REPORT OF THE INDEPENDENT INQUIRY

REFERENCE SUI 2005/2100

TO BE PRESENTED TO THE NHS YORKSHIRE AND THE HUMBER BOARD
5 JUNE 2007

COMMISSIONED BY THE FORMER
WEST YORKSHIRE STRATEGIC HEALTH AUTHORITY

UNDERTAKEN BY DR GEOFF ROBERTS AND MS ANN GORRY

Acknowledgements

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The author gives his condolences to the mother of patient B, his sister and other family members of the victim. The author is also grateful to patient B, his mother and sister for their assistance.

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1.0 Executive summary

1. The Department of Health issued guidance in 1994 on the care of mentally disordered patients discharged into the community in the circular HSG (94) 27, LASSL (94) 4. This included guidance on the conduct of external reviews where a patient has been convicted of homicide. This advice was modified in June 2005 and now allows for consideration to be given for a proportionate Independent Inquiry and increasing the discretion of the statutory agencies in the format and nature of the Independent Inquiry. This inquiry was carried out in the context of these changes.

2. The inquiry has been carried out in line with the Terms of Reference and this report is the result of the review.

3. Patient B was born on 3 September 1975. He was known to mental health services (statutory sector) in Dewsbury from 1997 to 2005 and addiction services (voluntary sector) in 2005. In June 2005 he was arrested for the murder of his step-father. He was subsequently convicted of murder. In October 2006 the verdict was successfully appealed to be replaced by one of manslaughter by way of provocation. Mental illness considerations did not form part of the defence. His life sentence was replaced by an eight year jail term.

4. The homicide took place at the family home where patient B lived with his mother and step-father.

5. Patient B's referrals to and treatment by mental health services were characterised by his failure to attend for appointments at the time of referral, or for follow up. He also has epilepsy and his referrals to a neurologist again showed a failure to engage with that service.

6. Patient B had a long history of significant alcohol and substance misuse, primarily with cocaine. He did not regard either to be a problem until March 2005. He had attended his General Practitioner (GP) in March 2005 with symptoms of deteriorating mental health. He was referred by his GP and assessed by the Crisis and Home Treatment Team at that time.

7. In April 2005, patient B's GP referred him to the local Community Mental Health Team (CMHT) for a consultation with the consultant. The GP was unaware at that time that the CMHT had changed the way it dealt with referrals. Patient B was referred to the drugs and alcohol service at Way Ahead, a voluntary sector service provider funded by the local Drugs and Alcohol Action Team. The GP was not informed of this referral by either agency. He was therefore not aware that the intended outpatient appointment with the consultant for his patient would not take place.

8. Patient B's mental health state worsened in late April and May 2005. The GP suggested to patient B's mother that she try and expedite the appointment with the consultant. The mother's clear recollection is that she did this and that she eventually arranged for a domiciliary visit by the consultant for 2 June 2005. The visit did not take place. There was no policy for the retention of records relating to conversations which are retained by the Trust. No records remain and it has not been possible to conclude the inquiry in this regard.

9. Following the incident, the Trust carried out an internal review using root cause analysis. The review was neither timely nor thorough. It did not identify or examine the changes in service procedure for referrals. The report was eventually signed off by the general manager in January 2006. The report's recommendations, although laudably directed towards service improvements, were not directly related to nor directly flowed from most of the facts of the case. The Trust Board has subsequently amended its policies and the Independent Inquiry has recommended that these be monitored.

10. It is the opinion of the Independent Inquiry that the treatment offered to patient B towards the end of the period reviewed fell short of that which should have been expected for the condition he was presenting at that time.

11. The Independent Inquiry has identified six areas for improvements in the safety of services and made eleven recommendations to support these changes. These areas are:-
    - i) Involvement and support for carers
    - ii) Service delivery (dual diagnosis strategy, reduction of did not attend (DNA) rates, future service reconfigurations and record retention
    - iii) Skills sharing
    - iv) Information sharing
    - v) Management of untoward incident and internal reviews
    - vi) Incident review reports

2.0 Terms of reference

The Terms of Reference for this Independent Inquiry, set by the former West Yorkshire Strategic Health Authority in consultation with South West Yorkshire Mental Health Trust, North Kirklees PCT and the author, were as follows:

To examine:

- The care the service user was receiving at the time of the incident (including that from non-NHS providers e.g. voluntary/private sector)
- The suitability of that care in view of the service user's history and assessed health and social care needs
- The extent to which that care 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 judgement 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, with particular reference to referral and discharge processes

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.

3.0 Chronology of significant events

(Direct quotes from the documentation are italicised)

Date of Birth 03/09/1975

12. Patient B had recurrent tonsillitis as a child which resulted in adeno-tonsillectomy and bilateral myringotomies (removal of adenoids and tonsils and the insertion of grommets) in 1981. In 1987 he was diagnosed as having asthma, although this did not prove a significant problem. The only other significant GP attendance recorded from his childhood was in 1988. He completed his secondary education with five GCSEs.

13. There was little contact with health services until 1997. After leaving school patient B worked for a time as a green keeper and later in landscape gardening.

1997

14. Patient B visited his GP on 19 May 1997. The records state:
    'Whilst walking around Dewsbury 3/7 ago 'collapsed' no aura/no forewarning.
    Taken into shop by nurse who said she thought he had a fit.
    Felt 'funny' after collapse
    Bit tongue
    Aching body after.

    No history of local injury
    Dx probable epileptic fit
    Disc / further investigation if has further problem'

15. This did not cause further problems until late in 1998 at which point he was referred to a neurologist.

16. On 3 December 1997, patient B attended his GP. The records state:
    'Felt depressed for about 1 year ↑ over that time
    Parents split up beginning 1996
    Losing job middle of 1996
    Split with girlfriend middle of 1996
    Living with father who is always nagging
    Alcohol ~ 60 units/week
    Diet also poor (no food in house) goes to mother's if wants 'any to eat' Has had suicidal ideation 'don't know what to do anymore'.
    Alcohol related depression
    FBC [MCV 95] (Full Blood Count, Mean Corpuscular Volume)
    LFT [normal] (Liver Function Test)
    Vit B Co
    → CPN
    → Psych'.

17. On 5 December 1997 patient B was assessed by a CPN. His notes read:

‘Reactive depression (some suicidal ideation referred to Psych OPD)
↑ alcohol abuse / poor diet / anxiety symptoms
1.Early 1996 parents split up.
2. Split up with girlfriend ‘Mid 1996
3. Lost job ‘middle 1996’
4. In prison for motoring offences ‘association with alcohol’. Living with father no communication feels father always nags him etc.
Assessment
22 year old single gentleman presently living with father, father’s partner, and sister in Cleckheaton.
Parents recently separated. Client has poor relationship with father and his partner. Good relationship with sister and mother. Hopes to go and live with mother when she finds appropriate accommodation. Qualified in landscape gardening although presently unemployed. Keeps in contact with a number of friends although quite anxious when out with them in pubs. Finds he starts to feel paranoid and on occasions leaves his friends and goes home. History of drugs misuse (Hash, LSD)
Now drinks to excess, but no drugs. Says that drugs cause him to feel paranoid and he tries to avoid this feeling. Wants to be able to go out socially without feeling overly anxious. Feels that his anxieties are becoming worse and incapacitating him. Has agreed to see for stress management counselling.
Problems identified
Social withdrawal resulting from paranoid thoughts and feelings.
Recommended intervention
Cognitive therapy aimed at helping client bring paranoid cognition under control.’

18. The offences were for alcohol related motoring offences. It is stated that he was given an eight week prison sentence and six driving licence penalty points.

19. On 8 December 1997 patient B attended his GP. He complained of symptoms of depression and was referred to a consultant psychiatrist. The letter was received by the hospital on 30 December 1997 and an appointment made for 4 March 1998. Blood tests taken in December were normal.

20. The referral letter to the psychiatrist states:

‘ROUTINE REFERRAL
Thank you for seeing this chap who came to see me “at the end of the line”. He feels he has been depressed, which he describes as lack of interest and intermittent anxiety for the past year which is getting worse, culminating in suicidal ideation, “I don’t know what to do anymore”. He mentioned to me that his parents split up at the beginning of 1996, rapidly followed by him losing his job and splitting up with a long standing girlfriend. He then went to prison later in the year for motoring offences connected with alcohol.’

He is currently living with his father who he obviously does not really communicate with and who he feels does nothing but nag him. He has a poor appetite and tends to eat only when he goes to his mother's house. He is consuming approximately 60 units of alcohol weekly, which I feel must contribute in large measure to his psychiatric symptoms.

However, I was reluctant to start him on antidepressant therapy directly, but discussed the options with him. I have organised a full blood count, liver function tests and prescribed vitamin B compound tablets. I have referred him as an interim measure to the CPN who visits the practice, but would be grateful for your overall assessment and advice.

Alcohol abuse -non dep
3/12/97 Alcohol abuse -non dep.
Depression NOS
very heavy drinker >9u/day : 60 units/wk
Refer to community psych. nurse
8/12/97 Psychiatric referral

11/93 Pain, anterior chest wall
1/94 Trauma self-referral--blow
7/95 Failed encounter
1/96Unemployed
1/96'Flu-like illness
5/97Fit - had one, symptom
12/97 Alcohol abuse -non dep
No record of drug sensitivities

Medication
HISMANAL 10mg tabs

- *one tablet daily 30 tabs*
- *VITAMIN B COMPOUND TABS*
- *take one daily 28 tabs'*

Patient B's mental health state deteriorated over the following week and his GP requested a domiciliary visit by the psychiatrist. By this time he had left his father's house and was living with his mother and her boyfriend.

21. The records hold a note dated 19 December 1997 from the consultant psychiatrist to GP which reads:

'Thank you for requesting a domiciliary psychiatric assessment on this gentleman whom I eventually caught up with on Thursday 16th December 1997 by prior arrangement.
[patient B] has now been living at this address with his mother and boyfriend for the past week, having fallen out with his father who he had been living with. He has been unemployed since June this year but had been working as a paint sprayer for 6 months and as a landscape gardener before that. He had been in trouble with the law recently and has only recently come out after serving time for motoring related offences.

There had been tensions between [patient B] and his father for some time resulting in arguments, fallouts, walk outs and even staying out. He had smashed up his bedroom and damaged doors in the last 2 years.
[patient B] admitted to drinking to excess for many years, spending up to £200 a day on drink and related matters, not surprisingly getting into debt. I hear his mother is now bailing him out. While inside, he found out that he had felt a lot better without excessive drinking and therefore these days seldom exceeds 4 pints in 1 session.
[patient B] also admitted to taking amphetamines, LSD, cocaine, cannabis and ecstasy since when he was about 16. He had never had heroin. However, he appears to have done reasonably well at school gaining 5 GCSE's although he admitted to truanting in the later years. He also mentioned taking an overdose of Paracetamol tablets with a bottle of vodka about 18 months ago. In more recent times he mentioned trying to hang himself while under the influence of alcohol but fortunately the belt broke and presently denies any suicidal or self harming ideas. His mood continues to fluctuate but there is no diurnal variation. His appetite is erratic but his weight is steady.
[patient B] seemed to be looking forward to starting up his job at Tesco's, kindly arranged by his mother's present boyfriend.
Opinion
There is clearly a mood fluctuation here, probably resulting from his past drug abuse and general intolerance of things not going his way. I am also seeing adaptive aspects about him and I am hoping he will settle down provided he keeps well clear of any further illicit drugs or alcohol.

I would recommend starting him on Citalopram 20 mg in the morning and I am arranging for him to be reviewed at my outpatient clinic in about 3 months' time. In the meanwhile I understand he is already being seen by the CPN, who will no doubt get in touch with me if there are any problems'.

1998

22. On 2 February 1998 the CPN wrote to the GP:
'I am writing to inform you that following assessment [patient B] failed to keep a further appointment with me and has not contacted me since that time. I have therefore discharged him from my care.
Fortunately during assessment we were able to look at a number of cognitive techniques aimed at helping [patient B] reduce his paranoid thoughts and feelings.
Perhaps these interventions were sufficient for your patients needs. Certainly [patient B] appeared highly motivated to try and practice the techniques suggested. Should [patient B] require further assessment at some later date we could of course see him in the Community Mental Health Clinic.
If you require any further information, please do not hesitate to contact us.'

23. Patient B failed to attend two hospital follow up appointments in April and June and was discharged back to his GP's care.

1999

24. In January 1999, patient B was assessed by a neurologist. He had experienced two episodes of unconsciousness. It was considered likely that he had a seizure disorder. It was arranged for him to be reviewed in six months, together with his sister. He failed to attend the appointments and two EEG appointments. He was discharged from follow up in April 2000.

25. Patient B had little contact with his GP until February 2002.

2002

26. On 6 February 2002 the GP wrote to the consultant psychiatrist:

    'Urgent Referral
    Thank you for seeing this 26 year old man urgently who has previously been under the care of your predecessor. In 1997 he was seen on a [domiciliary visit] DV because of depression and suicidal ideation. He was treated then with Paroxetine 30 mgs. daily with intermittent Temazepam and saw the CPN on a regular basis. He stopped attending after four or five months and things seemed to settle down.
    Unfortunately, he has now returned with a long list of problems. He has started drinking again, drinking around two bottles of Vodka per week, his girlfriend of one year has left him, he has relationship problems with his mother and step-father who he lives with, he has been having increasingly angry outbursts, is unable to sleep and he has also talked about "a pain inside which he cannot cope with anymore'. He has been having suicidal thoughts for 12 months now and regularly thinks about jumping off bridges or throwing himself in front of a train. The day before yesterday, he in fact, stepped out in front of a car, which swerved narrowly missing him. Although he had not made any particular plans to do this and had not written a note, he wishes the car had hit him and is still contemplating further suicidal acts.

    I suspect that his problems may be partly due to his personality and alcohol misuse, but I feel he has once again developed a depressive illness and is at serious risk of self-harm. I spoke to your secretary today and she is arranging for someone to contact him today.
    Current
    03/11/93 Pain anterior chest wall
    04/01/94 Trauma self-referral—blow bridge of nose
    25/07/95 Failed encounter
    04/01/96 Unemployed
    04/01/96 Flu like illness
    19/05/97 Fit
    15104/99 Abdominal pain and heartburn
    07/08/00 Did not attend - no reason
    06/02/02 Depression NOS
    Medication
    Rx 05/02/02 TEMAZEPAM tablets 10mg take one or two at night
    Sensitivities None.'

27. On 14 February 2002 patient B was seen by the Alcohol Specialist Nurse who subsequently wrote a letter to the GP:

    'I assessed a patient of yours today, [patient B]. and discussed the option of doing a home detox regime for his alcohol problem. After discussion, assessment and advice with him, I felt it would be appropriate for him to commence on the detox process on Tuesday 19 March.

    I have asked [patient B] to make an appointment with you prior to the commencement of the detoxification regime.

    I would be grateful if you would prescribe [patient B] the enclosed Diazepoxide regime with Vitamin B Compound Strong 2 tablets tds and Campral 2 tablets tds. Research proves Campral is very effective in reducing cravings and aids the maintenance of abstinence.

    If you have any concerns or queries regarding this or any other matter please do not hesitate to contact me.'

28. The psychiatric records show the following entry for 7 March 2002:

    'DNA

    Patient had house fire and could of missed appointment because of this. Will contact CPN to review at home.'

29. On 13 March 2002 the psychiatric Senior House Officer (SHO) wrote to Ravensleigh Resource Unit Community Mental Health Team (CMHT), the local CMHT:

    'I would be grateful if you could co-ordinate a visit of some sort to this gentleman who the GP sent an urgent referral through on the 6 February 2002.

    This gentleman has been suicidal and tried to step out in front of a car, which he narrowly missed and although he had no particular plans to do this and had not written a note, he wished the car had hit him and is still contemplating further suicidal acts.

    He was known to the service in 1997 with a similar episode and suspected that his problems were due to his personality and alcohol misuse, but should be assessed regard to depressive illness and risk of serious self harm.

    He has DNA his appointment and I would appreciate if he could just see him in the community and see what you think.

    We may organise an appointment depending on what you think.'

30. On 15 March 2002 there was a home visit by CPN, who noted:

    'Evidence of smoke damage to house. Unsure whether [patient B] living there. Note left to contact team.'

31. On 21 May 2002 staff at the Ravensleigh Resource Centre wrote to the consultant psychiatrist:

    'Thank you for referring the above to our service.

    Unfortunately he did not attend his appointment and has not responded to letters asking him to contact us.

    Therefore he has been discharged unseen.'

32. The intended detoxification treatment did not take place.

On 31 April 2002 there was a referral by the GP to a consultant neurologist:

> *'Thank you for seeing this 26 year old man whom I discussed with you last week. He had been under the care of your predecessor back in 1999. He had suffered what sounded like two grand mal seizures in May of 1997 and again in early 1998. On both occasions he bit his tongue but there was no incontinence. He has a long history of intermittent alcohol abuse but at that time he had not been drinking. He had however been on Paroxetine for a depressive illness. At that time an EEC and CT scan were planned but unfortunately he did not attend for either of these. He remained well for around 2 years but unfortunately he returned again in February of this year having a relapse of his alcohol problem and depression. He has once again made a good recovery from this but three weeks ago he had a further fit. This was witnessed by his work colleagues and once again sounds to be tonic-clonic in nature. He was not taking Paroxetine or drinking at that time.*
>
> *Following our discussion last week I have commenced him on Epilim 200mg. t.d.s. and plan to review him with a view to increasing the dose. I have advised him with regard to his work and driving. I would be grateful for your help with re-arranging his investigations and reviewing him in clinic in due course'.*

32. On 27 May 2002 the neurologist wrote to the GP:

> *'Thank you for your letter about [patient B]'s recent history. I note that he saw my colleague in 1999 when he presented with possible epileptic seizures and these may or may not have been related to alcohol exposure or withdrawal.*
>
> *I gather he had a definite weakness grand mal fit in early May of this year. This was not in the context of not abusing alcohol.*
>
> *We agree you should place him on Epilim 200mg tds increasing thereafter to 500mg bd. He is not allowed to drive Until he has been free of fits for 12 months and he must not work as a Tree Surgeon because of the significant risk to himself and others and he must not operate large petrol lawnmowers though he can do other types of gardening activities which do not entail too much risk to him or others.*
>
> *I will write to the EEG and CT scan department to reactivate his investigations and meanwhile I wait to receive your referral letter. I will send for him to come and see me in the clinic in August'.*

33. Patient B attended for a MRI scan on 4 July 2002, which was normal, but defaulted on his follow up appointments on a number of occasions and was discharged back to his GP's care on 12 October. He was referred back to the neurologist on 13 January 2004.

2003

34. There was little contact with any health provider.

2004

35. On 13 January 2004 the GP made a referral to the neurologist:

    'This gentleman has been attending annual follow up with a history of fits. My understanding is that so far he has had a normal EEG and MRI scan, I believe [patient B] has an appointment to see you in the next few weeks.

    [patient B] has been to see us twice in the past 2 months after episodes which do sound epileptic in nature. The most recent episode at work, it was witnessed by work colleagues who described his movements being that of a fit, and he was drowsy after the event and had bit his tongue and felt very weak and achy for a number of days afterwards, Because of this episode and the previous one [patient B] has missed a considerable amount of work. He is no longer driving but does work on a building site and I have advised him that when he returns to work, he should only be engaged in ground level activity.
    I was considering at this stage whether initiating some therapy would be appropriate and I am grateful for your advice.'

36. There was no record of this resulting in a consultation.

37. On 30 September 2004 patient B attended his GP, together with his mother. He complained of symptoms suggestive of psychomotor retardation. He complained of poor sleep and spent most of his time in his bedroom. The GP requested the opinion of the consultant psychiatrist based at the Spenborough CMHT.

38. The referral letter to the consultant psychiatrist read:

    'Thank you for seeing this chap who came accompanied by his mother to see me today. He was referred to your service in February 2002 by Dr Cameron, my partner, as an urgent referral. At that time, he was depressed and also drinking excessively. He had several appointments sent to him but in fact I believe never saw yourselves, since he defaulted all his appointments. He has subsequently had several fits and the diagnosis was made of epilepsy rather than alcohol withdrawal fits. He has not been on anti-epileptic medication until I saw him today, since he had not collected prescriptions beyond the first repeat. I started him on Epilim 200 mgs tds today'.

    His mother, who did most of the talking during the consultation, described a situation where be had been increasingly reclusive, latterly spending most of his time in his bedroom. He had become increasingly apathetic, walked out of his job as a landscaper some 3 months ago after 4¾ years in the same job. He had also "packed his girlfriend in". He still sees her, however, from time to time. His mother's description of the situation was 'had a lovely girlfriend but can't be bothered".

    Increasing apathy, lack of interest in everyday things, even difficulty getting out of bed or making a cup of coffee, is the principal presentation of his problem.

His bedroom had become reduced to such a state that currently, the contents have been transferred to a skip by his mother
and sister. He suffers with poor sleep but denies any particular suicidal ideation.

His manner was not that of someone severely depressed in my opinion. He did not avoid eye contact, he did not show evidence of psychomotor retardation in his speech or body posture. His descriptions of recent life events were, if anything, rather matter of fact. He does not appear to have been weepy or guilty about recent events.

I was not sure about the extent of depression here but felt it more appropriate to seek a second opinion. In the interim, I have started him on the drug he was on previously, Paroxetine at 20 mgs daily and I am due to review him in some 3 weeks. I enquired regarding his current alcohol consumption and it would appear, mainly due to financial constraint, he has cut down on his alcohol consumption. Last week, for instance, he drank 8 cans of lager on a Saturday night which I estimate is approximately 14-16 units of alcohol but otherwise, did not drink.

I would be grateful for your further opinion and help here.

Current
03/11/93 Pain, anterior chest wall [D]
04/01/94 Trauma self-referral--blow bridge of nose
04/01/96 Unemployed
04/01/96 'Flu-like illness
15/04/99 Abdominal pain and heartburn
06/02/02 Depression NOS
22/05/02 Epilepsy
05/07/03 Impetigo
07/11/03 Did not attend - no reason
29/09/04 Medication review

Medication
29/09/04 PAROXETINE tablets 20mg take one daily
29/09/04 EPILIM EC tablets 200mg take one, 3 times/day

Sensitivities
None.'

39. Patient B was sent an outpatient appointment for 19 October. He cancelled his appointment at outpatients for 19 October and subsequently one for 23 November 2004.

40. In October 2004 patient B was claiming incapacity benefit. In November he attended his GP having run out of his medications. He had started to have a recurrence of his fits. The GP increased his Epilim to 600 mgms twice daily and continued the Paroxetine.

2005

41. Patient B then failed to attend an appointment on 11 January 2005. He was discharged and his GP informed that no further appointment would be given. That letter was sent on 31 January 2005.

42. On 24 February, patient B attended his GP. He reported that he was getting good and bad days and that he had fallen over after a possible epileptic fit. His Paroxetine was increased to 30 mgms daily.

43. On 16 March patient B's mother telephoned the surgery and discussed her concerns about her son. She stated that she was very concerned that her son had three fits the week before and that he was 'suicidal'. He had cut his wrists and had required 18 stitches. He was saying *'give me paracetamol; put a gun to my head'*. The GP spoke with him. patient B said that he was not depressed, that it was the fits that were concerning him, but that he still wanted to die.

44. The GP made an immediate referral for a mental health assessment by the Crisis and Home Treatment Team. It was agreed that he would be seen in the Accident and Emergency Department that day.

45. On 18 March 2005 the Crisis Team Charge Nurse wrote to the GP as follows:

> *'Following referral to A&E department on 16.03.05 by yourself, for mental health assessment; I assessed [patient B] and also had the opportunity to speak to his mother.*
>
> *[patient B] stated that he is upset and frustrated with having frequent fits. He said he has had 4 epileptic fits in the previous 4 days. He showed me a bite mark on his tongue which he said he sustained during a fit. [patient B] also said the injury on his arm (for which he received A&E treatment earlier that day) was also an injury sustained during an epileptic fit. He said, 'people keep telling me I am depressed but I do not feel depressed", [patient B] certainly presented as elated, in a nice way, and he was well focused on the account he was giving me. He maintained good eye contact and certainly did not present as depressed. He was sober, coherent and rational at the time.*
>
> *"I have not tried to commit suicide; don't let anybody tell you otherwise", he said. He denied having suicidal/self-harm ideas. [patient B] said he is drinking a lot (i.e. 8 - 12 pints of 'strong cider/day). He said the drinking helps him get rid of the boredom. [patient B] revealed to me that neither his mother nor his G.P. is aware that he uses cocaine. He said he is on £120 per week habit. He went on to say he sees alcohol as a problem, not cocaine. I tried to gently educate him on the probable impact of cocaine on his behaviour pattern but he was having none of that. He said he has been using drugs for a few years and if cocaine ever becomes a problem, he would stop using it there and then.*

Towards the end of the assessment I invited [patient B]'s mother to join us in the assessment room. She said she believed [patient B] was depressed and also expressed concern at [patient B]'s changeable behaviour. He apparently can swing his behaviour from being calm and gentlemanly to being agitated and at times looking very depressed. Unbeknown to [patient B]'s mother, the behaviour/mood pattern she described is typical of that of a drug user. The cocaine will give him periods when he feels high and agitated. Then when the drug wears out of his body system, his mood drops to a low when sometimes drug users feel suicidal. It is all part and parcel of the illicit drug use package.
I discussed this assessment with our Consultant Psychiatrist and he did say it is possible the impact of cocaine on the central nervous system is exacerbating the frequency of epileptic fits. There is not a lot our mental health services can offer [patient B] until such time he shows a readiness to get the drugs and alcohol problems sorted. He refused help with his drugs and alcoholic problems.

Plan:
Discharge him home.
Please note that [patient B] authorised me to discuss the drugs issue with you but he still does NOT want the drugs use information passed on to his mother.
Charge Nurse
Crisis and Home Treatment Team
Cc Batley Enterprise Centre, File.'

46. The charge nurse subsequently discussed the consultation with the consultant, both in a telephone conversation and in a meeting. No further action was considered necessary at that time.

47. Patient B telephoned his GP on 18 March. He reported his visit to A&E and his assessment by the Crisis and Home Treatment Team. He referred to his usage of cocaine, which gave him sudden changes of mood and made him agitated, but he did not see this as a problem. He said his mother was unaware of him taking cocaine. He also reported drinking 12-14 pints of strong cider each day which he did see as a problem, although he did not seem motivated to do anything about it. He denied feeling depressed and did not give the impression to his GP that he was depressed. He denied any intentions of self harm.

48. On 26 March patient B contacted the 24 hour helpline run by the Crisis and Home Treatment Team. The records state:

'Phoned to have a chat. Felt bored generally. Says his epileptiform fits are increasing and that he had MRI and EEG which have shown normal. He has a GP appointment on Wednesday and I advised him to ask the GP if it was possible to refer him to a neurologist about which he sounded pleased and says he is making a note in his book so that he does not forget. He says he wants to get to the bottom of his problems and get back to work.'

49. No further action resulted from this call.

50. Patient B attended his GP on 30 March. The records state:

'Continuing to have 1 fit/week. 'Up and down' re – depression. Thinks feels better with ↑ b.d. dose. Now just 'pissed off' with fits.
Has cut down on alcohol. Says hasn't drunk 12-14 pints for ages. Now just drinking socially 3x/week. States cocaine use was last year.
→↑ Epilim to 3 bd
Only taking 2 bd.'

51. He re-attended the GP on 13 April, accompanied by his mother. The records state:

'With mother: Mood swings 'concerning' frightened by this, can't tell night from day. Taped self into bedroom (didn't want anyone to come in). Other days is fine. Has 5 bad days to 2 good days. V. poor sleep. 'Tired' with epilim. Thinks he has been referred to psychiatrist and neurologist.
→re-refer consultant psychiatrist.
Long discussion, husband alcoholic – not [patient B]'s Dad.'

52. At this point it was the clear impression of the GP that the referral to the consultant psychiatrist by his partner in September 2004 had yet to result in an appointment. He thought that an additional letter to the consultant would add further clarity to consideration of the current clinical situation. For that reason he wrote to the psychiatrist two days later as follows:

'15 April 2005
This 29 year old man has recently been in contact with the Crisis team who have in turn liaised with yourself When he was seen by the Charge Nurse last month, it appeared that his problems all seemed to be related to alcohol (8-12 pints of strong cider per day) and recreational drug use (Cocaine £120 per week). Saw him 2 weeks following this contact when his main problems seemed to be his continuing epileptic fits and he was having I per week and he felt that this was having the most significant affect on his mood, which he described as being 'up and down'. I challenged him with regard to his alcohol and cocaine use and he said that he had been drinking heavily for a long time, stating that he now only drinks socially around 3 times per week. With regard to his cocaine habit, he states that this is also in the past and he hasn't used anything for months.

I therefore increased his Epilim and then agreed to review him in 2 weeks.

This week he has attended with his mother who remains extremely concerned about him. He continues to have fluctuating mood swings and at times she is quite frightened by him. He is often disorientated in time and doesn't know whether it is day or night, let alone what day is. He has displayed some bizarre behaviour, including taping his door up with duck tape in order to keep people out.
There are other days when she describes his behaviour as normal, but these only occur on average, 2 out of every 7.

Both he and his mother seem to think you are planning to see him again, though this was not clear in the letter we received from the Crisis Team Charge Nurse. I would, however, be grateful if you could see him in the near future.'

53. On 15 April, patient B was admitted to Dewsbury District General Hospital under the care of a consultant physician. The discharge letter to the GP states:

    'Admitted 15/4/05, discharged 16/4/05 Epileptic fit
    Known epileptic – has been on Epilim
    Excess alcohol intake
    Depressive illness
    MCV raised at 106
    Drinking 15 pints of cider a day but recently cut down to one and a half cans of lager. With this in mind we treated him with Chlordiazepoxide, thiamine and Pabrinex.
    No follow up was arranged.'

54. By this time referrals to the consultant psychiatric service were being dealt with differently by the Community Mental Health Team (CMHT). Previously, letters written directly to the consultant were dealt with by the consultant and resulted in an outpatient appointment. The change meant that referral letters to the consultant were brought to an allocation meeting of the CMHT. Following discussion, the referral would be directed to the service felt to be most appropriate for the patient's needs. Unfortunately, this information concerning the changed procedures had not been communicated to the GPs who would be referring patients.

55. The CMHT allocation meeting on 20 April considered the GP referral. The team note reads:

    '20 April 2005. Discussed in referral meeting on 20 April. Referred to Way Ahead. Letter sent to GP'

56. Both the CMHT Team Leader and the consultant's secretary had intended to write to the GP to inform him of the referral. In the event neither did so and the GP remained unaware that the referral to Way Ahead had been made until he was interviewed as part of the Independent Inquiry. He had previously been interviewed as part of the internal review process.

57. The GP was well aware of the services offered by Way Ahead and had previously referred patients for those services. He stated to the Independent Inquiry that he would have also done so with patient B had that been the most pressing consideration. However, he was of the opinion that his patient required examination and assessment by a consultant psychiatrist; hence the referral to the CMHT.

58. Way Ahead is a voluntary sector service in Dewsbury. It is a part of the national charitable organisation,

59. Lifeline, which provides services to alcohol and substance misusers, amongst others. It has a contract with the Kirklees Drug and Alcohol Team to provide services for people with drug problems. It also provides the 'Outlook' service which assists with daily living and the Way Ahead counselling service.

60. The CMHT Team Leader wrote to Way Ahead the same day on a proforma referral form and the form was faxed to them. Although the letter was dated 14 October 2004, it is clear that it was faxed and received on 20 April 2005. It stated that patient B had been signposted by the CMHT to the triage service at Way Ahead and enclosed a copy of the GP's letter of referral to the consultant. There was no documented risk assessment of patient B by the CMHT. It is the opinion of the independent inquiry that this was an omission.

61. Way Ahead wrote to patient B inviting him to one of their drop-in sessions for an assessment.

62. Patient B attended his GP on 22 April. The case entry states:

'Admitted last week following fit 'on a drip'. Related to alcohol withdrawal. Further fit yesterday. Denies excess alcohol or sudden change in consumption. No change to epileptic meds.
→↑ epilim to 900 mgm bd over 3/7.
Med 4 Dep/epilepsy
Long standing essential tremor Several family members
ISQ prev. Hx of agitation
→try propranolol 40 tds 84 Worried re-breathing.'

63. On 27 April patient B attended the Way Ahead drop-in service for an assessment visit.

Contact by patient B with Way Ahead

64. Way Ahead provided the following report for the internal review which is confirmed by their records:

'[patient B] attended for an assessment on the 27th of April. An initial assessment took place in which he disclosed that previously he had been drinking alcohol heavily but more recently he had reduced this to a couple of cans of lager a day. He also stated that he took cocaine half a gram occasionally but did not feel this was a problem. [patient B] did not want support to address his cocaine use but requested support around his alcohol use. He informed us that he was waiting for an assessment to take place through outpatients at the Priestley Unit and that he was on medication to manage epilepsy.

[patient B] informed us that he was presently living with his mum but would like to live independently. Support to address his housing was offered but he declined this and stated his mum would support him to fill out applications. From the assessment the following action was agreed:

Referral to Lifeline's alcohol advice and information group
Referral to Outlook to address lack of daily structure
Referral to Way Ahead counselling service

Outcome

[patient B] was invited to attend the alcohol group starting 19.5.05, he did not attend this session, but following a reminder letter he contacted the service to arrange to attend week two. [patient B] failed to attend and [the case] was closed.

An appointment was made for an Outlook induction on the 12th May 05, [patient B] contacted us on the 12 May requesting for this to be rearranged. The induction was rearranged for 20 May 05 and [patient B] failed to attend this appointment and did not make contact with us.

[patient B] never attended the counselling drop-in which is our first point of access re: this service.

As per our procedures we had planned to contact [patient B] six weeks after his initial assessment to review how things were going. This would have taken place on the 8th of June however we were informed on the 6th June that [patient B] had been charged and placed on remand for murder. We have had no further contact from [patient B].'

65. A risk assessment had been carried out at the time of the initial assessment on 27 April. The risk of self harm was assessed as high; the risk of harm to others as low.

66. Two follow up letters were sent to patient B to encourage him to attend. There is no record of any follow up telephone call to him.

67. Patient B was asked to sign a confidentiality agreement at Way Ahead on 27 April. The purpose of the agreement is apparently to enable the client to limit the passing of information to other agencies or individuals. patient B did not indicate any limitations to information being distributed within the service, but did not give an explicit statement of his agreement to information sharing with stipulated others. The service did not inform the GP that he had attended.

68. On 18 May, patient B attended his GP with his mother. The entry states:

    '?due psych referral ↑ paranoid – not sleeping. Convinced friend trying to break into house. Running and in garden with knives. Given sister's sleeping tablets → IMIs
    → nitrazepam 5 mgm 28 1-2 every third night
    2. Bitten tongue →infected
    → amoxicillin 250 15.'

69. At this stage the GP, patient B and his mother were clearly still under the impression that patient B was expecting to be seen by the consultant in outpatients.

70. The GP suggested to his mother that she pursue this directly with the consultant. This was the last contact with the GP.

71. Patient B's mother informed the Independent Inquiry that she telephoned the consultant's secretary on a number of occasions to chase up the appointment with the consultant. Her son was reluctant to attend the hospital because he perceived that there was a stigma attached to his mental illness. For this reason she thought that the consultant would visit patient B at home. That recollection is shared by patient B and by his sister.

72. His sister informed the Independent Inquiry that she had telephoned the Priestley Unit one weekend during this period and offered to bring her brother to the unit. He was willing to be admitted as an informal patient. She was apparently told that access to the service would have to be via the consultant. At interview by the Independent Inquiry, patient B's mother stated that the reason for contacting the consultant's secretary was that she was exasperated with the lack of progress towards an appointment, rather than reflecting her desperation about her son's condition.

73. Unfortunately there is no policy for the recording and retention of telephone messages at the Priestley Unit, even when those conversations may contain relevant clinical information. Therefore the Independent Inquiry could not corroborate either version of events.

74. None of the secretaries, or the consultant was able to recall these conversations or arrangements. There are no written records retained. The Independent Inquiry has no reason to doubt the sincerity of the recollections of events by the patient, his mother and sister. Patient B's mother is clear that she was expecting the visit on 2 June 2005.

75. On 3 June 2005, patient B was arrested for the murder of his step-father at the family home.

4.0 Analysis of care and treatment

76. The care and treatment of patient B in 2005 took place at a time of considerable organisational change in mental health services. There were two particular initiatives which had a very significant impact across the NHS in general and in the South West Yorkshire Mental Health NHS Trust (SWYMHT). These were *'Agenda for Change'* and *'New Ways of Working for Psychiatrists'.*

77. *'Agenda for Change'* was a new pay and reform package that is designed to ensure that NHS employees are paid on the basis of equal pay for work of equal value. It applies to all directly employed NHS staff, except the most senior managers and those covered by the Doctors' and Dentists' Pay Review body. The implementation of the package necessarily meant that all relevant posts had to be evaluated to ensure that correct reward bandings were implemented.

78. In the first half of 2005 all NHS services were dealing with the implications of implementing the new reward system.

79. *'New Ways of Working for Psychiatrists'* is a joint initiative by the Department of Health, Royal College of Psychiatrists and the National Institute for Mental Health in England to promote the development of expertise and flexible working practices by psychiatrists and others involved in the care of people with mental illness. An interim report was first published in August 2004 and the final report published on 31 October 2005. The implementation of this initiative is a continuing process. It is likely that working practices will continue to evolve, together with the need for all stakeholders to be aware of the service provision available.

80. This meant that during the time of patient B's involvement with services, the NHS services were implementing these processes. Also, financial constraints at the South West Yorkshire Mental Health NHS Trust meant that the acting manager of the Spenborough Community Mental Health Team exercised restraint with the allocated budget. At interview she stated that she thought that a vacancy freeze had been imposed on the service. This was disputed by the manager of the service, although the temporary effects of implementing 'Agenda for Change' meant that a number of posts were classed as 'acting'. This meant that appointments to permanent or substantive posts could not take place at that time.

81. When the manager of the CMHT was appointed in June 2004 in an acting capacity, she also continued to carry a caseload of nine or ten patients with complex needs who were on enhanced Care Programme Approach (CPA) care pathway.

It is recognised that a full time case load of similar patients would be 15 patients. Her managerial time was therefore limited.

82. The team at full strength comprised four qualified staff, two CPNs, two social workers and two unqualified staff. At the time the team was short of one qualified worker who would have been a primary care co-worker.

83. This meant that the team was clearly under pressure to cope with the existing workload. In October 2004 the acting manager wrote to local GPs to inform them of the situation and asking them, where possible, to limit referrals to the team.

84. In addition, to help deal with the workload, the team decided to act as a 'signpost' for referrals and to pass them on to what they considered to be appropriate agencies where they did not provide the service themselves or did not have the capacity to assess them. This change was not notified to GPs at the time.

85. It has not been possible to identify the precise date this new process started, although it does appear to have been in early 2005. It was certainly in place by the time of patient B's referral in April 2005.

86. The changes to local working practices suggested by *'New Ways of Working for Psychiatrists'* included two significant developments. The first was to have one psychiatrist acting as the sole responsible psychiatrist for in-patient beds. This was a change from the former practice of consultant psychiatrists who had both community and inpatient responsibilities. The second change was from referrals by GPs made to either the CMHT or the consultant psychiatrist being replaced by one of referrals solely to the CMHT. The future care of patients referred under the new system is discussed by the CMHT at an allocation meeting which includes the consultant psychiatrist. An advantage of this system is that referrals are examined on a daily basis to ensure that urgent referrals are dealt with in a timely fashion.

87. In order to implement these changes it had been decided by the Trust to reduce the four previous CMHTs in North Kirklees to three, with one consultant taking responsibility for inpatients. The catchment areas of GP surgeries were then to be adjusted. Each CMHT had its own consultant and the CMHT staff redistributed to reflect the changed catchment areas.

88. The method by which CMHTs in North Kirklees dealt with referrals by GPs had evolved at different rates within the four teams. +In Batley, the consultant had written to GPs in October 2002 requesting that all referrals be made to the CMHT and that urgent and emergency referrals would initially be dealt with by the CMHT.

89. On 11 May 2005, the Trust's Medical Director and Director of Performance, Information and Professional Development wrote to GPs. The letter included:

> '*In line with National good practice, South West Yorkshire Mental Health NHS Trust is advocating to work within the' New Ways of Working for Psychiatrists' as supported by the Royal College of Psychiatrists, NIMHE and the DoH. This approach supports the improvement in working practices and workload of General Adult Psychiatrists. We feel that this will improve the recruitment and retention of psychiatrists and thus support the continuity of care of patients and reduce the cost and reliance on agency consultants. Where this approach has been implemented in other Trust it has also resulted in improved communication and response to primary care, and improved patient satisfaction.*
>
> *In order to support this approach, we need to develop a single point of access into secondary care, with consultants being an integral member of the Community Mental Health Team and acting in an advisory and consultancy capacity to the rest of the team. Many CMHT's are already working in this way, this will standardise good practice across all teams within the Trust, in line with what is considered good practice nationally.*
> *From 1 July 2005 we would request that all referrals previously made to consultant psychiatrists should be made to the relevant Community Mental Health Team. However, you will still be able to telephone the consultant directly for advice and guidance. This should not effect any existing urgent response arrangements.'*

90. On 28 July 2005, one consultant wrote to his colleagues, medical secretaries and the CMHTs to remind them to pass any urgent requests for domiciliary visits to the appropriate CMHT as *'they are the first port of call for all such communications'*.

91. On 3 August 2005, the General Manager wrote to the GPs in North Kirklees. The letter was accompanied by supporting documents on the single point of access, questions for referrals and lists of the GP practices served by each CMHT. His letter stated:

> *'There are some important changes taking place in the North Kirklees Adult Mental Health Services.*
> *As from the 1 August 2005, there will be 3 Community Mental Health Teams, Dewsbury, Spenborough and Batley. (See enclosed)*
> *In line with New Ways of Working' for Psychiatrists we are adopting a Single Point of Access. We are re-organizing the services to develop easier access and be able to provide dedicated resource within the sector.*
> *During office hours Mon- Fri all referrals including Domiciliary Visits will be via the Sector Community Mental Health Team. Out of hours access to Service is via Crisis and Home Treatment Team.*
> *Please find a referral flowchart, a list of questions to help us inform our prioritization of referrals, a list of GP Practices within the Sector and the Community Mental Health Team structure.*

We would like to visit your Practice to talk in more detail about the process and canvass your views. We will attempt to ensure that any disruption to services is kept to an absolute minimum. Thank you.'

92. It was therefore reasonable for patient B's GP to expect his referral to the consultant in April 2005 to result in an outpatient appointment for patient B. His advice to the mother of patient B at the time of her visit to the surgery on 18 May to contact the psychiatrist to expedite that appointment was also reasonable.

93. As the continuing changes resulting from *'New Ways of Working for Psychiatrists'* and other initiatives continue to affect the ways in which services are provided, it is essential that all stakeholders are made aware of the changes in a timely fashion.

5.0 Analysis of action taken in response to internal review recommendations

94. Following the homicide, the Trust carried out an internal review. The review did not include contact with the family. It is appreciated that police inquiries may well prevent detailed discussions with the family. However, it does not preclude contact to establish whether the family requires support. The report and action plan were subsequently signed off by the Trust Director of Clinical Risk. Staff involved in the review did not see the report prior to publication to comment on accuracy, nor was a copy provided to patient B's mother.

95. At the conclusion of the internal review seven points were incorporated into an action plan. These were as follows:

Recommendations	Action to be taken In internal report	Intended Completion date	***Independent Inquiry Comments***
1. Address feedback mechanisms within Mental Health Services. Ensure robust arrangements are in place whereby referrers are made aware of the route their request is taking.	Discussions to take place at Local Delivery Group to review process for communicating assessments and interventions	September 2005	***This has been implemented with the standard that referrers are aware of the route of their referral request.*** ***It should be the subject of clinical audit***
2. Staff to ensure that referrals are not delayed unnecessarily.	Referral protocols re-discussed at team business meetings	August 2005	***The single point of access system of referrals to the CMHTs means that referrals are seen and assessed on the day of receipt.***
3. Out Patient clinics may need to revisit the 'DNA' Protocol.	Agenda for the Division of Psychiatry and Outpatients Department Continuous Improvement Team	December 2005	***The Medical Director has produced a revised policy for patients who default on their outpatient appointments. However, it does not cover referral did not attend's (DNAs).***

4. Crisis Home Treatment Team and A&E to discuss the need for drug screening, blood tests and breathalysing. This can only be done on an individual basis, yet does need discussing as a possible assessment tool.	Agenda and discuss at A&E liaison meeting	September 2005	***This is a statement of the current policy.***
5. Services will not use Outpatients Department as a Risk Management Strategy but where necessary agree an outcome in a Multi Disciplinary Process.	.Establish a project team review for outpatients dept.	December 2005	***This has been implemented.***
6. IT department and Managers to explore the implementation of a service wide system for information input, storage and analysis.	Ongoing procurement of Clinical Information System	December 2005	***The Trust is implementing an organisation wide electronic record system 'RiO' which should address this recommendation.***
7. Any inconsistencies in information needs highlighting and sharing accordingly on a need to know basis.	Information sharing protocol in place	Ongoing	

96. The Trust is developing and implementing care pathways for patients with mental illness. This is a welcome and commended development which will improve the match of the patients' needs with the appropriate skill-mix of staff in the CMHTs.

97. The purpose of an internal review and root cause analysis should be to ensure that lessons are appropriately learned and implemented in a timely fashion. The Trust policy was that recommendations should be in a SMART format (specific, measurable, achievable, resource identified and timely) to aid implementation and the monitoring of implementation.

The Trust policy did not provide for the incident to be reported to the Trust Board, nor for the investigation and follow-up action to be monitored at that level.

98. The Trust has subsequently carried out its own review of how it responds to serious untoward incidents. At its meeting on 11 May 2006, the SWYMHT Risk and Governance Committee received the following report from the Director of Risk and Governance:

'North Kirklees

> *As a result of the review of Serious and Untoward Incidents in North Kirklees, it has become clear that further work is needed urgently on the culture in the locality, which, through historical leadership styles, has enabled an old institutional style of practice to continue. This had led to practitioner's inability to understand their responsibility and accountability crucially in delivering the policies and procedures of the Trust. A five-point framework will be put in place led by one of the Assistant Directors concentrating on implementation of policies and procedures and providing a clear management and leadership framework.'*

100. A revised Untoward Incident Management policy clearly stipulating roles and responsibilities as well as timescales was formally adopted by the SWYMHT Board in April 2007. The Trust's policy has now been amended and formally adopted by the Trust Board to remedy the shortcomings identified. Follow up mechanisms have been put in place to ensure that time limits for carrying out a root cause analysis are reviewed and implemented.

101. The Independent Inquiry is satisfied that the statutory Trust Board obligations and accountability will be met if the new procedures are followed.

6.0 Conclusions: summary of sections 4 and 5

Commentary points from the terms of reference
To identify:

- ***The care the service user was receiving at the time of the incident (including that from non-NHS providers e.g. voluntary/private sector)***

99. The care provided to patient B is detailed in section 4 of this report.

100. ***The suitability of that care in view of the service user's history and assessed health and social care needs***

101. Patient B showed no willingness to engage with services, other than to turn up for an assessment visit to Way Ahead on 27 April 2005. He did not see his use of cocaine as a problem. He very lately began to see his high alcohol usage as a problem, but still chose to disengage from services. The care offered towards the end of the period under review was not suitable for his condition.

102. ***The extent to which that care corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies***

103. The statutory obligation for the Trust in this case was to provide the most appropriate care for its patient. Patient B had been referred to the consultant psychiatrist. The case was considered by the CMHT and the patient referred on to Way Ahead. In doing so the Trust complied with its local operational policies. Patient B was not subject to the Care Programme Approach as he was not technically a patient of the service. The use of the Mental Health Act 1983 to detain or treat a patient is specifically excluded when the patient has mental illness secondary to substance and alcohol misuse[1]. Whilst the Trust complied with its own operational policies obligation, to provide the most appropriate care for this individual, was overlooked.

104. ***The adequacy of the risk assessment and care plan and their use in practice***

105. The referral by the CMHT on to the Way Ahead service was carried out without any adequate risk assessment of the patient. The risk assessment at Way Ahead was appropriate.

[1] Mental Health Act 1983, Part 1 Section 1(3).

106. ***The exercise of professional judgement and clinical decision making***

107. The Trust staff did not put themselves in the position to exercise clinical judgement and took no action other than to refer patient B to a voluntary sector provider. This was despite the GP referral letter expressly stating that he wanted a consultant opinion about his patient.

108. ***The interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical health needs, with particular reference to referral and discharge processes***

109. The Trust failed to inform the GP of the referral to Way Ahead. Way Ahead also failed to inform the GP of the referral. Way Ahead subsequently closed the case, as far as their alcohol service was concerned, but did not inform either the GP or Trust at that time. Way Ahead was intending to follow up patient B, but the date for this was after the homicide.

110. ***Learning points for improving systems and services***

111. Patient B had a long history of a reluctance to engage with services. Those services in both the statutory and voluntary sectors had a policy of discontinuing attempts to engage after two failed appointments. Bamford et al[2] reported a significant increase in attendance in a service where the follow up for appointments comprised two letters and (if these failed) a telephone call.

Recommendation:

The Trust should review methods of reducing DNA rates of both new and follow up patients.

112. The introduction of the modified pattern of working by the CMHTs left the referring GPs in a position where they did not have the information necessary to provide an efficient service for their patients. The future changes in practice which will be necessary to implement 'New Ways of Working for Psychiatrists' need the involvement of stakeholders and clear, timely and accurate information to all involved.

Recommendation:

Future changes in the configuration and process of services should be communicated to stakeholders in a timely fashion.

Recommendation:

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[2] Bamford et al. Maximising patient follow-up after alcohol treatment: the effect of a three-step reminding system on response rates. *J. Subst. Use* 2004, 9, p36-43

The Trust should ensure that all newly appointed managers are provided with sufficient support and training.

113. The failure by the CMHT to inform the GP of the referral to Way Ahead contributed to his understanding that an outpatient appointment for his patient was still awaited in May 2005. The lack of a confirmatory letter from Way Ahead to the GP was equally important in contributing to this misunderstanding.

Recommendation:

The Trust should conduct a clinical audit of compliance with minimum standards for communication with referrers which ensures they are aware of the disposal of referrals.

114. Despite the high likelihood of dual pathology with substance misuse and mental illness, there is very little formal contact between the agencies involved in Kirklees and no joint training. This means that the opportunity for understanding each other's roles and range of services provided is limited.

115. A meeting of the Kirklees Dual Diagnosis Steering Group recognised this at a meeting in January 2007 when it was minuted:

> *'…improvements could be made with extra training for staff. It was agreed that roles within Lifeline, Mental Health and SWYT need to be clearer.'*

116. The Independent Inquiry agrees with that view. SWYMHT covers a number of different Drug and Alcohol Action Team (DAAT) areas. In the absence of an overall dual diagnosis strategy for the Trust and other agencies involved in the care of patients with a dual diagnosis, there is a significant risk of a fragmentation of approach and to miss opportunities to develop best practice across a wider area than those served by individual DAATs.

Recommendation:

The PCT and partnership agencies should develop mutually agreed a strategy to oversee the development of dual diagnosis services. This should be performance managed by the Strategic Health Authority.

117. The strategy needs to address a number of specific intended objectives. These can be summarised as follow:

- To produce an agreed locally accepted definition of the term dual diagnosis;

- To establish clear care pathways for clients who can be classified as dually diagnosed in accordance with the locally agreed definition;

- To develop a health community wide training strategy in accordance with the proposed Dual Diagnosis Trust-wide training strategy;

- To highlight and clarify the function and scope of existing service provision;

- To develop an action plan for implementation of recommendations within this strategy.

Recommendation:

The Trust should appoint a 'local champion' to lead on the implementation of a jointly agreed strategy.

118. The lack of a policy to retain records of conversations with carers or patients, outside of entries made in clinical records; means that unnecessary uncertainties of recollection of events are built into working processes. It has also made the reconstruction of events impossible to achieve.

119. The records management guidance: *NHS code of practice, Parts 1 and 2*, became effective from 5 April 2006. Although diaries are not specifically mentioned, the guidance does refer to day books and recommends the period for retention should be two years after the calendar year to which the book refers.

Recommendation:

The Trust should develop and implement a policy for the safe retention of records, including diary and message books.

120. The Trust did not include a representative from the PCT as part of its internal review. This was an unusual omission in view of the fact that the PCT, through the DAAT, also commission the services of Way Ahead.

Recommendation:

A representative of service commissioners should be invited to attend post incident reviews carried out by provider organisations.

121. In drawing up its action plan at the conclusion of the internal review, the Trust failed to follow its own policy to make recommendations subject to SMART criteria, i.e. that the recommendations are specific, measurable, achievable, realistic and timely.

Recommendation:

The Trust should ensure that it implements and monitors its current Incident Management Policy to ensure clarity of goals and processes to be followed, including the adoption of SMART criteria for the recommendations of any future internal reviews.

An audit of the policy should be done on an annual basis to review how the policy is working in practice.

122. During the internal review process the Trust did not ensure that members of staff taking part in the review had the opportunity of examining the draft report for accuracy. This meant that the opportunity of ascertaining the GP's expectation of his patient attending an outpatient appointment was lost. This central learning point was therefore omitted from the internal review report.

Recommendation:

When undertaking an internal review, all staff involved should be identified, the extent of their involvement clarified and they should be given the opportunity to comment on that involvement prior to the publication of the report.

123. Unfortunately, the Trust did not include the mother of patient B in its internal review. This is regrettable on two counts. Patient B's mother needed help and support. Additionally, the Trust lost the opportunity of learning of her contacts with the service in respect of her son's out-patient appointment. It is appreciated that the ongoing police investigation may have prevented contact at the time to discuss the matter in detail, but this would not have prevented contact with an offer of support. The failure to contact her after the conclusion of the court process meant that the opportunity of learning of her contact with services was lost until the Independent Inquiry.

Recommendation:

The Trust should ensure that the family of patients involved in serious incidents are contacted to establish their possible care and support requirements.

124. ***Developments in services since the user's engagement with mental health services and action taken since the incident***

125. Since this incident the Trusts Assertive Outreach Team has become operational. The Trust recognises the need for a more assertive approach for patients with problems and presentations similar to those of patient B and together with the PCT is looking at ways of using their resources for this. This is to be commended.

7.0 Summary of Independent Inquiry recommendations

1.0 Involvement and support for Carers

The Trust should ensure that the family of patients involved in serious incidents are contacted to establish their possible care and support requirements

2.0 Service Delivery

2.1 Overall Dual Diagnosis Strategy

The PCT and partnership agencies should develop mutually agreed strategy to oversee the development of dual diagnosis services including information sharing .

2.2 The Trust should appoint a 'local champion' to lead on the implementation of a jointly agreed strategy .

2.3 Do Not Attend (DNA) for services

The Trust should review methods of reducing DNA rates of both new and follow up patients.

2.4 Future Service reconfigurations

Future changes in the configuration and process of services should be communicated to stakeholders in a timely fashion.

2.5 Record retention

The Trust should develop and implement a policy for the safe retention of records, including diary and message books .

3.0 Skills sharing

3.1 The statutory and voluntary sector agencies in Kirklees should develop and implement joint training in dual diagnosis for staff which must be financially supported by the Primary Care Trust and partnership agencies.

3.2 The Trust should ensure that newly appointed managers are given appropriate support and development.

4.0 Information Sharing

4.1 The Trust should conduct a clinical audit of compliance with minimum standards for communication with referrers which ensures they are aware of the disposal of referrals.

Appendix 1 - Job titles of persons interviewed

Patient B
Patient B's mother
Patient B's sister

Consultant Psychiatrist – NHS
Consultant's secretary
General Practitioner September 2004
General Practitioner 2005

Medical Director SWYMHT
Assistant Director Adult Services SWYMHT
Locality General Manager, North Kirklees, 2005 SWYMHT
CPA Manager, SWYMHT
Team Leader, Way Ahead
Charge Nurse, Crisis and Home Treatment Team
Senior Commissioning and Partnership Manager, Kirklees Drugs and Alcohol Team
Programme Development Manager, Kirklees Drugs and Alcohol Team
Acting CMHT Manager, at the time of the incident
Current CMHT Manager

Appendix 2 - Documentation reviewed in the preparation of this report

GP Records
Dewsbury Mental Health Records
Way Ahead Records

Health of the Nation Outcome Scores plus, developed by SWYMHT

South West Yorkshire Mental Health Trust (SWYMHT) SUI log for incident 2005/2100
Generic Cost Saving Measures/Changes to devolved budgetary authority issued by SWYMHT Director of Finance August 2003
Framework for the Management of Substance Misuse on Psychiatric Inpatient Wards issued November 2006
Models of Care for Alcohol Misusers, DH/National Treatment Agency for Substance Misuse June 2006
SWYMHT Risk Management Strategy 29 January 2004
SWYMHT Management Briefing Report for incidents
SWYMHT Guidance for Manager – Approving Adverse Event Report Forms
SWYMHT Basic Package of Care Version 2 July 2004
SWYMHT Policy for Lone Working December 2004
North Kirklees (Adult Mental Health Services) Relapse Prevention Pathway August 2006
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Kirklees Care Programme Approach December 2003
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Terms of Reference SWYMHT Strategic Risk and Governance Committee revised January 2007 Approved by SWYMHT Board 27 January 2007
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Kirklees Dual Diagnosis Steering Group, Minutes of meeting, 16th January 2007
Standards for Better Health – Lifeline Services 2007 – Draft 3

Appendix 3 - The authors

Dr Geoff Roberts

Dr Geoff Roberts was Medical Director for three mental health NHS Trusts between 1994 and 2004 and Director of Mental Health Services 1994 -1998.

He undertakes HSG 94 (27) inquiries and reviews and is an expert adviser to the National Centre for Policing Excellence. He currently acts as expert adviser to a number of HM Coroners for mental health associated deaths. He is lead examiner for the health sector for the Institute of Risk Management and Honorary Senior Lecturer in Risk Management and Governance at the University of Central Lancashire.

As a Lead Commissioner for the Mental Health Act Commission, he undertook over 100 reviews of the deaths of patients subject to detention under the Mental Health Act for the Commission. He also acts as investigating officer for a number of Primary Care Trusts advising on the suitability and efficiency for the retention or removal of medical staff in respect of Performers Lists.

Dr Roberts is a serving Assistant Deputy Coroner for Cheshire.

Ms Ann Gorry

Ms Ann Gorry is the joint lead for the Care Services Improvement Partnership (CSIP) Dual Diagnosis National Programme. This is a standalone programme within the National Institute of Mental Health in England (NIMHE) stream of CSIP. This role leads on the implementation of national policy recommendations set out in the key documents, by developing a National Programme for Dual Diagnosis to help service providers develop more effective services, and to improve the service user’s and carer’s journey.

She has helped develop and pilot a Dual Diagnosis Training Programme for Assertive Outreach Teams across the country. Her role includes raising the profile of Dual Diagnosis across DH work programmes, in particular Criminal Justice, Acute Care and Primary Care.

She works alongside key partners, in particular the Home Office and the National Treatment Agency to develop projects to improve services for people experiencing mental health difficulties in substance misuse services and within the criminal justice system.