REPORT OF THE INDEPENDENT HOMICIDE INQUIRY

REFERENCE SUI 2004/1904

STRICTLY CONFIDENTIAL

TO BE PRESENTED TO THE NHS YORKSHIRE AND THE HUMBER BOARD
SEPTEMBER 2006

COMMISSIONED BY WEST YORKSHIRE STRATEGIC HEALTH AUTHORITY

UNDERTAKEN BY DR GEOFF ROBERTS

Contents

Acknowledgements

The author thanks the staff at the Bradford District Care Trust and Bradford Metropolitan Borough Council involved in this review for their assistance and very open approach. In particular, Carol-Anne Farquhar for her 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, particularly those working in the Assertive Outreach Team.

1.0 Executive Summary

1. Patient D was convicted on 1 November 2004 at Bradford Crown Court of the manslaughter of his mother's common law husband on 3 July 2004. The Court was satisfied, on the basis of two independent opinions from two forensic psychiatrists, that he had a mental illness at the time of the offence. He was ordered to be detained in a High Secure Hospital on 24 October 2005.

2. Patient D had been a patient of the Bradford mental health services since 1995. He had a chaotic lifestyle characterised by illicit substance misuse and the consequences of his intermittent homelessness and drug misuse habits. His medical reports for his trial relate 27 convictions for a total of 54 offences. He had a number of periods of custodial sentences.

3. Patient D was under the care of the Bradford District Care Trust Assertive Outreach Team (AOT) from July 2002, although he had a period of inpatient care on the forensic unit in 2003.

4. The indications are that patient D's mental health deteriorated significantly around the end of June 2004. He required a high level of support from the AOT. He did not comply with his care plan and went missing on 1 July. Contact with patient D was re-established at lunchtime on Friday 2 July and it was decided to obtain a Mental Health Act assessment (MHA). A bed was identified should the assessment lead to admission. The referral for the MHA assessment was passed to the Trust's Approved Social Worker (ASW) and then on to the Social Services Emergency Duty Team (EDT). The MHA assessment did not take place. On the evening of 3 July patient D committed the homicide.

5. An internal review was held after the incident. The independent inquiry considers that the internal review did not adequately or thoroughly investigate the circumstances in which the Responsible Medical Officer (RMO) was not informed until 2 July 2004 that patient D had gone missing on 1 July 2004. That said, it is acknowledged that the internal review report expressed concerns that the RMO had not been informed. The independent inquiry shares those concerns. Where a clinical situation is apparently deteriorating, as in this case, the consultant should have been informed of the patient's disappearance to place him in the position of exercising his clinical judgement regarding the management of the case. It is not suggested that the outcome would necessarily have been different had this been done.

6. On the basis of findings identified by root cause analysis, the internal review made 20 recommendations for service improvement. These included actions to be taken following deterioration in a patient's condition, notably informing the RMO, communications between the AOT and EDT and with GPs and carers. In addition, recommendations covered issues around admission, patients' engagement with services, referrals, and record keeping. The author of the independent inquiry considers that the issue of record keeping was insufficiently addressed by the internal review and this is subject to two new independent inquiry recommendations. Otherwise, the independent inquiry author considers that all the relevant service issues were identified by the internal review and this is to be commended. It is further noted that the internal review identified areas of good practice in the care and treatment of patient D and the independent inquiry author agrees with this assessment.

7. Many of the recommendations of the internal review have been implemented, for example some aspects of the communications between the AOT and EDT. Some recommendations have not yet been completed and it is of concern that without clarity of the roles, responsibilities and operational working of the AOT and EDT (and the new Crisis Resolution and Home Treatment Team), the operational risks to patients arising from the services will not have materially changed since July 2004. These changes required the full support of the senior managers of both statutory organisations. This required support and commitment is now evident. The independent inquiry identifies those areas where action is still outstanding and makes recommendations so that these can now be addressed.

8. The independent inquiry also makes recommendations to improve the future management of untoward incidents and internal reviews, notably with regard to ensuring that in future, recommendations made by internal reviews follow SMART criteria (ie are specific, measurable, achievable and agreed, realistic and time specified). This would support the implementation of action.

9. The mother of patient D was invited to contribute to the independent inquiry. Regrettably, she declined the invitation at the time.

2.0 Independent Inquiry Recommendations

Care and Treatment

1. **Communication with the RMO** (paragraph 93). This builds on recommendation 10 of the internal review (see Section 9 of this report).

To ensure that the RMO is informed of any significant changes in circumstances or a patient's condition, an audit should be conducted on at least an annual basis of all patients admitted to hospital over a defined period to record the time of identification of a defined risk threshold and the time senior medical input was requested and delivered. (paragraph 91)

2. **Roles and responsibilities of members of the AOT, Crisis Resolution and Home Treatment Team and the EDT** (paragraph 88). This builds on recommendations 11, 13, 14, 19 and 20 of the internal review (see Section 9).

(a) There should be a joint agreement signed by the chief officers of the Trust and Social Services to specify the roles and responsibilities of all members of the AOT, the CRHT and the EDT.

(b) There should be an agreed, documented operational policy on how the three teams work to best meet the needs of patients and carers, including specific reference to how cases are prioritised and how contact is made with patients and carers

(c) There should be training for all staff on their roles and responsibilities and the operational policy

(d) The working of the teams should be subject to annual review and the outcome of this review should be reported to the chief officers of the Trust and Social Services.

3. **Record keeping**

(a) The Trust should formally adopt the standards for record keeping required by the relevant national standards for the disciplines working at the AOT (paragraph 80)

(b) Monitoring standards of record keeping and compliance with nationally recommended standards should form part of the clinical audit programme of the Trust (paragraph 81)

Management of Untoward Incidents and Internal Reviews

4. Involvement of staff in internal reviews (paragraph 73)

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

5. Involvement of service commissioners (paragraph 76)

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

6. Incident Management Policy and adoption of SMART criteria for recommendations (paragraphs 77 and 86)

The Trust should redraft its 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 service inquiries and reviews. The amended policy should be approved by the Trust Board and an audit should be done on an annual basis to review how the policy is working in practice.

7. Monitoring of action (paragraph 91)

The Joint Co-ordinating Group should be considered as the group for monitoring the implementation of recommendations affecting complementary services provided by the Trust and Social Services.

3.0 Terms of Reference

Independent Inquiry terms of reference

To review the report and the action plan prepared by the internal review team (October 2005) and carry out further investigations as necessary

To examine:

- The care the service user was receiving at the time of the incident
- 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, the clinical decision making process and communication of information and joint working between those involved in the service user's care

To identify:

- The root causes of the incident and key learning points for improving services
- The developments in services and action taken since the time of the incident

To make:

- A judgment as to the extent to which the action plan prepared by the internal review team and actual action taken to date addresses the root causes of the incident and key learning points
- Where necessary, realistic recommendations for further action to address the root causes and to improve services

4.0 Introduction

10. Patient D was in receipt of mental health services from 1995 to July 2004. This was both as an inpatient and outpatient in the Bradford area, but also whilst in prison. In July 2004 he was arrested on a charge of murder. He was subsequently convicted of manslaughter for a homicide committed whilst he was suffering from a mental illness. He was later transferred to be detained indefinitely in a High Secure Hospital.

11. The Department of Health issued guidance on 10 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 review was carried out in the context of these changes.

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

5.0 Chronology of significant events

Throughout the chronology, the use of italics indicates direct quotes from the clinical records.

13. Patient D was born in Germany on 12 January 1977. His father was serving in the army at that time. He was one of six children. He has one brother and one sister from his mother's first marriage and three half sisters from her second marriage.

1995

14. Patient D first came into contact with mental health services in Bradford in January 1995. He had been referred by medical staff at the Bradford Royal Infirmary where he had been treated for an overdose of methadone. The treatment included requiring respiratory support on the intensive care unit.

15. His mother reported that patient D had been well until two weeks previously. He had been remanded to Doncaster Prison over the Christmas period for shoplifting and had been released on 3 January 1995. He had a history of overdosing on alcohol when aged 13, but no psychiatric illness of note. He had a history of previous convictions for theft for which he had been fined.

16. He had previously had his own flat, but had sold his possessions to buy heroin. He had moved back to his family, but was disturbing the family with his behaviour.

17. Patient D was transferred to Lynfield Mount Hospital on a Section 2 (28 day) compulsory detention order on 9 January 1995. He was diagnosed as having an acute psychotic illness with paranoid delusional ideas. At the time of his discharge this was attributed to multiple drug use/use of psychoactive substances.

18. Patient D appealed against his detention. An independent medical report prepared by a consultant psychiatrist who interviewed him on 24 January concluded: *"However, on the basis of my own assessment, including a detailed interview and mental state examination, I am in a position to state that patient D is not suffering from any serious form of mental disorder at the present and there is no evidence that he is suffering from schizophrenia or a major form of depression."*

19. He was regraded to informal status on 25 January 1995 and discharged on 26 January. He failed to attend outpatient clinics on 17 February and 31 March and the consultant discharged him from further follow up on 24 April 1995.

20. On 17 August 1995, patient D was interviewed by the court diversion nurse. The interview was carried out at the request of the police at Bridewell where patient D had been charged with burglary. He had disclosed his previous detention under the Mental Health Act. The nurse concluded: *"I was unable to detect anything in his behaviour or verbal responses that would indicate mental illness to be present. My opinion is that patient D's health problems centre on his self disclosed drug habit (heroin). He indicated to me that he is not really motivated to stop using."* The nurse referred patient D to the drugs service.

21. On 14 September 1995, patient D was interviewed by a forensic psychiatrist at Doncaster Prison where he was on remand. The social history he gave at that time was of his parents separating when he was three, his step-father being violent to him and his mother. He had witnessed his mother being beaten on several occasions. For a time, he lived with his mother in a refuge for battered women.

22. He gave a history of starting to break into cars at the age of twelve. At the age of fourteen he was sent to an Attendance Centre for forty hours. At fifteen he received a twelve month Supervision Order after conviction for causing Actual Bodily Harm.

23. Patient D also gave a history of starting to use cannabis at the age of twelve, moving to amphetamines at fifteen. He had tried crack cocaine and LSD. He said that he had started to use heroin at the age of fifteen and a half because of the pain of his broken ankle. He thought he spent forty five pounds every other day on his drug habit. He had injected drugs on isolated occasions. In December 1994 he was prescribed methadone and temazepam by his general practitioner. He had not been seen by a specialist drug service.

24. The psychiatrist gave the opinion that patient D showed evidence of prolonged abuse of Class A and B substances, having used heroin regularly since the age of fifteen and a half. The behaviour did not form a mental illness within the meaning of the Mental Health Act. Patient D did not show any evidence of a formal mental illness. He commented that patient D did show abnormal traits in his personality, namely conduct disorder as a child, early substance misuse, an ability to blame others for his actions and an inclination to prolong the role of invalid. He did not consider that these amounted to a personality disorder within the meaning of the Mental Health Act 1983. He recommended a community drug rehabilitation programme if the Court made a probation order. There is no record in the clinical notes of the outcome.

1996

25. Patient D was readmitted to Lynfield Mount Hospital on 30 September 1996. He was brought to the ward by a cousin and a friend. He was agitated and overactive and expressing paranoid ideas. He expressed persecutory ideas about the staff on the ward. Patient D was considered to have a psychotic disorder and to be a risk to himself and others. He was assessed by a social worker and two doctors and placed on a Section 2 detention order.

26. The initial inpatient stay was marked by many episodes of absconding from the hospital during which he obtained and took heroin. His mother's concerns were published on the front page of the Bradford Telegraph and Argus on 7 October 1996. The clinical notes contain an exchange of correspondence between the consultant and hospital management about the high cost of providing an adequate level of staffing for the safe observation of patient D.

27. The consultant concluded in a report to the Mental Health Review Tribunal on 18 October 1996 that further time was needed to complete an assessment. The Tribunal agreed. The detention order converted to a Section 3 (six month detention) on 23 October 1996.

1997

28. Patient D was commenced on a depot antipsychotic medication. His symptoms settled and he was discharged on 30 January 1997. The diagnosis at discharge was of mental and behavioural disorder due to multiple drug use and use of other psychoactive substances.

29. Care Programme Approach (CPA) meetings were held on 6 March and 3 June 1997. The CPA was satisfactorily completed. On 3 June it was noted that patient D was avoiding his key worker. He was discharged from section 117 follow up, but was to attend outpatients. He failed to attend on 3 October, 21 November and 2 December1997.

1998

30. An entry dated 2 January 1998 stated that he was on remand in Doncaster prison. On the 5 January 1998, the consultant psychiatrist discharged patient D back to the care of his general practitioner.

31. On 26 January 1998, patient D was seen by the duty psychiatric Senior House Officer (SHO) at Bradford. He was accompanied by his mother who reported patient D had been sticking knives into the wall at home and had cracked a tooth with pliers. She also said that patient D had been abusing heroin up to the value of £90 per day, crack cocaine, as well as intravenous methadone 60 mgms. per day and methadone tablets and

nitrazepam. He had been shoplifting and was on bail to his father. He had been released from prison two weeks earlier.

32. The SHO discussed the case with the consultant. It was agreed that patient D would be seen in outpatients two days later and for an assessment to be undertaken by the drug and alcohol unit. The mother was advised to contact the police if Patient D became threatening.

33. Patient D did not attend the outpatient appointment, but his parents did. They reported that he had been arrested earlier for burglary. They described that patient D had said that he wanted to kill members of the family, including his mother's boyfriend, at that time.

34. Patient D was brought to the ward that day in handcuffs by the police. He was admitted as an informal patient, but the case notes indicate that he was to be detained if he tried to leave. He refused a depot antipsychotic and was offered an oral alternative.

35. He absconded from the ward on 30 January and attended his general practitioner who was unaware of his admission. The general practitioner prescribed methadone for patient D.

36. On 5 February he was subject to detention on a doctors' holding power (Section 5(2)). This would have lasted for up to seventy two hours. The section was converted to a Section 3 on 5 February 1998. He absconded on several occasions and on his return would inform staff that he been using heroin and cannabis. His behaviour was observed to be bizarre, chaotic and difficult. He was abusive and threatening to staff.

37. On 5 March 1998, patient D was transferred to a secure ward in the Lynfield Mount Hospital. The urine screen for illicit drugs became negative and he gradually improved. He was started on depot antipsychotic medication. A computerised tomography (CT) scan was undertaken and reported as normal.

38. Following his improvement, patient D was discharged to the community on 21 May 1998. His diagnosis at that time was of hebephrenic schizophrenia. He was to attend outpatients for the depot medication. A community psychiatric nurse (CPN) was allocated as Keyworker and a follow up CPA meeting was arranged for 26 August 1998.

39. On 21 July 1998, the CPN Keyworker wrote to the general practitioner in the following terms:

40. *"Just to inform you that I am having difficulty in keeping in touch with patient D. I have seen him two or three times now, made further*

appointments to see him but he never responds to the door. My social work colleague is also having the same difficulty and in fact has not been able to see him once since leaving hospital. He also fails to attend the consultant's outpatient clinic. I am at a bit of a loss as to know what to do next, although I am just about to organise a care programme meeting with the professionals who are involved and his parents and yourself if you can attend. It will be held on August 26 at 10.30am at The Elms. In the meantime I will endeavour to try and contact him."

41. Patient D did not attend that meeting and it was noted that there had been no contact since discharge. The social worker had made similar repeat attempts to contact him. By chance, patient D had been seen by the CPN at his father's house the previous day. There was no apparent sign of psychosis, but it was noted that the contact had been very brief. Patient D was discharged from his CPA, but remained on Section 117. This indicates a failure by those involved at the time to understand the CPA process and the requirements of section 117. However, there is no indication of any harm flowing from this. He did not attend a follow up appointment arranged for 7 September 1998.

42. On the 22 September 1998, the general practitioner wrote to patient D as follows:

43. *"I am giving you a written warning as it appears from our records that you are abusing your medication. If it happens again I will have no choice but to delete you from my list."*

44. On 14 November 1998, patient D was admitted to St Luke's Hospital in Bradford with an infected injection site at his right elbow. He was treated with antibiotics and discharged on 17 November.

2001

45. On 11 June 2001, patient D was discharged from HM Prison, Armley. Notice of his release was sent to his general practitioner. At that time he was prescribed an antipsychotic medication, olanzepine 10 mgm. daily. He was not referred to the Trust's mental health services.

2002

46. Patient D was an inpatient at Lynfield Mount Hospital in February and March 2002. The episode in February was 19 and 20 February. A similarly brief time was spent as an inpatient between 19 March and 21 March 2002. He discharged himself on both occasions. After missing three follow up appointments with the consultant at that time, patient D was discharged from follow up by the consultant on 18 June 2002. There is no record of these admissions in the hospital clinical notes, but the

Assertive Outreach Team (AOT) records indicate that the March admission ended when patient D took his own discharge.

47. Patient D was referred by his social worker to the AOT in June 2002. An initial review was carried out on 28 June and a follow up on 16 September. It was noted at that time that patient D was not on any prescribed medication and was not currently being seen by a consultant psychiatrist. His care was transferred to a worker in the AOT.

48. A risk assessment had been carried out by a social worker on 28 June 2002. His view was that patient D was at significant risk of vulnerability/exploitation and severe self neglect and low apparent risk of violence/harm to others and self harm.

49. The referral stated that patient D had frequent periods of being homeless or staying with different family members. He had most recently been sleeping in his mother's shed and staying with an uncle who could no longer accommodate him. He had previously been classified as 'priority homeless' and offered two properties which he failed to take up. The Housing Department stated they had discharged their duty regarding the homeless application for housing.

50. The AOT started to work with patient D in July 2002. The clinical records indicate a clear, intensive and continuing commitment to engage appropriately with patient D up until the time of the incident in July 2004.

51. Patient D was referred by his general practitioner to the drugs team on 27 September 2002. His GP wrote:

52. *"He is currently using £20 of Heroin a day. It seems that he sparks into action when he falls out with his family and becomes homeless and came to me today asking if he could be admitted to Lynfield Mount for detox. I said this was inappropriate as there had been no formal psychiatric illness diagnosed previously and I felt that referral to your team was more appropriate."*

1/11/02	Home visit by AOT consultant and team manager *"It appears that this home visit was brought about partly in response to patient D's mother's attempts to contact the duty social work team last weekend to ask for a Mental Health Act assessment. Patient D is a 25 year old single man currently homeless living with his mother who, since his mid-teens has quite a serious problem with heroin. At the age of seventeen he took an overdose of Methadone, experiencing a respiratory arrest*	AOT record

	which led to him being on a life support machine for two days. Mothers account is that her son has never been the same since, something that clearly distresses her a great deal. Patient D agrees, saying that his moods are up and down and his head is filled with strange troublesome thoughts. Both patient D and his mum agree that what he describes as "paranoid thoughts" only really became apparent following the episode of respiratory arrest. Since Then he has had a great deal of contact with mental health services, previously being under the care a consultant. He had a period of time of about fourteen to fifteen months, probably two or three years ago, when he was functioning reasonably well. He said he got rid of his depression, had no troublesome thoughts, wasn't using heroin, and things were going reasonably well. This appears to have followed an admission to hospital when he was started on Clopixol, but he discontinued the Clopixol shortly following discharge. *More recently he came out of prison (Armley) where he was sent for shop-lifting related to his drug habit. At the moment he is using £20 to £30 of heroin intravenously daily, and has been using this amount over the last twelve months. He described a lot of troublesome thoughts, worrying thoughts that friends and neighbours were going to get him and do bad things to him, although he was unable to be clear about the exact nature of these experiences. In the past he told me that he has heard voices, but denied this recently. His mum confirms that his behaviour has been really very difficult to cope with, presumably on account of his beliefs. He doesn't sleep, at times his behaviour is very disorganised, for example shouting in the garden at night. On occasions he has been physically violent, knocking out one of her teeth.* *Patient D was keen to have help, possibly because he is due to appear in court in connection with further charges next month. He clearly requires much more detailed assessment, and is willing to come into hospital informally so that we can do this.* *1. Admit informally to Lynfield Mount as soon as possible when bed available* *2. To start Methadone mixture on a variable dose initially until signs of withdrawal from*	

	opiates have settled (10mg oral as required up to a maximum of 40mg daily) *3. A full investigation including EEG and CT scan. The question in my mind is whether there is an organic basis to this young man psychosis."*	

53. Patient D was an inpatient at Lynfield Mount Hospital from 8 November 2002. He was noted at the time to be chaotic, disorganised and psychotic. He was started on depot antipsychotic medication and a mood stabiliser, sodium valproate. A feature of his stay was persistent absconding. He was placed on a section 2 detention on 14 November 2002 and this was converted to a section 3 on 11 December 2002.

54. He was noted to have been aggressive towards members of the nursing staff. On 6 December his notes record that he bit a nurse during an episode of restraint and that he head butted a nurse on 18 December. A CT scan performed on 6 December was reported as normal.

2003

55. Patient D's detention continued until December 2003. On 31 March 2003 patient D allegedly stabbed a patient on the ward with a potato peeler. He had returned from planned leave and was thought to have been drinking alcohol. He was arrested by the police and taken to the cells. He was charged, but the charges were later not pursued.

56. Patient D was transferred to a low secure environment at the Cygnet Hospital in Bradford (a private sector provider). His urine tested positive for opiates on admission. His medication was continued and he was started on a reducing dosage of methadone.

57. He was transferred to the low secure Kestrel Unit at Bradford on 16 April 2003 under the care of a consultant forensic psychiatrist. Patient D remained on the Kestrel Unit until 12 December 2003. He had made steady progress and was noted to have a stable mental state. Following a day of leave in October 2003, his urine tested positive for opiates.

58. At discharge the forensic psychiatrist made it clear that if there were problems in the community patient D should be readmitted to the acute wards and that if patient D refused his depot medication he should be re-detained.

59. Patient D was accompanied by a member of the AOT on the day of discharge. He was visited daily or on alternate days for the remainder of the month.

2004

60. Patient D continued to receive intensive support from the AOT during 2004. His care co-ordinator during this period was a part-time worker with the AOT, although the care input included other members of the team.

61. In May 2004, the AOT decided that a further period of inpatient detoxification treatment was required. Patient D agreed. A bed was available at Lynfield Mount Hospital on 11 May. However when patient D and the AOT worker arrived at the ward, the admission was stopped by the ward manager. It was stated that this was because of his previous behaviour which had left the staff traumatised and in need of counselling. Patient D was returned home.

62. An alternative referral was made to the Ripple Project, a community drugs service. Patient D attended his first appointment on 18 May accompanied by a member of the AOT. Support from the AOT continued through May and June. A documented risk assessment and revised Care Plan had been carried out by his Care Co-ordinator on 4 May 2004.

Assertive Outreach Records 28 June 2004 to the notification of the incident on 4 July 2004

28/6/04	*T/C 1800 from patient D's mother – sounding v. desperate & panicky. Contacted Prime Care to refer to GP service. Mother said patient D is using heroin & not taking any medication*	AOT notes Team manager Signed Name not printed
29/6/04 15.00	Reason for contact *Phoned back arranged with mother* Content *I spoke at length with mother, just allowing her to talk. She seems highly stressed. She has been experiencing panic attacks (won't take medication) lost weight down to 8st. 2lb. From 9st. Weighed herself at the Ripple Project when she visited with patient Ds' brother who is back on the drugs again. No support from her brother or sister. Patient D "back on the rocks" and taking his methadone on top. Mother said she is constantly crying but refuses to go to the GP. Worried she will lose her home – patient D hasn't paid any rent since he has lived there – all his money is being spent on drugs. Patient D has started shoplifting again. Out all day comes home starts arguing with her boyfriend. She can cope with the lads, it is her boyfriend who is hard to cope with, she talked about the time he blacked her eye. The boyfriend also using drugs/bullying patient D for his drugs. Patient D*	AOT notes CPN Signed Name not printed

	has been coming in the early hours of the morning and sleeping on the bedroom floor. Action requested *Arranged support visit at mother's request 11.00am 30/6/04*	
29/6/04 Not timed	Reason for contact *I spoke to mother some concern she states she is highly stressed and going to stay with her other son. Someone in the background talking to her, she then said I could phone back in an hour.*	AOT notes Community Support worker Signed Name not printed
29/6/04 Not timed	Reason for contact *To improve engagement with AOT in a meaningful way to help patient D to build confidence to tackle drug misuse & to improve social contact.* Content *Knocked repeatedly at the family home. No reply.* Action requested *Attempt again to visit on Friday, scheduled visit.*	AOT notes Team leader Signed Name not printed
29/6/04 Not timed	*Attempted to contact Ripple Project re current situation with patient Ds' drug usage. Ms T is patient D's key worker. She will be made aware of our current concerns & will contact.*	AOT notes Signed Name not printed
30/6/04 Not timed	Reason for contact *Team workers visited patient D and his mother. Planned visit to address concerns from mother & monitor patient D's mental state.* Content *Following visit I received a telephone call from one worker raising issues about patient D's mental state, he was paranoid, mum reported patient D had been into her bedroom approx 10 times overnight. She also reported patient D was hiding knives under his mattress. The worker reported the family was at crisis point with many family members abusing substances. The situation was discussed with the consultant who visited the house with the worker. The consultant did not feel the MHA needed to be utilised at this time. The worker brought patient D back to the team base. He presented as agitated, unable to stand still. Patient D's body language was becoming increasingly hostile towards the worker. I went out and spoke to patient D about 'respite' care. Patient D agreed to spend tonight at the 'Beehive' bed and breakfast and tomorrow to have 1 weeks respite at Oaklodge. As soon as patient D knew this he wanted to go. Worker took him to the Beehive. The consultant prescribed rispiridone 2mg and zopiclone 75mg 7 days supply. We*	AOT notes CPN Signed Name not printed

	attended the Beehive. Patient D was sleeping. The landlord gained access. Patient D took a lot of rousing! A bottle of cream sherry was in the room with ¼ bottle empty. Patient D took his medication. Following the earlier intervention with patient D, the worker reported patient D had made inappropriate remarks about female staff. His mother also reported that patient D was commenting inappropriately about girls walking past his house. Patient D was expressing ideas about Michael Jackson and shouted at a 'black' man who was waiting at the bus stop at Ashgrove. Patient D was much calmer at the Beehive. *Action required following contact* *Keep mother informed of how patient D is. Patient D can go to Oaklodge after 11am today.* *Worker contacted mum to keep her informed of events. Mum was tearful and worker reported she was slurring her words. She would like a telephone after today's visit.*	
1/7/04 11.00	Reason for contact *Rang Oaklodge to confirm place for patient D is available. Informed a place is available and they're awaiting patient D's arrival.* Action required following contact *We went to pick up patient D from the Beehive but he was not there. The owner said he had left with the room key and they need this back asap. Team manager informed of above*	AOT notes Community support worker Signed Name not printed
2/7/04 Not timed	Reason for contact *Received a phone call from worker who is at the ward. The consultant stated that we need to start contacting the police regarding patient D as a missing person and doing a section 136.* Action required following contact *I told the worker I would contact patient D's mother first*	AOT notes Student nurse Signed Name not printed Supervisor not signed
2/7/04 Not timed	Reason for contact *Contact patient D's mother regarding where patient D might be. She stated he has come home and is with her. Stated patient D did not like it at Beehive and needs supported accommodation* Action required following contact *I will let worker know that patient D is with his mum.*	AOT notes Student nurse Signed Name not printed Supervisor not signed
2/7/04 Not timed	Reason for contact *Contacted worker to let her know that patient D is at his mother's house. She advised me to let the consultant know and asked me to ask patient D' mother if he would still like his place at Oaklodge.*	AOT notes Student nurse Signed Name not printed

	If not the contact Oaklodge to cancel his place. Action required following contact *The consultant wants us to go and see patient D at his mum's house to see what the situation is and if they are worse than Wednesday. If so he can do section 3 papers.*	Supervisor not signed
2/7/04 Not timed	Reason for contact and contact *Spoke with consultant re concern around patient D, asked to visit and assess situation.* *Visited with worker. Patient D not initially present. Mother extremely distressed about current situation. It transpires patient D had returned from the Beehive at 7am, complaining people had been attempting to enter his room. Mother went on to say that patient D was very suspicious constantly awake through the night, trying doors etc., demanding money and threatening. Patient D eventually returned while this, noted to be very guarded, suspicious & notable 'paranoid' at our presence. Mother stated patient D refused to take any oral medications, but his increase of illicit substances was high. Stated we would have to speak to the consultant re-organise a MHA and that it would most likely be next week. Also advised mother if patient D was arrested or any incident to request a Mental Health Assessment straight away and would also request weekend staff to visit. It was apparent that family now at crisis point. Rang consultant and message left.* Action required following contact *Consultant rang back, explained current situation, instead of waiting until next week Section 3 MHA to be put into action. Consultant to contact duty team at Daisy Bank to commence proceedings. Mother contacted and informed.*	AOT notes Nurse practitioner Signed Name not printed
2/7/04 Time stamp 17.28	Facsimile referral to EDT Form A1 Referral by telephone undertaken by Duty Social Worker, Daisybank Reason for referral *Sect. 3 medical rec. done today – based on examination on 30/6 – left on Oakburn ward – bed available there also.* *Patient D is convinced Michael Jackson controls his thoughts and as a result is hurling abuse @ Asian & Afro-Caribbean people. Making inappropriate comments to teenage girls. When consultant saw him 30/6 he felt the whole household in chaos –(personal comment concerning mother) – her boyfriend using street*	ASW Duty Manager Signed and printed

	drugs (as does patient D). AOT thought this was manageable and got respite for him @ the Beehive but he never stayed there. Then patient D turned up at his mum's last night. Patient D appeared about 8 times in his mum's bedroom just staring at her – this she found alarming. AOT felt he was in need of hospital when seen today. He's refused meds. for the last 4 months and is driving around with his brother in his car using crack and heroin. Currently on DF118s and methadone – prescribed by the Ripple Project. Had a lengthy admission Jan 03 on Sect. 3. – <u>He knifed someone when but under the influence of alcohol – spent period of time with forensic services – mum says he may have a knife on him and believes he has some in his bedroom.</u> *2/7/04 T/C to mother (n/r) <u>she does not object – can we ring on her landline to confirm what time we're coming.</u>* *2/7/04 T/c to 5 Sec 12 Drs. (GP not rung back) <u>A Dr can attend at 6.45pm – ring back and confirm telephone number given</u>* *Mum states he's not there currently – <u>but due back between 6 & 7.</u>* *See case notes* Hand written facsimile form Re; MH Act assessment patient D *AOT referred patient D for MHA @ 3/30. A bed is reserved on Oakburn. Consultant has left a med. rec. on Oakburn.* *Patient D is not currently @ home. Whereabouts n/k. His mum thinks he <u>may</u> be home sometime between 6&7.* *GP has been contacted x3 but as yet had no response either way.* *AOT ASW phoned 5x S12 doctors. S12 doctor available from 6.45 as S12.* *Contact details are attached.* *Have tried to phone to discuss since 4.50pm. Will hold on here until we are in receipt. If you require more inf. Tel no. stated.*	

	5/30 Discussed with EDT social worker. He will liaise with n/r and S12 doctor ??? MHA *5/45 T/C to Oakburn* *Spoke to senior nurse* *Senior nurse concerned that this hasn't been cleared with duty senior nurse.* *Consultant had been to ward and left a medical rec. so they are aware, but nurse present wasn't senior duty nurse.* *Spoke to Senior duty nurse. She was aware it had been handed over from DN before 5pm. Spoke to duty nurse again and confirmed use of leave bed.* *<u>Asked them to reserve unless EDT advise otherwise.</u>* *<u>2nd facsimile</u> not timed* *More inf – confirming with Oakburn that EDT doing but to confirm need to reserve bed for Patient D till further notice.*	
3/7/04 Not timed	Reason for contact and contact *Phone call to EDT, spoke to duty social worker for feedback on situation re MHA assessment for patient D.* *Social worker informed me that he received the referral from duty team at 5pm yesterday, because they had been unable to find a doctor. The social worker had phoned mother who said that patient D was out – she was asked to ring EDT when patient D returned but she did not call back. The social worker called mother again this morning – she told him patient D had returned at 9pm, but she had not called back because he had been o.k. Patient D had gone out again this morning to collect his methadone and visit his sister, as he usually does. Mother has been asked to ring EDT back when patient D returns today. The social worker asked about the urgency of the MHA assessment – relayed to him our notes of events of yesterday/last week. The social worker asked if I could attend the MHA assessment if it goes ahead today. He will call and let me know when he has spoken to mother.* Action required following contact *To await call from EDT*	AOT notes Locum social worker
4/7/04	*On call. – phone calls Oakburn Lynfield Mount*	AOT notes

Midnight 00.10 00.20	*Hospital rang worker informing her that a detective constable would be contacting her shortly re incident involving patient D.* *Detective constable informed AOT worker of incident happened at Patient D' home. Step dad had been murdered.*	CPN

6.0 Response of the Local Services to the incident

63. Following the arrest of patient D, the Chief Executive of Bradford District Care Trust and the Director of Social Services of the City of Bradford Metropolitan District Council jointly established a review panel. Membership comprised a non executive director of the Trust, the medical director, risk manager from the Trust, the risk manager of the West Yorkshire Strategic Health Authority (SHA), a divisional services manager from the Council and a member of the service implementation team of the Northern Regional Development Centre of the National Institute of Mental Health. The group was chaired by the Operational Director of Adult Mental Health of the Trust.

64. The SHA had been advised of the incident by the Trust by way of a serious untoward incident report dated 5 July 2004. This is in accordance with both the SHA and Trust policies.

65. **Importantly, the Trust and its staff gave support to patient D's mother at the time and this support has continued. The Team Manager continues to accompany her on visits to see her son at a High Secure Hospital. Both the Trust and Team Manager are to be commended for this aspect of care.**

66. **Terms of Reference of the internal review panel**
Taken from the internal inquiry report (throughout this section the use of *italics* indicates direct quotes from the internal review).

"This review has been set up at the request of the Chief Executive of Bradford District Care Trust and the Director of Social Services of the City of Bradford Metropolitan District Council.

Its purpose is to review the care of patient D in the period from 30th June 2004 until the 3rd July 2004, which immediately preceded the killing of Mr X, for which patient D is presently on remand charged with murder.

The preliminary investigative process has produced a substantial volume of written information in the form of statements and interview records, which along with patient D's care notes will be available to the review panel. The panel may however wish to interview or reinterview some of the key players in patient D's care as the review progresses.

Having reviewed the case the panel should produce a report that highlights good and bad practice across and between agencies, and where appropriate make recommendations to improve services and reduce the likelihood of similar incidents recurring.

The report of the review team will be presented for consideration and action by their respective organisations to the Chief Executive of Bradford District Care Trust and the Director of Social Services of the City of Bradford Metropolitan District Council."

67. **Process followed by the Panel**
Taken from the internal inquiry report
"A core team of 4 senior staff from Bradford District Care Trust and The City of Bradford Metropolitan District Council carried out the initial enquires, namely

- *Collected initial written statements, from across agencies, of staff involved in the care of patient D in the period leading up to the death of Mr X.*

- *Reviewed the clinical notes relating to patient D's care since he came under the care of the Assertive Outreach Team.*

- *Produced an initial Time Line of events from Wednesday 30th of June 2004 until Saturday 3rd July 2004.*

Following analysis of this initial data a list of individuals for formal interview was compiled and dates set for interviews agreed. Two new people were added to the list of staff for interview who had not given initial written statements. Two Bradford District Care Trust staff were not interviewed as their involvement was limited to after the death of Mr X at the request of police to facilitate aspects of the criminal investigation.

- *All staff identified as having a contribution to make to understanding the care of patient D were interviewed by at least 2 members of the core team.*

- *Notes of the interviews were given to the interviewees for comment on accuracy and signature.*

The full panel was then convened and met for a half day session on three occasions

At the first meeting each panel member was given a file containing

- *Draft Terms of reference*
- *Summary of the case*
- *Original written statements and attachments*
- *Time line of events*
- *A chart of the services involved with Patient D*

- *Notes of the subsequent interviews*
- *The assertive outreach team operational policy*
- *Extracts from the Assertive outreach team Notes for the period of 30th June 2004 to 3rd July 2004*

Having accepted the terms of reference the panel were taken through the pack and were able to clarify a number of issues and to ask for further information to be gathered. Panel members agreed to review the contents of the pack in preparation for the next meeting. The panel were also able to request further information from or raise any queries with the chair.

There was much debate as to whether patient D and / or his mother should be interviewed. It was agreed that in view of the criminal investigation it would be inappropriate to persue an interview with patient D. The panel did feel however that provided the police expressed no objection and the mother was prepared to speak to us then two of the core team would interview her.

In between meetings:

- *Ms Y was interviewed at home in the company of one of her daughters.*
- *A number of points of information were received from panel members and clarified.*

At the second meeting panel members were apprised of the content of the mother's interview .In particular that it had raised some discrepancies with the information given by the Emergency duty team.

The panel also identified and discussed the key issues as they saw them relating to the care of Patient D and began to think about possible lessons to be learned.

In between meetings:

- *Two members of the core team re interviewed the social worker from the Emergency duty team to try and clarify the discrepancies raised by the interview with the mother.*

- *The chair drafted the final report based on the team's discussions and views.*

At the third meeting the team reviewed and amended the draft report and agreed its final form. The review team unanimously agreed the content of the report and that it should be submitted to the Chief executive of Bradford District Care Trust and the Director of Social Services of The City of Bradford Metropolitan District Council.

7.0 Independent Inquiry Comment on the internal review process

68. **The panel was convened promptly and statements taken and interviews carried out in a timely fashion. This was good practice.**

69. Although the panel intended to follow the process as detailed above and in the Trust incident policy for the review, in fact this did not occur to the extent that they subsequently believed. Three members of the AOT stated that they had not received the notes of their interviews to 'sign off' as complete or correct. Several said that they had not seen the terms of reference. Greater clarity of the procedure is required.

70. Although the terms of reference refer to the dates of 30 June to 3rd July 2004 as being of significance, the chronology clearly indicates that the impending crisis started on 28 June. The review should have included events of that day and the events of 29 June. The events recorded on 29 June demonstrate at some length a deteriorating social and clinical situation, the significance of which should have been more thoroughly investigated at the time.

71. Neither the team manager nor AOT worker, both of whom were involved with Patient D's care on the 1 July were asked by the internal review about their involvement that day. The team manager had also been involved in Patient D' treatment on 28 June which also did not form part of her evidence. Regrettably therefore, the opportunity for gaining potential additional information was not taken. What the information available from the records would have emphasised is the importance of the response from the EDT.

72. The panel itself highlighted concerns about events on the 1 July and the failure to inform the consultant of the situation. It did not pursue those concerns with the members of staff involved. Whilst it is now merely speculation as to whether events may have been different, informing the responsible consultant of a deteriorating situation must always be a priority for members of the team. It is essential when undertaking an internal review that all staff involved are identified, the extent of their involvement identified and that they are given the opportunity to comment on that involvement. This did not happen in this case. The reasons for this are not stated in the internal inquiry report.

73. **Recommendation - when undertaking an internal review, all staff involved should be identified, the extent of their involvement identified and that they are given the opportunity to comment on that involvement.**

74. The Trust has an Incident Management Policy which was approved by the Trust Board in October 2004. This gives the detail of the process to be followed. In fact, the process is not given in sufficient detail or clarity to prevent the misunderstandings and process failures described in this case.

75. Primary Care Trusts (PCTs) have the responsibility of commissioning safe and effective services for the population which they serve. The attendance of a representative from the primary care trust during an internal review of a serious incident is a particularly important point to assure the integrity and transparency of the proceedings. In this case the PCT was not a party to the review of the service which it commissions.

76. **Recommendation - a representative of service commissioners should be invited to attend appropriate post-incident reviews carried out by provider organisations.**

77. **Recommendation - the Trust should redraft its Incident Management Policy to ensure clarity of goals and processes to be followed. The amended policy should be approved by the Trust Board and an audit should be done on an annual basis to review how the policy is working in practice.**

78. Examination of the clinical records indicates that, although thorough from a clinical perspective, the records do not comply with the requirements of the Nursing and Midwifery Council. This was not picked up or commented on by the internal review team.

79. The Operational Policy of the AOT states at paragraph 19 a.,
RECORD KEEPING:

"Record keeping is an integral part of mental health workers practice, irrespective of discipline. It is a practice tool which should assist the care and communication process. It is not separate from this process and not an optional extra. Records are also legal documents and in a court of law "if it has not been recorded it has not been done".

The Assertive Outreach Team keeps a single multi disciplinary record which contains a minimum demographic dat set, initial referral form, initial assessment form, CPA documentation and progress and review notes.

20.3 All staff must ensure that an accurate and up to date account of all service user contact (direct or proxy) is detailed in the case notes.

20.4 Entries should be clear in content and legible and should, where possible be made immediately after a contact by/on behalf of a service user.

20.5 Each member of staff should be aware of their own particular professional guidelines and code of practice e.g. Nursing and Midwifery Council documents 01.12.00,

General Social Care Criminal Codes of Practice, Social Services Inspectorate Guidelines April 2000."

80. **Recommendation - the Trust should formally adopt the standards for record keeping required by the relevant national standards for the disciplines working at the AOT.**

81. **Recommendation - monitoring standards of record keeping and compliance with nationally recommended standards should form part of the clinical audit programme of the Trust.**

8.0 The Internal Inquiry Report (Reproduced as stated)

Throughout this section, the use of italics indicates direct quotes from the internal review.

Key Issues and recommendations
Having reviewed all of the information available, the Panel has set out what they see as the key issues in the Case.

The issues are dealt with as they arose over the key 4 day period, from 30th June until 3rd July 2004. The Panel have recorded their observations and where appropriate, made recommendations for change.

Wednesday 30th June 2004

Observations

The Assertive Outreach Team responded promptly to a deteriorating situation, with patient D and the home situation being assessed, firstly by his Care-Coordinator and secondly his Consultant Psychiatrist.

The risks in the situation were clearly assessed and a decisive plan of care was agreed upon introducing medication, respite care and increased support and observation by the Team on a daily basis.

The decision to go for 'Respite Care' rather than admission seemed to have been because of patient D's reluctance to go to hospital. Patient D's reluctance was partially attributed to a bad experience when staff refused to admit Patient D when he presented for a detox some months earlier.

The decision to use the Beehive public house/hotel for the first night of 'Respite' was questioned by some of the Team, but following a full team discussion this course of action was supported. The Team were clearly being innovative and applying a tactic of removal from the family home (which had worked in the past), this course of action is clearly inline with the model of Assertive Outreach.

Whilst there are a number of entries in patient D's Assertive Outreach Team notes, there is no re-visiting and re-writing of his formal care plan and although as assessment of risk by the Team took place, this was ***not*** *formally recorded by completing an updated face risk assessment.*

Thursday 1st July 2004

Observations

There is a lack of information and an apparent lack of action on Thursday 1st July according to the official notes. The use of non permanent methods of recording instructions like white boards and the use of brief notes as records of team meetings may have contributed to the incomplete nature of patient D's records during this time of a rapidly changing picture.

Although staff from the Assertive Outreach Team went to pick patient D up from his overnight accommodation and made enquiries as to where patient D was (including contacting the family), there was no sense of "proactive looking" for Patient D.

It is of some concern that patient D's Consultant was not informed of this turn of events until Friday 2nd July.

Friday 2nd July 2004

Observations

Once the consultant was informed of patient D not having complied with Plan of Care, a sense of urgency is evident.

Once the Assertive Outreach Team had re-established contact with patient D from lunch-time, a clear and appropriate change to the Plan of Care is agreed between the consultant and the Assertive Outreach Team.

The process of obtaining a mental health act assessment is agreed and communicated fully to the appropriate people and an appropriate bed identified should the assessment lead to admission.

It is noted that because of the absence of the only Approved Social Worker in the Assertive Outreach Team, that the Mental Health Act Assessment was passed to the Trust ASW Duty System immediately.

The ASW had some difficulty in finding a doctor for the second medical opinion ant it was evident that this was not an isolated incident. Patient D's GP also had some difficulty in contacting the ASW Duty Team by telephone.

Patient D's Mother was contacted by the ASW Duty Team and was agreeable to the Mental Health Act Assessment going ahead. She was very clear and she felt patient D should be in hospital.

At 17.30hrs the Duty ASW Team decided that they would pass the Referral for a Mental Health Act Assessment on patient D to the Local Authority Emergency Duty Team (EDT). There appears to be no formal guidance on when or why a referral is passed on to EDT. This is left for individual negotiation with EDT by

the Referrer. There is however a widely recognised professional expectation that where possible individual practitioners will finish assessments they have initiated.

Information about the referral of patient D was faxed to EDT and there was a one-to-one discussion between the ASW Duty Team Manager and the Senior Practitioner in EDT.

The information passed over appears to be adequate as to what the plan and reasons for referral was and the level of risks. However there was a lack of any contingency planning.

EDT appropriately made contact with patient D's mother and was informed that patient D was not at home. EDT believes they had an agreement with her that she would ring EDT if Patient D returned. EDT believed that this was an appropriate course of action. Ms Y has subsequently said her telephone can only receive incoming calls, and not make outgoing ones.

EDT was very busy that night, which they said was not untypical for a Friday night. The EDT handles all out of hours emergency referrals, which include all Childcare, Elderly and Mental Health Referrals it was of some concern that EDT could not articulate how prioritisation of referrals were made.

There was an inconsistency in understanding of the EDT Team Members as to the availability of Health Record information to them, it is not directly available but is available via the senior nurse at Lynfield Mount Hospital.

It was noted that patient D's mobile phone number was recorded on the records shared by all agencies but there is no evidence of anyone having attempted to contact him by this means.

Saturday 3rd July

Observations

EDT telephoned Ms Y at 9.00am, patient D had returned at 9.00pm on Friday but had already left to get his methadone and was not expected back until 12.00noon. Again, onus put on to the mother to contact EDT, even though she had not done so the night before.

Assertive Outreach telephoned EDT at 10.00am and again at 4.00pm. It was clear that no call had been made to the mother other than the 9.00am call. Assertive Outreach say they offered to get involved in Mental Health Act Assessment if needed. There was a disagreement about how long this second call lasted and if the Assertive Outreach Team had been as forceful about urgency of assessment as they said.

Although EDT had taken responsibility for the mental health act assessment, the responsibility for co-ordination of patient D's care overall remained with the AOT.

The next contact with EDT was from the police at 11.00pm who were looking for an appropriate adult to be present when they interviewed patient D who had been arrested on suspicion of having killed Mr X.

8. Conclusion

This has been a very a difficult case to review because of the tragic circumstances in which a family has been shattered, with one member of the family unit dead and another in jail charged with murder. The process has been made easier for the panel because of the open and co-operative way with which everyone has met our enquires.

The staff involved in patient D's care within the assertive outreach team have clearly worked very hard to build relationships with patient D and his family and to keep him engaged with services. They are also very committed to the assertive outreach model.

The panel acknowledged that mental health professionals working with people living such chaotic life styles frequently face difficult dilemmas when deciding what is the best way to provide the necessary care. They constantly struggle to find the right balance between ensuring the necessary treatment is provided and maintaining a positive therapeutic relationship. The panel considers that, in delivering care to clients with lifestyles that are often chaotic, often complex and often in crisis, a pro-active assertive approach to treatment must be taken despite the difficulty this may cause in relationships with the client.

There are clearly good working relationships between individual professionals, teams and agencies. However, there is evidence that the systems that underpin and support this joint working are in need of review. In particular, the joint review of the duty ASW systems, emergency duty services, and the development of crisis services are a great opportunity to ensure that the whole system is improved seamlessly and for the benefit of the people who need the services.

The review panel has made a number of observations about the shortcomings of some of the systems, highlighted some gaps in service infrastructure and has made strong recommendations that these issues are rectified quickly. The panel has also come to the conclusion that no professional could have anticipated the sequence of events which lead to Mr X's death and patient D's subsequent arrest on a charge of murder."

9.0 Independent Inquiry Commentary on Trust Internal Review Recommendations

82. As part of the independent inquiry, the lead officer nominated in the Trust Action Plan to take action on each recommendation was interviewed and appropriate support documentation examined.

Recommendation from internal review report	**Evidence assessed and action taken up to 15 July 2006**	**Comment**
1. As is the present policy, following such a clear deterioration of a client's condition, a formal care plan and risk assessment must be reviewed and recorded in the Client working notes. Such plans should clearly set out the Client's needs, i.e. how these needs are to be met and who is responsible for each aspect of the plan.	Operational policy Nov. 2005 Audit of adults on enhanced CPA Spring 2005	Complete Appropriate recommendation and response
2. The Care Trust needs to be clear about Criteria for admission and who has authority to refuse admission and the process to do so.	Admissions policy Minutes of ward manager meetings indicate implementation	Complete Appropriate recommendation and response
3. When clients are refused care in a particular setting, e.g. the Hospital, the reasons should be shared with the Client in an appropriate and professional manner. Failure to do this is liable to prejudice clients from accepting appropriate care in the future.	Training and appraisal package (ROAD) with monitoring of the implementation of the training package.	Complete Appropriate recommendation and response

4. The use of respite care in a local hotel/public house was an innovative tactic that had worked for other clients in the past. However, the panel feel that approved and appropriate "crisis" accommodation should be more readily available for use by this client group.	Accreditation of 'appropriate' accommodation' was rightly not pursued by the local authority	It is not the role of the Local Authority to accredit crisis accommodation and the recommendation should not be further pursued.
5. Assertive Outreach Team should review how they work in situations where domestic violence is an issue.	Operational policy Training package – Domestic Abuse Awareness course and attendance records (75% staff had undertaken training at the time of this review)	Complete and continuing Appropriate recommendation and response
6. In line with present guidance client notes need to be kept up to date and in the case of a client in crisis, it is imperative for good communication between team members. As a minimum, such client's notes should be up to date at the end of each working day.	Operational policy Nov. 2005 Forms part of audit programme	Complete Appropriate recommendation and response
7. If the practice of using white boards is to continue (and given the nature of this sort of team this can be understood) then Technology must be used like the white boards that allow a permanent record to be taken at the push of a button	No longer relevant to the working pattern of the AOT.	
8. Equally the practice of recording team meetings should be introduced for later transcribing as a permanent record.	New format and procedure for recording team meetings introduced April 2005	Complete Appropriate recommendation and response

9. In circumstances where a client who is giving concern fails to follow/comply with an agreed plan of care, and drops out of contact with the service, attempts to re-engage should be clearly recorded in a Care Plan.	CPA and DNA policies Audit of CPA for adults on enhanced CPA CPA and DNA policies include action to be taken in the event of a failed visit.	Complete Appropriate recommendation and response
10. Where a responsible medical officer is actively involved in the care of a client like patient D, they should be informed at the earliest opportunity of any significant change in circumstances, or a deterioration of the Client's condition.	CPA audit, but does not record the actual time of RMO contact	Appropriate recommendation but incomplete response See recommendation in Section 2.
11. The panel are aware that the Care Trust and Council have set up a review of ASW Duty systems and would encourage it to report quickly and any recommendations to improve the system be implemented as a matter of urgency.	This recommendation ties in with recommendations 13, 14 and 19. A post for an ASW was advertised in July 2005, but received no applications. A further advert in November 2005 did result in an appointment. With the development of the Crisis and Home Treatment service the post is to be readvertised. A meeting was held on 10 July 2006 between the independent inquiry author with the acting Chief Executive of the BDCT and acting Director of Social Services. At this meeting initial steps were taken to agree action to address the roles and responsibilities and operational workings of AOT, EDT and CHRT.	See recommendation in Section 2

12. Clients, in line with the rest of society use portable methods of communication e.g. mobile phones. Practitioners should be aware of this and use such channels of communication when available as in this case.	Operational policy October 2005 Indicated as complete in October 2005, but reliability of evidence is an issue. This is not a SMART recommendation and cannot be easily measured as completed.	
13. The need to clearly describe how priority decisions are made needs to be reinforced with the EDT.	See recommendation 11. Action has been taken through supervision, training and team meetings to ensure that staff in EDT are clear about how priority decisions are made	Partially Complete Appropriate recommendation and response, subject to recommendation 11
14. The stance taken was to place the onus of contact on the nearest relative. The panel believe that as a general rule the responsibility lies with the professional and not the relative or carer. The panel would expect this will be advocated as good practice for staff in all organisations involved in Mental Health Act assessments	See recommendation 11.	Appropriate recommendation
15. The GP had great difficulty in reaching the ASW Duty Team by telephone. The provision of a dedicated line, which is not to be used for outgoing calls, should be considered along with the use of electronic mediums such as e-mail.	A dedicated telephone line has not been identified as an issue on other occasions. Under consideration as part of a social services review of out of hours services. Date of completion of this project is not available.	Appropriate recommendation

16. The use of a standard referral document to EDT should be considered that specifically includes the referrer's assessment of risk and urgency of referral and should also include any contingencies.	Referral form Described as complete with the issue of a newly formatted Alert Form. Forms address appropriate information requirements. Stated as introduced May 2005	Complete Appropriate recommendation and response
17. There appears to be a significant problem with finding a 'second opinion' doctor for Mental Health Act Assessments. The Care Trust and Council should review this situation with the local Primary Care Trusts.	Register of S 12 (2) approved doctors issued June 2006 by Doncaster and Humber NHS Trust. Stated not to be a problem at present.	Complete Appropriate recommendation and response
18. The Care Trust's Total Care System should be directly available to EDT practitioners	The Total Care system is directly available to EDT practitioners. Stated by EDT as implemented February 2006 (stated as May 2005 in action plan)	Complete Appropriate recommendation and response
19. Although contact was made between the EDT and AOT, much more could have been made of the opportunities to plan and work together over the Saturday to try and find patient D and get the Mental Health Assessment done. Care Trust and Council Managers should review the way out of hours services relate to and work with each other.	See recommendation 11.	Appropriate recommendation and response

20. All those involved in mental health need to review how proactive they are in maintaining contact with relatives when a request for a Mental Health Act Assessment has been received. Written guidance incorporated into operational policies should be available. **One telephone call a day is not acceptable.**	See recommendation 11	Appropriate recommendation

10.0 Independent Inquiry comment on Internal Inquiry Report

83. Unbeknown to either the internal panel or the professionals at the time was the fact that patient D later stated that he had been experimenting with amphetamines in addition to heroin, methadone and crack cocaine in the two days prior to the killing which may have its own additional psychotropic effect.

84. The recommendations of the internal panel were appropriately presented to the Trust Board on a number of occasions since the internal review reported. A table was prepared to record progress towards implementation of the recommendations and individual leads for the recommendations identified. Many of the recommendations have been signed off as complete.

85. However, whilst the recommendations of the internal review were clearly designed to address areas identified for change and improvement, the lack of definition, clarity and measurability in some of them means that assessing their successful implementation is unnecessarily difficult.

86. **Recommendation - the Trust should adopt SMART criteria for the recommendations of future service inquiries and reviews.** The SMART acronym stands for the characteristics of a recommendation which is:

    S pecific
    M easurable
    A chievable and Agreed
    R ealistic
    T ime specified

87. One key recommendation of the internal review (and subsidiary in several others identified) related to the referral of out of hours cases to the Emergency Duty Team and the working relationships between the EDT and daytime services. Those recommendations have still to be implemented. **Without clarity of the roles and responsibilities of these parties, the operational risks to clients arising from the services will not have materially changed since July 2004.**

88. **Recommendation - roles and responsibilities of members of the AOT, Crisis Resolution and Home Treatment Team and the EDT**

    a. **There should be a joint agreement signed by the chief officers of the Trust and Social Services to specify the roles and responsibilities of all members of the AOT, the CRHT and the EDT.**

    b. **There should be an agreed, documented operational policy on how the three teams work to best meet the needs of patients and carers, including specific reference to how cases are prioritised and how contact is made with patients and carers**

    c. **There should be training for all staff on their roles and responsibilities and the operational policy**

    d. **The working of the teams should be subject to annual review and the outcome of this review should be reported to the chief officers of the Trust and Social Services.**

89. The above recommendation is designed to address the outstanding points from the internal inquiry (recommendations 11, 13, 14, 19 and 20).

90. Where an inquiry involves the staff and services of more than one statutory authority, consideration needs to be given to the appropriate forum to monitor the implementation of recommendations and to provide an assurance of this to the appropriate organisations. Whilst not detracting from the autonomous statutory responsibilities of the organisations, in the present case this role could be undertaken through the Joint Co-ordinating Group which monitors the Section 31 agreement between the Bradford Metropolitan Borough Council and the Trust. The Chair of the Group is the Acting Director of Social Services.

91. Recommendation - The Joint Co-ordinating Group should be considered as the monitoring group for the implementation of recommendations affecting complementary services provided by the Trust and Social Services.

92. In order to be placed in a position of exercising clinical judgement, it is essential to ensure that the RMO is informed of any significant changes in circumstances or a patient's condition. This did not occur on 1 July 2004.

93. Recommendation - to ensure that the RMO is informed of any significant changes in circumstances or a patient's condition, an audit should be conducted on at least an annual basis of all patients admitted to hospital over a defined period to record the time of identification of a defined risk threshold and the time senior medical input was requested and delivered.

11.0 Independent Inquiry Response to the Terms of Reference

TERMS OF REFERENCE FOR THE INDEPENDENT INQUIRY

To examine:

- **The care the service user was receiving at the time of the incident**
- **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, the clinical decision making process and communication of information and joint working between those involved in the service user's care**

94. Many aspects of the care received by patient D prior to the incident demonstrated the flexible responses of a dedicated service. The care reflected the patient's history, lack of engagement and presentation and can therefore be considered as appropriate. The risk assessment carried out on 4 May 2004 was adequately performed as was the resulting Care Plan. Standards of care met statutory and professional requirements, with the exception of record keeping. The internal review identified that the consultant should have been informed of the patient's condition on 1 July 2004. The independent inquiry author shares that view. However, it would be naive to suggest that the outcome would necessarily have been different had the information been imparted. The joint working within the AOT was of a good standard. The joint working between the AOT and EDT (and the new Crisis Resolution Home Treatment Team (CRHT) needs to be improved as a matter of real importance by a greater and agreed clarity in their mutual roles and responsibilities.

To identify:

- **The root causes of the incident and key learning points for improving services**

95. The independent inquiry considers that the internal review correctly identified through root cause analysis appropriate service and system issues and learning points for improvement.

- **The developments in services and action taken since the time of the incident**

96. The services have moved on with the adoption of many of the internal inquiry recommendations. For example, the communications between the AOT and EDT services have been strengthened with the adoption of a new referral form. However, there is still a lack of clarity about the roles and responsibilities of the AOT and EDT. Senior management input and direction was needed for this to occur. It is now clearly the intention of both the Bradford Social Services and BDCT that this will occur following a meeting between the independent inquiry author and the two acting heads of the statutory services. A CRHT has been developed and its role and the joint working between the three teams now needs to be clarified as a matter of urgency.

To make:

- **A judgment as to the extent to which the action plan prepared by the internal review team and actual action taken to date addresses the root causes of the incident and key learning points**

97. The action plan produced by the Trust addresses, as far as possible, the significant risks associated with patients arising in this case. Some additions around record keeping are recommended in section 2.0. The internal review's recommendations would have benefited from adherence to SMART criteria.

- **Where necessary, realistic recommendations for further action to address the root causes and to improve services**

98. The recommendations of the independent inquiry are listed in section 2.0 of this report. If adopted and implemented, these should have a positive impact on reducing risks in the service.

Appendix 1 - Job Titles of Persons Interviewed

Acting Chief Executive, Bradford District Care Trust
Acting Director of Social Services, Bradford Metropolitan District Council
Director of Operations and Nursing, Bradford District Care Trust
Medical Director, Bradford District Care Trust
Assertive Outreach Team Manager, Bradford District Care Trust
Assertive Outreach Team members, Bradford District Care Trust present on 14 June 2006
Divisional Services Manager, Bradford Metropolitan District Council
Assistant Director of Mental Health Social Care, Bradford Metropolitan District Council
Principal Care Manager, Children's Division, Bradford Metropolitan District Council
Senior Manager, Social Care, Bradford Metropolitan District Council

Appendix 2 - Documentation reviewed in the preparation of this report

BDCT hospital records
AOT clinical records
GP clinical records
Forensic psychiatric reports for prosecution and defence at D's trial
Forensic psychiatric report on referral for admission to a high secure hospital
Crown Court Order 28 November 2005

Internal inquiry report and supporting statements and interview notes

Untoward incident document 5 July 2004 (reporting the incident)

Incident management policy BDCT October 2004

Section 12 (2) Medical approved names register June 2006 published by the Doncaster and South Humber NHS Trust which also identifies local contacts for a 24 hour consultant on-call duty rota.

Audit of adults on enhanced CPA Spring 2005

AOT operational policy November 2005
Crisis resolution/home treatment Service operational policy March 2006

Review of Achievement and Development policy (human resources BDCT)

24 hour triage and gate keeping arrangements (BCDT admissions) 24 March 2005

BMDC Social Services Children's Division Emergency Duty Services Unit Plan 2004-2005

Service Improvement Group minutes: 4 April 2005, 14 April 2005, 9 January 2006, 6 February 2006, 23 February 2006, 6 March 2006, 9 May 2006

BDCT Trust Board minutes: 2 November 2004, 7 December 2004, 1 February 2005, 3 May 2005, 7 March 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 acts as expert adviser to HM Coroner for Cheshire 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.