Independent Inquiry Report
Reference 2003/2374

COMMISSIONED BY WEST YORKSHIRE STRATEGIC HEALTH AUTHORITY

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1. Executive Summary

The subject of this independent inquiry, Ms A, killed her boyfriend on 1 April 2002 by inflicting fatal knife injuries to him. Ms A was found guilty of manslaughter by reason of diminished responsibility. At the time of the offence, Ms A was under the care of South West Yorkshire Mental Health NHS Trust.

West Yorkshire Strategic Health Authority commissioned ECRI (an independent health service research organisation and collaborating centre of the World Health Organisation) to undertake this independent inquiry under the terms of HSG (94) 27 "Guidance on the Discharge of Mentally Disordered Offenders". The purpose of the inquiry was to investigate the care and treatment of Ms A and to make recommendations for service change where necessary.

The ECRI team reviewed the case notes, Trust policies and procedures and interviewed staff members and the mother of Ms A. ECRI produced a draft report following this review.

The terms of reference for the inquiry were to investigate:

- The care the patient was receiving at the time of the incident
- The suitability of that care in view of the patient'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 exercise of professional judgement and the clinical decision making process
- The adequacy of the care plan and its monitoring by the key worker

The **key conclusion** of the inquiry is that the homicide was not a preventable event.

2. Information Sources

This report has been produced following a review of the following documentation:

- Copy of the Draft Report by ECRI, including chronology of Ms A's care.
- Statement made by Dr C.
- General Medical notes
- Letters from the Child and Adolescent Services
- Letters from the Adult Psychiatric Services
- Notes from the A&E Department Halifax
- Records from the Deliberate Self Harm Team Halifax
- Primary care notes
- Forensic Psychiatric - report post incident
- Copy of the Mental Health Trust Internal Inquiry Report

3. Methodology

This review has consisted of a case note review and a review of the draft report produced by ECRI.

4. Brief Case Summary

Ms A was a 19 year old out-patient of the South West Yorkshire Mental Health NHS Trust, resident in Halifax. On the 1st April 2002 she was arrested and charged with the murder of her partner and assault on two police officers. She was subsequently found guilty of manslaughter by reason of diminished responsibility.

Ms A had been an out-patient of the Child and Adolescent Psychiatry Services at age 13-14 years, related to stress around her father's serious ill health and her own physical health problems.

She first presented to the adult psychiatric services following an overdose of the antidepressant Citalopram, prescribed by her general practitioner.

She was initially managed by the Deliberate Self-Harm Team, but was also referred to Dr B a Locum Consultant Psychiatrist in Halifax, and was subsequently seen by his Staff Grade Doctor in the out-patient clinic.

In December 2001 she was urgently referred to the Clinical Psychology service for a second opinion and assessment for Cognitive Behaviour Therapy, but was awaiting an at the time of the incident.
Throughout this period of contact she continued to present to the Halifax A&E Department with episodes of self-harm.

5. Child Psychiatric Contact

Ms A was referred to a child psychologist in 1995 by her GP, she was stressed by the death of her grandfather, her father's serious ill health and the fact she was overweight.
She had regular weekly therapy and her care was active, dealing with her problems including involving her school and arranging home tuition.

Comment

- Records indicate this seems to have been a success, she attended appointments and is reported to have improved. The management of her care appeared active covering all her active problems, the reporting back to her GP and other agencies was detailed and of a high quality.

6. Contact with Adult Services

a) Ms A first presented to the Halifax A&E Department in November 2001 following an overdose of the antidepressant Citalopram plus alcohol. She was assessed by a Community Psychiatric Nurse who was part of a Primary Care team. She was assessed as no longer being suicidal, with no sign of depression or psychosis.
The plan was to refer her to the Deliberate Self-Harm (DSH) Team for follow-up, which happened.

Comment

- There is no evidence of a formal risk assessment at this point.
- The DSH team notes also comment that she admitted to having deceived the "doctor" who made this assessment.

b) She was referred to Dr B (Locum Consultant Psychiatrist) by her GP, and was seen with SW1 (Social Worker from the Deliberate Self-Harm Team) in December 2001. The assessment was "Low mood since father died, anxiety and mood swings. No evidence of profound depression or psychosis". Responsibility for Ms A remained with the GP with specialist care from the DSH team offering support.

Comment

- At this point she was formally in secondary care, with a team member from the DSH team offering ongoing care yet no mention was made of any level of CPA or a formal risk assessment.
- The DSH and primary care team notes report the Ms A was very upset and unhappy with this interview, feeling it simplified her problems to bereavement alone, and she was not listened to. The notes record her mother was also unhappy with this interview and a formal complaint was considered. It also appears from the DSH team notes that they also believed her problems were more than a bereavement reaction. They reassured Ms A that she would not have to see Dr B again but another member of his team would see her instead (Dr C Staff Grade Doctor).

c) Ms A continued to receive support from SW1, who visited her at home and kept phone contact with Ms A, and also worked closely with her mother and boyfriend.

In December 2001 she became more upset and felt "out of control", feeling she may self-harm again, and a referral was made to psychology for a second opinion and also for cognitive therapy.

She was seen on several occasions in the clinic by Dr C, who made changes to her medication, adding a neuroleptic (Chlorpromazine) to her antidepressant treatment. Ongoing outpatient supervision was planned in addition to support from the DSH team.

Comment

- At this point there is no doubt she had been fully accepted into a secondary care system, with medical and DSH team input, including the prescription and monitoring of medication, and a referral to Clinical Psychology. This clearly fulfils the requirement for The Care Programme Approach, with a care plan, key worker, risk plan and contingency plan, which was not completed, although SW1 acted as if she were a CPA key worker.

She continued to be seen in the out-patient clinic, and was given a diagnosis of "Emotionally Unstable Personality Disorder".

It is noted in all records that she initially improved with her prescribed medication, although she presented with a further overdose over a weekend in March 2002 and was assessed by the duty doctor and discharged.

On the 1st of April 2002 she was arrested by the police.

7. The CPA and Risk Assessment

There is a requirement for anyone in contact with secondary care psychiatric services to be subject to the Care Programme Approach, and in this case an Enhanced Care Programme would be appropriate given the multiple services involved and the risk of self-harm which is obvious in the case. This must be seen as a failure of the system in place at the time.

There is no evidence anywhere in the documentation of a formal risk assessment of any sophistication or value beyond a simple statement of no risk and a description of behaviours. This is in spite of the fact that there have been several presentations with self-harm, the client herself stating at times she was out of control with urges to harm others, and recorded evidence of violence towards others (especially her boyfriend) which on two occasions during her contact with the service involved the police. The statements in the notes of "no immediate risk of harm to herself or others" was not evidenced and was contrary to the history given at that time.

There appear to be a series of "hand offs" in response to incidents rather than a long term management plan capable of responding to fluctuations in a clients state.

A care plan would include a risk plan and a contingency plan for any change in circumstances when key workers were not available, such as March 2002

when she presented at a weekend with an overdose and was assessed by the duty psychiatrist with only the case notes for guidance.

8. The Case Notes

There is a good case to be made for a single case record available to all involved with the case. Several sets of notes exist, case notes and separate DHS team notes.

Risk information was available in the DSH team notes which was not used in the medical assessments.

9. Clinical Systems

There is a discrepancy between the view of the psychiatrist (Dr B) and the DSH team about the scope of Ms A's problem, Dr B saw it in terms of "Profound depression and psychosis", which Ms A herself was unhappy about. The DSH team obviously felt the problem was serious enough to require the high level of input they offered, plus a second opinion and psychology. The fact that they arranged for further medical appointments with another doctor confirms there was a difference of opinion about the case and the degree and type of input it required.

Comment

- Where these different views amongst members of teams persist without resolution the risk of incidents will always be higher.

10 . The Deliberate Self Harm Team

The quality of input from this team, especially SW1 was high, the notes are impressive compared to the medical notes in the detail they contain about Ms A's real problems and feelings.

It is also clear that they were beginning to use cognitive therapy skills during their interventions, and were in close and supportive contact with the family.

Comment

- It is not clear if this team is a long term team such as a community Mental Health Team, as it appeared to be functioning as such, its was the only consistent input and support over a period of five months, or a short term service for the assessment and brief intervention in cases of self -harm.
- It is unclear why the case was not passed on to the Community Mental Health team.
- The Internal Review noted the DSH team was intended to hold cases until they could be seen by psychology services who had a waiting list, i.e. to act as a "buffer" for capacity problems within psychology. This is not satisfactory unless there is close prioritisation, support and supervision links with the psychology service. This did not appear to be the case as the referral was urgent and no appointment was given.

11. Psychology Services

An appointment was requested in December as urgent, yet no appointment was available until June 2002. This is clearly unacceptable.

The risk priorities should be the same across the whole system, even if elements of the service are provided by different organisations.

The use of the DSH team in isolation as a holding area for capacity problems in psychology is also unacceptable and potentially unsafe.

12. Recommendations

A. The Care Programme Approach

- Whilst the principles of CPA were applied, the Trust should ensure that all clients accepted into secondary care are subject to the Care Programme Approach. Boundaries and roles between teams must be clarified, CPA should be based on need, not the location and function of the main care team.

- Risk assessment should be formalised to include risk to others as well as risk to self, and should use information from several sources. Predictors of risk, responses and contingencies should be included in the plans, which should be widely available across the whole care system, including primary care and teams managed by them.
- An audit system should be set up to measure progress towards these standards.

B. A Common Language of Risk

- There should be an agreed single standard of risk and urgency which is agreed across all teams provided by the specialist mental health trust.

- The Trust should ensure that medical staff share a similar view of risk and urgency with other disciplines operating within the care system. This may be achieved by joint/multi disciplinary training.

- If team members, including consultants operate outside these standards, this should be fed back to the individual concerned and appropriate action taken.

- CPA should be the tool for resolving differences in opinion.

C. The Deliberate Self HarmTeam

- The role of this team should be clarified, including how long it retains responsibility for cases and its ability to initiate and operate the Care Programme Approach with clients it holds until they are passed on within the service.

- It should not act as a "holding area" for clients waiting for assessment in psychology.

D. Clinical Psychology

- This team should have the same system for response to risk and urgency as all other teams within the care system.

- The capacity, demand and flow through this system should be reviewed to ensure it is better able to meet service requirements.

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