REPORT OF THE INDEPENDENT INQUIRY

REFERENCE SUI 2005/3404

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

Acknowledgements

The author thanks the staff at the South West Yorkshire Mental Health Trust involved in this review for their assistance and very open approach. In particular, Joanna Vickerman and Ros Taylor for their help in co-ordinating the collection of evidence and arranging interviews. A consistently recurring theme in the review was the caring attitude and professionalism demonstrated by all those involved.

The author also gives his condolences to the victims and their families and to the mother of patient F. The author is grateful for the input of the late patient F and his mother.

Table of Contents

1.0 Executive summary

1 The Department of Health issued guidance in May 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 F was arrested on a charge of murder and two charges of attempted murder in September 2005. He was subsequently convicted of murder and two charges of causing actual bodily harm. The day prior to the murder, he had been convicted of assault against the father of the murder victim and was bailed pending sentence.

4 Patient F started to receive mental health services based at Dewsbury in 1992. In a period between 1992 and 1994 he was under the care of mental health services at Leeds. He received a course of seven treatments of electro-convulsive therapy (ECT) in January 1993.

5 Patient F transferred back to treatment at Dewsbury in 1994. This continued until the homicide, with the exception of a period from 1999 to 2001.

6 Patient F's psychiatric condition was complex, but was based around personality difficulties and depression. At various times he had received labels of various personality disorders, but the mainstay of his treatment had been for depression. He was compliant with his treatment to a varying extent and continuously tried to minimise his dosage. However he was still able to run his own successful business, as a motor mechanic. His treatment was prescribed by his GP on the recommendation of the consultant.

7 Patient F underwent an assessment by a private consultant psychiatrist in January 2003 at the request of his GP. He also underwent a course of brief cognitive behavioural therapy (CBT) from a private psychologist from November 2004 to February 2005. This latter treatment only came to light during the Independent Inquiry. The NHS consultant had not been informed of either intervention, nor did the patient inform him of his impending Court appearance in September when he was seen in outpatients in August 2005.

8 The murder was committed whilst Patient F was on bail. A contemporaneous newspaper report also referred to a physical assault in the same context in November 2004 and a long running dispute between Patient F and his victims. Following his conviction, Patient F was sent to HMP Armley, Leeds where he was found hanged in his cell on 22 February 2007.

9 Following the homicide in September 2005, the Trust carried out an internal review using root cause analysis. The review was neither timely nor thorough. It eventually reported in June 2006. The report recommendations, although laudably directed towards service improvement, were not directly related to nor flowed from the facts of the case. The Trust Board has subsequently amended its policies on internal review of serious incidents and the Independent Inquiry has recommended that these be monitored.

10 It is the opinion of the Independent Inquiry that this homicide could not have been predicted or prevented by the mental health services in Dewsbury, the GP or the private providers involved. The treatment provided reflected the standards of the day. Mental health considerations did not form part of the court disposal after the trial.

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 Primary Care Trust 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 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

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 16 June 1971

11 Patient F had an early history of recurrent otitis media *(inflammation of the middle ear)*. He was referred to the Ear, Nose and Throat surgeon in 1973 and had a bilateral myringotomy *(insertion of grommets)* with aspiration of fluid at Bradford Royal infirmary in 1974. He was reviewed in outpatients until he was discharged in 1983. This was a significant event to him and he continued to be troubled with tinnitus and deafness throughout his life.

1992

12 The presentation of patient F's psychiatric history started in March 1992. He was seen at home by a locum consultant psychiatrist from Dewsbury at the request of his GP on 2 April. The consultant's letter to the GP helps to set out the picture at that time. It states:

> *'I saw him in his home and found he was very depressed and withdrawn. Basically he is quite a shy sensitive person but with a good ability to work. He has left 6 jobs in the last 4 years. He has been suffering from depression on and off for more than 4 years and this has been the main cause of his instability at work. He easily becomes fed up with the sameness and gives up. He is a man of average intelligence. Although he didn't get any 'O' levels, he has City and Guilds in motor mechanics. His last job was a panel beater. He has also lost girlfriends as he finds fault with them and asks about previous boyfriends and so on. He knows he drove them away. His last girlfriend left him in November 1991 but still keeps in contact with him.*
>
> *He has a strong family history of psychiatric problems…… his father was brought up in a children's home and cannot forget the misery of it. After frequent arguments, his parents' marriage broke down nine months ago and since then the patient's condition has gone downhill. He has become depressed with sleep disturbance, lack of appetite, loss of weight with aggressive and violent outbursts. He is irritable inside himself and wants to smash things at home. He has no friends and according to his mother, stayed at home doing nothing but sit in a darkened room with the curtains drawn. He feels he does not belong anywhere.*
>
> *I offered him a bed in hospital and after initial hesitation he agreed to come in but later in the evening changed his mind and wanted treatment on an outpatient basis.'*

13 A follow up letter in April 1992 noted that it was apparent, after talking to his father, that patient F had a personality disorder and he did not trust anyone.

He had aggressive potential; 18 months previously he had hit another car driver without apparent reason.

His father stated that from the age of four patient F had shown antagonistic behaviour and did everything opposite to what he was asked to do.

14 Patient F was started on antidepressant treatment and regularly seen by the consultant in outpatients. In May 1992 he was noted to be expressing suicidal thoughts, but refused admission to hospital. He was referred for psychotherapy, but did not attend. On 8 October 1992 patient F was seen in the outpatient department by the locum consultant. His letter to the GP states:

> *'He stopped taking his medication three weeks ago and according to his mother became depressed again, withdrawn and aggressive when challenged. He stopped going to work following an argument with a client when he became physically aggressive. He took an overdose of tablets five days ago following alcohol intake. He vomited soon after. The patient denied the fact. From what I can gather, [patient F] was a strange child, did not show a lot of emotional excitement. His father has the same type of personality as [patient F].*
> *On examination he said he was all right and denied a lot of facts. However, he accepted that sometimes he feels like banging his head on the wall because he is disappointed with life. He did not look happy about his aggressive behaviour but said he cannot help [it]. He was pessimistic about the future and rather depressed and refused any psychological help but reluctantly decided to take Lofepramine which was prescribed for two weeks.'*

15 A lack of compliance with medication and self regulated levels of medication continued to be a feature of treatment throughout.

1 – 5 November 1992

16 Patient F was an informal admission to Dewsbury psychiatric unit as a transfer from the medical wards following psychiatric assessment. He had taken an overdose of Lofepramine and Seroxat prior to his admission. A diagnosis of Explosive Personality Disorder – ICD9 301.3, was made. [ICD9 was the World Health Organisation's ninth version of their International Classification of Diseases]. On discharge, one to one working with his keyworker was arranged together with outpatient follow up.

20 November 1992

17 Patient F was referred by his GP to a private consultant psychiatrist at Leeds at the request of his mother. He was seen the same day.

Although the personal clinical records of the private psychiatrist were not available to the independent inquiry (he retired in 1994), his letters to the GP from each consultation were present within the GP records.

18 The psychiatrist took a history of patient F who had by this time taken three overdoses and had been admitted on seven occasions at Dewsbury. Patient F was getting increasingly irritable, impulsive and had often been found to punch and bang doors and was getting into fights in the street. The psychiatrist noted marked mood swings and that patient F had been considered to be impulsive and unpredictable. He had had several motoring offences and on one occasion he was banned from driving a motorcycle. Parental discord was noted in some detail and also that patient F's father had given him a box of jellybabies and Smarties as his 21st birthday present.

19 The psychiatrist considered that patient F was most likely to be suffering from bipolar affective disorder even though his initial examination reflected the presence of severe immaturity of personality and personality disorder. Patient F was given an injection of Depixol and prescribed oral Procyclidine and Chlorpromazine. This medication continued to the follow up on 18 December 1992.

1993

20 Patient F was in hospital as an informal inpatient at St James's Hospital, Leeds between 4 January and 2 February 1993. The discharge letter stated:

> *'Diagnosis: bipolar affective disorder, personality disorder. Following admission, a course of ECT was started on 7 January and he had seven ECTs. By the end of the course he was feeling very well and he wanted to be discharged. He was discharged on 2 February and was started on lithium carbonate.'*

21 Patient F was followed up in outpatients in Leeds on a monthly basis.

March 1993

22 Patient F was referred urgently at his mother's request to the Dewsbury community assessment and short-term therapy team. It was explained that the treatment by the psychiatric services at Dewsbury was not thought to be satisfactory by his mother and patient F had therefore seen a consultant psychiatrist privately in Leeds. The psychotherapist clearly took the detailed history of conflict between the parents and the effects that this showed in patient F's behaviour.

23 In her letter to the GP dated 6 April 1993 discharging patient F from further follow-up, the psychotherapist in the community assessment team states:

'I am deeply concerned about this young man and after three long and arduous sessions feel that he has barely moved at all. [Patient F] does not want to continue with the sessions although he wanted me to make that decision for him - which I didn't.'

24 On 29 June 1993 Patient F was seen by the private consultant whose letter to the GP states:

'Apparently he gave up his job as a motor mechanic on 16 June 1993 because he did not see any purpose in working. Since he stopped work he seems to spend hours driving around without any purpose. Whilst he was less sullen and less tired than before, I understood that he had stopped taking Moclobemide which I've had prescribed for him about a week ago and that he does not think that the medication did anything to help. I get the impression from the patient that he does not see any purpose of living and that he does not want to waste his time working neither does he want to find out what sort of work he may be interested in or what sort of career he might choose to pursue in the future…. I am at a loss to know how to help him.'

25 Patient F was again admitted as an informal inpatient at St James's, Leeds, between 21 July and 3 August 1993 after threatening to cut himself with a Stanley knife. He described his problems and appeared to have a poor ability to tolerate frustration, anxiety and stress, coupled with a degree of social phobia. He said that when he went out with people he had nothing to talk about, and ended up "freezing", that he felt unable to know what to say or do. At one point during his admission he became quite angry and smashed a window with his hand.

26 He was referred to Tuke House, for assessment for his suitability to treatment within a group psychotherapy framework. However, after two sessions with patient F, and prolonged discussion amongst colleagues at Tuke House, it was considered that he would not benefit from their programme and could well suffer harm. The psychotherapist wrote to the consultant psychiatrist as follows:

'[Patient F] is a very schizoid character and his defences in themselves cause pain and difficulty, [patient F's] sense of "knowing something is missing", and in the way they hamper the possibility of unsatisfactory relationships with others. However, we feel great concern about what could emerge in the way of strong, possibly violent (to self and others) impulses and feelings, should his schizoid defences be weakened by exploration within a setting that cannot also offer the degree of containment that may be required. In other words, [patient F] may very much need his current 'cut off' way of being, to acceptably 'manage' the turmoil within…. this is a young man who can arouse both fear and threat, as well as pain and sympathy, in those working with him. The level of his schizoid disturbance, and the consequent limitations of his life, sit most uncomfortably with his hopes for the future, and his awareness that something is wrong. I regret we cannot help him.'

1994

27 On 25 April 1994 patient F was discharged from further follow-up by the Leeds psychiatric services after failing to attend an outpatient appointment. The consultant psychiatrist at Leeds had retired by this time and it was suggested that the GP referred him for more local treatment in the future, should that be necessary.

1995

28 In November 1995 patient F was referred back to the Dewsbury consultant psychiatrist by his general practitioner. His mother stated that she was very concerned about his mental state and that he had impulses and feelings to be violent to himself and others. He asked not to be seen by his previous consultant. The GP felt that this should be heeded as he had been violent in the past.

1996

29 Between 3 and 5 February patient F was an informal inpatient with Dewsbury mental health services but he discharged himself against medical advice. His presenting complaint was that he felt low in mood and preoccupied with his hearing problem. No medication was prescribed on discharge and outpatient review arranged.

30 On 23 February 1996 patient F attended his GP asking for a blood test as he believed he had been poisoned. He had seen a neurologist and had a CT scan, which was normal. He complained of ringing in his head. His GP considered that he was depressed and prescribed Paroxetine and Zopiclone.

31 On 28-29 February 1996 a Mental Health Act assessment was carried out at Dewsbury Accident and Emergency Department following an overdose of Zimovane. Patient F was offered a bed on the inpatient psychiatric unit as an informal patient. The purpose of the admission was for a period of observation to rule out any psychotic disorder. Patient F exhibited confrontational behaviour during his stay and required to be restrained from assaulting a member of staff. He self discharged on 29 February without medication and refused outpatient support.

> *'He denied that he was depressed and was preoccupied with physical problems; ears buzzing, feels he has been physically poisoned and wanted his blood testing. Diagnosis: personality disorder ICD:301.3 E-21.'*

32 On 12 March patient F attended his GP requesting that his tonsils be removed. He was examined, but no tonsillar abnormality was found. The GP concluded that he was depressed and continued his medically certified sickness for two months.

33 On 14 March Patient F was reviewed in outpatients. The letter to his GP states:

> *'[Patient F] tells me that since he was discharged from hospital he has been to see a dentist who has told him that his tonsils are enlarged and he should have them out. He feels that this is the cause of all his physical symptoms and therefore feels vindicated in that he has always said that he does not have any mental problems and never has had. He is now very suspicious of medical staff, and indeed during the outpatient appointment told me that he despises all doctors and they cannot help him. He says his symptoms of tinnitus have improved.'*

34 On 18 April the Community Mental Health Team (CMHT) nurse wrote to the GP following an assessment of Patient F:

> *'[Patient F] appears to think he may have been poisoned by vehicle emissions which are causing him to experience ear, nose and throat problems, particularly hearing difficulties. This appears to have been extensively investigated and no abnormalities have been detected to explain the symptoms he complains of.*
>
> *On assessment [patient F] appeared to be obsessively preoccupied with his physical health although willing to concede there may be a small stress related component to his difficulties.*
>
> *I have referred [patient F] to my own stress management group to address the above issues.'*

35 Patient F was reviewed on a regular basis in the outpatient department. The mainstay of his treatment was Venlafaxine. In August 1999 it was noted that he had maintained his improvement and he was discharged back to the care of the GP.

2001 – 2005 - Gastrointestinal and Surgical treatments

36 Patient F was referred in 2001 to a consultant surgeon. At that time he was complaining of diarrhoea and abdominal pain. A colonoscopy at that time suggested Crohn's disease of the terminal ileum (the end of the small intestine) and a small bowel meal showed abnormality of the mucosa. He was initially treated with steroids and monitored. In March 2002 a consultant physician considered that his symptoms of lack of sleep, general malaise, headaches and abdominal bloating were undoubtedly related to his psychiatric problems. He was informed of this and referred back to the psychiatric services. In October 2002 a small bowel meal, carried out in pre-consideration of an ileocaecal resection (surgery to remove part of the ileum and caecum), showed no evidence of Crohn's disease, and therefore he did not undergo surgery. Clarithromycin (an antibiotic) was tried and was successful in treating his symptoms. A colonoscopy carried out in 2002 was normal.

37 In July 2003 patient F reported to the consultant surgeon that he was no longer taking antidepressants. Patient F continued to be followed up at the Department of Gastrointestinal Surgery at Wakefield. A small bowel meal was repeated in June 2005 which again showed no evidence of Crohn's disease. He was informed of this finding.

2001

38 In March 2001 patient F was referred to the consultant psychiatrist at Dewsbury with progressively increasing insomnia, feeling continuously down, but no change in appetite. The registrar who had seen patient F at St James's at this stage was a locum consultant psychiatrist at Dewsbury. Patient F was aware of this and asked to see this psychiatrist, although the allocation of general practices in Dewsbury at that time to individual psychiatrists would have meant that he would ordinarily have been seen by a different team. As he had known patient F previously, the consultant did not ask for a full copy of the St James's clinical records to be requested. Patient F was then seen on a regular basis in the outpatient department by the consultant who continued treatment with the Venlafaxine. He was placed on a basic level care programme approach (CPA) and to be seen as an outpatient by the consultant. [CPA is a method of ensuring that all patients presenting with psychiatric conditions have a key worker who ensures that all other clinicians involved in their care are kept informed of changes in therapies, treatments and status of the individual and that all records are kept up to date and available].

2002

39 In September 2002 the consultant formed the view that patient F had a social anxiety disorder. He tried to give patient F some insight into the diagnosis, but patient F was reluctant to accept it. The consultant thought that the clinical picture was that of an anxious person with both psychological and physical sets of symptoms of anxiety. Patient F continued to attend on a regular basis and was prescribed Venlafaxine. He continued to try and minimise the dosage of medication at this time and regularly took a quarter of the recommended level of prescribed medication.

2003

40 January 2003, patient F was referred by his GP to a private consultant psychiatrist. In his letter of referral he states:

> *'[Patient F] tends to somatise his mental illness, such that he feels that it is his physical illnesses that have caused his mental state. He is convinced that he should have part of his bowel removed and this would improve him both physically and mentally. He says that his symptoms tend to fluctuate and sometimes he does feel good, however, at other times he feels frustrated and does not know what to do.'*

(Somatisation has been described as the unconscious expression of psychological pain in physical terms).

41 The private psychiatrist's opinion and management plan was as follows:

'Diagnosis

1 F45.9 of ICD-10 Somatoform Disorder, unspecified.

2 F41.1 of ICD-10 Generalized Anxiety Disorder.

3 F33.4 of ICD-10 Recurrent Depressive Disorder, currently in remission.

Recommended Management Plan

1 *Continue Venlafaxine 75 mg bd (says he is on Venlafaxine and not Prozac)*
2 *Needs more intense Anxiety Management and Cognitive Behaviour Therapy.*
3 *Preferably avoid reinforcement of physical health problems, lest he develops a convincing attitude to ongoing somatic complaints.*
4 *No further out-patient appointments with myself at this stage as there will not be any therapeutic productivity.*

5 *Counselling and reassurance given. Informed opinion provided. No underlying serious mental disorder.*

Diagnostic Formulation

This 31 year old, single male, who has had an extensive history of involvement with Mental Health Services, does not manifest an identifiable pathology of a psychotic illness or of a serious enduring mental ill-health. However, he has the classical features of Somatoform Disorder. This has manifested in the past and the present with repeated presentation of physical symptoms together with persistent requests for medical investigations. It remains unclear whether he has been diagnosed to have Crohn's Disease but is under the belief that more recently he was given to understand that he was suffering from this condition. Even if this physical disorder is accepted on histological findings, they do not explain the nature and extent of the symptoms of emotional distress and preoccupation with physical health.

[Patient F] has an understanding of the relationship of his physical complaints and his mental health. However, he remains with this notion on a short-lived basis and reverts to seeking the attention of his family and the doctors that there may be something essentially physical in his illness. He has never expressed hypochondriacal delusions in the past.
At this moment in time, there is no evidence to suggest associated depressive psychopathology.

However he has suffered from depressive episodes in the past. Stressful life events and other stressors would certainly lead to worsening of his subjective symptoms. It is difficult to attribute a psychological causation to his somatic symptoms, given the long history. However in the absence of a physical basis for his symptoms, it has to be accepted that he has a Somatoform Disorder.

Given the chronicity of his symptoms, the prognosis is poor. Nevertheless the main stay of treatment in association with Generalized Anxiety Disorder is that of Anxiety Management and Cognitive Behaviour Therapy. It is hoped that he would be able to seek these treatments in the medium to long-term in the NHS Sector. It would be preferable if there is no further re-enforcement from either family or the medical profession of his symptoms.

[Patient F] was relieved to know that he was not suffering from a psychotic illness. Nevertheless, there is no consolation that his enduring problem of somatisation that has caused a degree of emotional distress has a poor prognosis.'

42 At that time the waiting list for non urgent psychological therapies in North Kirklees was between two and two and a half years. The GP therefore considered this not a realistic option for patient F.

43 In any event, Patient F underwent cognitive behavioural therapy (CBT) on a private basis from November 2004 to February 2005 without any improvement. Neither the consultant, nor the GP, sent a copy of the letter to the treating consultant psychiatrist at Dewsbury.

44 In March 2003, patient F's GP tried another antidepressant, Lustral. Patient F was not able to tolerate this and the consultant changed his medication back to Venlafaxine.

2004

45 Patient F failed to attend the outpatient appointment on 19 February 2004. In April 2004 patient F attended the outpatient clinic, together with his mother. He reported that he had stopped his treatment with Venlafaxine two and a half months previously. He felt better for the first two months and then his problems started. His concentration had gradually reduced and he became progressively less confident. By this time he had been taking Prozac 20 mg for two weeks which had been prescribed by the GP. This was increased to 40 mg daily in May 2004.

46 Patient F was reviewed in the clinic on 28 October 2004. He had stopped taking the Prozac medication two weeks previously. He stated that he felt his motivation was low, but there had not been any change in his motivation after stopping Prozac. He said that he was continuing to have problems, his stomach remained bloated which he said had improved with a course of antibiotics. The ringing noises in his ears continued.

47 The consultant considered that patient F had made considerable progress in the 12 years he had known him, but that the somatic symptoms continued to persist. The ringing sound he experienced in his head was one of the symptoms and patient F reported that he could remember it from perhaps being five years old. He said that he had only recently realised that other people did not have ringing noises in their head. The consultant thought that patient F could continue without medication until his review in outpatients in three months.

48 In November 2004, patient F was seen privately by a chartered psychologist at the request of a friend of his mother who was also a consultant chartered psychologist. He attended for CBT on five occasions between 12 November 2004 and 25 February 2005.

49 The psychologist stated, in a report to the defence solicitors dated 10 November 2005, that he encouraged patient F to discuss his needs with his GP and that he had appointments with his GP during this period.

> *'[Patient F] when seen by myself came over as an unwell person who needed psychological support and evaluation and care from medical specialists. Had he not been seeing his GP and reported that he would be seeing a psychiatrist and others I would have encouraged him to do so. Within the limitations of my experience and qualifications I do not think he is an easy person to label and may require long term care.'*

50 No record of these attendances was sent either to the GP or to the consultant psychiatrist.

2005

51 The GP records indicate that patient F requested and was prescribed Prozac in a dosage consistent with 40mg daily from January 2005 onwards. He failed to attend the outpatient appointment on 24 January, but asked to be seen on 27 January 2005.

52 On 27 January 2005 Patient F was seen in outpatients by the consultant. The letter to GP read:

> *'Diagnosis: Social Anxiety Disorder (Minor Recurrent Depressive Disorder)*
> *Current medication: fluoxetine 20 mg daily*
> *Patient F said he was feeling down with no energy and ringing in his ears. This led to him restarting fluoxetine about four days back and as a result he has felt better. I have suggested that he should stop this practice of starting medicines on his own and then stopping. It really is not the most desirable thing that he is doing. I have asked him to continue with the medicines and arranged follow up on the next available appointment, which will be in a few weeks.'*

53 The Dewsbury NHS records make no reference by patient F to the attendance at the private psychologist, nor to the CBT.

54 On 27 April 2005 patient F was seen in outpatients by staff grade, the letter to his GP stated:

> *'Diagnosis: Social Anxiety Disorder (Minor Recurrent Depressive Disorder)*
> *Current medication: fluoxetine 40 mg mané*
> *[Patient]F said he was generally doing fine but complained of early morning awakening. He said he falls asleep later appointed up about 10:00 am., complaining of ringing in his head and floating sensation in his stomach. He also complained of anergia and said he has no social life. He continues to be self employed and is happy with this. He said his appetite is okay and he has no self harm ideas and is compliant with his medication. [Patient F] increased his fluoxetine to 40 mg mané on his own as the previous dose of 20 mg nocté to him any good. I advised not to change the dose of medication on his own and to consult with either yourself or the consultant for the same.*
> *I have not made any changes to his current medication and I advised him to continue the same. He will be reviewed in the consultant's clinic in three months time.'*

55 In May 2005 patient F committed assault against the Chairman of the haulage company that occupied land next to patient F's motor repair business.

56 On 15 August 2005 patient F was seen in outpatients by his consultant. The letter to his GP following this, dated 7 September, noted:

> *'Diagnosis: Social Anxiety Disorder (Minor Recurrent Depressive Disorder)*
> *Current medication: fluoxetine 40 mg mané*
>
> *I reviewed [patient F] in the outpatients' clinic on the 15th of August 2005.*
> *I am pleased to say he is doing well and maintaining his fluoxetine which is very reassuring.*
> *I have made no changes in his medicines and he will be seen in clinic on the next available appointment.'*

57 The consultant states that there were no active mental health issues at that time. Neither the assault committed in May, nor the pending Court appearance, was mentioned to the psychiatrist at the consultation in August.

58 On 13 September 2005, patient F was found guilty at the magistrates' court of the assault which had taken place in May 2005. He was bailed, pending sentencing which was scheduled for two days later.

59 On 14 September 2005 patient F was involved in a fight with the Chairman and two Directors of the haulage company next door to his own business. He used a knife as a weapon. One person was stabbed to death and two others, including the Chairman (whom patient F had assaulted in May) were seriously injured by stabbing.

60 At the trial, patient F was found guilty of murder and two counts of wounding with intent. The Judge said he should serve a sentence of at least 20 years. He was sentenced to six months imprisonment for the offence tried earlier. An appeal failed in January 2007.

61 Patient F was found hanged in his cell at HMP Armley on 22 February 2007.

62 After the offence, patient F's mother received support from the Trust which was appreciated by her. This was good practice, particularly on the part of the CPA manager, who eventually was asked to undertake the internal root cause analysis review.

4.0 Analysis of care and treatment

63 The psychiatric report prepared on behalf of the defence at trial stated: *'The evidence points to the defendant displaying various characteristics from a number of the specific personality disorders which does make him difficult to categorise and probably therefore merits an ICD-10 diagnostic classification of F61.0 mixed personality disorder. In general, personality disorders comprised markedly disharmonious attitudes and behaviour, involving usually several areas of functioning (affectivity, arousal, impulse control, ways of perceiving and thinking, style of relating to others) which tend to appear in adolescents and endure in the maladaptive fashion into adult life across a broad range of personal and social situations. They are not directly attributable to gross brain damage, disease or psychiatric illness……..*

……on the other hand, I do not give much credence to the defendant's own belief that his abnormal behaviour can be explained by an adverse response to the antidepressant Prozac (fluoxetine), even though this is a drug designed to manipulate mental state to some extent.

Notwithstanding the absence of a formal medical recommendation at this juncture, I can however envisage a time in the course of prison sentence when it might be deemed appropriate to transfer the defendant to a therapeutic prison such as Grendon Underwood, or even to explore the possibility of this section 47/49 transfer direction to a secure hospital with a personality disorder unit (such as Rampton Special Hospital) for perhaps 18 to 24 months of therapeutic work prior to his release back into the community; the need for a containing environment for such psychological work to be undertaken safely having been adeptly identified in the 1993 psychotherapeutic assessments.'

64 Patient F was considered medically and mentally fit to stand trial. The Independent Inquiry concurs with this analysis and supports the view that the homicide and mental health issues were unrelated.

65 Patient F was a patient of mental health services in Leeds and Dewsbury from 1992 to 2005. He had been an inpatient at Leeds on two occasions and an inpatient at Dewsbury on three occasions. All these were as an informal patient (that is, not subject to compulsion under the Mental Health Act). In 1993 he had undergone a course of seven ECT treatments for depression.

66 On the occasion when he had been discharged from psychiatric follow-up in 1999, he eventually became more distressed and needed to be re-referred by his GP to mental health services in 2002.

67 Patient F was seen in the outpatient department on 34 occasions between 1996 and 2005. He was seen by the consultant on 29 of

5.0 Analysis of action taken in response to internal review recommendations

68 Following notification of the homicide to the Trust in September 2005, the Trust informed the Strategic Health Authority on the 16 September 2005. The General Manager was asked by the Risk Management Department at the Trust to prepare a final report and action plan by 17 October 2005.

69 The General Manager asked for a report from the consultant psychiatrist on 14 October 2005. This was provided on 1 November 2005. A root cause analysis was carried out in May 2006. No reason for this delay has been put forward by the Trust.

70 The resulting report and recommendations were considered by a small group of senior staff at the trust. The initial recommendations were amended and the report adopted. The staff involved were not asked to comment on accuracy at the draft stage. The Trust policy at the time stated that any recommendations should fulfil SMART criteria (i.e. that the recommendations are specific, measurable, achievable, realistic and resource identified and that the timescale is defined). The recommendations in this case did not fulfil these criteria.

71 The procedures in place at the Trust at that time meant that neither the full report, nor the substance of the report, was reported to the Trust Board.

72 No representative of North Kirklees PCT, which commissioned mental health services from SWYMHT at the time of the incident, was invited to take part in the internal review.

73 In the light of the limitations of this process, the recommendations adopted by the Trust were aimed at general service improvements, rather than addressing any specific points arising from the immediate case. In that context, the recommendations were appropriate for the service at that time.

74 The Independent Inquiry found that subsequent progress has been satisfactory.

75 The purpose of a timely 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 to aid implementation and the monitoring of implementation. The Trust policy did not provide for the incident, incident investigation report or the implementation of action to be reported to the Trust Board.

76 The Trust has subsequently carried out its own review of how it responded 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.'*

77 A revised Untoward Incident Management Policy clearly stipulating roles and responsibilities as well as timescales was formally adopted by the SWYMHT Board in January 2007.

78 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 and response to the terms of reference

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)***

79 The analysis of Patient F's treatment is provided in section 4. He presented as a patient with complex problems based on his personality and tendency to somatise his problems. He was regularly monitored for his mental health state and his functioning. He had had difficulty in establishing a trusting therapeutic relationship, but was able to maintain one with the consultant psychiatrist.

80 Patient F was able to run his own motor repair business up until the time of the homicide. Until this time, the knowledge of the service was that he had not exhibited violent tendencies for some years. On that basis, the eventual incident was not predictable to services, nor preventable.

81 The clinical records indicate that patient F did not cope or co-operate with formal psychotherapy. Attempts were made to provide psychodynamic psychotherapy in 1992, relaxation in 1993 and group work in 1994. He received ECT in 1993. In 2003 and in late 2004/early 2005 patient F attended a consultant psychiatrist in the private sector and a psychologist, also in the private sector.

82 The attempt at CBT in 2005 did not produce significant benefits.

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

83 Patient F was on a basic CPA which was the routine for patients being seen in the outpatient department. This level of care corresponded with the requirements in place at the time.

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

84 It is clear from the clinical records that appropriate risk assessments were carried out as a regular part of patient F's assessments by his consultant. His risk of harm to self and to others was assessed on a regular basis.

85 His care planning was:

1. To maintain antidepressant medication.

2. To monitor the dosage to an acceptable level to avoid side-effects and to help ensure compliance.
3. Supportive work through the outpatient attendances.
4. Providing a therapeutic relationship which was accessible.

An example of this occurred in January 2005 when patient F failed to attend an outpatient appointment, then requested another 3 days later. The care planning was adequate.

- ***The exercise of professional judgment and clinical decision making***

86 After the initial presentation period between 1992 and 1996, patient F did not subsequently self harm, nor was there an apparent risk of harm to others, based on the information available to the Health Professionals. The Independent Inquiry is of the view that the exercise of professional judgment and clinical decision making was acceptable in this case.

- ***The interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical health needs***

87 The consultant psychiatrist was under the impression that he was the sole contact with patient F in respect of his mental health needs. The consultation with the private psychiatric consultant in 2003 was not communicated to him. The outcome of the consultations with the private psychologist in 2004/2005 was not communicated either to the GP or consultant. It is speculative to suggest that any outcome would have been different had this information been shared. Nevertheless, it did form part of the whole picture against which clinical decisions were made.

88 The GP agreed that it would have been helpful for a copy of the private consultant's opinion to have been forwarded to the NHS consultant. The Inquiry does not consider that this was material in this case.

89 Guidance from the British Psychological Society Division of Clinical Psychology to Chartered Psychologists in 1995 in respect of communicating with other health professionals states:

'It may not be appropriate in all cases to inform a client's GP about involvement if the GP is not the referrer. The psychologist must balance the risks attached to not sharing this information with those of respecting clients' wish for privacy.'

90 In this case, the psychologist formed the view that his primary role was in encouraging patient F to maintain his contact with mainstream NHS services. For that reason he did not consider it necessary to forward his findings either to the GP or NHS consultant.

His evaluation complies with the advice of his professional association at that time. An updated Code of Ethics and Conduct was issued in 2006 which does not materially alter this advice. Although not critically material to this case, disclosure of relevant clinical information from a psychologist to a patient's GP may well be helpful in developing a patient centred treatment plan.

- ***The extent of services' engagement with carers and the impact of this***

91 Patient F's mother accompanied her son to appointments on a number of occasions. Following the offence his mother was contacted by the member of staff, who had also had professional contact with patient F over a number of years. Patient F's mother was appreciative of the support given to her.

92 The independent Inquiry is of the opinion that the nature and extent of the engagement with patient F's mother was appropriate.

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

The Independent Inquiry concludes that the standard of care and treatment given to patient F was appropriate.

- ***Learning points for improving systems and services***

93 Following the incident, the Trust carried out a root cause analysis review. This was not carried out to the timescales stated in its policy and the recommendations were not SMART, as required by the policy.

94 The Trust has now adopted a policy which will enable it to meet its statutory requirements for accountability in respect of the management of the Trust response to serious untoward incidents.

95 Recommendations arising from any future review should be drafted according the Trust's own policy and incorporate SMART criteria.

96 In this case the staff involved were not asked to comment on the draft inquiry report for accuracy before it was actioned by the Trust. They should have been given that opportunity.

97 A representative of the PCT Service Commissioners should be invited to take part in any future internal review.

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

98 The most significant development in mental health services has been the adoption of ‘New Ways of Working’ for Psychiatrists. A single point of entry to the mental health services is in place since 1 August 2005 through the CMHT allocation meetings. This means that patients with complex needs are appropriately assessed and treated.

99 The Trust has also begun to implement care pathways based on their locally developed system. This includes using the Health of the Nation Outcomes Scores (HoNOS plus) as a measure of patient well being and to promote patient centred care. This is to be commended as leading good practice.

100 Kirklees PCT intends to implement a review of psychological services in full with the co-operation of SWYMHT to address the inequality of waiting times and access for patients.

7.0 Summary of Independent Inquiry recommendations

Service Delivery

Information Sharing

1 When a patient is known to have received services from another mental health provider, the previous clinical records should be obtained to enable as full a picture to inform clinical care and decision making. This should be monitored through clinical audit.

2 Where a patient has sought care and treatment from non-NHS sources through the GP, the GP should encourage them to share that information with the NHS in cases where the NHS is responsible for the provision of ongoing care.

3 The Strategic Health Authority should write to the British Psychological Society and the Council for the Regulation of Health Care Excellence to raise concerns regarding the guidance in respect of sharing of clinical information.

Management of Untoward Incidents and Internal Reviews

Involvement of staff in internal reviews

4 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.

Involvement of service commissioners

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

Recommendations' of Reports

6 The Trust should ensure that it implements its current Untoward 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.

Appendix 1 - Job titles of persons interviewed

Patient F
Patient F's mother

Consultant Psychiatrist - NHS
Consultant Psychiatrist – Private (January 2003 involvement)
Chartered Psychologist – Private (November 2004 – February 2005 involvement)
General Practitioner

Medical Director SWYMHT
Director of Organisation Development, SWYMHT
Assistant Director of Learning Disability Services, SWYMHT
Locality General Manager, North Kirklees, 2005 SWYMHT
Assistant Director, Adult Mental Health Services, SWYMHT
CPA Manager, SWYMHT
Assistant Director Mental Health/Learning Difficulties, Kirklees PCT
Head of Psychology, North Kirklees at time of the incident

Appendix 2 - Documentation reviewed in the preparation of this report

GP Records
St James's Hospital Records
Dewsbury Mental Health Records
Private Psychologist Records

Health of the Nation Outcome Scores plus, developed by SWYMHT

South West Yorkshire Mental Health Trust (SWYMHT) SUI log for incident 2005/3404
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
Single Point of Access to Mental Health Services in North Kirklees Policy from 1 July 2005 (issued 1 August 2005)
SWYMHT North Kirklees Locality Documentation Standards for Patient Case Records
Kirklees Care Programme Approach December 2003
North Kirklees Adult Mental Health Services Operational Policy August 2006
Minutes of SWYMHT Risk Trust Action Group, 29 November 2006
Organisational Risk Register
Minutes of SWYMHT Risk and Governance Committee, 11 May 2006, 30 June 2006, 8 September 2006, 10 November 2006
Minutes of SWYMHT Clinical Governance and Clinical Safety Committee, 1 December 2006
Minutes of Executive Management Team SWYMHT, 21 December 2006, approving revised management arrangements for incidents
Terms of Reference SWYMHT Strategic Risk and Governance Committee revised January 2007 Approved by SWYMHT Board, 27 January 2007
Minutes of the Private Session SWYMHT Board, 26 January 2006,

Appendix 3 - The Author

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 at the Institute of Risk Management and Honorary Senior Lecturer in Risk Management and Governance at the University of Central Lancashire. Dr Roberts is also a serving Assistant Deputy Coroner for Cheshire

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.