investigation team have also attempted to guard against the wisdom of hindsight.

At the outset of the investigation, we met Mrs D and JD's brother and discussed the Terms of Reference and clarified their specific areas of concern. The family held very strong views that the service had failed them. We subsequently met the family again and have communicated with them during the investigation. We have interviewed a range of clinical and managerial staff (some more than once), including some who had left the service, and the Trust's partner agencies, including a senior member of the South Yorkshire Police. We also interviewed JD in Rampton Hospital. All those we interviewed received copies of the transcripts of their interviews, and they were given the opportunity to amend or clarify points made.

On the 10 July 2008 we held a workshop, designed to clarify initial findings and themes. Key clinical and managerial staff were invited to attend and this proved to be of real value in a number of ways, including learning of improvements and changes since 2004. We also sought to engage those present in discussing the likely effectiveness of the recommendations which we were considering to use in this report.

We have received full co-operation from the Trust in completing the investigation, both in relation to documents and to staff. However the time which has elapsed over the past four years since this incident occurred has understandably made precise recall more difficult.

2 Terms of Reference

The Terms of Reference for this independent investigation, set by Yorkshire and the Humber Strategic Health Authority in consultation with Barnsley Primary Care Trust and Malcolm Rae are as follows:

To agree:

- To determine and gain consent for the methodology, outputs and time scale of the investigation.

To examine:

- The care and treatment the service user received up to and including the time of the incident.
- The suitability of that care and treatment in view of the service user's history and assessed health and social care needs
- The extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies.
- The adequacy of the risk assessment and care plan and their use in practice.
- The exercise of professional judgment and clinical decision making.
- The interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical health needs.
- The extent of services' engagement with carers and the impact of this, including the follow up and support offered following the event.
- The nature and adequacy of support offered to staff involved in this incident both before and after the event.
- The quality of internal investigation and follow up action.

To identify:

- Learning points for improving systems and services
- Developments in services since the user's engagement with mental health services and action taken since the incident.

To make:

- Realistic recommendations for action to address the learning points to improve systems and services.

Findings and recommendations will be reported to the Boards of Barnsley Primary Care Trust and Yorkshire and the Humber Strategic Health Authority.

3 Executive Summary and Recommendations

INTENTION

This report sets out the findings and summarised recommendations of the independent investigation team, following their analysis of the care and management of JD, provided by Barnsley Primary Care Trust. The investigation also specifically focussed on the extent and quality of the liaison and support provided to the family before and after the homicide.

PURPOSE

The purpose of the commissioned investigation was:

- To undertake a detailed and analytical chronology and time line, charting JD's contacts with mental health services since 1992.
- To critically analyse the documented care and treatment and to identify any areas which were weak or unsatisfactory, and then determine the significance of these features in relation to the subsequent course of events, which resulted in the killing of his father.
- To interview JD and his family, the key staff and partnership agencies involved to gain their perspectives.
- To examine the quality of the internal review.
- To identify learning points for improving systems and services.
- To be aware of service changes and developments since the incident which are likely to reduce the risk of similar incidents.
- To make realistic recommendations for action to address the identified concerns and improve the systems and processes of care, treatment and support to individuals and their families.

THE HOMICIDE

On the 7th November 2004, JD attacked and killed his father following their usual Sunday lunch together at the father's home.

On the 31st January 2006, at a hearing at Sheffield Crown Court, JD was considered unfit to plead to the charge of murder. A Mental Health Act hospital order with restrictions was imposed and JD was transferred to a high secure hospital, where he remains detained.

EARLY PSYCHIATRIC HISTORY AND BACKGROUND TO THE HOMICIDE

JD had been referred to the local mental health services on a small number of occasions since 1992 but his main history with the services commenced in January 1997 when he was arrested for the attempted murder of his mother, after stabbing her three times in the throat. He was not subsequently prosecuted for this very serious act but was detained at Wathwood Medium Secure Unit on the 9th January 1997, under a Section 3 of The Mental Health Act 1983. He had been diagnosed as suffering from schizophrenia with systemised delusions of persecution. His abnormal beliefs involved his parents, former school teachers, the police and mental health professionals.

Whilst JD's mental health fluctuated markedly at Wathwood he was deemed suitable for discharge to the district service in February 2000. This unusual discharge route was taken largely due to the configuration of the local services and patient and family preferences even though there was ambivalence from local Barnsley clinicians. Reports indicate that the delusional beliefs persisted and there were tensions between his parents and professional staff regarding the risks.

In November 2000, he was discharged from the Inpatient Unit on Section 25 of The Mental Health Act[1]. His care and treatment plan was developed by the Central Community Mental Health Team (CMHT), which included two staff who had worked at the Wathwood service and had known him during his treatment there. He remained on Section 25 until 18th October 2001. Subsequently he continued to receive care, support and supervision from the community team up until the homicide. The relationship between the service and his parents was reported as being tense, with limited communication or no active partnership working. JD continued to lack insight and intermittently made requests to reduce his medication, to disengage with services and declined to accept new therapy staff, when his original community staff were absent.

[1] Section 25 Mental Health Act – Supervised Discharge

On the 24th August 2004, the family support worker contacted a senior member of the community team, highlighting concerns from his mother that he was expressing strong paranoid ideas that the IRA were plotting against him, and that he had made distressing and disparaging remarks about her. Unfortunately his consultant was on leave, and there was no one else within the CMHT who was routinely involved with his care or family. Subsequently two members of the team visited and conducted an assessment, which was in some ways constrained by perceived duties of confidentiality. This assessment and a subsequent visit to his usual consultant on the 24th September did not identify any evidence of gross mood disturbance or psychosis. He was last seen by members of the CMHT on the 12th October when no concerns were identified.

He subsequently attacked and killed his father on the 7th November 2004.

INTERNAL REVIEW

An internal review was undertaken by a Senior Manager who was trained in Root Cause Analysis approaches.

There was a delay in starting the review which commenced in March 2005 and the final report was not completed until July 2006. The family expressed concern about the long delay and that the feedback to them was deferred due to the impending Independent Investigation.

The internal review was comprehensive in gathering information, was insightful in its analysis and objective in identifying the key contributing factors.

The recommendations were sound but some individuals we interviewed, asserted the recommendations lacked precision and clarity of understanding. We noted progress on actioning the recommendations.

Scrutiny of the internal review identified a number of concerns, including that a small number of key people or agencies were not interviewed, which resulted in insufficient information being obtained about the Wathwood Medium Secure Unit assessments and rationale for transfer and discharge. Also, the reasoning behind the decision by the Criminal Justice System not to prosecute the service user in 1997 following the serious attack on his mother was not confirmed.

The internal review made the following recommendations:-

1. That work commences to develop a Client Risk Classification Framework to be implemented throughout the Mental Health Service.
2. That a multi disciplinary team meeting be called to review a clients progress for discharge from inpatient services to a community care package or for consideration of discontinuation of medication, removal of Section 25 of the Mental Health Act
3. That clients subject to the Client Risk Classification Framework deemed to be high risk who are taking antipsychotic medication should be subject to three monthly checks to ensure they are attaining a therapeutic dose of their medication.
4. That the importance of the contribution that carers can make in the formulation of client care plans needs to be embraced more comprehensively by services.

COMPLAINT MANAGEMENT

The family had expressed concerns that after complaining about a range of issues there was a long gap before further contact was made, which added to their distress.

We were impressed with the support the family received from the Independent Complaints Advocacy Service and the support worker from Making Space.

We acknowledge the positive and sensitive attempts initially made by the manager of the service to respond to the family's concern and noted the apology extended by the Trust to the family for the distress they were experiencing. We also noted the family were properly advised of their rights in taking forward their complaints to other bodies.

We concluded that there were delays and gaps in communicating with the family and an absence of tracking and staying in touch. However, in general terms we consider the Trust response was adequate and have been assured that significant changes have been made to the complaints procedure.

SUMMARY CONCLUSIONS

We have concluded that JD was a complex person with a severe mental illness, who presented a range of challenges for both his parents and professional staff.

We have identified some failures of systems, omissions and misjudgements, however, we do not consider the tragic incident could have been foreseen or prevented.

We concluded that the coordination of planning for discharge from Wathwood Secure Services was inadequate, and we noted the absence of step-down facilities.

We also noted there was a gradual diminishing of appreciation of risk management strategies over the course of his care and treatment in the community, with insufficient attention given to assessment and recording of change in risk levels or reasoning behind decisions. We concluded that the clinical team's focus was on recovery and therapeutic optimism and aspects of risk and safety monitoring were not given the necessary equal importance, despite consistent indicators of concern including, distorted thinking regarding his parents, requests for discharge and harmful consumption of alcohol.

We have also concluded that the family and professionals did not enjoy a positive collaborative approach in supporting JD in the community. There was a breakdown in trust, tension, and a lack of confidence on the part of the parents in some of the professional staff. Whilst some staff believe the family seriously underestimated the risk of harm and impeded their efforts to provide supervision to JD and effectively liaise with his parents.

We did note the excellent support received by the parents from the representative from Making Space, but we have acknowledged that this should not replace the role of statutory staff, who are better placed to link with other multi disciplinary team members and advise on care management.

We have also concluded that some staff found the level of support available to them, at the time of the incident, was insufficient.

We were impressed with a range of service developments since 2004, which we consider will enhance the care, treatment and safety of service users and their families.

Whilst our primary focus has been on the concerns and areas for improvement, we noted the professionalism and openness of the staff we met and we were able to identify some noteworthy practice and individuals.

RECOMMENDATIONS

R1 FAMILY AND CARERS INVOLVEMENT

R1.1 We urge the Trust to use the family/carer concerns highlighted in this report as a spur to re-examine the current carer policy, with special regard to support and liaison arrangements.

R1.2 The Trust should ensure that all staff have training in assessing the needs of carers and are aware of their duties under the Carers (Recognition and Services) Act 1995.

R1.3 We recommend that the Trust should further consider how carers can be better supported and managed to enable them to understand the nature of serious mental illness and the associated risks, and how they can contribute to the care, treatment and support of their family member.

R1.4 The Trust considerations should incorporate both clinical and local authority risk assessments, with particular regard to: -

- Information, support, advice and supervision regarding risk assessments and management, including boundary setting, and compliance with the treatment plan.
- Carer assessment of needs and problems.
- Family therapy.
- Carer/family response to crisis and signs of relapse.
- Personal protection.
- Advocacy.
- Carer support groups.
- Engagement and strategies for overcoming resistance from family members.
- Training, guidance and support for staff in meeting carer/family needs.

R1.5 The Trust should ensure that CMHT's take into account the needs of carers when reducing the level of support to patients, and ensure that systems are in place to respond effectively to concerns of carers should circumstances subsequently change. This is especially important where patients present with a profile of significant risks, either to themselves or their carers.

R2 INTERNAL SERIOUS UNTOWARD INCIDENT INVESTIGATIONS

R2.1 Internal Investigations and Reviews into serious incidents should be undertaken in a timely manner, and the findings should be shared with staff involved and the families of victims, ensuring that any necessary lessons are learned.

R2.2 Those undertaking Internal Reviews should be given the necessary training, including approaches of root cause analysis, administrative and professional support along with protected time in order to undertake the duties and responsibilities effectively.

R2.3 The recommendations and action plan arising from SUIs should be reviewed after six months to check progress or otherwise, in the implementation of change and improvement.

R3 STAFF SUPPORT

R3.1 The Trust should review its processes and procedures for providing support to staff involved in serious incidents and seek to avoid reactions which may imply blame.

R3.2 Staff, patients or carers directly affected by a traumatic event should be offered support at the earliest opportunity and this should be sustained throughout the process of internal or external investigations including attendance at any inquest.

R4 EDUCATION, TRAINING AND DEVELOPMENT

A number of issues have emerged which the Trust should address through training and preparation of staff, including: -

- Family therapy, including psycho social interventions.
- Safeguarding Adults (for both clinical and managerial staff)
- Undertaking SUIs – Root Cause Analysis approaches and associated skills.

R5 CLINICAL SUPERVISION

Clinical supervision for support, reflection and guidance should be mandatory. The Trust should ensure that professional supervision takes place as set out in the Trust policies and that it is recorded and audited on a regular basis.

R6 ENGAGEMENT OF PATIENTS

The Primary Care Trust should review practice policies and training for the management of patients whose mental illness makes them reluctant to engage with services.

R7 MANAGING RISK

R7.1 The basis for referral of patients between forensic and generic services should be clarified with a specific understanding from both services as to what is expected from each side. For example this might include a structured clinical assessment of the risk of violence with agreements that forensic services offer support and advice to community teams when needed.

R7.2 A forensic opinion should be considered for those patients deemed to be a high risk of serious violence and criminality based on their history of aggression, poor anger control, use of illegal substances and alcohol.

R7.3 Those patients, with a history of serious violence and a higher risk profile should receive closer supervision and be subjected to frequent reviewing and monitoring, than others in the community. It seems highly unlikely that such patients would ever be suitable for standard CPA, and will continue to need the full panoply of the CMHT services.

R7.4 When dealing with patients with a history of violence and severe mental illness, Care Programme Approach meetings should set clear operational criteria for intervention, including setting of boundaries and essential requirement for compliance with treatment. These criterions should be communicated to patients and carers/family members in a way that is clear to them, so that they have a clear awareness of the expectations of supervision and understanding of the consequences of not complying.

R8 POLICE LIAISON

R8.1 The Trust should build on the current positive relationship with South Yorkshire Police. The development a joint working protocol as envisaged by the Memorandum of Understanding (MOU) between the Association of Chief Police Officers and the NHS Security Management Services (NHS SMS) should be undertaken.

R8.2 The Trust and the local police representatives should keep under review the question of prosecution of offenders who may have a mental illness.

R9 CARE PROGRAMME APPROACH POLICY

The Trust should ensure that it's Care Programme Approach Policy and Procedures are fully implemented and are supported with appropriate resources and training. The Trust should undertake frequent audits to ensure compliance with this recommendation.

R10 SAFEGUARDING ADULTS

The Trust should ensure that all Community Mental Health Team staff have training in Safeguarding policies and the protection of vulnerable family members.

R11 GOVERNANCE

The Trust should consider the development of a Mental Health Patient Safety strategy to complement the recently issued Risk Management Strategy in order to ensure that all issues relating to clinical risk and the safety of mental health service users are integrated and are robustly promoted and addressed within Barnsley PCT.

4 Chronology of Key Dates and Events

We have summarised in a timeline format comments taken from case notes in order to provide a history of JD's illness and a full picture of his care, supervision and management, along with the prevailing relationship pressures. The most important source of information is of course the contemporaneous record, as this is not contaminated by hindsight bias. We have added a commentary at various stages, identifying key issues and the reasoning which underpins our findings and recommendations.

EARLY HISTORY

JD was born in Barnsley, South Yorkshire, on 17 September 1963, the second son of Mr and Mrs D.

JD was a full term normal delivery with normal development milestones. There were no problems in his early childhood, though at school it was reported that he was generally unhappy and that he was picked on by teachers. At the age of ten, he was charged with extorting money from fellow pupils but this charge was later dropped due to insufficient evidence. At high school, it was again reported that he had difficult relationships with teachers. There was no history of truanting from school which he left aged sixteen years without formal qualifications.

After leaving school, he worked on a Youth Training Scheme for one year as a grounds man at Barnsley Football Club. At the age of nineteen he worked for his father as a lorry driver at which he continued for approximately the next eight years. It is reported that his father did not employ him from 1992 due to lack of work. From this time, JD was self-employed, owning his own ice-cream van and working mostly in the summer months.

From the early 1990's there are reports that JD was drinking excessive amounts of alcohol and there were incidents of aggression whilst under the influence of alcohol.

INVOLVEMENT WITH COURTS AND POLICE (1979 – 1990)

In 1979 JD was sentenced to three months in prison for throwing a brick through a shop window.

In 1985 JD was given a short custodial sentence for burglary.

In 1986 JD was given a custodial sentence for criminal damage.

Between 1981 and 1990 JD was also involved in the following incidents:

- Three drunk and disorderly charges, which resulted in fines.
- Two incidents where a vehicle was involved in an accident, without insurance.
- Two convictions for violence, one was an assault on a police officer and the other assault was classified as Actual Bodily Harm (ABH).
- Two convictions for criminal damage.

The consumption of alcohol was an underlying feature of his offending behaviour.

EARLY PSYCHIATRIC CONTACT (1992 – 1997)

JD was referred to the Substance Misuse Service by his GP in 1992 due to alcohol problems and depression

During 1993 JD gradually became more aggressive towards his mother. JD came home drunk one night and assaulted his mother and smashed up the living room. JD also started to accuse his father of attempting to kill him, citing an incident when he suffered a head injury whilst working for his father in 1987.

In 1994 JD was admitted to hospital for detoxification, the admission only lasted a few hours as JD felt uncomfortable. He was referred by his GP to see a Psychiatrist as JD reported that he had been feeling depressed for the last two years and was misusing drugs and alcohol.

He was referred again in June 1994 following concerns expressed by his GP that he was having difficulty with sleeping and concentration. An inpatient detoxification was arranged but JD disengaged from this within 24 hours of commencing treatment.

In 1996 JD was treated for depression by his GP and on 14 October 1996, his GP referred JD to Barnsley Community and Priority Services NHS Trust following concerns expressed by his mother that JD was expressing paranoid ideas. At this time there was a reported incident of damage to property at the family home but no charges were made against JD.

Subsequently JD failed to attend an out patient appointment on 3 December 1996.

Whilst appearing before Barnsley Magistrates Court on motor related offences he was approached by a Community Psychiatric Nurse (CPN) employed by the Court Diversion Service who was concerned about his behaviour. JD made it clear he did not want any involvement with the CPN.

On the 5 January 1997, JD was arrested for attempted murder of his mother. JD stabbed his mother three times in the throat with a salad knife saying "you're going to die now". His mother's injuries were severe enough for her to be admitted to hospital.

His mother did not press charges and it is recorded that JD was never convicted for the crime. Both JD and his mother felt that this was an isolated event and that it would not happen again.

When taken into custody following the attack on his mother, he made threats against CPN 1 who he had met during a previous court appearance.

Commentary

FAILURE TO PROSECUTE JD FOLLOWING HIS ASSAULT ON HIS MOTHER IN 1997

The decision not to prosecute JD in 1997 following the assault on his mother was flawed.

JD had a considerable prior history of offending behaviour, some of it involving violence, and had served time in prison. His assault on his mother was very serious and could easily have led to loss of life. The decision not to prosecute him for this offence was a significant error and was a key event in the subsequent management of JD. It appears to have set a tone which, played down the seriousness of what had occurred and possibly influenced subsequent risk management decisions.

Prosecution would have allowed disposal under Sections 37/41 of the Mental Health Act 1983. This would have promoted greater supervision of JD's mental health care with a heightened risk profile, it would also have facilitated a more systematic and monitored route back to the generic Barnsley Mental Health Services. Any plan to move JD to a less secure facility, or discharge him into the community would have had to be approved by the Home Office (Dept of Justice).

Prosecution might also have promoted adherence to treatment for JD by promoting insight or challenge to his denial over what had occurred.

The police indicated that prosecution of JD did not go ahead as Mrs D was not prepared to make a complaint. It appears that now other considerations would be taken into account by the Multi Agency Public Protection Arrangements (MAPPA) team, who would ensure that sufficient weight is given to the implications of not prosecuting an individual.

WATHWOOD (1997 – 2000)

JD was admitted to Wathwood Regional Secure Unit on 6 January 1997 under Section 3 of the Mental Health Act 1983 from police custody and was diagnosed as suffering from Schizophrenia with systematised delusions of persecution under the care and treatment of Consultant 1.

Wathwood at that time was a medium and low secure service.

JD was reported as believing that Mr and Mrs D were not his real parents. He believed that his real mother was Margaret Thatcher and that a conspiracy existed to keep this information from the public. This conspiracy was said to involve his parents, previous school teachers, mental health professionals and the police.

On admission 6 January 1997, Consultant 2 reported JD as - 'expressing paranoid ideas, delusional that his parents are impostors, that the police are after him, acting on his delusions he attempted to kill his mother, his reasoning and judgement are both impaired as such he presents a danger to both himself and others'.

Renewal of Authority for Detention 26 June 1997

'JD suffers from a severe form of schizophrenia. He continues to suffer outbursts of aggression. Unfortunately he completely lacks insight and does not accept that he is mentally ill or in need of any treatment. If he were not detained in hospital, his illness would be likely to worsen and he would again become a serious danger to others and may attack his mother or another member of the family who he believes are involved in the conspiracy to deny that he is Margaret Thatcher's son.' – Consultant 1.

Renewal of Authority for Detention 30 December 1997

'JD continues to suffer from a severe form of schizophrenia many negative signs of the illness. He continues to believe that he is the son

of Margaret Thatcher and that the police and others are deliberately persecuting him.'

'He is unable to accept that he is mentally ill. If he were not detained in hospital he would seek his immediate discharge and would not comply with the necessary treatment to prevent him from becoming more ill and violent to others. He is unable to consent with the necessary care on a voluntary basis. If discharged he will once again become a serious danger to others especially his parents.' – Consultant 1

In May 1998, it is recorded that JD has become preoccupied by abnormal perceptions, believes he is persecuted by the police, Home Office, previous teachers and his parents. He does not believe his parents are his real parents

On 20 August 1998, JD is reported as undertaking escorted leaves from hospital. 'Although he continues to lack insight, persistent delusions remain regarding the police and Margaret Thatcher. He is asking for increased duration of leave and decreased frequency of checks.'

On 27 August 1998, it was reported that JD's mother was oblivious to JD's on-going delusional beliefs and became distressed when informed.

On 3 September 1998, 'JD's delusions remain entirely unchanged and unshakeable'

Commentary

EARLY IDENTIFICATION OF RISK

The clinical assessments at Wathwood highlighted the danger he presented to his parents, or people he perceived to be involved in a conspiracy against him, and his unwillingness to comply with treatment. Earlier on, he had begun what became a regular feature of his care, requests to have a decrease in the frequency of checks. This lack of insight and understanding of his illness and need for sustained treatment was to continue throughout his care management.

On 10 September 1998, 'Modest progress made. Parents keen to continue with potential Clozapine trial. Parents eager to support unescorted leave and now accepting JD is ill and the need to report signs of relapse.'

On 17 September 1998, 'JD asserts that he now no longer believes Margaret Thatcher is his mother and alleges that other irrational

thoughts were a ploy to avoid being sent to prison. Due observation and vigilance was noted as being required to assess if delusions remain.'

On 9 October 1998, 'JD still maintaining he fabricated all beliefs to avoid custodial sentence. Not able to explain the reasons for attack on mother apart from claiming he was drunk.'

- He still lacks insight or appreciates he is ill.
- Parents shocked JD maintains delusional beliefs but understand the need to proceed cautiously and the potential future risks were again emphasised.
- JD reminded about being candid regarding delusions. Some signs of progress noted.
- Consultant 1 intended to write to Consultant 3, in charge of new Rehabilitation Services in Barnsley regarding taking over JD's care.
- Concern noted regarding his substantial risk and potential default from oral medication to minimise risk of relapse.
- Early warning signs explained to parents who re-iterated their assurance they would alert the clinical team if concerned.
- Reported as encouraging the parents to attend a new carers and relatives group.

On 29 October 1998 it was noted that JD was missing some therapeutic programmes.

17 December 1998 Renewal of Authority for Detention

'JD continues to suffer with schizophrenia. He remains convinced that he is still Margaret Thatcher's son. He is unable to accept that he is mentally ill, nor that he needs to remain in hospital, nor take medication. He is therefore unable to give valid consent to the necessary care. If he were not detained he is likely to take his own discharge, reinstate his heavy drinking and he would then be liable to again act aggressively to others. He therefore needs to remain under the protection of the Mental Health Act.' – Consultant 1.

6 January 1999 Renewal of Authority for Detention.

JD continues to suffer from schizophrenia. He remains convinced that he is still Margaret Thatcher's son. He is unable to accept that he is mentally ill, nor that he needs to remain in hospital, nor take medication. He is therefore unable to give valid consent to the

necessary care. If he were not detained he is likely to take his own discharge, reinstate his heavy drinking and would then be liable to again act aggressively to others. He therefore needs to remain under the protection of the Mental Health Act. It is hoped that he may be able to be moved on to non – secure facilities in the future. – Consultant 1.

JD was transferred to the Department of Psychological Medicine (DPM) on 15 February 2000.

Commentary

THE URGENCY BY WATHWOOD TO MOVE JD ON TO REHABILITATION AND THE TRANSFER OF CARE FROM WATHWOOD TO DEPARTMENT OF PSYCHOLOGICAL MEDICINE BARNSLEY

Within months of his arrival at Wathwood, there appears to have been attempts to have at least part of JD's treatment managed within the Department of Psychological Medicine. This possibly reflected confusion over his risk formulation, his therapeutic needs and what the Department of Psychological Medicine could offer and encouragement from his family to have their son nearer to home. We were led to believe that there was no psychologist in the team at Wathwood at this time, and this may have significantly impaired any multidisciplinary assessment of risk.

The transfer to an acute admission ward in Barnsley in 2000 appears highly unusual as part of step down from a Medium Secure Unit, though we were informed subsequently that this was not uncommon at this time due to the configuration of secure services and the lack of low secure beds locally. Consultant 1 indicated that the medium secure services at this time worked in tandem with the district services, and took patients with a relatively lower risk profile than might have been typical for other secure services.

The receiving consultant in Barnsley (newly in post) described feeling pressured to accept the placement due to the lack of low secure beds in the locality and expectations of the family and patient to move closer to home. The receiving consultant acquiesced to the apparent forensic opinion that this was a suitable transfer route; with a belief that their expertise in risk assessment meant that the acute admission ward was suitable. Reports indicate that a doctor at Wathwood had stipulated that JD could have transferred back if he had failed to engage into the Acute Unit. The rehabilitation unit at the DPM, which might initially have appeared as a more appropriate option, given his need for

continued care and treatment, apparently refused transfer as they felt JD posed risks beyond their capacity to manage.

It should have been made absolutely clear to JD and his family on discharge from Wathwood, of the need for systematic, careful assessment and monitoring of progress. Compliance with medication was an essential part of the treatment package and this should have been monitored assiduously in order to prevent relapse. That JD presented a substantial risk to his parents should have been spelt out and used to reinforce the need for their continuing involvement in the care planning process.

This initial lack of explicit understanding and specifying of what needed to occur had perpetuated and undermined future risk management strategies and ultimately, the protection of Mr and Mrs D.

The family clearly wanted JD home as soon as possible. Additionally there were differences in attitude from within the family – his mother thought he was mentally ill but minimised his risk, whilst his father appears to have conceptualised his son in terms of bad behaviour, possibly to avoid the mental health label. There was also tension within the family as to whether JD should have been subject to prosecution. Mr D thought if he had been sent to prison he would have been released sooner.

DEPARTMENT OF PSYCHOLOGICAL MEDICINE (FEBRUARY 2000 – NOVEMBER 2000)

On 15 February 2000, JD was admitted *to* the Department of Psychological Medicine (DPM) in Barnsley from Wathwood medium/low secure facility. JD commenced care at the DPM under the care of Consultant 4.

JD discussed his beliefs with the SHO in relation to Margaret Thatcher. 'JD still believed she (Margaret Thatcher) was his biological mother. He was also consuming alcohol. As well as his delusional beliefs regarding Margaret Thatcher he still thought that the police were keeping a close eye on him and that they "know everywhere he goes." JD was allowed leave as planned, he was prescribed Clozapine and the Amitriptyline was stopped.'

A risk history and risk profile were completed at this time.

On 22 February 2000, SHO reported that JD was still delusional, that his Clozapine was being increased and JD was having leave.

On 4 March 2000, Dr 1 reported that JD was feeling low, concentration on and off, occasionally tearful.

- Appetite OK
- Looking forward to future
- Amitriptyline helped for a few weeks, but then had little improvement
- Still delusional – fixed

On 21 March 2000, SHO noted change Paroxetine to Citalopram 20mg of (once daily) – may be interacting with Clozapine.

- Participating in activities
- Has his own house (bought by parents)
- Meeting was planned with Consultant 4, but cancelled
- Query where he will go on discharge
- Need to consider supervised discharge
- Need to advocate care coordination

On 28 March 2000, Dr 1 noted that 'JD's mood appears brighter, no problems, doing well.'

- Attending activities and leave
- Important to continue with medication/activities on discharge, therefore consider section 25 when discharge approaches.

On 4 April 2000, Consultant 4 reported that JD was attending physiotherapy and the Activities of Daily Living assessment was fine.

On 6 April 2000, at the first review meeting it is recorded:

'A fair response to Clozapine although continues to hold fixed delusions. No fresh psychotic features but some remaining negative symptoms. Some apparent improvement in depressive symptoms. Plans for discharge in progress but unlikely to be finalised for 6 months in view of risk factors.' - Consultant 4

On 7 April 2000, Consultant 2 noted that 'JD still holds the delusion belief about Margaret Thatcher and has only limited insight. However, he has no associated psychotic symptoms and has no intention of acting on the delusion. He is aware that he has an illness and co-operates fully with treatment.'

On 11 April 2000, Consultant 2 discussed with CPN 1 and Consultant 1

- Will have forensic review of level of dangerousness
- Appears warmer and more normal, still has delusions which do not interfere with functioning
- Would like leave attempt at own home (meals at parents)
- Aim to get house habitable, will need Central Community Mental Health Team care coordinator
- Encourage to pursue Occupational Therapy programme
- Referred to the Mental After Care Association for worker
- Consultant 4 to discuss with JD parents

On 11 April 2000, Mr and Mrs D met with social worker

Both (parents) are concerned that JD has been misunderstood in the past and that his psychiatric social worker has been over protective.

On 18 April 2000, a multi disciplinary meeting took place (JD present)

May 2000, leave arrangements in the hospital grounds started almost immediately.

On 9 May 2000, Consultant 4 recorded that JD was requesting leave

- Remains settled on the ward
- Attended Occupational Therapy for woodwork, but does not stay more than 20 minutes
- Consultant 4 is waiting to discuss with Consultant 1.

On 12 May 2000, JD appealed against his continued detention under Section 3 of the Mental Health Act 1983. The Mental Health Review Tribunal decision was not to discharge JD from the Section 3.

On 23 May 2000, overnight home leave commenced following a Care Programme Approach review and was reviewed and extended on 13 June 2000, 7 July 2000 and 21 September 2000.

On 31 May 2000, CPN 1 reported that 'JD was informed that a future Care Programme Approach is to be convened. JD continues to have fixed delusional symptoms, believes sometimes that his mother is

Margaret Thatcher, but currently has insight and will not currently act on them.'

On 5 June 2000, in Practice Notes it was recorded by Locum Consultant that a 'care plan review – to create a tight plan for JD's eventual management in the community. CPN 1 and CPN 2 to be key workers. Care Support Worker (CSW) to be involved as knew JD from Wathwood. Leave to be increased and assessment to take place of JD while on leave. Daily programme to be constructed.'

On 5 June 2000, visit to Mrs and Mr D for Tribunal Review Report:
Mr and Mrs D were:

- Not happy to talk about the past
- 'Found it difficult to know that I would have to refer to the past and use previous records'
- Expressed the view that they wanted to move forward and co-operate with other mental health services to support JD in the community
- Identified the need for JD to take his medication and recognised that alcohol intake needed monitoring.
- Wanted reassurance that the support services would be available over a long period of time. The parents attitude to the past suggests that they have little insight into the issues of risk and dangerousness

On 6 June 2000, a ward round/professional meeting took place to review risks and a future after care package.

On 20 June 2000, it was reported that JD remains settled. Goes on overnight leave; and is complying with his medication.

On 11 July 2000, SHO reported that JD was having two nights leave/week

- Continuing to do well/more relaxed
- Happy with situation
- Tribunal on Friday
- Bloods taken for Clozaril level last week
- Refer to Clozapine Clinic

On 14 July 2000, a Mental Health Review Tribunal took place which decided that JD should not be discharged from detention and recommended that JD should not be granted leave from the hospital.

The recorded rationale for the decision of the Mental Health Review Tribunal was: 'having read and heard the evidence, we are satisfied that the patient still suffers from a mental disorder of a nature and degree which requires his continued detention in hospital for treatment which is required in the interests of the patient's own health and for the protection of others. The patient is still deluded and lacks insight into his own actions and also the need for medication. Whilst we recognise the excellent progress that has been made, we find that the patient's continuing treatment should be within the rehabilitation process, currently organised by the hospital.'

On 28 July 2000, A Senior Occupational Therapist undertook an occupational therapy home visit. JD and both parents were present at JD's home.

On 31 July 2000, Registered Mental Health Nurse recorded details of a phone call received from the Clozaril Clinic. On attendance – routine urine sample showed raised glucose levels. Random blood sugar taken and sent for analysis.

On 1 August 2000, CPN 2, recorded that a Multi Disciplinary Team – discussed the home situation, CSW, reported that 'JD has no furniture. Discussed with JD some practical ways of helping him to buy furniture. CSW to help JD to decorate his house. Social Worker will continue to pursue finances. Working towards gradual discharge in November 2000. CPN 2 to start to visit with CSW whilst at home JD will continue to attend Clozapine Clinic for monitoring. Further Care Programme Approach to apply for Section 25 (Mental Health Act) 10-10-00.

Section 25 Mental Health Act – Supervised Discharge:

- Supervision of the after-care of detained patients once they have been discharged into the community, to ensure they are receiving the after care provided for by s117.
- Supervision is for sixth months, renewable initially for six months and then for periods of up to one year.

On 11 August 2000, discussed the diagnosis of diabetes with his mum on the telephone. Confirms no family history.

On 16 August 2000, Consultant 4: Community Mental Health Team meeting. To continue with current plans regarding leave, CPN 2 to continue visits when JD goes home.

On 18 August 2000, a home visit was made, 'JD parents not present. Spent one hour with JD discussing his overall coping mechanisms.'

On 22 August 2000, during Consultant 4's ward round – 'JD was quite well now, plan to discharge as before, leave arrangements as before, to discuss with diabetic nurse again.'

On 30 August 2000, CSW and Staff Nurse 1 visited JD at his home and also his parents at home, whilst he has been on leave from Ward 9. JD appears to know what he wants when he is discharged and has plans to make his home very comfortable for himself.

On 26 September 2000, during Consultant 4's ward round – 'JD was wanting to get his recommendation ready for discharge in November.'

On 29 September 2000, Staff Nurse 2 visited JD at his mother's home with CSW. 'JD was in bright mood and very talkative.'

On 10 October 2000, a Care Programme Review meeting (including section 25 review) took place: In attendance were Mr and Mrs D, JD, a representative from Making Space, Staff Nurse 1, CPN 2, Social Worker 1, Consultant 4 (Responsible Medical Officer).

Plan

- Agreed to discharge 14 November under section 25
- Agreed to weekly visits from CPN
- Bi-weekly visits CSW
- Monthly – Clozapine Clinic and Occupational Therapy clinic
- Regular Physiotherapy sessions

On 11 October 2000, Approved Social Worker, reported an interview with JD for the purpose of considering Section 25 of the Mental Health Act 83. **'**In my opinion he fits the criteria for supported discharge under section 25 and I have completed my recommendations as I believe his history shows he might otherwise deteriorate and has potential to harm others.'

On 20 October 2000, CPN completed a Crisis and Contingency Plan in relation to the care of JD. This plan was continued unchanged at reviews on 07.05.2001 and on 30.07.03

On 9 November 2000, JD was transferred to Ward 5 for sleeping purposes.

On 11 November 2000, CPN 3 conducted a home visit whilst JD was on leave, he was busy decorating.

On 14 November 2000, attended Section 25 meeting which has been accepted by the Hospital Board.

On 14 November 2000, JD was discharged from the Department of Psychological Medicine on Section 25 of the Mental Health Act 1983.

Commentary

THE NATURE OF HIS CARE IN THE ACUTE UNIT

The acute ward lacked most of the necessary resources and orientation for the management of a patient requiring longer term rehabilitation following step down from a Medium Secure Unit. This was a busy acute district service, used to dealing with district general psychiatry. That is, the service was used to dealing with short term patients requiring emergency assessment and treatment. Once in an acute setting he appears to have fallen into the acute model of care i.e. rapid planning for discharge. Never the less, JD did appear to respond well to escalating doses of antipsychotic medication in as much as his delusional beliefs were becoming less fixed and prominent. It is of note, however, that the Mental Health Review Tribunal report in July indicated that JD remained deluded and lacked insight into his need for continued treatment. Yet, just over two weeks later the team are well advanced in preparations for his discharge in November. As such his discharge from hospital appears to a certain extent to have been preordained, and it is far from clear as to what parameters as regards risk management the team were operating.

CENTRAL COMMUNITY MENTAL HEALTH TEAM (CMHT) (November 2000 – November 2001)

JD was discharged from the Department of Psychological Medicine on 14th November 2000 to the care of the Central Community Mental Health Team. His allocated key worker was CPN 3 who had had previous contact with JD whilst working at Wathwood; however she was not forensically qualified.

A Section 25 meeting and a community care plan was implemented and CPN 1 from Court Diversion was to visit once weekly for the first six months. JD was to be checked at the Clozaril Clinic on a monthly basis and have regular reviews with Consultant 4.

A Care Programme Approach Review Summary and a Collaborative/Care Programme Approach Care Plan (v3) were

completed at this time. In the review summary 'no change in risk status is recorded.

On 27 December 2000, a Risk Profile Assessment Summary records a history of risk and a risk score of three – serious apparent risk (zero equals no apparent risk, four equals serious and imminent risk). This same profile is recorded as amended on 2 June 2004 with a risk score of zero.

JD was visited regularly weekly throughout December 2000 and January 2001.

On 17 January 2001, JD attended his outpatient appointment with Consultant 4, CPN 3, and CSW. A Care Programme Approach Review Summary was completed at this time (v3) future risk assessment was discussed and it is recorded that there was 'no change in risk status and to review in three months.'

On 22 January 2001, CPN 3 visited JD at home, spent time discussing diagnosis of schizophrenia, particularly focussing on delusions. 'JD spoke openly about his ideas of Margaret Thatcher and stated, "she can't really be my mother can she?" He has challenged his own ideas whilst being in hospital; he also felt that medication helped him challenge his ideas.'

On 29 January 2001, CPN 3 and CSW visited JD at home. 'Mrs D also at JD's home today. Mrs D has requested that I make a letter of support to Department of Social Security in relation to Disability Living Allowance (same completed). Mrs D thinks JD is making good progress but is concerned about his diet and amount of cigarettes he is smoking.'

February, March, April 2001, regular weekly visits maintained, despite JD missing two home visits, which were followed up immediately by CPN 4.

On 8 May 2001, there was a Section 25 meeting with Mr and Mrs D, JD and CPN 2. Section 25 meeting – it is recorded that care plans were evaluated, a new section 25 care plan agreed and that the Crisis and Contingency plan remained unchanged.

Regular visits maintained in May and June.

There were regular home visits maintained in July by CPN 3 where the issue of increased alcohol consumption was discussed with JD.

On 9 July 2001, a home visit was made by CPN 3. 'Spoke to JD about general motivation levels which he does not see as a problem. JD is also going out drinking two pints, three times a week. Strongly advised JD about the dangers of the increase in his alcohol intake and how this relates to care plan obligations. JD does not see his alcohol intake as a problem. CPN to continue to monitor.

On 8 August 2001, JD attended an outpatient appointment with Consultant 4. It is noted in the records that JD

- Drinks two pints of beer only
- Appears very well

On 20 August 2001, CPN 3 reported – 'Spoke about alcohol consumption and the changes in this over the past 12 months – increase in abstinence to drinking 2 pints 3 times a week. JD does not feel this is a problem. To see 1/52.'

On 21 August 2001, a telephone call was received from Mrs D who expressed concern that she thought JD was spending too much time at their house and she wanted to help JD become more independent.

On 3 September 2001, CPN 3 visited JD at home.

On 10 September 2001, CPN 3 reported that a telephone call was received. 'JD in Barnsley District General Hospital Ward 33 with a fracture to his left arm.'

On 17 September 2001, JD was visited at home. 'JD is currently staying at his mothers due to being unable to cope properly with his injury.'

On 24 September 2001, CPN 3 carried out a home visit to JD's mothers house. 'Spoke about the accident, JD denied being intoxicated and stated he had only had two pints of lager. Discussed pending renewal of section 25 Mental Health Act again. Also discussed his care with Mrs D. JD's mental state remains settled without any change. Compliance remains good.'

On 18 October 2001, a Care Programme Review Meeting was undertaken with Mr and Mrs D, JD, CSW, CMHT Team Leader, Consultant 2 present. A Care Programme Approach Review Summary (v4) was completed.

The Section 25 was stopped at this meeting on 18 October 2001. At the same meeting the CPN visits were reduced to two weekly.

Commentary

DISCHARGE FROM SECTION 25

The Section 25 was possibly discharged prematurely. Whilst undoubtedly JD was presenting as progressing well at this time, the background issues and risks remained largely unchanged as indeed historically they were unlikely to do so. Having said this, the requirements of the original Section 25 were fairly minimal, and as such its utility would have been likewise. However, we noted there were indications of concerns in respect of his lack of insight and propensity to consume alcohol to excess.

The Section 25 could have been used more creatively and assiduously to enforce rehabilitation and adherence to supervision. It could have also created the expectation of continued involvement of the family in care planning; significantly the family appear to have been excluded after the Section 25 was allowed to lapse at JD's request.

On 18 October 2001, a Care Programme Approach Review was undertaken, no risk assessment score was recorded. JD's parents were present and it was agreed to review in six months.

At this time CPN 3 commenced leave and JD's care was taken on by CMHT Team Leader who visited twice before handing the case to CPN 4.

Following the ending of the Section 25 JD refused to allow his parents to attend his Care Programme Approach meeting.

On 22 October 2001, CSW visited JD at home.

On 29 October 2001, CMHT Team Leader and CSW visited JD at home.

On 12 November 2001, CMHT Team Leader visited JD at home.

On 14 November 2001, CMHT Team Leader telephoned JD and discussed change to CPN 4.

On 26 November 2001, CPN 4 visited JD at home.

CPN 4 visited JD once monthly, CSW continued to visit weekly and JD was reviewed monthly by Consultant 4.

JANUARY 2002 – NOVEMBER 2003

On 6 January 2002, JD attended an outpatient appointment with Consultant 4. It was noted that 'JD continues to do well – no delusions.'

January to March 2002, regular visits were maintained by the Community Mental Health Team.

On 22 April 2002, CPN 3 returned from leave and resumed home visits to re-established contact as Care Coordinator. 'Discussed new care plans which he agrees with CPN to see him every three weeks. CSW to see weekly. JD denies any psychotic thoughts.'

A Collaborative/Care Programme Approach Care Plan (v4) is evidenced as a result of this review although the 'risk' section is not completed. This plan also includes later unsigned evaluation dates of 30 July 2003 and 2 June 2004.

On 13 May 2002, CPN 3 made a home visit to JD, 'discussed and went through the new care plan. JD not happy with me writing, "at times JD can lack motivation". He disagreed with this statement. He was also unhappy that his mother was being invited to the Care Programme Approach without me asking him first and her receiving copies of his care plans.'

May 2002, When CSW went off on leave, JD refused any involvement from any other support worker, effectively ending this part of the care plan. Consultant 4 was also on leave at this time leaving CPN 3 as the only professional providing support and monitoring to JD.

On 10 June 2002, CPN 3 visited JD at home. JD was informed that Consultant 4 was currently on leave from work, however, Care Programme Approach continues to go ahead.

On 20 June 2002, CPN 3 telephoned JD who wishes to cancel Care Programme Approach today as Consultant 4 is on leave and he does not want to see another doctor. The case review appointment was cancelled.

On 4 July 2002, CPN 3 visited JD at home.

On 22 July 2002, CPN 3 visited JD at home.

29 July 2002, At the Care Programme Approach review the CPN visits were reduced to monthly and JD requested to be discharged from

mental health services. It was agreed that JD would continue with the service (CPN 3 visiting monthly) and Consultant 4 reviewing him every six months in the outpatient clinic. During this period it is recorded that JD appears to be mentally well and his mother reported no problems.

On 12 August 2002, CPN 3 visited JD at his parent's home. Spent time talking to Mrs D who feels very frustrated that JD has been turned down for middle rate Disability Living Allowance.

On 2 September 2002, CPN 3 visited JD at home. 'Told JD that I have received a message from the Clozaril Clinic saying that they are concerned about JD not taking his Clozaril, due to not collecting prescription for nine days after it was due.'

On 23 September 2002, CPN 3 reported that JD was seen at Clozaril Clinic with his father.

On 24 September 2002, home visit made. 'Discussed next Care Programme Approach meeting 25-10-02, he said he would prefer it if his parents were not invited to the meeting. He would not expand on his reasons for this.'

On 25 October 2002, a Care Programme Approach Review and Summary (v5) was undertaken with Mr D present. At this time 'risk' was recorded as zero (despite a significant risk history) with the comment that 'there is no current risk in the Risk Profile Assessment Summary. This to be reviewed in six months.'

On 12 November2002, CPN 3 visited JD at home. 'Discussed recent Care Programme Approach. JD is keen to reduce input from Mental Health Services.'

On 10 December 2002, CPN 3 visited JD at home.

On 13 January 2003, CPN 3 visited JD at home – 'mother has had a fall and broken her ankle.'

On 17 March 2003, CPN 3 visited JD at home. JD is a little worried about pending Disability Living Allowance tribunal.

On 7 April 2003, CPN 3 visited JD at home. 'JD presented as pleasant and appropriate today. General sociable discussion. No evidence of deterioration in mental state. States he is taking prescription medication. Mother and father also present who confirm that JD is doing well without any concerns. Mother has employed a cleaner for JD.'

On 28 April 2003, CPN 3 visited JD at home. 'JD's mother present. Mrs D become a little hostile with JD saying he "didn't do anything in the house", which then escalated into an argument between JD and his mother. JD stated he felt his mother interfered in his life. Escorted JD to gym and JD stated he had no feelings towards his mother "she just gets on my nerves a bit". Appropriate in speech, content and behaviour – no evidence of a relapse of psychotic symptoms.'

On 10 May 2003, CPN 3 visited JD at home

On 17 June 2003, CPN 3, appointments cancelled today.

On 19 July 2003, CPN 3 visited JD at home. 'JD was pleased to tell me that he had received £1800 back money from Disability Living Allowance. Discussed CPN input. JD continues to lack insight into why he requires mental health follow up after care.'

On 30 July 2003, a Care Programme Approach review was undertaken (v5). JD, Consultant 2 and CPN 3 were present. Risk was recorded as 'zero' in the summary with a comment of 'no change'. The Crisis/Contingency Plan was unchanged from 20 October 2000. The next review was to be in six months.

On 17 August 2003, CPN 3 visited JD at home. 'JD states he was happy with the last Care Programme Approach, however would prefer to disengage from mental health services altogether. Discussed this and JD says he will continue to see CPN 3 once per month but would like minimal input.'

On 8 September 2003, CPN 3 visited JD at home. 'JD has been on holiday to Wales for a week on a coach trip, but it seems as though JD was drinking alcohol to excess.'

On 7 October 2003, CPN 3 visited JD at home.

On 11 November 2003, CPN 3 visited JD at home.

Commentary

CARE PROVIDED BY THE COMMUNITY MENTAL HEALTH TEAM (CMHT)

Central CMHT was a stable team with a range of clinical expertise and experience. Within this team Consultant 4 optimistically wanted to give JD a chance to comply with his assessment and treatment regime and his rehabilitation. There is some evidence that the team were resource

lean and had to divide their time with primary care psychological services. Latterly Consultant 4 was planning to leave the service.

The community support plan in our view was of a very limited nature given JD's history and risk. It is far from clear that the CMHT had the requisite skills to manage someone with the risk profile of JD. Whilst his care coordinator had worked at Wathwood*, and knew JD from the time working there, she had no specific forensic training and did not regard herself as forensically skilled. The service did not subsequently call upon forensic teams to review progress or to assist with continued care planning, nor did they call upon other disciplines or services. For example the expertise of a clinical psychologist to assist with insight and treatment adherence may have been valuable, whilst an alcohol service might have been usefully deployed to assess and treat the suspected maladaptive drinking. The team appear to have been too ready to accept reassurances from JD that all was well and it is not clear how his requests to be discharged from the service were challenged.*

Even at this later stage there should have been greater emphasis on his risk profile with an appropriate level of supervision and monitoring. Increasingly it appeared JD had little insight and JD was left to own devices, with minimal support and supervision. JD was skilled at concealment and has subsequently stated at interview that he was not compliant with his medication but would take it only 2-3 days prior to visiting the Clozaril Clinic to avoid detection.

Clozapine is an effective antipsychotic with a licence for use in treatment resistant schizophrenia. It has a rare but potentially fatal side effect which requires regular monitoring of the white cell count. All patients at this time (2004) had to register with the Clozaril monitoring service and have satisfactory haematological results for continued administration of medication. However, this was not a measure of compliance with treatment. Clinicians could request plasma levels of the medication, and this is often used to detect compliance and to assist with side effect management. It was not apparent to us that Clozapine levels had been obtained for JD and as such there was no objective measure of his compliance with treatment.

Once a patient is established on an antipsychotic, which appears to have been effective, there usually follows a treatment plan negotiated with the patient which includes how long the medication needs to be taken for and at what doses. Factors which need to be taken into consideration are the side effects of the medication and the risks of relapse. Patients are often informed that as the dose of medication is reduced then the risk of relapse increases, and that the aim of a

successful plan is to balance these two issues. For JD there was no recorded plan regarding medication dosage levels, and reduction appears to have been driven by JD's requests. Given the magnitude of risks in this case, it would have been reasonable to have indicated to him that Clozapine therapy had to continue for the foreseeable future, and that medication dosage had to be within the therapeutic range. The latter could then have been obtained using plasma Clozapine levels. The explicit message being that therapeutic levels of Clozapine were the end result of continued community treatment.

For much of his treatment JD appears to have been directing his care plan, for example, specifying no support worker other than CSW, which effectively removed a major part of the monitoring process when CSW went on sick leave, likewise leading the care process when his care coordinator went on extended leave saying that he wished to go without a CPN. We also noted JD refused to see any other doctor than Consultant 4 when she was off due to sick leave. Also he refused to allow his parents to attend his Care Programme Approach review.

JANUARY 2004 – JUNE 2004

On 19 January 2004, CPN 3 visited JD at home. No contact for over a month due to CPN being on leave.

On 16 February 2004, CPN 3 visited JD where he spoke again about his wish to be discharged from Mental Health services. CPN 3 advised JD that this could be discussed at the next Care Programme Approach review on 2 June 2004. JD's mother was present, there continues to be no concerns or problems expressed by mum or JD.

On 15 March 2004, CPN 3 visited JD at home.

On 13 April 2004, CPN 3 visited JD at home.

On 17 May 2004, CPN 3 attempted to visit JD at home; there was no answer, a card was left. Telephone reminder to JD regarding impending Care Programme Approach review on 26th May 2004.

On June 2 2004, CPN 3 was due to commence leave. She attended the Care Programme Approach meeting on 2nd June 2004 with JD and Consultant 4.

It is recorded from review meeting in the Risk Profile Assessment Summary that 'risk' was rated as 'zero' on the same form from 27 December 2000.

The Collaborative/Care Plan (v4) remained unchanged from 22 April 2002 and the Care Programme Approach Summary (v5) recorded no change in risk status and that Consultant 2 was JD's new Care Coordinator.

The meeting agreed that as JD was mentally stable with no problems reported. That CPN input would be stopped temporarily until CPN 3 returned from leave and that JD would be reviewed again by Consultant 4 in outpatients on 24 September 2004.

There is evidence at this time of Incident Report 1 reports from the Central Community Mental Health Team highlighting staffing issues.

Commentary

THE MANAGEMENT OF CARE AND RISK

The panel found it difficult to identify care planning or frequency of visits by CPN 3. JD had not been seen by Consultant 4 since July 2003 for Care Programme Approach review. JD exerted too much influence on his care planning and was driving the treatment plan. The Consultant and the CPN stated at interview that on reflection they should have had a replacement CPN and that they should have insisted that this took place. It is possible that the decision to temporarily stop CPN visits to JD at this time was pragmatic but flawed.

We have questioned, did JD become a 'routine' Community Mental Health Team patient, i.e. less surveillance of relapse and risk factors? The withdrawal/decrease in supervision (driven by JD, and possibly his lack of insight), removed a major part of the care package that would have detected early warnings. Given JD's ability to hide symptoms, subtle changes would not have been detected by the Clozaril Clinic, and the final care plan (3/12 appointments with a consultant who had little recent contact with the patient or family) was inadequate in this regard.

The Community Mental Health Team emphasised the model of 'recovery', which is commendable in maximising the quality of life that the patients can achieve. However, it is possible that this might have led to confusion or conflicting visions as to the long term care plan. JD was a very ill man, who had seriously assaulted his mother as a result of this illness, and whose delusional beliefs involved his parentage. He had made significant progress after four years in hospital and three years of community treatment, yet there can have been little doubt that he would require this type of treatment and supervision for the foreseeable future, if not forever. During the course of 2004 there

were signs that JD's insight was at best variable and at worst none existent, he was discussing reducing medication and disengaging from the services. There were also indications that JD was continuing to use alcohol in a maladaptive or inappropriate manner.

We consider the team had lost sight of the high risk profile and the need to provide the appropriate level of monitoring and supervision.

We believe it was the wrong decision to have Consultant 4 as care coordinator and consultant, and the only team member with continuing involvement with someone who was such a complex patient.

PRE-INCIDENT PERIOD (17 June 2004 to 8 November 2004)

On 17 June 2004, JD was reported as remaining very well. 'He was compliant with Clozaril. No evidence of mood disorder. Wishes to reduce medication. Advised to wait until next year when it will be reviewed, when CPN returns from leave.'

On 24 August 2004, JD was reported to be a regular attendee at the Clozaril Clinic.

On 24 August 2004, CMHT Team Leader received a telephone call from a representative from Making Space, she has spoken to Mrs D today, as she is so upset by JD's current mental state. Mrs D has contacted Consultant 4's secretary this morning, but had refused to discuss the situation or speak to anyone else other than Consultant 4. The representative from Making Space stated that Mrs D had reported that JD is saying that the IRA are plotting against him and saying that his mum is no better than Myra Hindley. Mrs D does not want JD to know that she has made contact. 'Explained to the representative from Making Space that this was understandable but made it more difficult to engage.'

On 25 August 2004, 'Mother worried that son will find out about her reporting him. He is imagining things again. Called her Myra Hindley again. Dad visited him yesterday and said he was fine. Talked to father about the IRA'

SpR spoke to Mrs D who was concerned that her son would find out that she has been talking to Mental Health services about him.

On 25 August 2004, SpR recorded that: "Mum does not see him much. Mum visits infrequently 'does not seem to want me to go.' Mum convinced he spends too much time at home. JD thinks there are two IRA men watching his home. Mum very worried that we will go around

and it will become apparent that she has been talking to us. Mr D seeing him everyday. JD – 'Myra Hindley is a saint compared to you.' Long discussion about what we are to do. Asked if we could visit maybe next week."

Mother reports two points of concern since Sunday:

- His reaction to her on Sunday when she went round
- His comment to his father about the IRA.

Against this we have his father's report from yesterday about him appearing fine and the reports from Clozaril Clinic that he appeared fine.

On the 27 August 2004, a letter was sent to JD to explain that CMHT Team Leader and CSW would be visiting 'for a chat' and SpR spoke to Mrs D again about JD's mental state.

His father reports that he seems fine.

On the 1 September 2004, we were informed that Mrs D was offered an appointment with Consultant 4 but Mrs D did not attend.

On 3 September 2004 at 16.20, CMHT Team Leader visited JD at home with CSW. 'Asked about thoughts that bother or concern him. Asked if I meant paranoia. No evidence of psychotic mood. Appropriate behaviour – appropriate to situation.'

Plan

- JD due in clinic for review by medic 2/52
- I will return for follow up visit in early October, agreeable to this.
- Reiterated if he needs further assistance, to contact us.

On 24 September 2004, JD attended an outpatient appointment with Consultant 4 where he appeared talkative and pleasant.

- No evidence of any psychotic symptoms
- 2/3 week – 5/6 pints/session

On 12 October 2004, CMHT Team Leader and CSW visited JD at home as arranged at their previous visit to him.

On the 8 November 2004, A representative from Making Space called the Central Community Mental Health Team to inform them that JD had killed his father.

Commentary

CONTINGENCY PLANNING AND RESPONSE

Whilst there is some evidence that contingency planning did occur, it does not appear that this was thoughtfully updated, nor is it clear how it was used (if at all) when JD appeared to be relapsing in late summer of 2004.

When Mrs D raised her concerns through the representative from Making Space, it did trigger an intervention by two members of staff, one being CSW, who knew JD well. Their assessment did not discern anything untoward. We have also taken into account the difficulties staff experienced associated with visiting JD and not being able to disclose his mother's concerns that had precipitated the visit. However, we consider that safety concerns should have been given a priority in these circumstances. We acknowledge that we are commenting with the advantage of hindsight however the issue of communication between JD, the family and professionals should have been comprehensively addressed at the outset in terms of open exchange of information and concerns if relapse was to be avoided or managed successfully.

A contingency plan should have been in place to enable engagement by all parties in these circumstances. This was clearly a dilemma for the staff involved in responding to Mrs D's reports and a consequence of the earlier failures. When called upon to respond to his mother's concerns it is apparent to us that the family and the service were not therapeutically engaged. The team made their assessment and took into account the reassuring comments from JD's father. In the prevailing circumstances it would have been extremely difficult for them to have confronted JD by saying 'we don't believe you as your mother has reported concerns and we intend to step up the monitoring of you because of what had happened before'.
If the care plan had been clearer, and the communication between the clinicians and the family more robust, then his mother would have known that an early relapse sign was evident, that confidentially could not be assured and the service would respond swiftly and assertively.

Mrs D, when expressing her concerns to us, believed that visits by the two members of staff only lasted fifteen minutes, although the members of staff assured us the meeting with JD was for a longer period. JD had made them a cup of tea, which seems to suggest a longer period, was spent at the house. Given that the team had no mandate to disclose what Mrs D had said, then realistically little more could have been done i.e. they could not pursue matters of signs and

symptoms given in confidence. However, a social visit of this type does include many valuable observations to the skilled eye e.g. home in good order, executive functioning to make tea, social skills to offer hospitality, assessing affect/hostility, evidence self care etc.

We also noted that SpR, when acting for Consultant 4, fed back to Mrs D the outcome of the assessment undertaken by CMHT Team Leader and CSW. This contradicts the assertion made by Mrs D that no one had informed her of the outcome of their assessment.

At the final appointment with Consultant 4 on the 24 September 2004 a number of issues were relevant to this assessment. These factors include the recent emergency assessment following contact from his mother; potential delusional content of this alleged outburst; JD querying his past history; decreasing medication and monitoring; and his possible harmful use of alcohol. These risk factors were potentially undermined by apparent reassurance from those who had conducted the emergency home assessment and reports from his father, in addition to his apparent stability over recent years. Never the less, given his history and risk profile, then it would have been reasonable to have been cautious, and to have stepped up monitoring and supervision at this stage, including reinstating multidisciplinary support and the appointment of a care coordinator. This would also have facilitated the necessary communication between the family and the team.

5 Findings

We have endeavoured to provide background information and a context and rationale for the more significant findings.

Where appropriate we have provided a commentary to assist understanding of our analysis.

MEDICATION

There is little doubt that JD had a severe form of schizophrenia with complex delusional ideas concerning his family. Whilst acutely unwell he had attacked his mother which could have had fatal consequences. Initially his response to treatment appears to have been poor and he was subsequently treated with Clozapine with good effect. Clozapine is the only antipsychotic with a licensed indication for treatment resistant schizophrenia. This is an oral medication and requires acceptance and agreement from the patient to make long term therapy successful.

On the ward JD had his medication administration supervised, but once discharged he managed the medication himself. Other than monitoring JD picking up medication from the clinic (at monthly intervals) the Community Mental Health Team did not deploy any other significant measures to check compliance. It is of note that JD subsequently said that he took the Clozapine for two to three days before his Clozapine clinic visit, presumably on the assumption that compliance was being measured, which it was not.

Once established on Clozapine, then it should have been made explicit to JD, and his family, that adherence to therapy was of the utmost importance for the foreseeable future. The only rationale for reducing the dose would have been due to side effects of the drug, or excess plasma levels. Given his continued fractured insight into his illness, his risk profile, and his avoidance of effective supervision and monitoring, then we can see little support to accede to JD's requests in this regard.

CARE PROGRAMME APPROACH

In an attempt to simplify matters, and to bring together the key elements of the health led "Care Programme Approach" and the social care led "Care Management", the NHS Executive and the Social Services Inspectorate issued new guidance in 1999 entitled '*Effective Care Coordination in Mental Health Services: modernising the Care Programme Approach*'.

The key statement taken from the National Service Framework states:

"Services will be much more accessible; intervene more quickly to offer help and support; seek out those who are difficult to engage; involve service users in planning developments; use effective care processes; and be delivered in partnership across health and social care as well as other key agencies".

The new approach saw the introduction of two levels of Care Programme Approach, standard and enhanced and abolished the need for Supervision Registers. A care coordinator was to be identified who would pull together all aspects of care and there was to be an emphasis on recognising the needs of carers subsequent to the Carers (Recognition and Services) Act 1995.

The guidance clearly illustrates that it is critical that the care coordinator has the authority to coordinate the delivery of the care plan and that this is respected by all those involved in delivering it, regardless of agency or origin. An emphasis was also placed on risk assessment and management. Risk assessment is an essential and ongoing part of the Care Programme Approach process. Care plans for severely mentally ill service users should include urgent follow up within one week of hospital discharge. Care plans for all those requiring enhanced Care Programme Approach should include a 'what to do in a crisis' and a contingency plan. The guidance goes on to say that where service users are the shared responsibility of mental health and criminal justice systems, close liaison and effective communication over care arrangements, including ongoing risk assessment are essential.

The Care Programme Approach is a system designed to act as a 'net of care' for those patients who access secondary Mental Health Services to ensure that service users receive a comprehensive package of care. As standard it includes an initial assessment, an assessment of risk, a care plan and regular reviews of this plan as the individual needs change. A care coordinator is assigned to support engagement and to ensure that planned and agreed actions are implemented.

The Care Programme Approach review process would have been a critical support to manage JD and to ensure regular reviews, compliance and the continuing assessment of current and past risk.
It is clear from the evidence of the records and from statements from staff that this was not a robust and priority process within Central Community Mental Health Team.

The Care Programme Approach process was not adhered to assiduously as agreed in the care plans i.e. meetings every six

months. This was a missed opportunity to discuss issues in relation to risk, engagement, and compliance and family concerns on a routine basis.

Visits to JD were cancelled both by himself and members of the Community Mental Health Team.

Permitting JD to decline replacements for CPN 3 and CSW whilst on leave, or another Responsible Medical Officer when Consultant 4 was on leave, weakened and sabotaged any chance of the Multi Disciplinary Team providing robust supervision. The Care Programme Approach review processes, or lack of them, should have provided alerts to the team that this was happening given the risk history of JD, allowing them to consider how to manage such disengagement and to develop a contingency plan.

There appears to have been at least three versions of Care Programme Approach documentation over four years, and only latterly a brief triage risk assessment form (2000 – 2004). Not only must this have been confusing to staff but will have also created difficulty in assessing changes in presenting behaviours.

CMHT Team Leader stated “that it was for the patient to decide who was present at Care Programme Approach reviews.” This may be relevant in terms of family representatives but should not have limited the professional input. Professional meetings were held in the Community Mental Health Team to discuss and plan care.

The consultant appears to have been remote from the Community Mental Health Team and Care Programme Approach process in the last two years. It is not clear how realistic it was for her to be the sole worker, care coordinator and consultant, especially given her other extensive commitments. This was compounded by her planned withdrawal from the service and the appointment of a locum consultant i.e. who would be providing continuity and expertise in managing the patient following her departure.

When JD’s CPN went on leave the consultant was left as the only professional involved with his care. By default she became his care coordinator without serious consideration of the Care Programme Approach policy, and as to whether she could fulfil the role required by his enhanced CPA status. She had only met JD on a few occasions over recent years, and was herself in the process of withdrawing from the service with significant commitments elsewhere. The impression given is that JD had now become a ‘routine’ patient with a low risk profile. Whilst this was denied at the interviews with some of the

clinicians, the risk assessment documents are clear in repeatedly identifying him as being of low or no risk. Yet the historical risk factors remained unchanged, and during 2004 there was mounting evidence that JD was not as well as he had been.

The final care package that JD received from the Community Mental Health Team appears wholly inadequate, and does not appear to have been arrived at by systematic and thoughtful consideration of the patient's needs. It appears to have been driven by expediency and by JD's fractured insight into his own requirements for care, and more specifically his desire to be discharged from the service.

RISK ASSESSMENT/MANAGEMENT AND COMMUNICATION OF RISK HISTORY BETWEEN AGENCIES

There is evidence that a number of clinicians over the years expressed concerns about the significant level of risk that JD presented, especially to his parents.

There was also concern that his parent's perception of this risk to themselves was not always fully appreciated, thereby adding to the problem.

At one stage the clinical team appeared to be considering a geographical approach to managing this risk i.e. rehabilitation away from Barnsley. This was ultimately overcome by JD's parents buying a property locally for him to use following his discharge.

Throughout JD's time with mental health services the recurring theme appeared to be that the tenor and pace of his care plan was being set by JD and his family.

The Section 25, which was ultimately used to facilitate his discharge from the acute admissions ward, was an opportunity to manage these risks. Conditions could have been placed upon his discharge care plan for both the immediate and long term future i.e. specifying more supported living circumstances, agreeing the minimum level of monitoring and supervision necessary, and the extent of continuing care that he would need, together with warning signs in relation to relapse and contingency planning. It could have also created the expectation of continued involvement of the family in the care planning process.

It is evident that JD's degree of 'dangerousness' was not widely understood. The focus of risk was on his mother not his father; this

was down played as the perception of the clinical team was that he was doing well.

JD's alcohol and drug misuse was raised by a number of witnesses. From the evidence it was unclear how the assessment of drug and alcohol issues would have been recorded and managed within the Community Mental Health Team.

These were clearly difficult circumstances, presenting a dilemma for staff to be honest and open with JD yet not appearing to collude with his mother's request to keep confidential her concerns. We take the view that the risks superseded this consideration.

PRIMARY CARE AND GP LIAISON

Although the psychiatrist kept the GP well informed of JD's progress, there is little evidence that he was significantly involved.

It is regrettable that we were unable to interview the GP for reasons beyond our control. The views of the GP in relation to his assessment of the quality of care, specialist advice and liaison with the Trust would have been helpful. Also there would have been value in being able to discuss with him if communication with the family could have been improved.

FAMILY

We met with Mrs D and Mr RD (brother of JD) at the start of the investigation to discuss the terms of reference, establish precisely their concerns and to outline the intended approach. We met with the family subsequently to clarify matters and deal with issues raised.

Mrs D and Mr RD felt badly let down by the Mental Health Services. They raised a number of concerns and issues about the care and treatment given to JD.

These concerns were:-

1. Experience, support and decisions made by the staff in dealing with JD's care and treatment;

2. Timing and length of the final assessment visit prior to the incident and lack of interaction with the carers;

3. Supervision of JD when he requested to come off medication;

4. Frequency of monitoring his medication levels;

5. Levels of professional input at a time when there were indications of JD's instability;

6. Lack of response by the service to Mrs D's concerns that JD was relapsing.

The family also raised concerns about the length and time of the internal review and lack of communication from the trust.

Mrs D deeply cared for JD she was a loving parent who had the best of intentions for JD. It was understandable that she could not be objective in her reasoning and understanding of the decisions by the service in the treatment of JD and the risks to the family.

It is clear that throughout JD's lifetime that Mrs D sought to advocate for him speaking up on behalf of her son and defending his behaviours including offending behaviours. She had an overwhelming desire to do what she believed best for him.

Mrs D showed resourcefulness by reading a great deal about schizophrenia to obtain a better understanding of the condition and treatment. She contacted a specialist in London to find out more information about the medication prescribed for JD. She then acted as an advocate for her son in making positive suggestions to the clinical team at Wathwood for changes in their prescribing.

Staff Comments on engagement with the family

We spoke with some of the staff involved in the care and treatment of JD. The service considered that attempts to engage with the family were difficult and challenging. The family struggled to accept JD's illness and the dangers and risks that JD presented to them. Mrs D reacted defensively to staff when they tried to discuss JD's condition. They thought Mrs D was blaming herself, disassociating and minimising the risks JD presented and that she, at times viewed comments from staff in a less than positive manner.

Engagement with the family was initially problematic which led to difficulty in gaining the cooperation of JD's parents and achieving a therapeutic alliance. It was felt that the family initially only worked with the clinical team as an expediency to achieve JD's early discharge from Wathwood.

Mr D was described as being a little more distant, not actively engaging in conversation with professional staff but that he appeared to listen but not verbalise.

The parents did not make known to staff that they had divorced. Staff reported that they were concerned that this breakdown in the parents' relationship may have impacted on JD's wellbeing.

Despite being offered and encouraged to participate in community support groups the family had been reluctant to be involved because they would have had to travel to Sheffield or Rotherham from Barnsley. This was regrettable as often the information and peer support can be valuable in helping families cope with the difficulties of having a son with a serious mental illness.

Staff reported that at times they felt there were tensions and antagonism between JD and his parents which led to JD feeling aggravated and hostile.

Commentary

It appears that there were divergent and conflicting views regarding JD's illness, care medication and treatment planning and the level of risk he presented.

Mr and Mrs D reacted as deeply concerned parents in an overprotective way to concerns expressed by the professionals. Mrs D appears to have found it difficult to accept the risks and concerns expressed by the staff. She sought to explain and defend his aggression as "he was poorly". She was not concerned about her own safety, her concern was that her son got better.

Mr D appears to have been more pragmatic in his approach to the risks but that he also appeared not to fully appreciate the seriousness of the risks he and Mrs D faced.

Despite efforts by the staff to raise the risk profile arising from JD's history of violence, delusions and beliefs and his resentment towards his parents they did not fully appreciate the risk they faced.

From the evidence it appears that the service did not establish an early positive connection with the family which would have allowed for the development of close alliances and valuable input from the family to foster better outcomes and recovery or well being for JD.

This initial lack of explicit understanding and specifying of what needed to occur was perpetuated and undermined future risk management strategies and ultimately the protection of Mr and Mrs D.

Following the serious assault on Mrs D by JD in 1997 it was clearly a fraught dilemma for his parents in deciding not to prosecute JD. Mrs D clearly forgave her son and reasoned that the attack was a manifestation of his illness and he needed medical help. It appears that the Criminal Justice System decided they were unable to prosecute without the consent of Mrs D. We believe that this was a mistake by the Criminal Justice System that undermined JD's future care and treatment.

Reports indicate that the parents accepted that JD was ill and understood the need to report the signs of relapse. The potential future risks were explained to them and they confirmed that they would inform the clinical team if they had concerns.

The relationship between social work staff and the family had broken down. The family had lost trust because they considered that the staff had been over cautious and misrepresented them. This had led to the family only partially cooperating and frequently challenging the professional's opinions.

It is noted that Mrs D often proactively took the lead in making decisions on JD's behalf, including the purchasing of a house nearby without taking account of the clinical plan.

The professionals considered JD's future needs would be served by independent living to avoid an overdependence on his parents' support. The clinical team were aware of Mrs D's own physical health problems and took into account the stress she would encounter.

We consider that JD would have benefited from more independent accommodation, which would have provided an appropriate geographical and emotional distance from his parents and diminish the potential for stress and antagonism between JD and his parents and thereby have reduced the risk of harm.

The reported hostility displayed by JD towards his mother should have been of significant concern to the care team, as apparently this was a feature in the period prior to his attack on his mother in 1997.

The social worker had attempted to engage with Mr and Mrs D attempting to explain how he was at the time by describing the concerns of the Wathwood Clinical team about JD's neglect of self

care and lack of motivation to maintain his personal hygiene. Apathy can be a feature of the illness JD was experiencing. The social worker was attempting to explain how JD was at the time and what might the position be in the future. Being honest and straightforward about risk issues is not easy to convey but is vital.

It appears that the social worker was seeking to promote self reliance not dependency and trying to get Mr and Mrs D to recognise the need for change. We consider this was positive practice.

In the circumstances such as those under review, the challenge for all concerned is to achieve meaningful carer involvement in the care planning and review, which positively affects the experience of the service user and family member.

The goal should be seeking to meet both the needs of the individual and the identified needs of their carer or family member, supporting, valuing and respecting them on both a practical and emotional level. Sadly, for a variety of reasons, this did not occur and as a consequence effective partnership work did not happen.

We consider the competencies required in dealing with the complexities and dynamics of family relationships and problems of management of serious risk were of a higher order than those which existed in the community mental health team. JD's severe illness and level of dangerousness needed the involvement of forensic expertise.

There is no doubt that the parents' response to JD's illness was mixed and understandably, difficult and stressful for them to deal with.

We consider that due to the conflicting interpretations and interests the parents would have benefited from a separate statutory worker to the professionals involved with their son.

We reviewed the concerns highlighted by Mrs D that the clinicians should have responded more diligently to JD's expressed view that he wished to stop taking medicines. However, we have also taken into consideration that it is not unusual for many other service users to express similar views. JD was not presenting with any side effects and routine clinical assessments did not indicate any problems.

We noted, and to some extent share Mrs D's concerns regarding the level of supervision provided for JD in the month leading up to the offence. However we took into account the prevailing context of a diminished risk focus evidenced by the care inputs that had

incrementally reduced over a period of years, which indicate the clinical team were satisfied with JD's progress

When latterly, Mrs D did raise her concerns re JD's relapse through a representative from Making Space the service response in August 2004 was insufficient. At this late stage the service had little room for manoeuvre; they conducted an assessment as best they could in the circumstances, and were not able to detect any evidence of acute change. As such the options open to them were very limited. Clearly this can seem grossly inadequate in the light of subsequent events.

INTERNAL REVIEW OF TREATMENT AND MANAGEMENT

An Internal review was undertaken by an experienced senior Manager, identified by the PCT and trained in Root Cause Analysis approaches, to examine the circumstances surrounding the death of Mr D by his son JD. This meeting was undertaken at the family's home address.

The review focused on the history of contact between JD and his family with the forensic services at Wathwood, and with the Barnsley Health Services. The report of the review was submitted to the Trust Board in July 2006.

We noted the methodology used, including a summarised chronological timeline, scrutiny of records and interviewing of key staff.

Mrs D raised as a concern with us the long delay in the process being completed, and the inadequacy of the feedback, as this was deferred due to the impending Independent Investigation.

We formed a generally positive impression of the investigation. The Internal Review was comprehensive in the gathering of information, and insightful in analysis, with a fair, objective and good appraisal and understanding of the contributory factors.

However, there are a number of concerns arising from our scrutiny of the Internal Review, which are identified below: -

- There was a three and a half month delay in starting the Internal Review in March 2005 and the final report was not completed until July 2006.

- The investigator did not interview the consultant psychiatrist in charge of JD's treatment at Wathwood, JD's GP, SpR or the police. As a consequence, there was insufficient information about the Wathwood assessments, the rationale for transfer and discharge.

- Additional forensic expertise should have been made available to support the investigator in identifying issues and the interpretation of responses.

- The recommendations lacked precision and clarity of understanding.

- Some staff felt unsupported throughout the process of the internal review by their managers.

- The report's findings and recommendations were not made known to many of the staff involved. In fact, many of the staff we interviewed had only recently had sight of the report.

We noted that during the period of the review, the investigator's managerial responsibilities increased. Initially a specific period of time was created to begin the review but the increased workload distracted and prevented him from completing the review within a reasonable timescale.

Other factors contributing to the delay included:

- Key staff on leave.
- Gathering all the information and case notes together.
- Agreeing the action plan.

We found the Internal Review findings helpful to us in our investigation.

Senior staff in the PCT acknowledged the inordinate two year delay taken to complete the review, and indicating as unacceptable the absence of the reports findings being made known to key staff. We were also told there was some concerns and confusion in respect of confidentiality which added to the delay.

We were advised that, despite this, the lessons learned and recommendations for change and improvement had been implemented. We have been assured that in line with recognised standards and timescales, in future, consideration would be given to supporting the lead investigator with additional expertise, together with protected time and support to undertake the review.

We were also reassured that it has been appreciated that the lead investigator role requires high levels of skill, experience and

resourcefulness in interviewing and questioning experienced professional staff.

We noted that the Trust had developed new policy guidance in respect of incident investigation, which included standards and timescales expected.

We were further advised that the Trust now appreciates the benefits of effective feedback to both families and staff, can help to disseminate learning and provide a measure of reassurance and assist in the resolution to traumatic events.

We were informed that there was senior management commitment to rapid change and embedding the improvements into practice. External support was being planned to assist in the training and development of awareness to both frontline and managerial staff. The intention is for training to be delivered in the workplace in order to ensure all who require training receive it.

We were also advised that a specific specialist post was to be created, which would have designated time to strengthen the process by scrutinising and overseeing incidents.

COMPLAINT MANAGEMENT

Mrs D had expressed her concerns that after complaining about a range of issues to a senior manager, there was a long gap before further contact ensued.

We measured the Service response against the following criteria:

- Timelines
- Appropriateness
- Sensitivity
- Support arrangements
- Apologies given
- Explanations given
- Openness
- Avoidance of defensiveness
- Did the service actively address the concerns?

We studied the files and copies of correspondence between Mrs D and the Service, discussed the Service response with Mrs D and

interviewed a senior manager responsible at the time, who had subsequently left the Service early on in the process.

We understand that there was a short delay in the initial meeting between the Service Manager, her assistant and the family, but appreciate that there were difficulties in finding a date and time which was convenient to all.

We positively acknowledge that the meeting took place at Mrs D's home rather than Kendray Hospital, apparently at Mrs D's request. Mrs D was supported by her son Mr RD, her daughter-in-law, and a representative from Making Space. The manager assured us she had preferred to demonstrate appropriate sensitivity, a willingness to engage, and had personally offered explanations and support to the family. The short delay enabled her to seek to untangle some of the complicated issues.

We were told that the meeting was understandably distressing and lasted over one and a half hours. The manager assured herself that Mrs D and her family were being supported by a representative from Making Space, who was well known to the family. We were advised that an apology was given for the distress the family were experiencing.

The family also received support from a volunteer from Victim Support, who apparently indicated that they may wish to contact the Support after Murder and Manslaughter organisation (SAMM).

The meeting took place in March. The manager left the Service in August 2005 passing the file on to her successor. The manager expressed her regret that she did not meet with the family again prior to her leaving the Service.

There was then a short delay before the family were interviewed by another manager who was leading the internal Serious Untoward Incident, following which the family were apparently only occasionally kept informed of what was happening.

The family were unhappy with the outcome of the internal investigation and further complained on the 28 September 2006, about the length of time the investigation was taking to complete. The family generally accepted the explanation given for the delay but expressed their dissatisfaction that the delay had caused them additional distress and prevented them from achieving an early understanding of what had occurred.

We note the family were very well supported in expressing their views by the Independent Complaints Advocacy Services (ICAS).

Many of the family concerns remained after the internal review, but the family accepted the advice given to them that in future, if a similar review was necessary, a senior person would be appointed unencumbered by other duties, to speed up the process.

The family had also expressed their dissatisfaction that they had not been given a better opportunity to have their own views included in the Serious Untoward Incident report.

The family also challenged some of the views staff had expressed in the internal review.

On 7 November 2006, the Trust responded with an apology for the delay and misery experienced by the family and for any aspects of JD's care, which did not meet the high standards of professional practice, which the Primary Care Trust (PCT) set themselves.

The family were also advised of an SHA commissioned external investigation, and that they would be invited to contribute to this. The letter also described recommendations arising from the Serious Untoward Incident, in how information is now better shared to inform future decision making.

The family were also advised of their rights to ask the Health Care Commission to investigate if they remained dissatisfied.

We have noted with regret that there does not appear to have been any further contact between the PCT and the family.

This prompted Mrs D to write to the PCT in February 2008, highlighting the delay and questioning what the current position was in respect of the SHA investigation.

We have concluded that in general terms the good practice criteria we identified was largely met.

Of particular note, has been the support the family received from Advocacy Services.

We acknowledge the nature and content of the correspondence and regard this of a good standard.

We have been advised that the complaints procedure has been further developed and is regarded as robust and complaints investigations are overseen by an experienced complaints manager, who meets with families or individuals if necessary. We understand there is close links with the Local Authority whenever a complaint has a multi agency concern.

However, we have noted occasional delays in the system, and have commented elsewhere in this report about the delay in the internal review being completed and the delay in the outcome being made known to interested parties.

The absence of tracking and staying in touch with Mrs D is regrettable. The aggrieved family should not have had to take the initiative and contact the PCT in order to clarify what was happening. The Service should have had a system in place to prompt regular update and indeed support for the family.

GOVERNANCE

Following the incident in November 2004, Barnsley PCT initiated a Serious and Untoward Incident review which reported in July 2006. The report included an action plan which has been under development since this time which addressed key issues for clinical governance and service development in relation to quality improvement and to patient safety. These were:

- That work be commenced to develop a Client Risk Classification Framework to be implemented throughout the Mental Health Service that considers the risk factors associated with individual clients taking into account forensic history, relapse signatures, levels of engagement with service adherence to treatment plans etc.
- This framework will rate a client's risk factors and provide guidelines on the ongoing management of the case with regard to decision making and the sharing of information with others.
- In accordance with the above process, that client's assessed with significant risk factors of harm to self or others that at the time of significant milestones in the progress of a client's recovery that a comprehensive multi-disciplinary team meeting be called to review the clients' progress with reference to the original relapse signature identified at the commencement of treatment.

- Those clients' subject to the Client Risk Classification Framework deemed to be high risk, who are taking antipsychotic medication, should be subject to three monthly checks to ensure they are attaining a therapeutic dose of their medication. This will be in addition to the routine blood tests for tolerance of the medication.
- That the importance of the contribution that carers can make in the formulation of client care plans need to be embraced more comprehensively by the service.
- That policy and procedures around the provision of cover arrangements for health and social care workers have been reviewed to ensure continuity of monitoring service user needs. The implementation of the Client Risk Classification Framework will make this system more robust by the identification of prioritised needs and plans for intervention for each service user.
- A Training Needs Analysis of the skills of Mental Health workers in the assessment of risk needs to be conducted to inform a structured Training Plan on Risk Assessment and Risk Management.

The Trust has made significant progress in relation to these objectives since 2006 which is commendable. We have considered these improvements in the context of the findings of this report, particularly that: -

- There is now a Care Programme Approach/Risk Assessment/Risk Management policy in place and in operation across the mental health service. This includes a three day mandatory training programme for all qualified health and social care staff.
- The training programme is evaluated and reviewed quarterly.
- The Sainsbury Centre for Mental Health's Risk Management model has been adopted and was implemented in 2005.
- The review of the role of Care Coordinator in multi disciplinary Care Programme Approach and discharge planning from Crisis Care to Community Mental Health Services is underway.

- The Care Programme Approach documentation is to be reviewed yearly.
- All staff (including unqualified) now attend a three yearly mandatory Record Keeping training.
- The Care Programme Approach documentation now requires carers to be asked if they would like a carers assessment and the client care plan asks for carers comments to be included.
- An Enhanced Clinical Supervision Pathway (ECSP) has been developed.
- The PCT has established a fully functioning Clozapine Clinic.
- Two additional Carer Support Workers commenced in October 2004.
- In order to ensure that the offer of carers assessment is completed it is now stipulated in the Mental Health teams Operational Service Agreements' (Operational Policy).
- A named lead for carer involvement and a Carer's Information Pack has been developed in acute in patient wards.
- A contract with Making Space for work with carers has been established
- Staff 'cover' arrangements were completed September 2004 and implemented within the Adult Community Mental Health Teams.

Clinical governance is a priority for Trusts to ensure safe, high quality care from all involved in the patient's journey and to ensure patients are the main focus and priority.

In recognition of the tragedy that has been experienced by the Family we believe that the principle must not just be 'lessons learned' but 'lessons implemented'. In this context, it is important that the critical improvements that Barnsley PCT have already made are maintained and developed and also that reflection and review continues to take place to encourage the further development of a culture of openness and quality improvement.

6 Police Liaison

The police indicated that prosecution of JD did not go ahead as Mrs D was not prepared to make a complaint. It appears that other considerations would now be taken into account by the Multi Agency Protection Panel team (MAPPA). This would ensure weight is given to the implications of not prosecuting and avoiding any similar circumstances of a decision being unduly influenced by the family member.

We interviewed a senior member of South Yorkshire Police, with the purpose of trying to ascertain why JD had not been prosecuted in 1997 following the assault on his mother, and the circumstances of his arrest in 2004, following the death of his father.

We were also keen to learn of developments in liaison between the police and the local Mental Health Services, and to understand what would happen if a similar incident occurred now.

The two police officers responsible for the investigation and engaged in the decision not to prosecute were not available for us to interview, one had retired and the other had moved out of the area. However, the Acting Detective Chief Inspector we met was very helpful in reviewing the reports from 1997. It appears the crime report had been written off as “Detected, Inexpedient to Prosecute”, therefore no formal prosecution was continued.

It appears Mrs D refused to give a statement of complaint as she blamed herself for her son’s behaviour and did not want to get him into trouble.

Of importance, we were advised that if a similar offence took place today, the offender would be identified under Adult Protection criteria by the relevant agencies, and be the subject of a Multi Agency Protection Panel (MAPPA) meeting. The police investigation would be victim focused in order to support the complainant in their decision of whether or not to pursue a prosecution. Early notification to the Crown Prosecution would be sought. We were also reassured by the many positive comments relating to developments and consistent approaches adopted in information sharing and liaison, which have occurred since 1997.

This is due to a number of reasons, including:

- Multi agency local arrangements through the extension of neighbourhood policing and the ‘wider police family’ and local protection units.

- Obligation to share information under Management of Police Information (MOPI) Code of Practice.
- Effective information sharing agreements between partners, which effectively provide safeguards for and confidence in shared information.
- Establishment of Safeguarding Adults Board, which is a strategic level meeting between the senior managers of the relevant partnerships.

We were assured the above arrangements make certain that information is consistent and timely; the early identification of potential vulnerable adults is ensured, with all partners contributing to the relevant harm reduction interventions.

We were also advised that local Public Protection Units (PPU) have access to police intelligence through their own systems, and the Intelligence Unit systems. This apparently works well within the Barnsley District with the PPU areas of note being included within the fortnightly tasking process.

We were also told that there is a South Yorkshire Police policy relating to mentally disordered persons who commit offences, included within this is the necessity to notify relevant persons where certain criteria apply. The policy also refers to mentally disordered persons who are due to appear before court, and instructions for remand for medical report application.

We understand that all policies are reviewed and updated on an annual basis.

The force's PPU Policy Unit is now responsible for carrying out Adult Protection Homicide Reviews. This would now be undertaken if a similar offence to Mr D's death occurred and is deemed to be good practice.

We were also advised that the South Yorkshire Police provides training courses in relation to Adult Protection and the Mental Capacity Act. The training is run on a joint agency basis enabling all agencies to learn together.

We also discussed the current police liaison arrangements with service staff, who all commented on the changes and improvements and expressed satisfaction with the present liaison arrangements.

7 Critical Factors Summary

No one single factor triggered this tragic incident, but an interplay of a range of complex issues.

We have the benefit of hindsight, and it is important we and the readers of this report take into account the prevailing context and circumstances at the time including the policies, systems, workloads, pressures.

We believe that the following factors contributed: -

- The decision in 1997 not to prosecute following the serious wounding of his parent
- The pressure on the Barnsley Service for speedy discharge by the family and Wathwood Medium Secure Service.
- The absence of risk assessment undertaken by a forensic psychologist.
- Inconsistencies and different emphasis on supervision and care between the Wathwood and Barnsley Services.
- The absence of adequate step down facilities from the Medium Secure Services.
- The decision to accept directly into the Community Services without forensic team continued involvement or the requisite skills and resources within the Community Mental Health Team.
- The tensions and poor engagement and communication between the Service and family.
- The services inability to convince the family of the true extent of the risk.
- The lack of forensic MDT expertise and inputs to support the community team, along with the absence of maintaining a high risk profile and monitoring, and responding to changes in JD's presentation.
- Leadership problems, workload pressures and exodus of five Consultant Psychiatrists within a short period created difficulties for Consultant 4, who was

undertaking Consultant and Medical Director roles together with the lead for Clinical Governance responsibilities.

- Maternity leave and sickness, lack of cover for key Community Mental Health Team members.
- Lack of clear and comprehensive and accurate risk profile, regularly updated, with clear contingency plans, within the framework of robust Care Programme Approach.
- Absence of clear explanation being given to JD and his parents regarding the life long nature of his illness and ever present risk of relapse, and a firm indication of the need for compliance with treatment, support, regular monitoring and supervision along with the consequences of failure to comply.
- Partial adherence to the Care Programme Approach policy and process and different versions of the Care Programme Approach policy being implemented over a relatively short timescale confused some staff.
- The Consultant Psychiatrist's covering role as care coordinator was inappropriate.

8 Conclusions

Mr D's very sad death reminds all of us involved in Mental Health Services, of the complexities and extraordinary difficulties in accurate risk predication.

We saw no evidence of closing ranks and we were impressed with the openness of those people interviewed. There was no evidence that the Trust is a particularly poor performer or that there were high levels of incidents.

JD was a complex person with a severe mental illness, without insight, who presented a range of challenges for both his parents and professional staff.

There were periods of apparent stability with no major concerns detected by a range of professional staff or reported by his parents.

Whilst we have concluded that there were some failures of systems, unfortunate omissions and misjudgements, we do not believe that the tragic death of Mr D could have been foreseen and prevented.

We have summarised our conclusions in line with the specific requirements of the Terms of Reference.

THE QUALITY AND SCOPE OF JD'S HEALTH CARE AND TREATMENT, SOCIAL CARE, RISK ASSESSMENT AND MANAGEMENT

The staff involved with JD's care impressed us as caring and concerned. They demonstrated, through their clinical records and verbal statements, a professional manner with the general standard of care, treatment, record keeping, and general clinical competence being reasonable.

We have concluded that the coordination of planning for discharge from Wathwood was somewhat inadequate, lacking in the required rigour and anticipation of contingencies. The team at Wathwood should have fully explored the therapeutic benefits of a higher dose of Clozapine (as happened on his transfer to the acute service), to have used Section 17 leave to engage with the community team in Barnsley whilst on leave home, which he was already enjoying, and that the discharge from Wathwood should have taken much longer. This strategy would have had the benefits of assessing the family dynamics and emphasised the high risk concerns.

We also noted the absence of suitable step-down facilities from the Wathwood Secure Services.

We consider the appreciation and application of risk management strategies following JD's discharge from Wathwood greatly diminished with time. Whilst JD's changing risk levels were sometimes addressed, on the evidence of the notes there was intermittent recording of risk levels, risk reasoning or responses to changing risk concerns.

It is difficult to achieve the correct balance between safety and encouraging empowerment and a sense of wellbeing and optimism. A too heavy focus on risk can be counterproductive. In JD's case the ever present risks warranted constant and close focus. We believe that the notion of recovery and therapeutic optimum took precedence over risk and safety.

We acknowledge the care team were attempting to maximise JD's quality of life. They encouraged his engagement in community/social activities, attending the gym, going away on holidays, and appropriately exploring preparation for employment activities.

However, they did not appear to adequately distinguish between the recovery model and care, or make it clear to JD and his parents, that the nature of his serious illness and risk would require continuing care and treatment, including risk monitoring for an indefinite period and probably throughout his working life.

The impression given by the Community Mental Health Team was that medicines and supervision would be progressively withdrawn, driven by JD's wishes, and there appears to have been no effective challenge to this.

The monitoring available to the Community Mental Health Team in the final year was exceedingly limited, with infrequent CPN contact and latterly only scheduled out patient visits with a single clinician.

We conclude that these arrangements meant there was no possibility that the service could effectively monitor early relapse indicators, and given JD's previously explosive violence, they were effectively hostages to fortune with little opportunity to take corrective action should the need arise.

This is of serious concern to us. Compliance with care and treatment is the key to ensuring wellbeing and safety.

We have concluded, that the limited focus on risk management incrementally occurred, following insufficient rigorous discharge planning and anticipation of contingencies during the course of his care in the Barnsley Service. With hindsight, this is not surprising, as the key clinicians involved in JD's care and supervision were not forensically trained and did not receive the benefit of continuing forensic expertise. It is apparent that JD was evasive at times and capable of being deceptive. As such the Community Mental Health Team would have to have been extremely vigilant for subtle signs of relapse and be especially attuned to the concerns of his carers.

Specific risk concerns considered not to have been given sufficient attention include:-

- JD's persistent delusional state/lack of insight and focus on distorted thinking in relation to his parents and previous assaults.
- His objection towards his parents' involvement in his Care Programme Approach review and them receiving copies of his care plan.
- His objection to his CPN and support worker being replaced when they were unavailable, and his refusal to be seen by another consultant when Consultant 4 was on leave.
- His requests to be discharged.
- His wish not to take medicines, his late take up (nine days) of his prescriptions, indicating he was not complying with medication.
- His previous propensity for higher levels of alcohol consumption, and signs of alcohol excess (binge drinking) were not given sufficient weighting.

Whilst we appreciate the difficulties encountered by the clinical staff in developing and retaining a therapeutic relationship with a person who believes they are not ill and is reluctant to engage, the fault line began at the outset. Strict rules for compliance and explanation of the consequences of not doing, where not identified for JD and his family. Whilst this may lead to tension within the therapeutic relationship, it is never the less necessary given the risk profile.

We also understand the dilemmas associated with JD's reluctance to involve his parents in the Care Programme Approach and care planning. In most circumstances, the individuals request must be respected. However, in this instance, greater caution, discretion and assertion should have been applied.

JD's delusional condition, with a specific distortion of thinking towards his mother and father, his history and potential for relapse with dangerous consequences, meant that his parents should have been included.

The clinical team should not have acquiesced to his demands. The many reasons for the inclusion of his parents should have been explained to JD, together with a reminder of the consequences of not co-operating. Any personal issues he did not wish his parents to be aware of could have been clarified in advance and agreement reached on what not to share with them.

Additional evidence of the inadequacy of responses to risk was the period at the end of 2003 and beginning of 2004. At this time JD was not seen by a professional for eight weeks whilst his CPN was on leave.

This was replicated in May and June 2004, when he was not seen for a six week period.

We noted, in the summer of 2002, his CPN was the only professional providing support as both the consultant psychiatrist and support worker were both absent from work on leave. This was in the context of a potential for relapse with a high risk of harm, further compounded by the decision not to replace his CPN when she went on leave. These decisions and gaps in contact with JD meant fewer opportunities to carry out in-depth assessments into the nature of his thinking towards his parents, his alcohol consumption, medication compliance, levels of insight and risk of harm.

JD's alcohol consumption does not appear to have been sufficiently monitored or addressed, despite records revealing concern and his history of heavy drinking and offending. We noted triggers for concern including the fracture of his arm following a fall, and the reported concerns following his trip to Wales.

We would have expected more focus on assessing levels of alcohol consumed and explanations regarding problems of alcohol and medication being reinforced.

Of particular concern to us was the length of time before he was further assessed, following the strong indicators of relapse in September 2004.

THE QUALITY OF CARER INVOLVEMENT

It is clear to us that Mrs D was deeply devoted to JD.

Mrs D was active in challenging and expressing her concerns. She was constantly seeking improvement in relation to JD's condition and prospects.

We consider she minimised JD's previous behaviours and believed that she and her husband were best placed to support JD.

Mrs D's strongly expressed views and at times her challenging and forceful approach, had a negative impact on the ability of staff to engage in a meaningful way.

We have concluded that there were significant tensions between the family and some members of staff, who were endeavouring to keep risk at the forefront of JD's care planning and supervision arrangements. This resulted at times in antagonism and a breakdown of trust, confidence, and a lack of regard on the part of Mrs D.

Instead of a united collaborative approach, Mr and Mrs D were divided from the care team. They felt angry and distressed that their perceived needs and expectations for both JD and themselves were not being met.

After a period of time there was an apparent truce and an acceptance of the difficulty of relationships and limited connections, with most of the family's support being provided by a representative from Making Space.

Whilst in some ways this was commendable, it does seem that a significant social dimension to multi-disciplinary assessment and care planning was missing. This is especially important, as latterly the family were the only people who were frequently involved with JD, and there were some limitations to their capacity to detect early warning signals and the ability to alert services in a timely fashion.

We do note that when JD did appear unwell to his mother, she alerted services through the non-statutory worker. This third party message was relayed to a community mental health team, where no immediate care was available, or likely to be available for some time.

The staff clearly struggled to engage Mr and Mrs D. However, the CPN continued in her regular connecting with the family and support to JD. We noted little significant proactive attempts to enhance Community Mental Health Team involvement with his parents.

We consider there should have been more attempts to engage with the family. Whilst Making Space was a positive resource, there would have been benefits to having an experienced and skilled worker who understands family dynamics.

A statutory worker, envisaged with skills in family work, could have acted as a lightening conductor and advised on care management. They could have assisted in managing the conflicting interpretations and interests.

The family liaison role was an expected generic competence for Community Mental Health Team members, and regarded as a routine role for care coordinators. In this instance it was not sufficient. It would have been preferable for renewed attempts to have been proactively made to engage with the family

It is clear that the situation was unsatisfactory and detrimental to JD's wellbeing. The stress and conflict was not appropriate for a person with his condition, and the nature and parental focus of his delusions and distorted beliefs.

We do acknowledge the difficulties faced by both parties. We consider that a specific and separate carer's assessment might have resulted in a better understanding of the family's perspective and more effective practical support and advice being offered and importantly, accepted.

It was an enormous challenge facilitating JD's autonomy and sustaining his independence, whilst at the same time being responsive to Mr and Mrs D's expectations and their strong and at time divergent views on what was best for him.

There clearly was a difference of opinion early in the course of JD's illness between the clinical team and family on how to manage his illness and the associated risk. Tensions with the family did get in the way of arriving at a common understanding of the objectives and agreement of how best to meet JD's needs. The rationale for managing the obvious complex illness and risk was not apparent or acceptable to his parents.

Given the risk concerns, it might have been advisable for those involved to have further considered alternative ways of engaging with the parents, and providing support for JD's care and treatment goals. It certainly would have been desirable to have agreed the boundaries

and rules for compliance at the outset and endeavoured to have maintained these with strict monitoring and feedback.

THE NATURE AND QUALITY OF SUPPORT OFFERED TO STAFF INVOLVED IN THIS BOTH BEFORE AND AFTER THE EVENT

It was evident that the circumstances surrounding the death of Mr D had been traumatic and distressing for many of the staff involved.

A number of staff expressed their concerns to us that the level of support provided to them was insufficient and that they had to cope with the impact of Mr D's death by using their own personal resources.

In general terms, it is widely acknowledged that the effects of a significant event such as this can interfere with how an individual functions from both a personal and professional basis.

Trauma of this nature can encompass a range of emotional responses, including tension, anxiety, demoralisation, feelings of guilt, failure and self doubt. In turn, this can lead to fear of blame, scapegoating, undermining of confidence and disorganisation. It can also lead to the team resorting to over caution, defensive practice and an inability to sustain positive therapeutic engagement. Fear of future incidents may also lead to impaired judgements and avoidance of decision making.

Evidence suggests that unless staff feel supported in making sense of their feelings it can interfere with their ability to manage their clinical work. Fear of blame may be exacerbated by the formal review processes, which seek to understand the incident and to identify lessons learned after objective scrutiny of the facts. Some staff did express concern that they felt the senior managers' reactions conveyed blame.

Experience from elsewhere, indicates that the absence of a sense of formal support to staff before they have been able to fully process the experience, can make them feel vulnerable when subjected to questioning, which can be interpreted as blaming, punitive and a feeling of 'being on trial.'

Therefore, Trust Managers and Clinical Leaders should consider having in place, models of support, protocols and training for ward teams and individuals who may experience grief reactions or distress following any future serious incidents or episodes of trauma. Arrangements should take account of perceived negative feelings, hostility, and seek to minimise them.

When considering future protocols, action, and practical arrangements we urge senior managers and clinical leaders actively to demonstrate their support to individuals and teams, by indicating their awareness of the difficulties and stress staff face, and to indicate that the organisation values and supports them. They should also ensure that priority attention and the necessary time and resources are given to the requirements of supporting staff. They should also be alert to the potential for individual strain and distress, team vulnerability, conflict, blame or team splitting and the need to sustain team integrity.

We have concluded that the Trust has made significant progress in improving safety and delivering models of care which are person centred and address their vulnerability and risk to others. We have formed the view that the progressive developments and changes are in line with modern positive practice and will help to reduce the likelihood of similar tragic incidents in the future.

9 Improvements and Developments

POSITIVE PRACTICE

Whilst our planning focus has been on concerns and areas for improvement, we were also alert to identifying and commending noteworthy practice.

We were impressed with the professionalism and openness of the staff we met.

Specific areas we identified were: -

- The Criminal Justice Liaison Team and their links with Forensic Services, Courts, Probation Services.
- The links with and support to the family provided by Making Space.
- Clinical leadership provided by Dr Suresh Chari, Consultant Psychiatrist and Medical Director Margaret Kitching, Director of Nursing and Professions and Dr. Gill Kirk, Consultant Psychiatrist

SERVICE DEVELOPMENTS

We were keen to learn of developments in services since 2004. We were impressed with the many changes and innovations, which were described to us, which we consider will enhance care and treatment.

We consider that these positive developments are strong indicators of a progressive organisation, seeking to improve service delivery.

We give below, in summarised form, the many changes and improvements noted: -

- The appointment of two carer support workers.
- Increase in resources for substantive Consultant Psychiatrist posts and the modernising of the medical workforce.
- Changes in operational management structures and functions.
- Closer integration and improved Multi Disciplinary Team relationships with Wathwood, with multi agency access to forensic psychology.

- Revision for the arrangements to cover for maternity leave and when staff are on sick leave, which allows for prioritisation of patient need.
- Systems for reviewing of caseloads have been revised.
- Team leaders now have control of budgets.
- More flexible financial arrangements.
- Clinical management enhanced supervision pathway developed.
- Ground breaking, state of art acute facilities incorporating modern therapeutic environments.
- New policies and procedures relating to the reporting, recording and investigation of incidents, in particular with a focus on serious untoward incidents.
- Plans to develop staff support systems and ensure mandatory clinical supervision are now in place. This includes rapid access to psychological support, including out of hours requests
- Changes in governance arrangements and improved links with risk management departments
- Complaints policy and procedures have been revised and improved.
- The development of a clinical risk classification framework, which has been incorporated into the Care Programme Approach process.
- Appointment of experienced Operational Managers with a mental health background.
- Redesign group developing a model to improve assessment, management of risk with links to care planning, documentary evidence and using best practice guidance.

10 Recommendations

R1 FAMILY AND CARERS INVOLVEMENT

R1.1 We urge the Trust to use the family/carer concerns highlighted in this report as a spur to re-examine the current carer policy, with special regard to support and liaison arrangements.

R1.2 The Trust should ensure that all staff have training in assessing the needs of carers and are aware of their duties under the Carers (Recognition and Services) Act 1995.

R1.3 We recommend that the Trust should further consider how carers can be better supported and managed to enable them to understand the nature of serious mental illness and the associated risks, and how they can contribute to the care, treatment and support of their family member.

R1.4 The Trust considerations should incorporate both clinical and local authority risk assessments, with particular regard to: -

- Information, support, advice and supervision regarding risk assessments and management, including boundary setting, and compliance with the treatment plan.
- Carer assessment of needs and problems.
- Family therapy.
- Carer/family response to crisis and signs of relapse.
- Personal protection.
- Advocacy.
- Carer support groups.
- Engagement and strategies for overcoming resistance from family members.
- Training, guidance and support for staff in meeting carer/family needs.

R1.5 The Trust should ensure that CMHT's take into account the needs of carers when reducing the level of support to patients, and ensure that systems are in place to respond effectively to concerns of carers should circumstances subsequently change. This is especially important where patients present with a profile of significant risks, either to themselves or their carers.

R2 INTERNAL SERIOUS UNTOWARD INCIDENT INVESTIGATIONS

R2.1 Internal Investigations and Reviews into serious incidents should be undertaken in a timely manner, and the findings should be shared with staff involved and the families of victims, ensuring that any necessary lessons are learned.

R2.2 Those undertaking Internal Reviews should be given the necessary training, including approaches of root cause analysis, administrative and professional support along with protected time in order to undertake the duties and responsibilities effectively.

R2.3 The recommendations and action plan arising from SUIs should be reviewed after six months to check progress or otherwise, in the implementation of change and improvement.

R3 STAFF SUPPORT

R3.1 The Trust should review its processes and procedures for providing support to staff involved in serious incidents and seek to avoid reactions which may imply blame.

R3.2 Staff, patients or carers directly affected by a traumatic event should be offered support at the earliest opportunity and this should be sustained throughout the process of internal or external investigations including attendance at any inquest.

R4 EDUCATION, TRAINING AND DEVELOPMENT

A number of issues have emerged which the Trust should address through training and preparation of staff, including: -

- Family therapy, including psycho social interventions.
- Safeguarding Adults (for both clinical and managerial staff)
- Undertaking SUIs – Root Cause Analysis approaches and associated skills.

R5 CLINICAL SUPERVISION

Clinical supervision for support, reflection and guidance should be mandatory. The Trust should ensure that professional supervision takes place as set out in the Trust policies and that it is recorded and audited on a regular basis.

R6 ENGAGEMENT OF PATIENTS

The Primary Care Trust should review practice policies and training for the management of patients whose mental illness makes them reluctant to engage with services.

R7 MANAGING RISK

R7.1 The basis for referral of patients between forensic and generic services should be clarified with a specific understanding from both services as to what is expected from each side. For example this might include a structured clinical assessment of the risk of violence with agreements that forensic services offer support and advice to community teams when needed.

R7.2 A forensic opinion should be considered for those patients deemed to be a high risk of serious violence and criminality based on their history of aggression, poor anger control, use of illegal substances and alcohol.

R7.3 Those patients, with a history of serious violence and a higher risk profile should receive closer supervision and be subjected to frequent reviewing and monitoring, than others in the community. It seems highly unlikely that such patients would ever be suitable for standard CPA, and will continue to need the full panoply of the CMHT services.

R7.4 When dealing with patients with a history of violence and severe mental illness, Care Programme Approach meetings should set clear operational criteria for intervention, including setting of boundaries and essential requirement for compliance with treatment. These criterions should be communicated to patients and carers/family members in a way that is clear to them, so that they have a clear awareness of the expectations of supervision and understanding of the consequences of not complying.

R8 POLICE LIAISON

R8.1 The Trust should build on the current positive relationship with South Yorkshire Police. The development a joint working protocol as envisaged by the Memorandum of Understanding (MOU) between the Association of Chief Police Officers and the

NHS Security Management Services (NHS SMS) should be undertaken.

R8.2 The Trust and the local police representatives should keep under review the question of prosecution of offenders who may have a mental illness.

R9 CARE PROGRAMME APPROACH POLICY

The Trust should ensure that it's Care Programme Approach Policy and Procedures are fully implemented and are supported with appropriate resources and training. The Trust should undertake frequent audits to ensure compliance with this recommendation.

R10 SAFEGUARDING ADULTS POLICY

The Trust should ensure that all Community Mental Health Team staff have training in Safeguarding policies and the protection of vulnerable family members.

R11 GOVERNANCE

The Trust should consider the development of a Mental Health Patient Safety strategy to complement the recently issued Risk Management Strategy in order to ensure that all issues relating to clinical risk and the safety of mental health service users are integrated and are robustly promoted and addressed within Barnsley PCT.

11 Appendices

1 Glossary and Abbreviations

2 Provision of Mental Health Services

3 Barnsley PCT Clinical Governance Structure

4 Barnsley PCT Clinical Governance Proposed Structure

5 Barnsley Primary Care Trust Board

6 Barnsley Primary Care Trust – Care Services Board

7 Documentation Reviewed

APPENDIX 1

Glossary and Abbreviations

ADL	Activities of Daily Living Assessment
ASW	Approved Social Worker
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPM	Care Programme Meeting
CPN	Community Psychiatric Nurse
CSW	Care Support Worker
DLA	Disability Living Allowance
DPM	Department Psychological Medicine
DSS	Department of Social Security
GP	General Practitioner
ICAS	Independent Complaints Advocacy Services
IRA	Irish Republican Army
MACA	The Mental After Care Association
MAPPA	Multi Agency Public Protection Arrangements
MDT	Multi Disciplinary Team
MHA	Mental Health Act
MHRT	Mental Health Review Tribunal
MOPI	Management of Police Information
MOU	Memorandum of Understanding
MSU	Medium Secure Unit
OT	Occupational Therapy

PCT	Primary Care Trust
PPU	Public Protection Unit
RMN	Registered Mental Health Nurse
RMO	Responsible Medical Officer
SAMM	Support after Murder and Manslaughter
SHA	Strategic Health Authority
SHO	Senior House Officer
SMS	Security Management Service
SN	Senior Nurse
SpR	Specialist Registrar
SUI	Serious and Untoward Incident
SW	Support Worker

APPENDIX 2

Provision and Delivery of Mental Health Services

Department of Psychological Medicine (DPM)

The DPM provides in-patient care and treatment for people suffering from acute and severe mental health problems. Referrals are made via the Crisis Resolution and Home Treatment Team, who are also based on the in-patient site. The service consists of two wards that cater for men and women on separate floors, but with the opportunities to participate in mixed activities or group work in the Acute Therapy area.

Community Mental Health Team

There are four teams (also known as Community Mental Health Team or Sector Team) in Barnsley caring for adults (aged 16-64). The teams are made up of community mental health nurses (sometimes referred to as CPN's), social workers, occupational therapists, psychologists and support workers.

There are four sector teams organised by area and GP practice. These teams support people who are experiencing mental health problems of an acute or enduring (long term) nature. All referrals from any source (including self-referral or from carers) should be made directly to the Sector Team through which an initial screening will be undertaken to determine the most appropriate form of help.

Recovery Teams

Referrals are made by consultants at the DPM, via Community Mental Health Team or from Ward 5 at Kendray Hospital. The team link up with voluntary agencies and sector teams to provide a rehabilitation/resettlement services to clients aged 16 – 64.

Kendray Hospital In-Patient Services

Ward 5 provides rehabilitation and respite for adults with enduring (long term) mental illness. The ward has eight beds designated for rehabilitation and two beds for short term medical or nursing respite. Patients are referred from either the DPM or from the Community Mental Health Sector Teams.

Court Liaison/Diversion Team

The primary function of Court Liaison/Diversion is to act in the best interest of seriously mentally disordered people by diverting them away from the Criminal Justice system, where appropriate, to hospital placements, of no greater security than is justifiable and proportionate, by assessing the level of risk they propose to themselves or to others.

Substance Misuse Service

The Substance Misuse Service, consisting of a community drug team and a separate alcohol team, offers detoxification programmes for both drug and alcohol misusers, and maintenance programmes for opiate dependant clients. For those clients assessed as needing an inpatient stay to address their dependence, an inpatient stay is available at the specialist unit at Kendray Hospital. Referrals are received from Tier 2 drug treatment partners, Community Mental Health Team, GPs and secondary services. This service offers treatment for drug and alcohol problems as well as advice and information to other professionals.

Barnsley Alcohol and Drugs Advisory Service (BADAS)

BADAS offers counselling, advice, information and holistic therapy to anybody experiencing problems with drugs or alcohol. It also runs needle and syringe exchange and a specialist young people's service based at 'The Barn'. Clients can access BADAS or The Barn via the duty service, without an appointment if necessary.

Crisis Resolution and Home Treatment Team

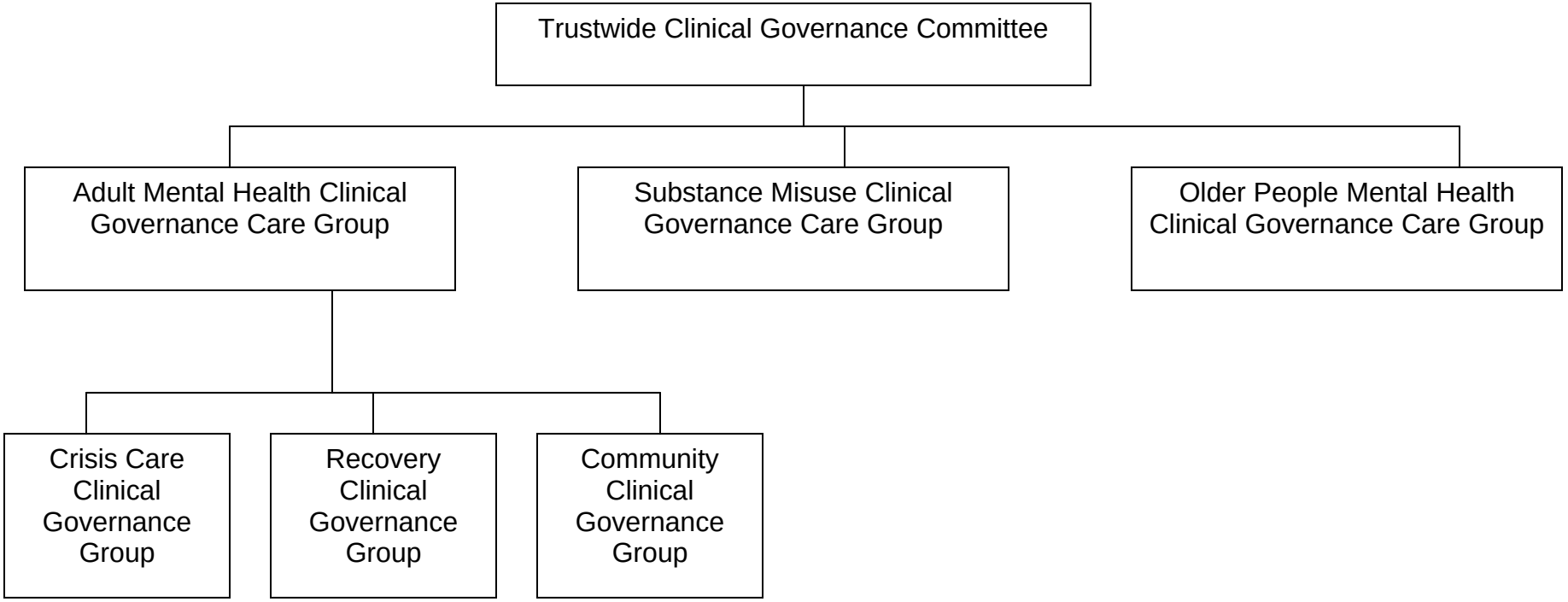
The Crisis Resolution and Home Treatment Team, based at the Department of Psychological Medicine, Barnsley District Hospital, offers an alternative to hospital admission for those people experiencing an acute mental problem/episode. Referrals to the team are by mental health professionals, or GPs. The team provide a 24 hour/7 day a week service to clients and their carers until the crisis is resolved, following which arrangements for referral to longer term support and/or treatment agencies are made.

Assertive Outreach Team

This service is aimed at people with severe mental illness with complex presentations who are at risk of recurrent hospitalisation due to difficulties engaging with more traditional services. The service also offers support to people who find it difficult to accept help, putting them in an 'at risk' or vulnerable situation. Referrals are through Community Mental Health Teams, DPM and Out of Area Secure Services. Focus is on the delivery of community support through a team approach with a high staff to service user ratio.

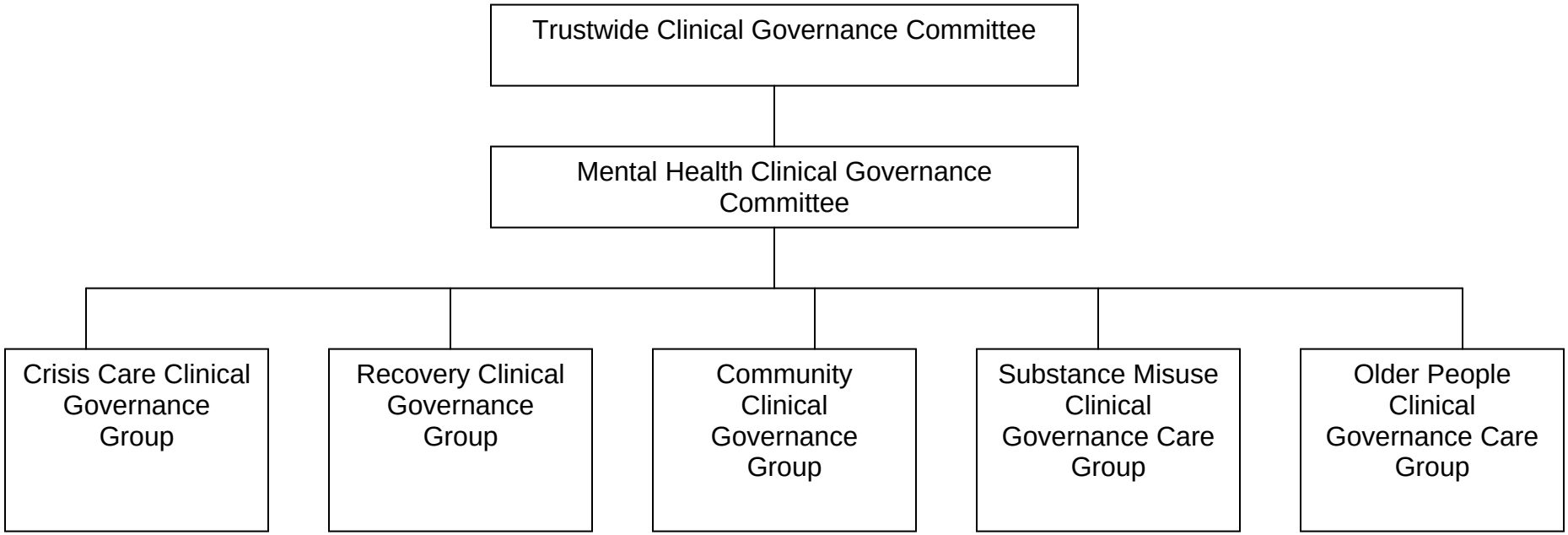
APPENDIX 3

Barnsley Primary Care Trust Clinical Governance Structures (2004)



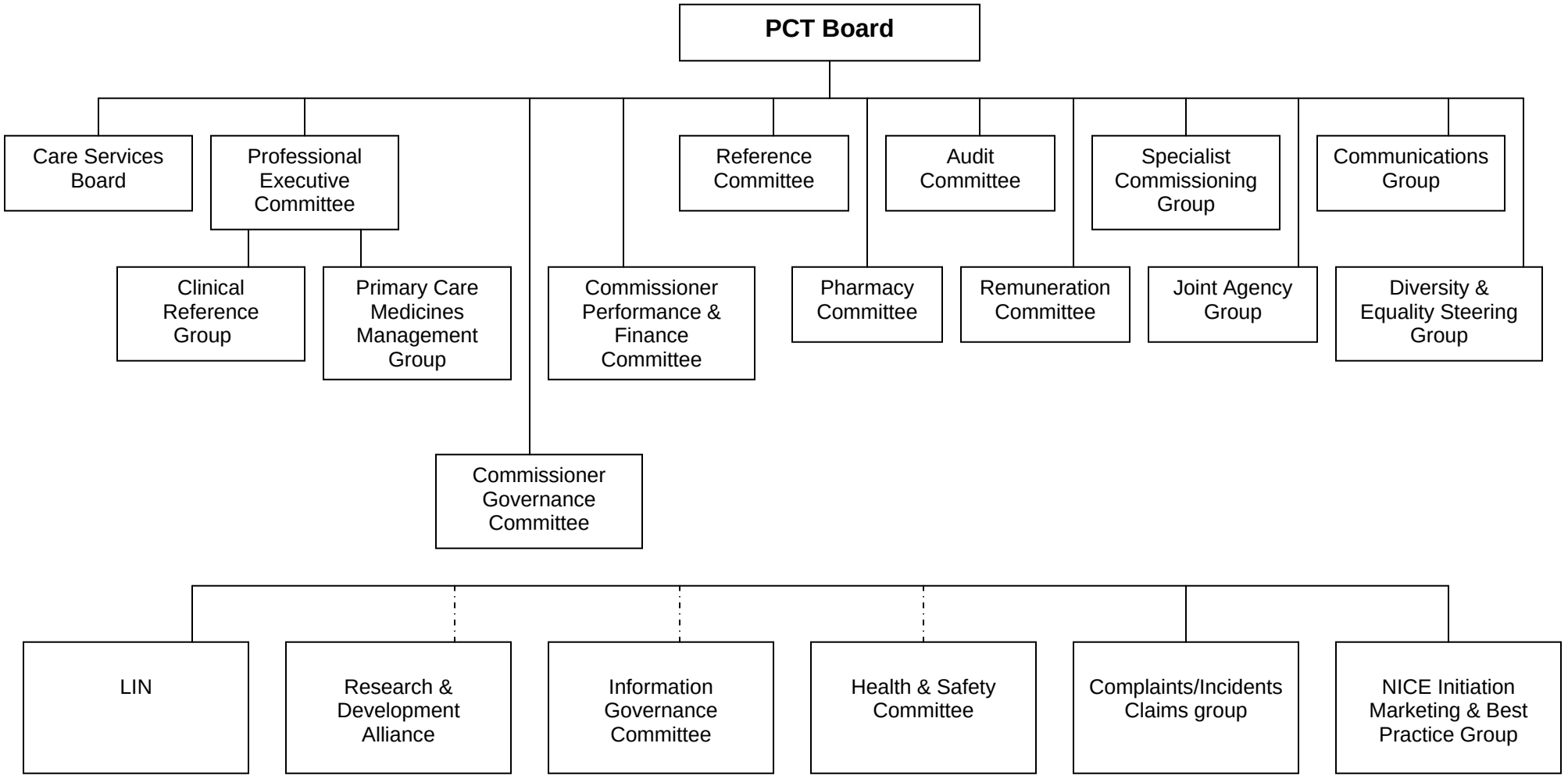
APPENDIX 4

Barnsley Primary Care Trust Proposed Clinical Governance Structures (May 2004)



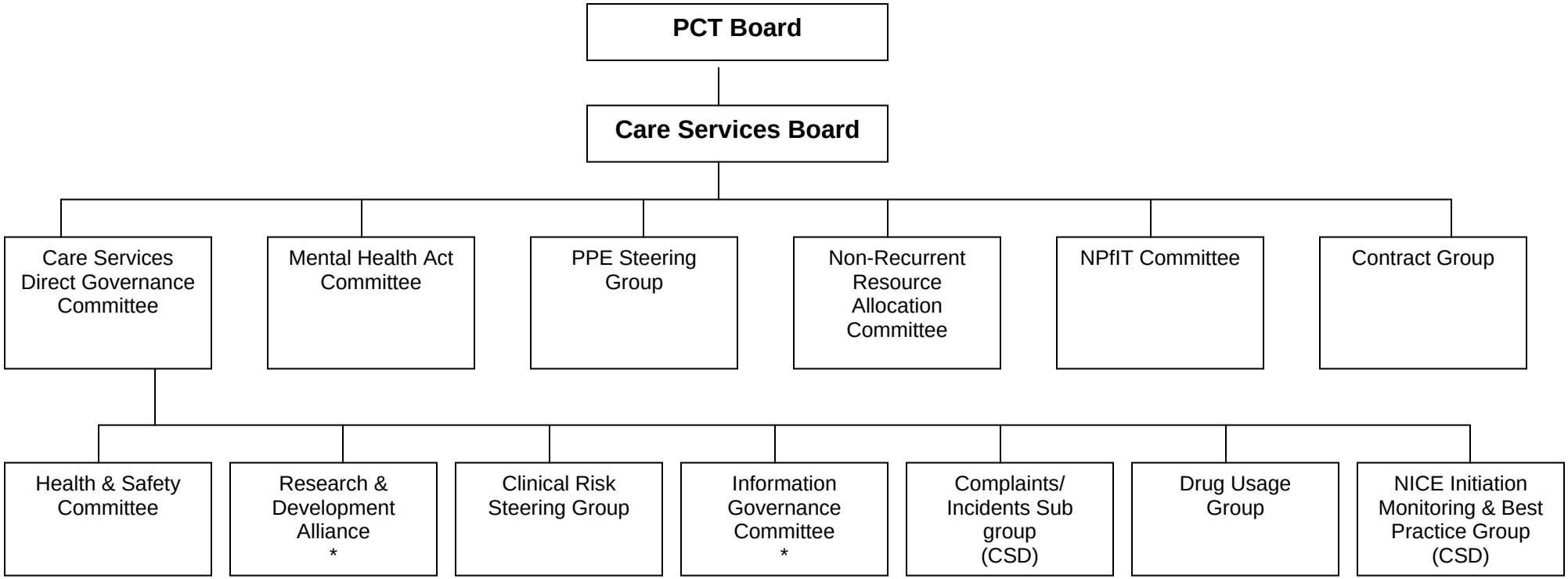
APPENDIX 5

Barnsley Primary Care Trust Board



APPENDIX 6

Barnsley Primary Care Trust – Care Services Board



* linked to PCT Commissioner Governance Committee

APPENDIX 7

Documentation Reviewed

Document/Information	Electronic or Paper	Comments
Corporate Strategies/Policies/Procedures/Annual Reports		
Notes of 1st meeting with SHA, PCT and ourselves	Electronic	Received
Letter sent to Family – 7th November	Paper	Received
Complaints correspondence	Paper	Received
Press Releases	Paper/ Electronic	Received
Information re: Coroners Outcome		
List of carer support groups	Paper/ electronic	17/3/08
SUI – Recommendations and Actions	Paper	Received
Progress on Recommendations	Electronic	Received
Notes of meeting with family and Jill Jenks (4-3-05 – filenote dated 4-3-05 included within reference 4)	Paper	Received
Medical release form signed by AJC		Given to Malcolm Rae on 24-4-08
Internal review of the treatment and management of AJC	Paper	Received
MH Service Structure	Electronic	Received
Clinical Governance Reporting Structure	Paper/ Electronic	Received
Risk Management/Safety Structure and Reporting – Terms of Reference Document	Paper/ Electronic	Received
Carers	Paper/ Electronic	17/3/08
Terms of Reference – SUI 2004/3403	Electronic/ Paper	Received
Procedure for Commissioning and Reporting of Independent Investigations – August 2007	Electronic/ Paper	Received
Guidance: Independent Investigators and Coordinators	Electronic/ Paper	Received

Document/Information	Electronic or Paper	Comments
Risk Management Annual Report 2004/05	Electronic/ Paper	Received 17/3/08
Risk Management Annual Report 2006/07	Electronic/ Paper	Received 17/3/08
Risk Management Strategy - 8 December 2003 (2002 – 2004)	Electronic/ Paper	Received 17/3/08 Includes corporate structures for Risk Management
Risk Management Strategy – April 2007	Electronic/ Paper	Received 17/3/08
Policy on the Reporting, Recording and Investigation of Accidents and Incidents. (Barnsley PCT & Barnsley MBC Social Services) - June 2004	Electronic/ Paper	Received 17/3/08
Policy on the Reporting, Recording and Investigation of Accidents and Incidents. (Barnsley PCT & Barnsley MBC Social Services) – UP TO DATE VERSION	Electronic/ Paper	Received 17/3/08
Procedures & Guidelines for the Management, Recording, Reporting grading & Analysis/Investigation of all incidents and & Near Misses – March 2005. Incident Procedures as at November 2004	Electronic	Received 14/3/08
Policy on the Reporting, Recording and Investigation of Accidents and Incidents – Procedures and Guidance for the Management of all Incidents. (March 2008)	Electronic/ Paper	Received 17/3/08
General Procedure on the reporting of incidents	Electronic/ Paper	Received 17/3/08
Procedure to follow in the case of a serious incident (or near miss)	Electronic/ Paper	Received 17/3/08

Document/Information	Electronic or Paper	Comments
Procedure for the reporting of incidents under on call arrangements	Electronic/ Paper	Received 17/3/08
Procedure for the investigation of incidents	Electronic/ Paper	Received 17/3/08
Health Records Policy as at 2004 – Dated April 2003	Electronic/ Paper	Received
Health Records Policy as at 2008 – Dated Jan 05	Electronic/ Paper	Received
Whistling Blowing Policy as at 2004 – Dated March 2002	Electronic/ Paper	Received 17/3/08
Whistling Blowing Policy as at 2008		Same as 2004 policy dated March 2004.
Staff leave Policy as at 2008	Electronic/ Paper	Received 17/3/08 (dated June 2007)
Policy on Bereavement Leave (dated March 2002)	Electronic/ Paper	Received 17/3/08
Information Sharing Policy as at 2004		No policy in place
Information Sharing Policy as at 2008	Electronic	Received 22/4/08