Ms A Outline Incident - July 1998 Inquiry 2004 SUI 1998/204

Introduction

The incident that is the subject of this report concerns the killing on 7 July 1998 by Ms A of Mr B, both of whom were patients receiving mental health services in Calderdale. This report outlines the background to the independent inquiry in respect of the incident (serious untoward incident (SUI) 1998/204). The report addresses the inquiry's three terms of reference by presenting the key findings and issues in relation to mental health services, together with an action plan to address the issues. The action plan shows progress to date and further action identified by the provider and commissioning organisations. The inquiry chair's view of the action taken following the incident is outlined, in addition to comments in relation to the inquiry's third term of reference.

Background

Health Service Guidance HSG(94)27 indicates that an independent inquiry must be established in all cases of homicide committed by people in receipt of mental health services.

However, this was not done by the former Calderdale and Kirklees Health Authority, as it was anticipated that the guidance would change imminently.
When West Yorkshire Strategic Health Authority (WYSHA) inherited the case, advice was sought about its future handling from the SHA's solicitors, the Directorate of Health and Social Care (North) and the Investigations and Inquiries Unit at the Department of Health.

It was agreed that the SHA should appoint a chair to undertake an independent inquiry at an appropriate level. The need for pragmatism was recognised, given that a significant length of time had elapsed since the incident, that the trust responsible for the service at the time (Calderdale Healthcare NHS Trust) no longer existed and that the model of services had changed significantly.

Mrs Anne Galbraith, who had been commissioned by the SHA to chair a previous independent inquiry in Calderdale and Kirklees, undertook the inquiry.

The approach taken in this case was different from other inquiries, in that Mrs Galbraith was working independently rather than with a panel, and her inquiry consisted of *a documentation review*, but *no witnesses were interviewed*. Mrs Galbraith's conclusions have been reached following an extensive review of health services and social services documentation and records, *and records of the coroner and the police.*

Independent inquiry terms of reference

The terms of reference were

to:- • review the investigations made to date and identify whether these were sufficiently comprehensive; • review the action taken in response to the recommendations made and identify whether this has been implemented;

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• identify and address any further matters considered to be relevant. First term of reference – to review the investigations made to date and identify whether these were sufficiently comprehensive

The independent inquiry chair, Anne Galbraith, reviewed the joint internal 'serious incident inquiry' which was undertaken using joint procedures agreed between Calderdale Metropolitan Borough Council and Calderdale Healthcare NHS Trust. Anne Galbraith's review sought to assess the thoroughness of the conclusions and recommendations in the serious incident inquiry report, and her findings are expressed as follows:
'I would endorse the view (of the internal inquiry) that the incident was an unpredictable event, and there is nothing to suggest that the weaknesses in the services affected what happened. From my own reading of the files and records in relation to these two patients, a number of key themes emerged, which it seemed would have been appropriate for review by the internal inquiry.
Some of these themes were of sufficient importance to merit further consideration in the conclusions and recommendations.

The key themes I identified related to

formal risk assessments, particularly in relation to long term patients;

appropriate use of CPA; appropriate level of CPA;

care plans;

carer involvement;

seeking information from out of district;

record keeping; continuity of care; handover arrangements;

and non- attendance at out-patients.

Many of these issues are addressed in the report (of the internal inquiry), to the extent that some evidence was given to the panel on most of these points.

However, the emphasis in the recommendations is principally on CPA processes. These recommendations do pick up some important elements from the themes I identified earlier.

However, in my view, it is unfortunate that the internal inquiry report did not act as a trigger to generate recommendations in relation to review of the interface between community mental health services and specialist alcohol services. Evidence was given to the panel that Ms A had not been prepared to engage with specialist alcohol services.

This must give rise to a question whether there was appropriate communication and liaison between these services, to encourage or support alcohol dependent patients in engaging with the specialist service.

It must also give rise to a question about the appropriateness of using the CPA processes in these circumstances. Although there is a recognition in the conclusions within the report that there had been a lack of formal risk assessments, this aspect is not carried forward with any specific recommendation.

A concerning feature of the limited risk assessment made in relation to Ms A is that little emphasis seems to have paid to her allegations of rape.
It may be the case that these allegations were of doubtful validity, but without more regular and formalised assessment of the risks posed to her, as well as assessment of the risk she may have posed to others, there is little to guide any of the professionals working with her.

It is also worth noting that the professionals who had been working with Ms A may not have had information available to them from outside Calderdale when she moved into the area, but they themselves did not elicit from her the information about her past history of aggression.

This may well reinforce how necessary a formal risk assessment and review system is. Some review of risk assessment documentation and the regularity of review of risk could usefully have been recommended at that time.'

Anne Galbraith found a number of shortcomings in the inquiry process, notably its tardiness in reporting and the failure to interview certain witnesses (including Ms A's mother and Mr B's support workers) whose recollections and observations of events were likely to have been pertinent.

This was felt to have compromised the comprehensiveness of the investigation.

On the basis of Mrs Galbraith's independent review of the internal inquiry, she wrote to the SHA in January 2004 to say that

'it is my firm belief that there would be little to be gained by now holding a full scale inquiry. Much of the evidence will be stale.
Organisations have been restructured.
Services are delivered in different ways.
New policies and procedures exist.

Staff are changed or retired from the service.

What seems to be important is to establish what the key learning points should be from this incident, and determine how much progress the relevant organisations have made on those points.'

Second term of reference - to review the action taken in response to the recommendations made and identify whether this has been implemented

Anne Galbraith's review found that some steps had been taken almost at once after the incident to inform relevant personnel, prepare for and establish an internal inquiry.

However, there was a significant delay in producing the internal inquiry report and this delayed action to address service issues, as there were no recommendations against which to develop an action plan.

The internal inquiry initially reported in the summer of 1999, but the report was not finalised until October 1999 and not circulated until December 1999.
Anne Galbraith notes that, 'it (the inquiry report) was circulated to key personnel on 1 December 1999 in readiness for a meeting on 6 January 2000.
Thus, eighteen months had elapsed since the incident and there was still no action plan in preparation…..the clear timescales in the joint policy "*When things go wrong*" had been breached'.
The action plan was eventually circulated on 15 February 2000.

Anne Galbraith's findings in relation to services were made available in December 2003 to WYSHA, South West Yorkshire Mental Health NHS Trust (SWYMHT, which took over mental health services from Calderdale 34 Healthcare NHS Trust), Calderdale Primary Care Trust, Calderdale Social Services and the Social Services Inspectorate.

These organisations have jointly developed a new action plan which identifies all action taken to date and further action identified as necessary in relation to the issues highlighted by Anne Galbraith's review, namely:-

• regular review and analysis of risk assessment, particularly in relation to long term patients;
• interface of specialist alcohol services and community mental health teams;
• joint working between mental health services and Drug and Alcohol services;
• **involvement of family members and informal carers**;
• policy, including timescales, for 'When things go wrong;'
• background information relating to patients moving into the area; and
• adherence to CPA policy and procedures.

The action plan is shown at Appendix A.

Anne Galbraith's view on the adequacy of the action taken to date and planned for the future is expressed as follows:

'First of all, I would like to commend the organisations involved in this case for their ready acceptance of the findings of my review, and for their willingness to work together to address the issues raised. I have had the benefit of attending a meeting at which all of the organisations were represented, when it was possible to take stock of work already in hand, work to be undertaken, and responsibility and leads for that work. I have reviewed the action plan, paying particular attention to the further action required and the timescales set for this work. Much has already been achieved, and the timescales for the remainder of the work seem appropriately challenging. I am particularly pleased to see the response in the action plan in relation to joint working between mental health services and the drug and alcohol services.
Many of the action points will require rigorous reporting procedures and regular monitoring and review, and again, I have been pleased to note that these are clearly specified in the action plan'.

Third term of reference – to identify and consider any further matters considered to be relevant
The third term of reference had been included to allow the independent inquiry chair to address any further pertinent issues arising from the documentation review, if necessary in conjunction with one/more experts in the field.

It is considered by the independent inquiry chair that all issues have now been covered within the action plan shown at Appendix A.

Conclusion
The independent inquiry chair has concluded that the incident was unpredictable and would not have been affected by any shortcomings in services.

The independent inquiry has also concurred with the internal inquiry in respect of the service issues identified, although some of these were felt to have been insufficiently developed in the internal inquiry's recommendations.

In particular, the independent inquiry highlighted the internal inquiry's failure to generate recommendations in relation to the interface between community mental health services and specialist alcohol services and in respect of formal risk assessment.

The independent inquiry was also critical of aspects of the internal inquiry process and the delays in the production of the internal inquiry report and subsequent action plan to address its recommendations.

The action plan that has recently been developed to address all the issues drawn out by the independent inquiry is considered to be a robust piece of work, which demonstrates the commitment and practical steps that the organisations concerned have already taken or are planning to take.

Recommendations

1. To note the key findings of the independent inquiry.
2. To note and agree the action taken and planned in relation to the key findings.
3. To agree to monitor the action plan on a six monthly basis until all actions are completed,
4. to liaise with the Social Services Inspectorate in respect of those elements involving Calderdale Social Services.

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APPENDIX A

INDEPENDENT INQUIRY 1998/204
ACTION PLAN
APRIL 2004

CALDERDALE COUNCIL
CALDERDALE PRIMARY CARE TRUST
SOUTH WEST YORKSHIRE MENTAL HEALTH NHS TRUST

Recommendation	Action Taken To Date	Further Action Required	Lead Organisation / Individual	Timescale	
1	Regular risk assessment undertaken, particularly in relation to long term patients.	CPA Procedures were re-written to include clear instructions on when risk assessments are to be undertaken. A Risk Management Review process was developed as set out in Mental Health Services Care Programme Approach Procedural Guidance (April 2003 Revised). The guidance sets out how and when risk information should be shared. The Mental Health Information System IMS MAXIMS Mental Health Module incorporates Risk assessment including risk and relapse management planning. Instructions for completion of these screens including timescales are set out in a memo to Team Leaders which forms an addendum to the CPA Procedural Guidance	Continued audit programme annually of case files/adherence to CPA Procedures. Joint monitoring of system through IM&T Governance Policy Action Group.	SWYMHT/Calderdale MBC M Blewett SWYMHT/Calderdale MBC M Blewett	June 2004 Ongoing

		(issued August 2003). The system is networked across hospital and community sites and is used jointly by health and social services staff in mental health services.			
2	Interface of specialist alcohol services and community mental health teams.	A review of dual diagnosis was commissioned in 2000 by Calderdale and Kirklees Health Authority and Calderdale Metropolitan Borough Council using a Leeds based Research & Development Consultancy (RSDC) which reported back making recommendations on : Referral and assessments, Treatment integration and joint working Contact protocols and Training. These have been incorporated into the NSF work plans which were overseen by the dual diagnosis sub group.	Monitoring by Dual Diagnosis working group reporting to NSF Local Implementation Team and Drug Action Team.	SWYMHT John Ketteringham	6 monthly report June 2004 to NSF LIT & DAT

3	Joint working between mental health services and Drug and Alcohol services	CPA Procedures (Revised 2003) also contain specific guidance on co-working between mental health and substance misuse services including a clear statement about who is responsible for care co-ordination. The dual diagnosis sub group has commissioned An internal review of the interface between mental health services and Calderdale Substance Misuse Services (SMS) to identify adherence to the guidance.	Dual diagnosis liaison nurse leading review of service and developing standard report format. First report April 2004 – R. Dellar.	SWYMHT John Ketteringham	6 monthly report June 2004 to NSF LIT & DAT
4	Involvement of family members and carers in the inquiry process	The revised SWY Trust Risk Management Strategy has been launched (February 2004) It clearly sets out how investigations into serious incidents should be conducted including liaison with family and carers. It also sets out the context in which such investigations should operate including how and when they should report. The system will be computerised using DATIX and Calderdale will be in the initial roll out for implementation in Spring	Implementation through training support and facilitation of Root Cause Analysis will be further developed through 2004. Implementation monitored at Trust Board level.	SWYMHT Dave Sharp SWYMHT Sheila Dent	2004 November review June 2004

		2004.			
5	Policy including Timescale for “When Things Go Wrong”	The revised Trust Risk Management Strategy launched February 2004 contains information on what to do when an untoward incident occurs including a matrix to aid decision making on grading the seriousness of incidents, and a set of time-scales for action. This covers all aspects of the incident, inquiry and reporting process. Social Services to complete a review of internal processes to ensure that these align to the new Trust Risk Strategy	Implementation monitored at Trust Board level. In progress led by Michael Blewett CPA/Risk Manager	SWYMHT Sheila Dent Calderdale MBC Phil Shire	Review in Nov 2004 June 2004

6	Background information about patients moving into the area.	CPA procedures (revised April 2003) set out what information should be sought when a patient moves into the area, the timescales for completion of risk assessments and the process for information sharing with other agencies (Police, Probation etc). CPA Association has also issued guidance on transferring patients between areas including a pro-forma which is in use in Calderdale	Continued audit programme annually of case files / adherence to CPA Procedures.	SWYMHT/Calderdale MBC M Blewett	June 2004
7	Adherence to CPA policy and procedures	A CPA audit was undertaken in 2001 as a result of the action plan produced by this inquiry team. The audit reported to senior managers in Health and Social care in November 2001 and the recommendations were incorporated into the NSF action plan for CPA. These points have subsequently been actioned and there have been two subsequent CPA audits which have reported back to the Calderdale LIT.	Annual audits of CPA to be undertaken	SWYMHT/Calderdale MBC M Blewett	June 2004

SOURCE : http://www.schizophreniawatch.co.uk/Galbraith_%20Mrs%20A.html