NHS
West Midlands

The Report of the Independent Investigation into the Care and Treatment of PW

Commissioned by the West Midlands South Strategic Health Authority
[now part of the West Midlands NHS Strategic Health Authority – 2006]

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APPENDICES

INVESTIGATION PANEL MEMBERSHIP

Mr. Martin Bradshaw	-	Operations Manager and Approved Social Worker, Oxfordshire County Council, Social and Community Services Directorate
Mrs Jane Mackay	-	Independent Healthcare Consultant – Chair of Independent Investigation
Dr. Kwame McKenzie	-	Senior Lecturer in Psychiatry at University College London and Consultant Psychiatrist
Dr. Brian Pollard	-	General Practitioner and Medical Member of a Crisis Team
Mr. Mick Tutt	-	Head of Service Governance, Plymouth Teaching Primary Care Trust.

INVESTIGATION ADMINISTRATOR

Ms. Pearl Green

VERBATIM REPORTING

Mrs Fiona Shipley, Fiona Shipley Transcription Services

TERMS OF REFERENCE

1. To examine all the circumstances surrounding the care and treatment of PW by the mental health services up until the manslaughter of Ms. CL and the injury to Mrs HL, CL's mother on 3rd February 2005. In particular:

   (a) The quality and scope of his health, social care and risk assessments;

   (b) The appropriateness of his treatment, care and supervision in respect of:

      (i) his assessed health and social care needs and;

      (ii) his assessed risk of potential harm to himself and others;

      (iii) the role of informal carers and in particular, PW's partner and his brothers;

   taking account of any previous psychiatric history including use of drugs and the number and nature of any previous court convictions.

   (c) The extent to which PW's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC (90)23, and local operational policies.

   (d) The extent to which his prescribed care plans were:

      (i) effectively drawn up
      (ii) delivered and
      (iii) complied with by PW

2. To consider the appropriateness of the professional and in-service training of those involved in the care of PW or in the provision of services to him.

3. To consider the specific L family concerns detailed in their statement to HM Coroner for Warwickshire.

4. To examine the adequacy of the collaboration and communication between:

   (a) The agencies involved in the care of PW or in the provision of services to him and;

   (b) The statutory agencies and PW's family;

5. At the discretion of the Independent Inquiry Chairman, the Terms of Reference may be more definitive with respect to important matters. This may include issues relating to other agencies which impact materially on the functioning or actions of the health services.

6. To refer all matters related to children at risk, or child protection, regarded as outside the scope of this inquiry, to the Chairman of the appropriate Area Child Protection Committee (ACPC) – now known as the Safeguarding Children Board.

7. To consider practice in regard to available evidence and current expectations, and identify sources of support and/or evidence of good practice which will assist service and/or professional development.

8. To prepare a report with recommendations, to what is now, the West Midlands Strategic Health Authority by October 2006. If during the course of the inquiry it becomes clear that this timescale cannot be met, the Inquiry Team Chairman must inform the Director of Private Office and Communications.

9. To provide a report on progress within 3 months of the establishment of the inquiry and three monthly thereafter until the Inquiry Team has concluded.

10. To consider such other matters as the public interest may require.

PROCEDURE TO BE ADOPTED BY THE INDEPENDENT INVESTIGATION TEAM

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing them:

   (a) of the terms of reference and the procedure adopted by the Investigation; and

   (b) of the areas and matters to be covered with them; and

   (c) requesting them to provide written statements to form the basis of their evidence to the investigation; and

   (d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the investigation; and

   (e) that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them with the exception of another investigation witness; and

   (f) that it is the witness who will be asked questions and who will be expected to answer; and

   (g) that their evidence will be recorded and a copy sent to them afterwards to sign;

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the investigation may make written submissions for the investigation's consideration.

5. All sittings of the investigation will be held in private.

6. The findings of the investigation and any recommendations will be made public.

7. The evidence which is submitted to the investigation either orally or in writing will not be made public by the investigation, save as is disclosed within the body of the investigation's final report.

8. Findings of fact will be made on the basis of evidence received by the investigation. Comments which appear within the narrative of the Report and any recommendations will be based on those findings.

PREFACE

The West Midlands South Strategic Health Authority (which from July 2006 became part of the West Midlands Strategic Health Authority) commissioned this investigation under the auspices of the Department of Health Guidance EL (94)27, LASSL(94) 27, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

> "*in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved*".

This guidance was slightly amended the following year and the particular paragraphs in the guidance relating to 'when things go wrong' further amended in 2005. Now the criteria for conducting such an investigation include:-

i) When a homicide has been committed by a person who has been under the care, ie; subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.

ii) When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.

We are grateful for the co-operation and help of the Independent Police Complaints Commission (IPCC), in particular, Mr. John Crawley, who shared some of their findings with us. The events leading to Colette's death have highlighted both the difficulties and benefits of joint working in all the agencies engaged with the mentally ill living in the community.

The links between domestic violence, mental health and risk are well known. These should increase rather than decrease the perception of risk. This report should be used by all those agencies, the police, mental health services and social services as the basis for closer working relationships through shared training, sharing

information, acceptance of differing backgrounds and better understanding of each others' roles, responsibilities and levels of accountability. Staff working in the Rugby area must have a better understanding of what constitutes a 'domestic' issue and how that impacts on mental health wellbeing, if they are to deliver safer mental health services.

An investigation such as this should facilitate openness for members of the families concerned and the public, learning lessons and create change to improve mental health services.

Most people trust the NHS and assume that 'things are going to be made better' by the way professionals competently carry out their work and with confidence in the framework that overarches their clinical decisions. However, we found that in this case the system was far from supportive to the professionals involved with PW and has let down both families with such tragic consequences.

We were asked for Colette's name to be used throughout the report, which we have done. We were grateful to her parents for coming to see us and sharing with us, a more detailed account of their efforts to engage with the Police, mental health services and social services to help protect their daughter and, in particular, the night of 3rd February 2005.

For those of us who have not lost a loved one in this way, it is difficult to imagine how we would feel if we found ourselves in the same circumstances as the families involved. However, we are able to sympathise and show our empathy by completing our task in a thoroughly professional manner.

We are very aware that family members have been left desolate because they have lost a daughter, sister, mother, aunt, partner and friend following Colette's tragic death. We can only hope we can do justice to her memory in seeking answers to the questions asked by her family. These questions were constantly in our minds whilst we conducted our interviews and in fact were similar to ones we, too, required to be answered.

ACKNOWLEDGEMENTS

We would like to thank everyone who came to give evidence to the Investigation Team and who spoke so freely to us. In all we interviewed 35 people who in one way or another have become involved in this tragic incident. We did meet PW and it was unfortunate that, despite asking other members of his family to come and see us, we were only able to meet with one brother.

An investigation such as this requires good management and organisation and in this respect we are indebted to Ms. Pearl Green who carried out these duties with a great deal of professionalism. We received much of the written material during our investigation and were greatly helped by having her prepare all the papers into working documents for us.

In addition to taking verbal evidence we read a great deal of written material including medical case notes, selected Social Service and GP records. In all we read some 5000 pages of documentation. A full list of documents can be found at Appendix 3 and Appendix 4.

We would also like to thank Mrs Cathy Courtney for looking after us whilst we took evidence at the Linden Unit, Hospital of St Cross, Rugby.

Lastly our task was made easier by the efficient manner that the Fiona Shipley Transcription Service provided us with the transcriptions of all our interviews.

EXECUTIVE SUMMARY

PW (date of birth 3.11.1969) was born in Rugby and was the youngest of nine siblings. His parents were of Jamaican origin. He attended schools in the Rugby area, leaving aged 16 without any particular qualifications. On leaving school he worked in an engineering warehouse, becoming a supervisor two years later - a post he held for another two years. He then worked for another company for five years. During this time he married, had two children and moved away. However, this marriage was short lived and he returned to Rugby in 1999.

He met Colette and although they were considered a partnership and had a child they maintained separate houses. He visited her daily,S spending a lot of time with her at her own home. She had two children from a previous relationship.

He had looked after his sister until her death of cancer in 2002, following which PW became the guardian of his nephew.

From 2003 until July 2004 PW attended his General Practitioner (GP) complaining of backache and was given medical certificates, as he was unable to work, and medication for the pain.

In July 2004 he attended the GP but on this occasion PW was more concerned about abdominal swelling and that he might have sickle cell disease.

PW was also referred to the Crisis Team based at the Linden Unit, Hospital of St. Cross in Rugby. A Staff Grade doctor (a middle grade doctor not of consultant status) assessed him and concluded that he did not have a mental health problem but needed to have his physical symptoms reassessed and to have an electro encephalogram (EEG). He was referred back to the GP for him to organise the test, and an outpatient appointment was given for four to six weeks.

11TH NOVEMBER 2004

PW, with his partner Colette, kept his outpatient appointment when another Staff Grade doctor saw him.

Later that month PW contacted the Police because there had been a family argument over the guardianship of his nephew.

9TH DECEMBER 2004

PW attended the outpatients department. The Staff Grade doctor he saw, did not identify any underlying mental illness. He concluded that PW may well have been suffering from 'somatoform' disorders (physical symptoms that seem as if they are part of a general medical condition, however, no general medical condition is present. Psychological conflicts may become translated into physical problems or complaints, if and, when physical causes are ruled out).

19TH JANUARY 2005

Colette phoned PW's GP and expressed concern about her partner's behaviour, which she described as being "*paranoid and aggressive*". In the afternoon PW went to Rugby Town Hall to 'sort out' his housing benefits. Police Officers were called because of his threatening behaviour. One of his sisters worked in the building and was asked to help placate him. Apparently, he told her that he had a knife but this was **not** reported to the Police.

The following day, 20 January 2005 PW, with Colette, attended the GP surgery. He told his GP that he was not using cannabis but hearing voices and was able to change the weather by changing his clothes. The GP requested an urgent assessment with the Crisis Team.

Colette accompanied PW to the Linden Unit that afternoon, at about 16.30 hours, for an assessment. The Crisis Team Nurse decided to seek a new appointment with a Psychiatrist and for the Crisis Team to give support until this appointment was made. He had a discussion with the Staff Grade Psychiatrist following which an appointment was made for a second opinion with the Consultant.

The following day Colette contacted the Crisis Team. She was assured that an appointment was sent and that the Crisis Team would try to keep contact with PW but they were unsuccessful.

25TH JANUARY 2005

PW did not keep his appointment with the Neurological Consultant and as a consequence was discharged from his clinic.

26TH JANUARY 2005

Colette telephoned the Crisis Team as PW was experiencing bizarre thoughts and hearing voices. She was advised to either take him to the Crisis Team, or the Accident and Emergency department at the Hospital of St. Cross, if the situation deteriorated.

1ST FEBRUARY 2005

Colette called the Crisis Team at about 12 midday regarding PW's continued strange behaviour and that he had threatened his brother, saying that he would cut his heart out. He was also carrying a knife. She told them that PW did not intend to keep the outpatient appointment made for the following day.

Colette twice called the Police as she had seen a previous partner in the street and she was concerned that he might be trying to get into the house. She was advised to call 999. Later in the evening PW broke into Colette's home and assaulted her, threatening to 'slit' her throat. She climbed out of a window sustaining injuries. She was taken to Rugby, Hospital of St. Cross.

At 21.49 hours three Police Officers, a Special Constable and a Community Safety Officer attended. **PW was not arrested.** The Police arranged for the windows to be boarded up. PW had injuries to his hands requiring emergency treatment and was taken to hospital by ambulance. He left hospital without having any treatment, having dressed his wounds himself.

Later that night the duty nurse from the Crisis Team contacted the Police as she too had been told that PW had a knife and thought that Colette might be at risk.

2ND FEBRUARY 2005

05.00 hrs - Another nurse from the Crisis Team informed the Police of their concerns about PW's mental health state and that, apparently, he was carrying a knife.

10.30 hrs - Colette phoned Crisis Team. She had seen PW and he presented as if nothing had happened.

10.45 hrs - The Crisis Team discussed the situation with the Consultant who informed the GP that a Mental Health Act (1983) assessment was

necessary. The Crisis Team informed the Police of the Consultant's concerns for the safety of PW's nephew, Colette and her children. The Consultant also informed the Children and Family Team at Social Services.

12.10 hrs - The Children and Family Team spoke to the Child Protection Police Officer and they agreed that an urgent Strategy Meeting should be held later that afternoon. PW's nephew had not been at school that day. The GP informed the Strategy Meeting that it was not safe for the nephew to remain at home as he had had concerns about PW for three months.

14.00 hrs - The Consultant referred PW to Social Services for a MHA (1983) assessment.

17.10 hrs - Colette's brother phoned the Crisis Team because he was concerned about PW's unpredictability. The Team, mindful of patient confidentiality, would not discuss any details of PW's health with him.

The outcome of the Strategy Meeting was a decision for the Children and Family Social Worker and a Duty Social Worker to visit PW with the Police in attendance. When they visited, PW told them he had been involved in a domestic violence matter but denied that he had been carrying a knife when he had visited the Council Offices on 19th January 2005. As there were no discernible symptoms such as violence, aggression or thought disorder, the Police felt that immediate detention was not possible and the Social Worker felt that an immediate formal MHA assessment was not required. The Duty Psychiatrist supported this decision. PW's brother arrived at the scene with Colette and told the Social Workers that he would arrange care for PW's nephew with the family. The Social Workers also reminded them about the appointment for the following day.

3RD FEBRUARY 2005

The Children and Family Team Social Worker contacted one of PW's brothers and he told her that PW was stressed because of relationship problems with Colette. Colette's brother telephoned the Children and Family Team Social Work Team.

09.50 hrs - The Approved Social Worker (ASW) on duty that day tried to contact another of PW's brothers. He later returned the call saying that PW was just depressed and not a risk to himself or anyone else. The ASW discussed PW with the Consultant who agreed that an informal assessment should be carried out at the Linden Unit. Colette was informed, and she, with PW's brother tried to persuade PW to keep this appointment and attend with him. However, PW did not attend the Linden Unit.

14.00 hrs - The GP telephoned the Consultant to say that friends of Colette were warning him about PW's behaviour and that another friend had said not to wait until PW killed someone.

15.30 hrs - The Consultant and the acting Locality Manager called an emergency multi-disciplinary meeting with two ASWs and a nurse from the Crisis Team. It was agreed that a further formal assessment should be arranged for 4th February 2005.

Later that night, PW came to Colette's home with a knife, took his daughter, attacked Colette's mother with the knife and then, still holding his daughter, chased after Colette into the street where he stabbed her in the back, killing her.

A neighbour telephoned the Police to say that a woman had been stabbed and that a man had been seen running away with a baby.

PW was arrested and taken to the Police Station. He was seen by the forensic community psychiatric nurse and told her that he was hearing voices of a Jamaican person and another lady who called herself the 'Queen'.

PW was charged with Colette's murder and assault occasioning grievous bodily harm to her mother and remanded in custody. On 16th February 2005 the visiting Consultant Psychiatrist assessed him and stated that in his view PW should be transferred to a secure hospital, which happened in March 2005.

PW pleaded guilty both to manslaughter due to diminished responsibility and to causing grievous bodily harm (GBH) and was detained in a secure hospital under section 37/41 Mental Health Act 1983.

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

From all the evidence we heard, we cannot say with surety that the outcome for Colette would have been any different if a Psychiatrist had assessed PW in early February. However, we did find serious lapses in critical thinking and decision making by the senior professionals involved in the period of time from 20th January 2005 until 3rd February 2005.

The Investigation Team concluded that in not undertaking a mental health assessment, either informally or under the auspices of the Mental Health Act, **was unreasonable** before the night of the 3rd February 2005. The level of concern from both families was rising, given the number of telephone calls to the GP, the Police, the Children and Family Team and the mental health services and should have warranted action by the mental health services. The Consultant should have led by example as he made the initial referral with concerns as to the safety of PW's nephew, Colette and her children.

Our GP member said it was almost unprecedented in his experience that a fellow GP insisted on disturbing a Consultant during a clinic. The professionals allowed 14 days to elapse without PW being seen by a Psychiatrist despite reports being received about significant psychotic features. The cumulative risks are documented in Appendix 7.

In these few weeks there was a great deal of information available, perhaps locked in separate 'compartments' which, had a full multi-disciplinary meeting taken place with all practitioners and agencies contributing, then a more complete picture would have been available and the quality of the decision making improved. On more than one occasion Colette raised the alarm herself, to be left on her own only with the support of her family, who too, were unable to influence the decision making of the professionals. Protecting people in the community as well as the patient should be paramount in any community based mental health service. When properly managed in a multi-agency approach it should also mean that the public too are protected. This aspect of public protection was sadly lacking in Rugby in February 2005.

In addition, these are the Investigation Team's major findings which support this conclusion

The Investigation Team spent a lot of time in discussing whether the Crisis Team was 'fit for purpose' and whether we should recommend that it be closed as we felt that the people in Rugby would not have been well served.

We **implore** the Commissioners and the new specialist mental health Trust to take note of this comment when drawing up their action plan in response to our findings, conclusions and recommendations, to ensure that the Crisis Team is fully staffed with appropriately experienced practitioners who understand the needs of patients in crisis and also the needs of their carers.

1. The GP responded to the physical symptoms reported by PW when he came to the surgery and requested appropriate (and extensive) tests. He never deviated from the view that PW may well have a mental illness and continued to refer PW for assessment by the Crisis Team. He is to be commended for his persistence.

2. The GP practice was also proactive in advising the Staff Grade Psychiatrist that PW had reported to them the use of cannabis and ecstasy.

3. Whilst not a major aspect of our investigation, we were dismayed to learn that having failed to attend one outpatient appointment to see the Consultant Neurologist, PW was removed from the 'follow-up' list and therefore not sent another appointment. Patients who have a mental illness do not always remember or appreciate the relevance of attending appointments and whilst we do not expect that these patients require different treatment, many other patients may well miss out on their follow-up appointments as a result of this policy.

4. The Consultant Psychiatrist informed his on-call colleagues of the situation on 2nd February. However, the Investigation Team were uncertain as to why the on-call Psychiatrist and a second Doctor did not go out with the ASW to assess PW. At that time there appeared to be a reluctance on the part of the doctors to carry out assessments in the community, especially without the Police being present.

5. The Children and Family Team Social Worker was right to respond to the concerns about the welfare of PW's nephew. It was, therefore, unfortunate that although the referral came from the Consultant Psychiatrist in the morning of 2nd February 2005, no one from the mental health services attended the Strategy Meeting later that afternoon.

6. Whilst we full appreciate that the referral to the Children and Family Team was primarily about PW's nephew, more consideration should have been given to the safety of Colette and her children, as PW was in regular contact with them and Colette was the subject of one of his delusions. Child protection is not just about individual children but must take account of all children in a family relationship.

7. Although there were good communications between the Children's Social Worker and the Approved Social Worker (ASW), it appeared to us that there was an unclear agenda for the home visit on 2nd February 2005, particularly on behalf of the mental health services. The interview with PW by the ASW in accompanying the Children's Social Worker gave subsequent professionals the impression that an assessment of PW's mental health had been completed.

8. The concept of 'partnership' working arrangements has been integral to the principles of effective child protection policies for some time. This was borne out, in this case, by the calling of the Strategy Meeting within only a few hours of receiving the referral from the Consultant Psychiatrist. The focus of all the information gathered was the safety of the nephew, with a decisive outcome to visit that day. It was in sharp contrast to the changing decisions and lack of focus in the discussions by the mental health service about PW and his mental health and whether he was a danger to either himself or others. The result of their indecision about conflicting evidence was that PW remained unassessed.

9. Despite a Care Programme Approach (CPA) being in place for many years no care co-ordinator for PW was identified. No one person was assigned to communicate with either other professional or indeed family members, which might have built up a more comprehensive picture of PW's mental state.

Despite most of PW's care being arranged by either Colette or PW's brother, no Carer's Assessment was ever undertaken.

10. The Crisis Team reported that the current CPA documentation did not address their needs because of their usually short term involvement

11. There was, and is still, not a routine daily meeting in the Crisis Team to review all their current cases. This would have given the opportunity for all staff to discuss what they had in turn learnt about PW and family concerns for his mental health. The Crisis Team should have taken on the role of 'entry point' to the mental health services and responsibility for liaising with the other organisations involved with PW. In addition, they could have called a 'case conference' for all to share their information about PW as there appeared to be differing views. In fact the meeting held on the afternoon of 3rd February 2005 only seemed to dissipate the risk and anxiety previously expressed.

12. The response of the Crisis Team to Colette's telephone calls about her feelings of being 'unsafe' with PW was naïve to say the least, especially as they had been given information about her previous relationship, which had an element of violence in it. From their notes it appeared that they made detailed records of what was said to them but little was written down about their response and critical thinking.

13. There was no effective leadership in the Crisis Team and as a result it was not performing effectively as it appeared to be a 'telephone' service, not being able to intervene either through lack of experience or lack of staff.

14. Although PW was seen by the mental health services on four occasions in response to the GP referrals, he never saw a Consultant. Neither was PW's care reviewed by a Consultant until 2nd February 2005.

15. There was a difference of opinion between the GP's, Crisis Team and Consultant and Social Work Services about the threshold for initiating a Mental Health Act Assessment. The Consultant and ASW had different views about whether a formal or informal approach to an assessment of PW's mental health was the most appropriate. During 2nd February 2005, the

Consultant was concerned about both the danger/risk that PW represented and the viability/urgency of a formal assessment. He referred what information he had to the Children and Family Team Social Worker and reported his concern for the safety of PW's nephew, Colette and her children following alleged reports of dangerous behaviour. On 3rd February 2005, he concluded that an outpatient assessment of PW's mental health should be pursued despite a view that PW might not attend. Later that day the Consultant confirmed that he did not now consider immediate action was required to protect PW's nephew although the young man was still with PW. The information provided to the mental health services about PW's mental health and dangerousness was inconsistent throughout. A member of the public contacted PW's GP about his concerns about PW's aggressive behaviour. He reported this to the Consultant Psychiatrist. He did not contact the Police because he believed that the mental health team was in control of the situation. Surely this telephone call from the GP should have been taken more seriously? The Consultant did not take a leadership role, but played a waiting game with tragic consequences.

16. The Police and the Crisis Team never had a conversation to discuss whether mental health or criminal matters (domestic violence) was the key issue in this case and, if so, what their respective responsibilities would be. The Crisis Team and Police did discuss the fact that PW may be mentally unwell and that he was reported to be carrying a knife. The Police and the Forensic Nurse told the Crisis Team about Colette making similar allegations about a previous partner. There was no record of formal assessment of the relative weighting given to these different pieces of information by the mental health services and how they were used.

17. The junior staff who saw PW did not have regular supervision and not all cases were considered by a Consultant before discharge. The locum consultant was not qualified for autonomous work but did not receive any supervision. There were no processes in place to ensure that the medical staff were providing clinical care of a sufficient quality.

18. The Investigation Team came to the conclusion that there appeared to be something of an 'office hours' culture within the mental health service. The result was that outside office hours patients were seen by medical staff who did not know them and possibly did not have access to their records which was not good practice. This rigid cut-off at 17.00 hours also applied to Mental Health Act assessments, instead of a more flexible 'shift' system operating across North Warwickshire.

19. The Internal Inquiry process was unnecessarily complex – perhaps because the Trust, by their own admission, was new to this form of review. The Trust's Serious Untoward Incident (SUI) policy (the version of which the Trust provided to the Independent Inquiry was out-of-date) prescribed the arrangements for sharing the outcome of the Internal Inquiry - meaning that neither the families of those involved, nor the practitioners, were privy to the full document. Although this detailed, report contained many comments that were critical of the mental health services, these were not obvious because they were lost in the detail of the text and 'third parties' (including the families and the practitioners) only received a summary; which did not make those criticisms clear. Had the families been able to see this transparency much of the distress expressed by members might have been alleviated.

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RECOMMENDATIONS

The recommendations of the Internal Inquiry can be found in Appendix 2 and we have taken each one into account when formulating our own recommendations. Many are about the same aspect of mental health care but where necessary we have been more forceful and expanded the recommendation.

The Independent Investigation recommends that

The Mental Health Service, which was at the time of the investigation, provided by North Warwickshire Primary Care Trust (NWPCT)[1] has to provide better outcomes for people using its services, their carers and those who provide services; by working with Commissioners and other partners to:

1. Ensure that the Crisis service, across North Warwickshire and Rugby, is consistent with the aspirations and requirements of the Mental Health Policy Implementation Guidance (PIG), 2002 – and is a model that is acceptable to and agreed with Commissioners of the service - (Chapter Six).

This will include :

a) a comprehensive Review of the current establishment of the Crisis Team – including, of critical importance, the medical establishment and medical engagement with a commitment – to act on any Findings and Recommendations including, if necessary, recourse to the Local Delivery Plan investment process for 2007/8 if required.

b) an undertaking to, as soon as possible, provide those practitioners and Managers charged with the responsibility for delivering the agreed service with dedicated 'Time Out' during which they will be able to explore and understand the very different role which they were being asked to undertake, and confirm their ability to undertake this role.

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[1] *Since commissioning the investigations Warwickshire and Rugby PCTs have been dissolved and are now part of a new organisation, Warwickshire PCT who are responsible for commissioning mental health services. Mental health services are now provided by the new Coventry and Warwickshire Partnership Trust. Each of these new organisations came into being on 1st October 2006. The new Trusts have taken responsibility for producing and implementing the action plan in response to the recommendations set out in the OS and PW reports.*

2. Provide the necessary arrangements that will enable people to be assessed in their own homes and the community, including out-of-hours if necessary, without there having to be a formal Mental Health Act (1983) assessment process - (Chapter Five).

3. Increase the flexibility of out-of-hours Mental Health Act Assessment procedures. This should enable better continuity, so that cases can be assessed routinely during the evening or at weekends if they begin during the working day, without recourse to 'emergency systems'- (Chapter Five).

4. Support all medical practitioners, at a grade lower than Consultant, to provide optimum quality patient care - (Chapter Seven).

This will require:

a) a regular supervision system; to which all practitioners have access;

b) explicit understandings of all duties delegated by Consultants to junior grade doctors, including discharge arrangements - which should always be discussed with the Consultant.

5. Review the application of the local CPA policy; to ensure that it reflects both the Department of Health (1999) Guidance, and the experience of Best Practice within Crisis services, nationally - (Chapter Six).

This must include:

a) a system which ensures that all information relating to the care and treatment of a person in contact with services is available to all practitioners involved in that care and treatment – across all disciplines and equally applicable to Health & Social Care.

6. Enable all practitioners to work to an appropriate Domestic Violence Strategy. (Chapter Eight).This will entail undertaking a multi-agency training programme

7. Comprehensively review its SUI processes to take account of a more open approach to help staff and families - (Chapter Eight).

This will ensure that:

a) a senior person makes contact with families who are the victims of serious incidents;

b) staff take account of the sensitive nature of support required, seeking guidance from and including the various voluntary agencies such as Victim Support in the preparation of the training programme;

c) the level of competence and confidence of staff, when dealing with serious untoward incidents is enhanced;

d) a supportive framework is provided - which includes counselling if necessary, adequate time for briefing and the opportunity to receive feedback as well as full discussion about any action plan which has to be implemented.

e) the internal processes must take account of parallel investigations of other organisations such as Coroner's office and or Police.

8. Consider all the comments made in this Report; regarding aspects of the interactions between PW, Colette and their respective families with all statutory agencies - particularly during the critical period of 1st to 3rd February 2005 and to amend their practices and processes accordingly - (Chapter Eight).

BACKGROUND INFORMATION ABOUT THE COMMISSIONING PROCESS IN RUGBY

Both clinicians and managers told us that the mental health services in Rugby have experienced periods of uncertainty resulting in mistrust and poor communications over a number of years. Indeed on closer reading of the internal investigation these issues were raised during that process. As the organisations responsible for both commissioning and providing services in Rugby will be different from 1st October 2006, we felt it important to discuss some of our findings following interviews with senior managers in the then Rugby and North Warwickshire PCT's (now Coventry & Warwickshire Partnership Trust) in this report. We learnt that there were several contributory factors. To help it might help to go through the organisational changes in the commissioning and providing of services in Warwickshire.

Chronology of Organisation changes

On April 1st 1991 the Rugby Health Authority was dissolved and replaced by North East Warwickshire Health Authority.

Two years later on 1st April 1993, this Authority was dissolved and replaced by Warwickshire Health Authority. The North Warwickshire NHS Trust was established. On 1st April 1998 the Rugby NHS Trust was dissolved and the mental health, learning disability, community and therapy services transferred to the North Warwickshire NHS Trust. The acute services in Rugby transferred to the Walsgrave Hospital NHS Trust.

From 1998 the Warwickshire Health Authority commissioned services from the North Warwickshire NHS Trust for its population in North Warwickshire and Rugby. The previous commissioning authority was of the view that commissioning the mental health provision for the population of Rugby from the North Warwickshire NHS Trust would improve the service and give it a greater degree of stability and robustness. However this was not the perception of the Commissioners we interviewed who put forward a view to the investigation that there was an artificial 'boundary' in relation to the service in the Nuneaton and Bedworth geographical area and Rugby.

Through the Government initiative, '*Shifting the Balance',* On 1st April 2002 Warwickshire Health Authority was dissolved and replaced by Rugby Primary Care

Trust (PCT), North Warwickshire PCT (NWPCT) and South Warwickshire PCT (SWPCT). Whilst the Rugby PCT commissioned mental health services in Rugby, they continued to be provided by the newly created North Warwickshire PCT.

This configuration of services in Primary Care Trusts providing mental health services, is comparatively rare – although there is a 'cluster' of such organisations within the West Midlands geographical region – and does not mirror similar rationale for such configurations elsewhere (eg; Milton Keynes, Plymouth, Portsmouth) which were based on co-terminous boundaries with Local Authorities.

Further changes in the NWPCT management of mental health services in Rugby came about because of the unexpected and tragic terminal illness of the previous manager who had been a key figure in local leadership and development of local mental health services. There had been prolonged periods of time with 'acting' management arrangements. Some six months before this incident, the NWPCT appointed a dedicated Director for Mental Health Services, across the whole of its area of operation. At the time of the incident there were 'acting' management arrangements in the Rugby Locality – which were then confirmed by late Spring 2005.

Following the death of a Consultant, who had been in the 'patch' for many years, there had been a prolonged period when locum Consultants were appointed in Rugby.

The Rugby PCT, as the commissioner of mental health services in Rugby, took advice from the Mental Health Local Implementation Team – a group of senior managers and professionals as well as other interested parties in mental health. Originally there were two groups, set up to implement the Mental Health National Service Framework in North Warwickshire and Rugby. The two teams were combined into one Local Implementation Team (LIT) and predated the establishment of the PCTs in 2002. The model for the Crisis Team and the staffing arrangements appear to have originated before the creation of the PCTs – and very few of the practitioners or managers interviewed could explain how it came into being, other than, a similar service to that in Nuneaton had to be set up in Rugby.

Rugby PCT took advice from the LIT when funding the implementation of the Crisis Team and was really only concerned with its overall quality and performance rather than the day-to-day issues such as staffing. The PCT was assured by the LIT that the Crisis Team was functioning 'appropriately'.

North Warwickshire PCT may well have understood this particular service model together with an understanding of the work that had led to its implementation but this was not necessarily conveyed to the Commissioners (Rugby PCT), and this has continued to be a source of tension between the two organisations. Rugby PCT made available additional funding but was of the view that they were never sufficiently informed of how the money was used- particularly how existing, therefore already funded, ward staff were being used to support the Crisis Team.

Members of the Crisis Team told us that there was low morale in the team because of several influencing factors. Members of the Rugby Crisis Team felt that they were 'the poor relation' when compared with the equivalent service in the north of the county. This was partly due to their lower staffing levels, at the time of the incident, which we were told was due to difficulties with commissioning. Historically, Terms & Conditions have been developed differently. It was thought to be quicker and easier for 'D' Grade nurses to gain promotion in the rest of the Trust, causing staff to move away from the Rugby services. There were also difficulties in recruiting 'F' Grade nurses to the Crisis Team. More senior nurses were needed in the Team because of the competencies and confidence required to carry out the complex range of interventions effectively.

A review of the Crisis Team, was commissioned by the Local Implementation Team (LIT) in September 2003, and resulted in a critical report being presented to the NWPCT and Rugby PCT in July 2004. An action plan was signed off by the LIT in September 2004.

This plan included:

1. Changes to the Crisis Team's organisation.
2. Agreement from the Commissioners in Rugby to recruit one additional staff member, relocation to a larger team room.

3. Increased availability of home treatment and closer working with the crisis day service.

These actions were implemented.

The on-call rota for medical staff covered both districts, the North of the county and Rugby, and as a consequence, there were occasions when the duty doctor was called to see patients not known to him or his team. It also meant that doctors who lived in the North of the county had to travel 25+ miles to see patients in the Rugby area at night.

COMMENT

It is fair to say that during our time in Rugby in May- June 2006, with the exception of medical staffing arrangements, the Crisis Team had an establishment which appeared to reflect that set out in the Policy Implementation Guide (PIG), published in 2002. We were concerned to learn that on occasions 'D' Grade nurses continued to be the most senior staff on duty in the Crisis Team. However, we were assured that the Crisis Team had now developed rotas so that 'D' grade nurses are not on duty when less experienced medical staff are also on duty. Although the nurses and medical staff report that they have 'back up' from more senior on-call clinical staff, the Crisis Team also reported that the nurses can feel as if they are left to make vital initial clinical decisions on their own.

At the time of the incident the Manager of the Crisis Team was also the Manager for the In-Patient unit. This could, at times, result in a conflict of interest, e.g; between the need to cover the shifts on the ward and those for crisis resolution and home treatment. A dedicated Team leader has been appointed in the Crisis Team who reports to the Crisis Team/Inpatient Manager. At the time of the incident the Crisis Team/Inpatient Manager was part of an on-call out-of-hours managers' rota, with responsibility for the locality of Rugby which draws on a pool of four managers. However, in contrast, the equivalent rota in North Warwickshire was one in twelve. We now understand that the *out-of-hours* managers rota has been combined to form a single rota with two managers across Rugby and north Warwickshire on call.

Medical cover for the Crisis Team was provided via a local on-call doctor rota during working hours. The duty doctor for Rugby and North Warwickshire provides this cover out-of-hours. It was also reported from more than one source that there have often been issues of concern regarding the experience and competency of some of the medical staff.

North Warwickshire PCT, as a provider of mental health services, appear to have identified the need for additional investment to staff the Crisis Team to the levels set out in the national guidance and brought this to the attention of commissioners (ie; both NWPCT and Rugby PCT) in 2003. In the meantime it could have sought permission internally to exceed the available budget and proactively re-configure the Crisis Team to meet this guidance. Recruitment overall was difficult and managers in NWPCT, mental health provider service, felt that recruitment without agreed recurrent investment was not possible. NWPCT, as a Commissioner of services, implemented the changes agreed by the LIT review and supported by the Rugby PCT. Both PCTs, as Commissioners of mental health services, recognised the need to further enhance the service during 2004 and highlighted this as a priority in the Local Delivery Planning process for 2005/6.

COMMENT

The confusion about service models appeared to be a source of tension between the two organisations. The Investigation Team recognised that as. Rugby PCT is a predominantly commissioning organisation and North Warwickshire PCT is both a commissioning organisation and a large provider organisation, there may well have a difference in culture between the two PCTs. The investigation initiated a session with managers, which highlighted clear differences in vision, values and leadership in the two PCTs.

There was a strongly held view by North Warwickshire PCT that they did not receive sufficient funding to support the service provided in Rugby. Rugby PCT did not believe that they received sufficient information about service provision and consequently concerned that they were not receiving value for money. One of the outcomes of this tension was that North Warwickshire PCT and Rugby PCT have not been able to sign off a Service Level Agreement for the mental health services provided by North Warwickshire, each giving a differing view on their respective communication/engagement as the main reason.

Additionally and, perhaps, co-incidentally, there was a lack of understanding regarding the remit and outcome of the (NWPCT) Internal Inquiry. Whilst the Vice Chair and a senior member of the medical staff from Rugby PCT were part of this process, Rugby PCT had some concerns regarding both the content of the final report and its submission to the Strategic Health Authority. The Investigation Team were informed that this had now been resolved.

Rugby PCT has developed a service specification for mental health services to progress future commissioning arrangements and was in the process of entering a tendering process with other providers. We learnt that the local organisations have undertaken a consultative exercise in light of the national changes in the way in which services are commissioned and provided. The tendering process has been postponed because a new specialist mental health Trust will cover the existing services in Warwickshire, Rugby and Coventry from October 2006.

CHAPTER 1

PW'S EARLY YEARS

PW (date of birth 3.11.1969) was born in Rugby and the youngest of nine siblings. His parents were of Jamaican origin. He attended schools in the Rugby area, leaving aged 16 without any particular qualifications. On leaving school he worked in an engineering warehouse, becoming a supervisor two years later, a post he held for another two years. He then worked for another company for five years. During this time he married and had two children having moved away. However, this marriage was short lived and he returned to Rugby in 1999.

One of his sisters was diagnosed with cancer and PW was her primary carer until her death in 2002. He then took on the role of guardian for her son, who was at that time about 12 years old.

He met Colette, they were considered a partnership and had a child, in 2003. They maintained separate households. He visited them and Colette's other two children, from a previous relationship, on a daily basis, spending most of the day with them. They had shared a house but then reverted to their respective homes because of lack of space for their growing family.

Throughout 2002 and 2003 PW attended his GP complaining of backache and was given medical certificates, as he was unable to work, and given medication for the pain. He had issues about the deaths of both his parents and his sister. He looked after her until her untimely death, following which PW became the 'prime carer' of his nephew.

CHAPTER 2

EVENTS IN 2004

FEBRUARY 2004

PW attended his GP who referred him to an Orthopaedic Consultant. In the referral letter he set out PW's current medication.

JUNE 2004

PW attended the orthopaedic clinic and was diagnosed with *"recurring episodes of degenerative low back pain, + right leg S1 root pain."* The follow up letter to the GP finished with:

> *"…….clinically there were no positive findings on examining his lumbar sacral spine or his lower limbs, and the question is whether his recurring episodes are due to instability at any one particular disc, or nerve root and therefore we are going to get an MRI scan, and at this stage keep all treatment options open."*

16TH JULY 2004

PW attended the GP but on this occasion he was more concerned about some abdominal swelling and that he might have sickle cell disease. He had been prescribed Tramadol for the pain and Indomethacin, an anti-inflammatory drug, which could have caused the abdominal swelling. He had various blood and urine tests, all of which proved to be normal.

COMMENT
During this month PW saw three different GPs on 13 occasions complaining of anxieties about physical illnesses including athlete's foot, abdominal swelling for ten years, concerns about his long bones, sickle cell anaemia, a dental abscess and shortness of breath. All blood tests proved negative. He also had an ultrasound, which, in time concerned him but did not reveal any abnormality.

The GP referred PW to the Crisis Team based in the Linden Unit at the Hospital of St. Cross as he wanted to rule out any underlying mental illness, and PW was feeling 'anxious'. The GP discontinued the painkiller, Tramadol.

The GP recorded:

"V anxious

Lots of anxieties re physical illness

Quite paranoid today

Says he is very short of breath – but no obvious breathlessness. Chest clear.

Says he's been taking Tramadol for SOB

(attended with sister)

To St. C to be assessed by Psychiatric Crisis Team today"

On the same day a Staff Grade doctor and a Psychiatric Nurse assessed PW. They concluded at the end of this assessment that he needed to seen again and to have his physical symptoms reassessed including an EEG. He was referred back to the GP for the EEG and given another psychiatric outpatient appointment. The Staff Grade doctor wrote:

> *"….Mr. W started the interview by saying that "he doesn't know (*sic*) why [the GP] asked him to see a Psychiatrist as he thinks he is not suffering from anxiety".*
>
> *Mr. W then went on to say that his problems started in 1999 when he experienced back pain and swelling of his back from his neck downwards. He received Tramadol treatment, which initially helped, but now the Tramadol is not helping him. The swelling has moved to the anterior chest wall and this happens regularly. Two years ago his right ankle swelled and was treated successfully with Indomethacin and it was thought that he had gout. About six weeks ago Mr. W began to have shortness of breath. This morning he had another bout of shortness of breath lasting for about two hours. It was associated with some sweating and feeling hot. There are no other symptoms of panic attacks. According Mr. W all blood tests are fine. On specific enquiry I could not elicit any symptoms of depression or generalised anxiety. There is also no evidence of psychotic symptoms. There are no visual or auditory hallucinations. Mr. W is bright pleasant and reported no suicidal thoughts at the time of his assessment. He is orientated in all four spheres. Mr. W denied misuse of illegal drugs and/or alcohol. He smokes cigarettes occasionally. He reported no problems in his personal life and no problems at work (he is self employed).*
>
> *There is no past psychiatric history in his family and there is no past psychiatric history for Mr. W either.*
>
> *At the end of the interview Mr. W added that he has regularly had a feeling of stomach churning and tension and a feeling of losing consciousness. There is no history of head injury or epilepsy in his family. He suffers from hay fever and has no major medical problems.*

Conclusions and Opinion

I think that Mr. W is not suffering from a major mental illness as such like, psychosis, depression, or anxiety disorder. I would consider a preliminary diagnosis of somatoform disorder.

Plan

1. *I would be grateful if you could arrange an EEG for Mr. W in order to exclude epilepsy.*

2. *A referral to psycho therapy could be a valid option.*

3. *Ffollow up in four to six weeks time with The Staff Grade Psychiatrist.“*

It was agreed that there was no role for the Crisis Team at this point in time.

COMMENT
When the nurse completed the Care Programme Approach (CPA) documentation PW was described as ‘**white British**’. This is especially significant as the Internal Inquiry gave quite a lot of emphasis to his ethnic origin and this aspect of his care. However, we were unable to come to any conclusion as to whether his ethnicity made any difference to the way he was treated by any of the professionals who were in contact with him.

9TH AUGUST 2004

PW attended the GP surgery and saw one of the partners. He was complaining of ‘retaining urine” everything is swollen. The GP notes state:

“Nil to see bladder not palpable. Advised to stop Indomethacin”.

COMMENT
The Investigation Team were told by PW that some of his physical symptoms abated after stopping the medication.

9TH SEPTEMBER 2004

PW was due to be seen in the psychiatric outpatient department but did not attend.

15TH OCTOBER 2004

PW saw a Consultant Neurologist to whom he described all the symptoms that he had complained of to his GP in the past.

In the Consultant Neurologist's letter to the GP he stated:

> *"…. On further general enquiry he initially did not recall any form of loss or alteration of consciousness but subsequently indicated that he may pass out occasionally whether standing or sitting, subsequently indicating that this might occur on a daily basis. He would normally manage to sit down if standing, feeling light headed for a few moments before and feeling drained afterwards for up to 10 minutes. He states that he is thought to be asleep on these occasions and denies having fallen onto the floor, bitten his tongue or been incontinent.*
>
> *He stated that he had been thought to be anxious in the past but gave no other reason to account for psychiatric referral.*
>
> *… On examination he appeared well. I could find no abnormality on neurological examination.*
>
> *..Although his history of uveitis raises the possibility of sarcoid and therefore I suppose diabetes insipidus, his history of passing stronger urine on waking in the morning seems to provide some evidence against this. He requested to visit the toilet at one stage during his interview but did not give any indication of excessive thirst and subsequently did seem to agree that he is able to exert at least some control over his fluid intake.*
>
> *….It is difficult to believe his fluctuating story but I will send a copy of this letter to Dr. B to ask if he would be kind enough to consider including contrast views at the time of the MRI scan with the possibility of T2 weighted images of brain and pituitary fossa.*
>
> *A further appointment was made to follow progress"*

The Consultant Neurologist also wrote to the Staff Grade Psychiatrist, asking him to request an EEG as the current waiting list in his hospital was *'quite long'.*

COMMENT
When we interviewed the Consultant Neurologist, he told us that he thought PW was 'a bit odd', his complaints were unusual but he had no suggestion of a mental disorder. If there were somatoform manifestations then the Consultant Neurologist did not remember PW being like that. We were concerned that he had not been told of the incident prior to hearing from the Independent Investigation inviting him to give evidence us.

11TH NOVEMBER AND 9TH DECEMBER 2004

PW attended two psychiatric outpatient appointments. Colette accompanied him on the first occasion. On the second occasion he attended by himself. The same Staff Grade Doctor saw him on both consultations.

PW told the Doctor that his problems started about three years previously and he reiterated the same symptoms as in the previous consultation. He denied any depression or psychiatric symptoms.

The Staff Grade Doctor did not identify any underlying mental illness. He was reluctant to conclude a diagnosis of somatoform disorder – defined as physical symptoms that seem as if they are part of a general medical condition, however no general medical is present. In this case psychological conflicts may become translated into physical problems or complaints - until physical causes ruled out. PW told the doctor that he was not using any illegal drugs.

The Psychiatrist outlined PW's medical history as:

"… *i) lower back ache and swelling that radiates to his right lower limb;*

ii) recurrent swelling of his lower abdomen that radiates to the upper chest with shortness of breath and severe itching;

iii) polyurea polydypsia and nocturea;

iv) periods of extreme tiredness accompanied by shaking of his whole body with sweating and palpitations and this continues until he passes out for a number of hours, not followed by any convulsions or confusion;

v) recurrent bloating sensation of his abdomen and diarrhoea;

vi) feeling of fullness all the time.

In addition he has dry skin, eczema and recurrent fungal infection of his toes. He noticed that these symptoms occur only when he takes milk or sugar in his diet and disappear completely if he avoided them. On direct enquiry he denied having any anxiety symptoms, depression or psychosis. He is worried that his physical symptoms prevent him from enjoying life.

… ***CONCLUSION***

After two successive long interviews with this gentleman and taking his history and examining his mental state, I myself am unable to conclude

whether this young gentleman is suffering from a major mental illness, such as anxiety, depression or psychosis. It is possible that he might have underlying somatic disorder based on his multiple physical symptoms, and does not conform to a normal medical illness. However, and on the other hand it is also possible that he might have an underlying genuine physical cause which may need special investigations.

I am inclined to withhold a diagnosis of somatic form disorder until an organic cause for his illness has been excluded. For this reason, I would be grateful if you could refer him to the physicians for further investigations. Since he has no definitive mental illness I have not offered him a further outpatient appointment, but of course I am more than happy to see him again if you think it necessary."

COMMENT
The experience of physical symptoms that cannot be explained or diagnosed as having a physical cause can be a symptom of psychological or psychiatric illness – this experience of physical symptoms is called somatisation. The letter about the two consultations, dated 10th January 2005 was not sent to the GP until the New Year. When we interviewed the Staff Grade Doctor he told us that he wrote the letter after the two consultations thus causing the delay. Another GP in the practice responded to this letter by stating that PW was using drugs such as ecstasy and cannabis.

Later that month PW contacted the Police because there had been a family argument over the guardianship of his nephew and other family members wanted to take him away from PW's care.

COMMENT
By the end of 2004, in addition to his GP (with a background in psychiatry) on many ocassions, PW was seen by the neurologist because of his bizarre presentation. As a result he was seen by two psychiatrists and a psychiatric nurse, to make sense of his presentation as there were no physical symptoms identified. It is a great pity and poor practice that these latter professionals did not seek more corroborative evidence from his family members.

COMMENT
We were unable to find any evidence of PW having had mental health issues prior to 2004. However several family members were aware that he was depressed after his sister's death and when he learnt that his previous partner was intending to emigrate taking his children with her. They described him as being 'paranoid' and talking rubbish as if he wasn't all there. PW described the Government as 'covering up' a serious sugar problem that would slowly kill off everyone. He thought he was 'God'and talked to the radio, listening for messages of what to do next.

CHAPTER 3

PW'S MENTAL HEALTH IN 2005

7TH JANUARY 2005

PW saw a partner at the GP practice and reported that when he took cannabis, ecstasy or sugar he developed auditory hallucinations.

On 10th January 2005 the GP practice received the letter from the Psychiatrist and a reply was sent stating that PW was using cannabis and ecstasy.

19TH JANUARY 2005

Colette phoned PW's GP and expressed concern about her partner's behaviour, which she described as being "paranoid and aggressive". An appointment had been made earlier for PW to see his GP later that day – he did not attend.

PW went to the local Town Hall, where one of his sisters worked. He wanted to discuss his housing benefit with her and became agitated and banged on the desk, so much so that the Police were called. When they arrived, PW was verbally aggressive to them. His sister was called and on seeing her, he calmed down. The Police were only there for few minutes as his sister took PW into a nearby park when he told her about his recent problems with Colette. He showed her a chef's knife but assured her that he had no intention of using it. This knife was later described as being 14 inches long, with a blade of up to two and half inches. This knife was usually kept in PW's kitchen.

This was **not** reported to the Police at the time.

20TH JANUARY 2005

PW, with Colette, attended the GP surgery. He told the GP that he was not using cannabis but hearing voices and was able to change the weather by changing his clothes. The GP requested an urgent assessment with the Crisis Team.

COMMENT

The GP told us that Colette was…."a very nice pleasant young lady, a very caring person. She was a good historian and very reliable in that she would make sure PW attended his follow-up appointments and she would always let him know if there was a problem."

Colette accompanied PW to the Linden Unit that afternoon at about 16.30 hours. PW told the nurse that he was hearing voices and could change the weather by changing his clothes. PW was concerned about his physical symptoms and memory loss and so requested the results of the MRI scan. He was sure that music was sending messages to his head and that he needed to regulate his breathing, which he was able to do when asleep. He also said he had been smoking cannabis and resin leaves. He also said that he had had a lump under his arm, which disappeared after he had 'detoxed' from using sugar.

During the interview it was noted that he became 'irritable' and verbally hostile to Colette, but when asked to calm down, he did so.

The duty nurse noted that there were differing opinions from the GP and the Staff Grade Doctors about PW. He discussed his assessment with the Staff Grade Psychiatrist who had seen PW previously. They were both aware of reported drug use by PW. The notes stated the following plan:

1. *"The Staff Grade Psychiatrist contacted as mental health illness presentation questionable."*
2. *D/W the Staff Grade Psychiatrist – who will D/W with the Consultant and offer OPD.*
3. *CT to provide support until decision made to offer OPD.*

COMMENT

When we interviewed PW he remembered this interview and told us that the nurse was leaving in a couple of days, which was confirmed when we interviewed the nurse in question, as he left the Trust for another position. Given that the nurse was leaving the Trust and PW had presented before, having another face-to-face professional opinion might have made for a fuller assessment.

The nurse wrote to the GP the same day:

Consultant Dr …

Community Key Worker

The Crisis Resolution Team saw the above client today after your referral to us. The following action was taken after assessment.

1. *Discussed with The Staff Grade Psychiatrist, who will in turn discuss with the Consultant, events of this case for second opinion and to offer OPA*

2. *Crisis Team will provide support for PW until decision is made about his outpatients appointment.*

Should you have any queries about this client, please do not hesitate to contact us.

COMMENT
The GP records do not contain this letter.

21ST JANUARY 2005

Colette contacted the Crisis Team as she was worried about PW as she felt there was no change. She was assured that an appointment was being sent and that the Crisis Team had tried to contact PW on his mobile telephone but there was no reply. This number had changed and Colette gave the new number to the Crisis Team, which they dialled to try and contact PW with over the next three days but were unsuccessful.

25TH JANUARY 2005

PW should have attended a GP appointment. He should also have attended an outpatient appointment with the Consultant Neurologist. As he did not keep this, latter appointment he was discharged from the clinic.

COMMENT
When the Investigation Team interviewed the Consultant Neurologist, he was quite distressed that he had not been in a position to follow up PW's non-attendance. It was the policy of his hospital to discharge patients when they did not attend an appointment.

26 JANUARY 2005

The Consultant Psychiatrist arranged an outpatient appointment for the 2nd February 2005.

Colette telephoned the Crisis Team to tell them that PW was experiencing bizarre thoughts and hearing voices. She was advised to either take him to the Crisis Team or to the Accident & Emergency (A&E) Department at the Hospital of St. Cross if she felt the situation was deteriorating. She was also informed that an appointment had been made for PW to see the Consultant Psychiatrist on 2nd February at 10.00 hours.

COMMENT
The Investigation Team considered that, by this stage, a Contingency Plan should have been established by the Crisis Team – in the event of PW failing to attend an outpatient appointment. We did not think that giving the sole responsibility to Colette to make sure that PW attended this appointment was appropriate, given her concerns about his behaviour which she had been trying to impress on the mental health practitioners.

27TH JANUARY 2005

The Children and Family Social Worker made her last home visit to Colette as the work with the children was now completed.

COMMENT
The Investigation Team learnt that Colette was so worried about PW in January 2005 she wrote a series of notes and gave them to his brother. These notes were produced as evidence during the Police investigation following Colette's death.

1ST FEBRUARY 2005

At about 12 midday, Colette again called the Crisis Team about PW's behaviour, as he was still hearing voices and talking about being able to change the weather. She no longer felt safe as he had become more aggressive and threatening. She also said that PW would be angry if he knew she had telephoned. PW accused her of trying to poison their daughter by giving her hot chocolate with sugar – rather than hot chocolate with glucose.

She also told them that PW had threatened one of his brothers a couple of weeks ago. He had a knife most of the time and had threatened to cut his brother's heart out. She also said PW did not intend to keep the outpatient appointment made for the following day at 10.00 hours.

The note of this conversation finished with:

"to discuss with The Staff Grade Psychiatrist and make a plan of care"

Later that day, Colette called the Police twice as she had seen her ex partner in the street, visiting a neighbour, and she was concerned that he (PW) might be trying to get into her home. She was advised to call 999.

COMMENT
Colette's previous partner, father of her two older children, had a reputation for violent behaviour which had resulted in her leaving him.

Later that evening PW broke a window to gain entry to Colette's house. He assaulted her with a stick – apparently a snooker cue - and stole her mobile telephone. As PW went upstairs, Colette left the house via the broken window, cutting her wrist and hurting her feet.

She went to one of her neighbours and asked them to telephone the Police to inform them that PW had smashed the windows of her home to get in and had attacked her.

At 21.49 hours two female Police Officers and a Community Safety Officer attended in one car, whilst another Police Officer and a Special Constable attended in a second vehicle. The neighbour offered to give the snooker cue to the Police but was told to throw it away which left her with the feeling that the Police were not taking the incident seriously enough. Colette was badly shaken by the incident and the Police Officers arranged for her to go to hospital by ambulance. They also arranged for the windows to be boarded up. The Police recorded that Colette did not wish to press charges, as all she wanted was something to be done to have PW 'sectioned'.

Her friend decided not to go to the hospital with Colette as the Police agreed to bring her home following any treatment. In fact this did not happen and Colette left the hospital on her own going to her parent's home. Her father then took her and her

mother back to her own house. Her mother had decided to spend the night with Colette to help with looking after the children.

PW left Colette's address and was later located near his own home. He was bleeding and had an injured hand. PW told the Police that he suffered with diabetes and needed Lucozade, which they acquired for him. They arranged for an ambulance to take PW to the A & E Department for his lacerations to be dealt with. PW would not wait for a nurse to see his injuries and dealt with his injuries himself before leaving.

COMMENT

This incident was not dealt with in accordance with Warwickshire Police's domestic violence policy, crime recording policy and call handling policy. In all, 30 entries were made on the command and control computer between 9pm and midnight.

No positive action was taken to interview or arrest the offender or deal with the incident, no crimes were recorded and insufficient information was obtained, despite two Police Officers locating PW a short distance away. Both PW and Colette were being treated in the same accident and emergency department and were not accompanied by any Police Officer. This kind of situation must happen frequently and staff need to take account of the need to protect patients when their injuries are the result of a so-called domestic incident.

23.30 hrs - Colette telephoned the Crisis Team to inform them of the earlier events in the evening when PW had broken into her house and smashed the place up with a stick. She was very concerned that his mental health was deteriorating. Colette rang again to say that a neighbour had seen PW outside her home and telephoned the Police but felt that she was not being taken seriously. The Crisis Team telephoned the Police to inform them of Colette's concerns and the Police telephoned her back to advise her of how they could help and what she might do if PW came back.

At first Colette chose not to lodge a complaint with the Police about PW's violent behaviour and then changed her mind. As the Police were busy that night she was given an appointment to be interviewed the following day at 15.30 hours.

2ND FEBRUARY 2005

The nurse on duty with the Crisis Team contacted the Police as she thought Colette might be at risk as, allegedly, PW had a knife. He was due to see the doctor the following day but it was felt unlikely that he would attend. The Police were told that when PW was found he would need a full mental health assessment. Two Police Officers were dispatched to Colette's house but, before they got there, they were diverted to another violent incident and were not replaced by any other Officers, neither was any contact made with the duty nurse from the Crisis Team.

The duty nurse on the Crisis Team informed the Police Communications Department of their concerns about PW's mental health state and that he was carrying a knife. The nurse was told that the Police Officer, who had attended the night before, thought that PW was "*of sound mind*".

COMMENT
The incident of the previous night was closed down at 05.28 hrs and for some reason the appointment was never followed up by the Police.

10.30 hrs - Colette telephoned the Crisis Team. She had seen PW and he presented as if nothing had happened. She was reassured that PW would be discussed with the Consultant Psychiatrist that morning. Following the discussion with the Crisis Team, the Consultant Psychiatrist telephoned the Children and Family Team.

The agreed plan was to:

1. *Inform the GP about the seriousness of the incidents and concerns about mental health.*
2. *Inform the Police about the need to respond to this case and concerns about mental health.*
3. *Inform Social Worker, Children and Family Team who were involved with the children.*
4. *Dr. to offer another appointment to see PW at the Linden Unit.*

COMMENT
The Investigation Team were dismayed by the Consultant's decision to offer another appointment when clearly a more proactive stance should have been taken.

11.00 hrs - The nurse on duty telephoned Colette to inform her of the appointment and advised her to contact the Crisis Team if she needed any support. A further telephone call was made to the Social Worker in the Children and Family Team to inform them about PW's mental health state and the current incidents as they had been reported to them. The Social Worker agreed to telephone PW's relatives to ask them to take care of the nephew.

The Crisis Team discussed Colette's telephone call with the Consultant and the Staff Grade doctor. As a result they contacted the GP practice to initiate a MHA (1983) Assessment. One of the GPs, who had seen PW on a previous occasion, took the call. The Crisis Team asked her to initiate the assessment but she told them that she could not do so as the information about PW had come from a third party (Colette) and that PW had the right to refuse treatment. She also said Colette had contacted their Practice and told them that PW would not attend the planned out-patient's appointment. The GP advised her to persuade PW to be seen at A&E or, if she felt at risk, to contact the Police who could take PW to a place of safety to be assessed.

COMMENT
The Investigation Team felt that it was totally inappropriate to expect the GP to initiate a MHA (1983) Assessment.

The Consultant Psychiatrist left a message with the Crisis Team to say that the Social Worker was going to contact the Police and that there was a possibility of carrying out a MHA (1983) assessment as part of enacting the *Child Protection* Policy.

14.00 hrs - The Consultant referred PW to the Social Services Department for a MHA (1983) assessment. An assessment was arranged for 3rd February 2005 at 12.45 hours at PW's home. The Consultant Psychiatrist stated his concern that if Children and Family Team went to remove the nephew it would complicate the assessment process.

Colette telephoned the Children and Family Team to tell them that PW was suffering from mental health problems and that he had broken into her home the previous night. PW accused her of trying to murder their daughter and he threatened to 'finish' her and cut her throat.

The Consultant Psychiatrist also telephoned the Team and told them that PW had not attended for an appointment, as requested, and that when he was seen on 20th January 2005 his presentation was quite different. He went on to tell them that he was now concerned about the safety of PW's nephew, Colette and her children as PW was rumoured to be carrying a knife all the time and had said he would cut her heart out.

COMMENT
The Police did not follow up the telephone call from the Crisis Team nurse, nor did they keep the appointment with Colette to discuss her complaint.

15.00 hrs - Colette's brother telephoned the Police to inform them of the family's fears for Colette's safety, that PW was acting violently and *'talking murderously'* and also complained that they did not think that Colette was being listened to by the Police. He told them it was an extremely serious situation and went on to say ***"tomorrow may be too late"***

He telephoned again relating all the same information.

17.10 hrs - Colette's brother phoned the Crisis Team about PW's unpredictability. He was told that the Team had to maintain confidentiality and so were not in a position to discuss PW with him. He also telephoned the Children and Family Team about his concerns for PW's mental health. He told them that he felt very frustrated and annoyed and that *"blood had already been shed",* referring to the incident the previous night. He went on to say that he would continue telephoning the Linden Unit as he had previous experience of mental health services.

The Children and Family Team and the Child Protection Police Officer held a Strategy Meeting to discuss the safety of PW's nephew, especially as he had not been to school that day.

The notes of the Strategy meeting stated:

- "He (PW) did not attend an appointment today.
- PW has been known for approximately six months.
- They were going to ask the GP and Police today to request that they look for him.
- The locum Consultant Psychiatrist – PW has been referred by GP as having a multiple psychosomatic illness
- No evidence of psychiatric illness.
- At an appointment on 20 January 2005, PW's presentation was very different – psychotic delusions. He (PW) feels that this presentation together with the two aggressive incidents and use of LSD and Cannabis has increased the risk to himself and others.
- Was carrying a knife most of the time.
- Very concerned about nephew and Colette's children.
- Has arranged an assessment for PW tomorrow (03.02.05) at 12.30 hrs.

No one was able to, or, would attend from the Linden Unit but on the telephone, the Consultant Psychiatrist, stated that in his view.

"there is no clinical or factual evidence that (PW's nephew) was at risk"

COMMENT
This view was in **sharp contrast** to what the Consultant seemed to imply when he referred this case to the Children and Family Team earlier in the day. Neither did he refer to the risk to Colette and her children, which had also perturbed him earlier.

The GP was not able to attend the Strategy Meeting but informed them that it was not safe for PW's nephew to stay the night with PW as, for the last three months, he had had concerns about PW's mental state.

Neither the Social Worker nor the Police Officer felt that they could leave the situation as it was.

The identified risk factors were described as:

- ❒ Initial referral regarding level of risk posed by PW.
- ❒ Violent incident against Colette the previous night.
- ❒ Whereabouts of PW and his nephew unknown.

The Social Worker arranged for a Duty Social Worker from the Emergency Duty Team (EDT) – an out-of-hours team of social workers who respond to urgent referrals, to accompany her on the visit to PW at home, primarily for child protection reasons. The duty Social Worker was a trained Approved Social Worker (ASW).

COMMENT
The fact that the Duty Social Worker was an ASW meant that the visit could have had two purposes. Whilst the primary objective might have been a child protection referral, there was an opportunity to initiate some form of assessment of PW's mental health.

The Police were also asked to attend that night to ensure the safety of all involved.

The ASW informed all attending that she had spoken to the on-call Psychiatrist, based in the north of the county. The ASW recorded that the on-call Psychiatrist:

"'… did not want this man to be left in the community tonight"

does not want him alerted to a Mental Health Act Assessment

suggests that the Police remove him – to a place of safety or arrest him and take to Police station

…will not attend to make assessment until he (PW) is in 'safe' place"

20.00 hrs - One of PW's brother with his chauffeur/guide went to see Colette and persuaded her to accompany him to see PW.

The two female Social Workers, accompanied by two Police Officers, one of whom had been involved in the incident the night before at Colette's home, went to seek out PW at his home. The property was in darkness but PW arrived after a few minutes carrying a bag of chips and half a bottle of brandy as he had drank the other half and was a little drunk. He said he had been visiting his sister. PW was pleasant, a bit surprised to see the Social Workers and Police Officers and initially thought he

was being arrested for breaking in to Colette's home the previous night. He offered both his wrists to the Police to handcuff him, which they did not do, saying he was quite agreeable to go to the Police Station. The ASW suggested to the Police that they just *'take him'.*

PW told them that there was nothing wrong with him and declined any psychiatric examination that night but willingly agreed to go to his GP in the morning. He also agreed that his nephew, who was currently out, should remain with other family members overnight and agreed to any plan that Social Services might have in mind, even accommodation in foster care. Concerns about the break-in were raised with him. He said he had just broken a window to get into Colette's house, as she would not let him in to see his daughter. Concerns were expressed about the incident at the Council Offices and PW threatening staff with a carving knife. PW adamantly denied having a carving knife with him and said 'it was not true'.

When the Police told PW he was not being arrested for previous night's events, he became less cooperative and said he was going indoors because he wanted to be left alone, and would not allow anyone into his home.

According to the ASW, PW did not manifest any sign or symptom of mental disorder. He was happy, agreeable and showed no trace of paranoia or thought disorder. The Police advised the Social Workers that they had no grounds to apply Section 136 MHA1983, which gives a Police Officer the power to arrest a person who appears to be mentally disordered in a public place.

The ASW telephoned the on-duty Psychiatrist to give him an update. He agreed, on being told what had happened, with the proposed plan of no further action that night and having PW seen the following day for the assessment already arranged by the Linden Unit.

COMMENT

The Police and Social Worker accepted that there appeared to be no grounds to seek an urgent Section 135 warrant – this allows Police Officers to force entry to private property for the purpose of a MHA1983 assessment.

Whether the Police should have taken any action in response to the previous night's incident is a matter for the Independent Police Complaints Commission Inquiry.

Shortly after this, whilst the two Social Workers and the Police Officers were discussing what had happened, a visually impaired male relative of PW arrived, together with a female friend of his and Colette. The relative introduced himself as a doctor and agreed to find accommodation for his nephew within the wider family. He voiced his disagreement with a MHA (1983) assessment or admission, until he had seen PW for himself. This brother had visited Colette's house earlier in the evening and persuaded her to go with him to see PW, against her parent's advice.

The ASW advised them, as she had the Police and Social Worker earlier, that it was possible for relatives to underestimate the risks in mental illness, not necessarily appreciating the effects of mental illness on a person's thinking.

When we interviewed the ASW she told us that she had not met Colette before and when we asked her about Colette, she told us

"…she was very frightened. Yes, very tense and very frightened."

Colette told the ASW that she had considered going to a refuge but was staying at her mother's house with her children. She agreed to stay away from her own address until PW had been assessed the following day. The family and friends insisted on remaining there to see PW, but he would not actually let them in.

The Social Workers and the Police then left. The ASW contacted the Crisis Team by sending a report by fax later that night to update them about the visit.

COMMENT

Between midnight the night before, and midnight 2nd February 2005, 25 entries were made on the Police computer in relation to PW and Colette.

The ASW told us that she did not go out to conduct a Mental Health Act Assessment. She was just accompanying the Children and Family Team worker as they went out in pairs. She would have preferred PW to be arrested under Section 136 if he had met the criteria.

The Children and Family Team Social Worker had one agenda – the safety of PW's nephew.

The ASW had a slightly different agenda, which was to make a preliminary assessment of PW's mental health and to take further action if necessary.

We were told that this conversation with PW lasted no more than five to six minutes. It appears, however, that subsequently this was accepted by some professionals and at the Internal Inquiry as either an assessment of his mental health or indeed a formal Mental Health Act Assessment. At best it was a quick observation of PW and it must be noted that **neither a Psychiatrist or GP were present as would be necessary for a Mental Health Act Assessment**. Both the Police and the ASW concluded that PW did not meet the criteria for 'arrest' under Section 136 and subsequent assessment under the Mental Health Act (1983) although the ASW did recommend a full assessment in 'office hours' the following day.

The on-call Psychiatrist supported this action following a telephone discussion with her.

3RD FEBRUARY 2005

The Psychiatric (Forensic) Nurse who worked closely with the Criminal Justice system, telephoned the Crisis Team and told them that the Police had no record of an incident at the Council Offices, involving PW and a knife. She also informed them that Colette had complained to the Police about her previous partner and his violent behaviour towards her but that no charges were ever brought against him. However, this did not necessarily mean that there had been no actual abuse as Colette had been sufficiently worried because of his behaviour that she had moved into a women's refuge with her children to protect them against his attacks.

COMMENT

The staff in the Crisis Team did not follow up this with Colette. If they had then they may well have discovered that during their 2 year relationship, in which they had two children, he frequently physically assaulted her as well as being verbally abusive, necessitating her to move house so that even her family did not know where she was living.

PW's brother, who worked in Bath went to see PW at about 11.00 hours as he wanted to be there for the assessment, arranged for midday. PW was in the bathroom and refused to come out. As it happened the assessment was then changed to take place in the Linden Unit. Another brother and a friend arrived and between the three of them they tried to persuade PW that he should go into hospital. PW became extremely abusive, speaking in Jamaican and they became concerned for their own safety, leaving PW at about midday.

Following this outburst, the brother who had gone to see PW with a friend, was concerned and visited Colette to see how she was and described her as 'scared'. This brother also telephoned the Linden Unit, to try and get help for PW and later went to see PW with a view to persuading him to attend the Linden Unit, but he refused.

Colette and her mother went shopping to buy another mobile telephone to replace the one taken by PW the previous night.

12.30 hrs - Colette's brother again telephoned the Crisis Team as he was deeply concerned about PW's mental health and his sister's welfare. He expressed his disgust at the lack of action from the doctors and felt that both PW and Colette were at risk because of PW's behaviour.

He was advised to telephone back if he had any more concerns!

In the morning the ASW tried to contact PW's brother and as there was no reply, a message about the setting up a formal MHA (1983) Assessment was left on the answerphone.

Colette's brother telephoned again at 13.35 hours to say that he had been trying to get help for PW for the last six months. He telephoned again asking questions about Colette's health as she was 'hysterical' and he was not able to help her.

COMMENT

We asked various witnesses whether this information from the 'Forensic' Nurse about Colette's previous relationship and resulting contacts with the Police featured in their decision making but we were never able to reach a firm conclusion one way or the other. However, if they had had any training in domestic violence, they would have known that victims do not always make consistent complaints because of their own guilt and feelings of self worth.

In all Colette's brother made approximately **16-18 telephone calls** to the Police, the Linden Unit and Social Services. He saw little or no outcome from any of these telephone calls. He even telephoned PW's GP who told him that to date he had little response from the Linden Unit – the Crisis Team in particular.

It is not surprising that he had no faith in the Inquiry process and chose not to be interviewed.

The Consultant arranged a formal MHA (1983) Assessment for between12.30 hours and 13.00 hours that day as that was the only time the GP could attend. Contact was also made with PW's other brother who felt that PW's mental health problems had been exaggerated and that PW's problems were more to do with his relationship with Colette, which of course was untrue.

The duty Approved Social Worker contacted Colette, who said that she did not want to get involved with the assessment. She had been told by one of PW's brothers that she was the cause of PW's problems and that if PW was 'sectioned' it would ruin his life. The ASW told Colette that, in accordance with the Mental Health Act, another brother was PW's nearest relative and the person who needed to be consulted about its use to detain PW.

Following a discussion between the ASW and the Consultant, the formal assessment under the Mental Health Act became an informal assessment at 12.30 hours, to be conducted at the Linden Unit. Colette and the brother, who was the nearest relative, were informed. In the event PW did not attend.

COMMENT

The Investigation Team were at a loss to understand why this assessment, which had been so necessary, had become less important as all the information now being received was of **more** concern and as yet no professional had seen PW to complete a fuller assessment of his mental health state.

13.00 hrs - Colette visited PW's brother. She was agitated and distressed as nothing was happening and no one was offering any help.

14.00 hrs - PW's GP telephoned the Consultant, demanding to speak to him whilst he was conducting his clinic. He told the Consultant that friends of Colette had telephoned him and warned him about PW's behaviour. One of these friends had said *'not to wait until PW had killed someone'.*

PW's GP he told us that he became very frustrated as, over the past 24 hours, he had been pushing for an assessment and that the situation seemed to be changing from:

"… yes we will go out and assess" to *"no, we are going to persuade him to come to the unit"*

he went on to tell us;

…"I thought it had gone beyond that at that stage and there was serious risk to the patient or to others, and there are grounds for assessment and possibly sectioning under the Mental Health Act. I made it extremely clear – I didn't mince my words…

...at the end of the conversation I was reassured that something was going to happen. Nobody got back to me. I phoned the Linden Unit before I left, I wondered whether I was the one who needed the assessment!

I was reassured by one of the Community Psychiatric Nurses (CPN's) that they would deal with it and he would be attending the Unit the next morning but if he didn't attend there would be a definite requirement for me to go out. I asked why no one had let me know and the person I spoke to was just the messenger, they won't pass on information so they didn't know why."

The Consultant told us that he was alarmed by this phone call and felt the situation was becoming more chaotic with many conflicting messages.

15.00 hrs - The Children and Family Team Social Worker telephoned the Linden Unit and also spoke to the acting Locality Manager, expressing concerns about the children in this situation.

COMMENT
When we spoke to this Social Worker, she told us that she was frustrated and surprised that no risk assessment had taken place especially as this was the reason for the referral to the Children and Family Team in the first place some 24 hours previously.

15.30 hrs - An emergency multi-disciplinary meeting was called by the Consultant and acting Locality Manager with the Duty ASW, the Duty ASW from the day before and a Nurse from the Crisis Team. Apparently, the Consultant had asked the Crisis Team to make a home visit but they declined to do so without the Police being in attendance. The acting Locality Manager ascertained that a bed was available. This meeting went on until nearly 17.00 hours when the Consultant was due to finish work. It was decided not to complete an assessment that evening as a Police escort was felt necessary and it was not possible to organise one at short notice.

A further formal assessment was arranged for 4th February 2005. The agreed plan was:

1. *ASW to contact PW's family to bring him to the office the next morning at 10.00am. If PW suffering from any mental disorder Section 4 MHA 1983 could be used to detain PW if he should refuse to stay.*

2. *If contact with PW's family not possible then arrangements to be made for the duty Consultant Psychiatrist to make assessment on 4 February 2005.*

3. *The Acting Locality Manager to locate an ITU (Psychiatric intensive care) bed at the Linden Unit.*

4. *If PW did not come at 10.00am 4 February 2005 then Police support would be initiated and Dr to be available all day.*

COMMENT

Earlier in the day the Crisis Team declined to go out and assess PW because it was 'too dangerous.'

The Consultant told us that the Social Worker wanted to take the least **'restrictive approach'.**

Despite the Consultant having ultimate clinical responsibility for the patient he too agreed to this plan of action and therefore not to do anything else at that time. The Consultant should have been more proactive in his response to this 'restrictive' approach, after all he was the person who made the referral about the safety to PW's family and as yet he still had not seen him.

From our interviews, we have to accept that this decision was one arrived at by consensus; by all present. This meeting was not recorded in the clinical notes. Somehow the anxiety of the day before seems to have dissipated. The Children's Team Social Worker was not invited to this meeting.

The Approved Social Worker informed one of PW's brothers, who was deemed to be the 'nearest relative', of this plan. He said that he would try again to get PW to attend at outpatients the next day. The acting Locality Manager asked the ASW to ascertain the whereabouts of PW's nephew. PW's brother told the ASW that their nephew had in fact spent the previous night with PW.

The acting Locality Manager also asked the Consultant whether he thought immediate action was required to protect the nephew that night as he was expected to return to PW's house. The Consultant told her that he did not consider immediate action was required to protect the nephew.

The Approved Social Worker understood the Consultant would update the GP but this did not happen.

18.00 hrs - 19.00 hrs Colette telephoned PW's brother, telling him that PW had been at her house, accusing her of giving sugar to their daughter. The brother told Colette to lock the door and not let him in if PW returned.

21.20 hrs - Colette's mother heard a noise, which sounded like someone hitting the boarded up window. Colette and her children were asleep upstairs. PW broke in and entered the house. He was carrying a knife. He wanted to know where his daughter was and when Colette's mother

told him, he went straight upstairs. Colette was at the top of the stairs telephoning the Police. She told them that PW had broken into her home. She came down the stairs and went outside and was hysterical. PW came downstairs, carrying his daughter with one hand and a knife in the other. He stabbed Colette's mother in her back and shoulders. He rushed outside, still carrying his daughter and when he saw Colette he raised his arm and stabbed her in her back.

A few moments later, the Police received another telephone call to say that a woman had been stabbed and was bleeding heavily. Colette and her mother were taken to hospital in different ambulances. Colette died of her wounds. Whilst her mother was treated in A & E, Colette's father arrived and later, together, they identified their daughter.

PW, still holding his daughter, ran away. He gave the little girl to someone in a nearby road, who brought her back to Colette's house. PW was arrested and taken to the Police Station at 21.56 hours.

4TH FEBRUARY 2005

The Forensic Nurse interviewed PW and he told her that he had been seen at the Linden Unit but was uncertain why this had been necessary. He told her that he had been seen by his GP because of swelling to his face, feet and hands. He spoke of hearing voices of a Jamaican woman and another calling herself the 'Queen'.

6TH FEBRUARY 2005

PW was not orientated to time as he thought he had been in the Police Station for 11 days. His solicitor and the Appropriate Adult felt he was unfit to be interviewed. PW then dismissed his solicitor. His brother appointed another solicitor and during another interview PW acted in a bizarre manner, grimacing inappropriately and staring at a piece of paper.

7TH FEBRUARY 2005

PW was charged with Colette's murder and with wounding her mother contrary to Section 18 of the Offences Against a Person Act 1861. The prison doctor interviewed PW the following morning.

The doctor wrote:

> *"had prior warning about Mr. W and that there were concerns expressed about his mental health… although he did answer questions in a very brief manner he would not elaborate. Kept stating that he was 'sane' and was not mentally ill. Appeared agitated much of the time and his manner was also threatening and appeared unpredictative. [sic] Admitted to the healthcare centre and to be seen by the visiting Psychiatrist".*

11TH FEBRUARY 2005

The visiting Consultant Psychiatrist assessed PW and wrote to the Reaside Clinic, a medium secure hospital, requesting that he was placed on the waiting list for a bed. The doctor stated:

1. *"There seems to have been a gradual deterioration in Mr. W's mental health over the last few years. He went from being an individual who worked full time to not working. His behaviour seems to have become increasingly bizarre over the last year. There also seems to have been concern expressed by the alleged victim regarding his mental health, including her contacting the mental health services to seek help.*

2. *Due to his family's negative image of mental health services and the unfortunate course of events with regard to Mr. W's father' s death, there seems to have been some difficulties in seeking help.*

3. *Over the last several months he seems to displayed symptomatology consistent with a major psychotic illness, including persecutory delusions.*

4. *His illicit substance abuse, especially cannabis abuse and its effect on his mental state needs further assessment.*

5. *Considering the seriousness of the alleged offence and his extremely disturbed behaviour at HMP (he smashed up his cell), I would be grateful for an assessment by your team with a view to considering inpatient treatment.*

6. *I am aware that you have assessed him last Monday and would be taking this forward.*

7. *Should he be placed on the waiting list, I would be grateful for some advice as to whether you would be happy for anti-psychotic medication to be started in a custodial setting, should he be willing to take it. In my opinion this would be the best course of action, considering the potential delay in his transfer to hospital."*

PW was transferred to a medium secure hospital bed in March 2005.

PW pleaded guilty to manslaughter due to diminished responsibility and grievous bodily harm to Colette's mother and detained in a secure hospital under section 37/41 Mental Health Act 1983.

CHAPTER 4

PW'S PRESENTATION

Before July 2004 PW's attendance at his GP surgery was unremarkable. He had had a number of common problems but his main medical problem was recurrent lower back pain.

There was a significant change in his presentation in July 2004. He complained of numerous symptoms, some of which he said he had had for a decade. When, on 16th July 2004, PW presented complaining of shortness of breath even though there was no obvious breathlessness, his GP concluded that PW was possibly suffering from an anxiety state and referred him to the Crisis Team. He noted that PW was *"… quite paranoid"* that day.

COMMENT
The GPs had screened PW for physical illness. Most common illnesses would have shown up on the tests. It is rare for there to be so many symptoms in so many different areas of the body that are so distressing and yet for all the tests to be normal. The GPs had taken PW's symptoms at face value and had referred him when he complained of symptoms that seemed bizarre. They had made a diagnosis of anxiety and referred PW for an assessment by a Psychiatrist. On referral, PW's GP had stated that Mr. PW was paranoid but did not give the Crisis Team more information about this.

Initial contact with psychiatric services

PW was seen and assessed in the A&E department on 16th July 2004 by a Staff Grade Psychiatrist and a Nurse from the Crisis Team. Although PW attended willingly, he did not think he had mental health problems. He came with his sister.

Four different records of this interview were available:

i) the hand written notes by the Staff Grade Psychiatrist

ii) the Crisis Team initial contact form and the duty nurse's written notes

iii) the Staff Grade Psychiatrist's letter, dated 21 July 2004 sent to PW's GP

iv) the North Warwickshire Primary Care Trust Review Form, 6th January 2005, completed by another nurse from the Crisis Team.

According to the Crisis Team initial contact sheet dated, 16th July 2004, the duty nurse that day knew that PW was anxious, that the GP was worried that PW was paranoid and that PW was presenting with multiple physical symptoms. The Duty Nurse noted that he did not find any anxiety or paranoid symptoms or agitation. In addition he also wrote that:

> *"GP fears deterioration in mental health if not supported".*
>
> *"Sister generally believes brother but felt nothing wrong with him mentally"*

The Staff Grade Psychiatrist's letter recounted a number of symptoms presented by PW. These included swelling of his back from his neck downwards since 1999; swelling that moved to his anterior chest wall which happened regularly. PW also complained of shortness of breath lasting 2 hours associated with sweating, feeling hot, stomach churning, as well as tension with a feeling of losing consciousness.

COMMENT
Many experienced doctors would find this constellation of symptoms most unusual. Moreover, one would hope that they would question why a patient, such as PW, had presented today if these worrying symptoms had been present for 5 years. It was not clear from the notes whether the doctor took an independent history from PW's sister which we consider would have been good practice.

There was no legible diagnosis in the handwritten notes of the Staff Grade Psychiatrist. The Crisis Team form stated that he had made a diagnosis of psycho-somatic symptoms. The letter to PW's GP from the Staff Grade Psychiatrist stated that PW:

> *"is not suffering from a major mental illness such as like [sic], psychosis, depression or anxiety. I would consider a preliminary diagnosis of somatoform disorder"*

The review form, filled in some months later by another member of the Crisis Team, who had not seen PW, gave a diagnosis of generalised anxiety disorder with a low score for the severity of symptoms 4 out of 48.

The risk assessment sheet of the Crisis Team assessment was incorrectly completed.

"Has a risk management plan been developed?" It also noted that PW was *"British White".* The Crisis Team's impression was: *"Further investigation by GP no role of CT (Crisis Team)".*

The Crisis Team considered that they were the Care Co-ordinator when they accepted the referral. However, the review form stated that they terminated their contact and their Care Co-ordinator role on 16th July 2004. The nurse circled the box 'method of discharge': *"finished on professional advice".*

The plan by the Staff Grade Psychiatrist, as previously stated, was:

1) for the GP to arrange an EEG to rule out epilepsy,
2) that a referral to psychotherapy was a valid option, and
3) that there would be a follow-up to see the Staff Grade Psychiatrist in 4-6 weeks time.

COMMENT

There were three questions that needed to be answered by the assessment,

1) was there evidence for a mental illness;
2) why was the GP so worried about this man;
3) was there a role for support by the Crisis Team as requested by the GP?

The GP was clearly concerned about PW as he sent him as a same day emergency rather than as a routine appointment. The GP had six months experience as a psychiatric SHO in Rugby and so would have been aware of the difference between urgent and non-urgent cases.

The Crisis Team did document the major concerns of the GP. There was **no** direct communication between the medical staff to allow proper understanding of concerns of risk that day.

This may have been because it was out of hours. It is not clear that an attempt was made to gain a full collateral history from PW's sister in a way that would have allowed her properly to voice her concerns.

The questions that should have been answered by the assessment were not and probably could not have been answered because of inadequate information. The duty Staff Grade Psychiatrist, therefore, made a follow-up appointment and referred back to the GP for an EEG to rule out epilepsy, which was appropriate from the information that was available to him.

COMMENT cont ….

In fact the GP did not have access to EEG investigations, this necessitated referral to a neurologist and was a slow process. It would have been quicker for the mental health services to arrange the EEG than the GP. Indeed the EEG was never done. The Staff Grade Psychiatrist was seeing PW as a 'crisis' but PW did not seem to be in crisis. His assessment was that this man could be seen as an outpatient and he arranged this.

However, there was a significant difference between the presentation to the team and the presentation and worries of the GP which should have been investigated. – for instance by the Staff Grade Psychiatrist telephoning the GP the next day or by him indicating to the person who was to see PW in outpatients that a conversation with the GP was required.

No formal risk assessment was undertaken. Using a standard risk assessment could have led to further assessment which may have uncovered other symptoms but the likelihood is that the risk assessment screen would have been filled in from available information and this would not have led to any change in the plan.

No firm diagnosis was made, though all the written diagnoses are of the ICD10 category "neurotic, stress related and somatoform disorders" The diagnoses given are different – generalised anxiety disorder, possible somatoform disorder and "psychosomatic symptoms" which is a description of the symptoms rather than a diagnosis.

Though an unusual presentation, no discussion with a senior colleague was initiated. There was no review of the case or the plan. With the Crisis Team finishing their involvement but with further appointments it was unclear who the care co-ordinator was or who was responsible for the case.

Time between initial contact and second appointment

PW did not keep the appointment on 9th September 2004 which was made with a Locum Psychiatric SHO. Another appointment was made for two months time.

COMMENT

It is unclear why PW was referred to the Locum SHO's clinic.

In the meantime the Consultant Neurologist saw PW, following a GP referral made after he received the Staff Grade Psychiatrist's letter. The Consultant Neurologist took an in-depth history. As he was 'sceptical' about PW's presentation, he ordered further blood tests for completeness rather than in the expectation that they would yield positive results.

The Consultant Neurologist wrote back to PW's GP on 30th November 2004, stating that all the tests were normal but that the EEG was still outstanding.

PW's visits to the surgery decreased from July 2004. He required ongoing medical certificates to claim sickness benefit.

Second Assessment by Psychiatric Services

The Staff Grade Psychiatrist saw PW for a two stage assessment on 11th November and 9th December 2004. On the first occasion he was seen with Colette and their two year old daughter.

PW recounted bizarre physical symptoms that he said he had had since 1999. These were different from the original symptoms he had presented with. They included recurrent bloating, pain, having to urinate frequently, having to drink water frequently, and recurrent swelling of his lower abdomen radiating to his upper chest with shortness of breath and severe itching with lower back pain and swelling which radiated to his right lower limb. He also complained of periods of extreme tiredness accompanied by shaking of his whole body with sweating and palpitations which continued until he passed out for a number of hours. PW said that the symptoms only occurred if he had milk or sugar in his diet. He also said that he had allergic symptoms as a child but they had improved when his mother had excluded milk and sugar from his diet.

COMMENT

The Staff Grade Psychiatrist attempted to undertake a thorough face-to-face assessment of PW. He did this over two sessions to make sure he had all the history. This is good practice. PW attended both appointments. On the first the Staff Grade Psychiatrist could have taken a full collateral history from Colette. There is no evidence that he did that. This may have alerted him to PW's developing psychosis.

The Staff Grade Psychiatrist did not telephone the GP as it had become unusual for doctors to ring a GP from clinic.

He could have written asking the GP for an update between his two appointments but he did not. No risk assessment was undertaken.

The Staff Grade Psychiatrist was unsure of the diagnosis, acknowledging that PW may have a psychiatric illness or it may all be physical. There was no evidence that he discussed this unusual presentation with any other clinician. He discharged

COMMENT cont…

PW from clinic with no firm diagnosis or management plan.

PW had by now had three hours of psychiatric assessments. He had been seen by two doctors and a Crisis Team worker. He had also had assessments at the GP surgery. He had been seen in the presence of his sister and his partner. Worries about bizarre thoughts concerning his health were documented but no clear psychotic symptoms were documented in the notes. PW was clearly a man who, though attending for appointments, was not presenting any of the psychotic symptoms that he was suffering from to clinical staff.

There was no history of self-harm, forensic history or history of substance misuse. Though a risk assessment was not undertaken, given the available evidence, PW would have been unlikely to be considered very 'risky'.

There was no evidence of a CPA discussion (a meeting between at least two professionals to discuss the care plan and document the outcome) being undertaken. PW was presumably on standard CPA but this is not documented. The care co-ordinator was presumably the Staff Grade Psychiatrist but this was not documented.

The Staff Grade Psychiatrist concluded that:

> *"After two long interviews with this gentleman and taking his history and examining his mental state, I myself am unable to conclude whether this young gentleman is suffering from a major mental illness such as anxiety, depression or psychosis. It is possible that he might have an underlying somatic disorder based on his multiple physical symptoms, and does not conform to a normal medical illness. However, on the other hand it is also possible that he might have an underling genuine physical cause which may need special investigations."*

The Staff Grade Psychiatrist, in a letter to PW's GP, dated 10th January 2005, asked that PW be referred to the physicians for further investigation. Since no definite mental illness was detected PW was not given a further psychiatric outpatient appointment.

AUGUST- DECEMBER 2004

Between August and the end of December 2004 the GP surgery only received information that PW had not turned up for his September appointment. There appeared to be no concerns about his mental health documented in the GP notes.

PW attended outpatients with the Consultant Neurologist twice and had investigations.

JANUARY 2005

PW next attended the GP with mental health concerns on 7th January 2005 and saw another partner in the Practice.

He told her that when he took cannabis, ecstasy or sugar he had auditory hallucinations. At this point in time the GP did not pass this information on to the psychiatric services. However, after receiving the Staff Grade Psychiatrist's letter, dated 10th January 2005, she wrote to the Linden Unit informing them that PW did, in fact, take cannabis and ecstasy. The letter was not a formal re-referral to the service. She did not state that PW was suffering from any psychotic symptoms nor did she ask for a further appointment.

On 19th January 2005 Colette telephoned PW's GP to tell him that PW was behaving in a paranoid and aggressive manner. An appointment had been made for the same day to see a GP but we have to assume that he did not keep it, as there was no entry in the GP records.

On 20th January 2005 PW and Colette attended the surgery and saw PW's usual GP. PW had not smoked cannabis for over a week but there were florid psychotic symptoms including, auditory hallucinations, bizarre delusions, strange behaviour and outburst of anger. The GP arranged for PW to be seen by the Crisis Team that day and made a note to review PW in one week.

COMMENT
Between August and December PW did not attend the GP surgery very much and when he did attend there was little in the way of psychiatric symptoms. The surgery knew that he had not attended psychiatric outpatient initially but they had had no communication about what had subsequently happened. PW had seen the Neurologist and there was no particular concern expressed about his mental health at this appointment. From their contact with PW and the information that they had it was reasonable to conclude that there was no florid mental illness that needed urgent treatment or monitoring.

Third Assessment by Mental Health Services

The Crisis Team Duty Nurse saw PW on 20th January 2005. In his evidence this nurse told us that he saw PW alone because the team was expected to be more

'pro-active' which meant not always seeing patients with a doctor present. He believed that PW was referred because the GP was concerned about deterioration in his mental state, and, in his evidence to the Investigation Team, he agreed that there had been a significant difference in PW's presentation.

Again PW attended as requested. This time he was more forthcoming. He presented with florid psychotic symptoms. These included auditory hallucinations, bizarre delusions concerning his ability to change the weather by changing his clothes, and delusions of control (he believed that his nephew's music replayed in his mind and drained him of energy).

PW stated that he was very anxious and paranoid about things. He stated that he had frequent changes of mood and became angry. PW believed that the music was sending him messages and this changed his breathing patterns. He had 'somatic' complaints, problems with his memory and PW stated that he was depressed since the death of his sister. PW stated that he had been using cannabis.

The duty nurse told us:

> *"comparing him to the first time I met PW, I generally felt instinctively something wasn't quite right this time. He was a lot more agitated, irritable and sometimes aggressive towards his girlfriend."*
>
> *….When the girlfriend was trying to explain how he had actually been … PW stopped her in her tracks and said he literally did not want her saying anything"*

From the crisis assessment form the plan was:

1. *The Consultant contacted as mental illness presentation "questionable" (in his evidence to the investigation the nurse noted that this meant that previously there were few symptoms but on this presentation there were "all different oddities..")*

2. *Discuss with the Staff Grade Psychiatrist who will discuss this with his Consultant and arrange for an offer of an out patient appointment.*

3. *To provide support until a decision made to offer an out-patient appointment (arranged to telephone on 21 January 2005 at midday).*

4. *GP to be informed.*

The outcome of this assessment was:

- The doctor 'involved' in the case was identified as the Consultant.
- The provisional diagnosis as made by the assessing nurse was anxiety.
- PW was assessed to be on standard CPA. He was noted to have increasing anxiety symptoms causing him distress but:

  "observed to display no real mental health problems"

The views of the carer were stated as: *"would like (PW) to be helped"*

The initial 'risk screening' part of the form did not mention any of the psychotic symptoms and was not completely filled in. It stated that a risk management plan had been developed but we were unable to find one.

The Crisis Team Duty Nurse told us that he discussed the case with the Staff Grade Psychiatrist to inform him of PW's current mental health state. He said:

> *"The Staff Grade Psychiatrist did say he was going to seek a second opinion with the consultant at the time because he had seen him in outpatients and he at the time believed that he did not have an identifiable mental illness. More or less his words were, that the GP keeps sending him back to mental health services and the GP is not really looking at his physical problems."*

He felt in the middle of the GP and the Psychiatrists because it was not clear who would follow up PW, or whether his problems were physical or psychological. He told us:

> *"…..so I was the one who decided that we would hold on to him while the GP and Psychiatrists were trying to make up their minds we would follow him up and monitor his mental health…"*

When we interviewed the Staff Grade Psychiatrist, he did not remember much of the content of the conversation with the nurse. He said that, in his view, there was no urgency to do anything from this conversation. He agreed that he was told that the GP wanted PW to be seen again and that as he had seen PW twice it would be more appropriate for the nurse to contact the Consultant instead.

COMMENT

This was the only assessment of PW's mental state by a mental health professional from the Linden Unit in 2005. The presentation is of florid psychosis. There had been a significant change in PW's mental state since his previous assessments. There was no clear documented assessment of risk but there are significant indications of risk. PW stated that he was paranoid, had mood swings, got angry and was noted to be irritable towards his girlfriend. He did not think he was in control of his behaviour and this was unpredictable. PW was also taking cannabis which is known to exacerbate psychotic symptoms.

There is no evidence that the GP was contacted. The Consultant Psychiatrist was contacted but no outpatient appointment was made that day and it is not documented whether the new symptoms were discussed with the Consultant.

The nurse did not discuss this assessment with the other members of the Crisis Team. The provisional diagnosis on the crisis form did not fit with the symptoms presented.

The nurse did arrange for the Crisis Team to keep in contact with PW but this was in a supportive role until an outpatient appointment was made.

The assessment was thorough but though significant psychotic symptoms had been identified, an urgent outpatient appointment had been organised and the Crisis Team were to keep in contact with PW, the diagnosis given was not one of psychosis and despite documented risk no firm risk management plan was developed.

The absence of having no dedicated doctor in the Crisis Team or regular discussions about all patients was a major omission at this time of the continuing care plan for PW.

The nurse who saw PW was leaving the Trust and may not have been as proactive as he should have been.

The Staff Grade doctor or the Consultant should have seen PW before he left the Linden Unit.

21ST JANUARY – 31ST JANUARY 2005

The Crisis Team received a telephone call from Colette on 21st January 2005 stating that PW's mental state had not changed. She was informed about the Crisis Team's efforts to contact PW. The Crisis Team rang PW and left messages on 22nd, 23rd and 24th January 2005. There was no answer and so they left a message to telephone them if he wished.

The Crisis Team notes of 26th January 2005 stated that an outpatient appointment had been made for 2nd February 2005 at 10.00 hours.

The duty nurse telephoned Colette, and she told him that PW's mental state remained '*…vague and bizarre*' and that he was complaining of auditory hallucinations. He also noted that:

> *"reassurance and time provided, informed outpatient appointment on 2.2.05 at 10am with The Staff Grade Psychiatrist and agreed to contact Crisis Team on need or bring PW down to A&E for any deterioration in mental health."*

The GP noted that there would be follow-up in one week but there is no documentation of this happening.

COMMENT

From the notes available to the Crisis Team PW was floridly psychotic and unpredictable. No risk assessment had been properly completed. Risks to his partner, and to the children who were in his care or children with whom he spent time were not assessed.

There was no assessment of risk to himself or of the possible problems with deterioration in his mental health while he waited for an appointment.

PW's case had not been reviewed by the team.

By default it was decided that it was safe for him to be left untreated in the community for two weeks until he was assessed in out patients.

Telephone support was offered initially but from 24th January 2005 the onus was on PW to contact the Crisis Team and from 26th January 2005 it was left to Colette to contact the Crisis Team or bring PW to A&E if he had deteriorated.

There is no evidence of the GP being contacted.

1ST FEBRUARY 2005

On 1st February 2005, Colette telephoned the Crisis Team at midday. She reiterated her previous concerns about his delusions and other psychotic symptoms but stated that now PW had accused her of trying to 'murder' their daughter by giving her chocolate without glucose in it. Colette reported that PW had become more aggressive and threatening and that she did not feel completely safe. She told them that PW would be angry if he knew that she had telephoned them, adding that PW would not attend the appointment on 2nd February 2005.

After this telephone call, the decision taken was to discuss the situation with the Staff Grade Psychiatrist and make an appropriate plan of care.

COMMENT
No plan of care was documented in the notes and therefore it was not clear what was going to happen .

A Crisis Team Nurse called the GP surgery and spoke to the GP who wrote in January, informing the team about PW's drug taking. She informed the GP of their concerns about PW and the incident at the Council Offices. The nurse discussed initiating a MHA Assessment at PW's home but the GP thought that this was inappropriate, as PW, as the patient, had the right to refuse her entry if she went to his house to see him. She offered to see PW in the surgery that afternoon. Failing that they should try to encourage PW to attend A&E. The nurse informed A&E of this plan and that he may be carrying a knife.

The GP notes stated that :

> *"….Team expecting me to initiate the Act (Mental Health Act) Assessment when an urgent mental health assessment can be made at the patient's home as patient is refusing to go to OPD (outpatient department) tomorrow, though from the last assessment they have deemed him safe. I feel I am unable to do this: 1) the story is from a third source; 2) patient has rights to refuse treatment, have spoken to girlfriend and can either persuade him to be seen in A&E or if she feels she is at risk to call the Police so they can take him to a place of safety where he can be assessed…".*

The GP told us that Colette had agreed that she may be able to persuade PW to attend A&E. The GP also said that her decisions were based on the fact that she was told by the Crisis Team on the telephone that in the last assessment of the 20th January 2005.

> *"they (the Crisis Team) felt he was safe."*

At 23.30 hours the Crisis Team Duty Nurse received a telephone call from Colette. She was very concerned that PW's mental state continued to deteriorate and his level of aggression was rising. She spoke to the A&E department and found out that PW had attended, dressed his own wounds and then left. She later received another telephone call from Colette saying PW was outside her home and she had telephoned the Police.

The nurse rang the Police to inform them of the Crisis Team's involvement and the current risks and to reinforce Colette's telephone call.

COMMENT
The Crisis Team were faced with an escalating situation and they should have reported the situation to the Consultant and manager. They had received information about PW's psychotic symptoms, aggressive behaviour, the possession of knives and the use of a weapon to gain entry. Threats had been made to individuals and at least some of these seemed to be linked to paranoid ideation. No risk assessment was completed. No plan was documented in the notes. The Crisis Team did not communicate any of the problems to senior management or clinicians that night. The Crisis Team did not consider initiating a Mental Health Act assessment themselves on 2nd February 2005 though it could be argued that as they were the last team to have seen PW and they had more information than others. The Crisis Team did speak to the GP. It is not clear why it was considered likely that the Police would remove PW to a place of safety and under what law they would do this. It is unclear how Colette was expected to persuade PW to go to A&E if she could not persuade him to attend outpatients. The GP stated that an urgent mental health assessment could be undertaken at PW's home. However, it is unclear how realistic this would have been given the history that the team had received and her belief that he may not open the door to her. No timescales were given to the pursuance of this plan.

2ND FEBRUARY 2005

Crisis Team Involvement and Risk

The Crisis Team Duty Nurse spoke to the Police and was given an account of the incident the night before when both PW and Colette had been injured. The notes of this conversation stated that Colette had had to use her car to get away from him.

At 10.30 hours Colette telephoned the Crisis Team. She asked if there had been any developments in PW's case and told them that he presented, that morning, as if nothing had happened the night before.

At 10.45 hours there was a meeting between the Consultant and the two nurses from the Crisis Team who had been in contact with Colette over the last 24 hours. The incidents from the previous night were discussed.

They agreed a plan:

1) *to inform the GP about the seriousness of the incident and concerns about PW's mental health.*

2) *to inform the Police about the need to respond to this case and concerns about mental health.*

3) *to inform Children And Family Team Social Worker.*

4) *the Consultant to offer another outpatient appointment to see PW in the base.*

COMMENT

Using only their notes of the situation at 10.45 hours on 2nd February 2005, the Crisis Team knew that PW was psychotic. He was alleged to have broken into Colette's house and she had fled in fear.

He had been injured and Colette had been injured.

PW had attended A&E but left before getting proper treatment.

PW was aggressive and unpredictable and was possibly carrying weapons. There was possible danger to children.

PW was known to take cannabis.

His mental state fluctuated and though he previously attended arranged outpatients, he had not attended the one organised for that day and also told Colette that he was not going to attend.

He had not returned the calls of the Crisis Team. It had been suggested that his girlfriend should persuade him to attend A&E but this had not happened.

It is unclear why the clinicians thought that PW may attend an outpatient appointment having previously missed them. Given the seriousness of the concerns it is unclear why the meeting considered that it was acceptable to leave PW untreated and un-assessed remaining in the community.

It is unclear why a MHA (1983) Assessment was not initiated at this point.

No formal risk assessment was undertaken.

At 11.00 hours The Duty Nurse telephoned Colette to tell her the outcome of the meeting. She was advised to contact the Crisis Team if she needed any support. Five minutes later the nurse telephoned the Children and Family Team Social Worker. Between this time and 22.00 hours there were many telephone contacts with the Crisis Team by other agencies, mainly concerned with Child Protection issues. The Consultant told the nurse "*….MHA arranged for tomorrow at 12.45 hours Crisis Team to attend."*

At 22.00 hours the EDT Social Worker telephoned the Crisis Team telling them that PW was under the influence of alcohol, he was pleasant, not aggressive and did not show any psychotic symptoms. He declined to be seen but was apparently aware that he was going to be seen tomorrow by two doctors. He was happy for his nephew to be removed. He admitted being involved in domestic violence and being at the Council Offices but did not say he was carrying a knife.

COMMENT
The Crisis Team continued to receive information and relay information to different parties. All the parts of the plan set with the Consultant had been 'actioned'. The people now driving the clinical care were the Consultant and the Social Work Team.

Social Work Involvement and Management of Risk

Information about the social work involvement and their management of risk was contained in the Warwickshire County Council Case recording system. A Social Worker working in the Short Term Team Children and Family Service received a number of calls on 2nd February 2005. A telephone call was received from Colette, who told them that *'PW was suffering from mental health problems, he was becoming dangerous"*. He had broken into her house the previous night, saying she was trying to murder their daughter. He thought he was 'God' and 'hanging' around in the street. She said he had called around earlier and was threatening to *"finish"* her. He said he would cut her throat. Colette told the SW team that he had taken a knife to the Council Offices the previous week – the Police were called. Colette said

he needed to be 'sectioned', as he was not on any medication and did not realise he had problems.

The Adult (Mental Health) Services social work notes stated that there was a telephone call to the Linden Unit Crisis Intervention Team who told them the Police had been informed about their concerns. There was no plan to section PW though he had not turned up for his appointment. The next social services note was a telephone call from the Consultant stating that PW had not seen a doctor and that there had been a change from the first presentation to the current presentation.

The notes also recorded that PW had psychotic symptoms. PW had been aggressive in the Council Offices twice and had smashed a window in Colette's house. It was noted that he went to the A&E Department and that Colette did not press any charges. PW was said to be using LSD and cannabis.

According to the notes, the Consultant was said to be very concerned about safety of Colette and her children. The GP was asked to visit and encourage PW to go to the hospital. The Consultant rang the Children and Family Team because of the child protection issues of a young man who was living with PW.

The Adult Social Work Team made a telephone call to one of PW's brothers. He said that his nephew was not attending school, PW was suffering from depression and struggling to care for himself and his nephew.

Colette's brother telephoned the Crisis Team as he, too, was concerned for PW's mental health. He said that PW had been threatening towards his sister, there had already been blood shed. He was frustrated and annoyed. He thought PW had been 'batted' from the GP to the Linden Unit for six months and no-one was helping him. He said *"it will end up in someone getting seriously hurt".*

Some of the other notes were more confusing and it was difficult to ascertain exactly who made them. One stated that there was a telephone call to the duty ASW stating that*, "assessment tomorrow. GP can't make it until tomorrow. GP knows PW best."* A telephone call to PW's GP was recorded *" … is not safe for him to stay there tonight. Concerned for three months. Sent PW to Crisis Team twice."* A telephone call was made to the Consultant and recorded as;

"MHA assessment will take place 3rd February 2005 at 12.30 hours Police, GP and social worker.

No reason for them to see him today."

"[the Consultant] does not feel that there are grievous concerns about the boy tonight. Violence directed towards girlfriend."

Psychotic, will complicate assessment

Then there was a further note about a conversation with PW's brother, *"a psychologist.*

" He was reported as saying.

PW's nephew) stopped at friend's house unaware of what happened. PW under stress. Relationship problems with Colette – Colette may have exaggerated what had happened. She had not been supportive to him. He had gone to check H this morning and had "no concerns".

In his professional opinion PW is under a lot of stress – "doesn't suffer from mental ill health".

The Manager of the (Short Term Team), Children and Family Social Workers, made notes of her involvement, commencing at 17.00 hours. She recorded a telephone call from PW's GP, who contacted them as a matter of courtesy as it was 'out-of-hours' for him. She then rang the Crisis Team and requested that somebody attended their 'Strategy' Meeting. She was advised that no one could attend and that she should arrange a Mental Health Act Assessment with the Emergency Duty Team. The Children and Family Social Worker and the EDT Social Worker agreed to carry out a joint visit, preferably with a Psychiatrist and GP in attendance.

The Child Protection Police Officer had spoken to [PW's nephew] earlier who told him that although PW was calmer he still thought that Colette was trying to kill their daughter by giving her chocolate milk.

The on-call Psychiatrist had made it clear that he did not want PW left in the community and wanted the Police to remove him so that he could be assessed in a safe place. The Duty Psychiatrist, when interviewed by the Investigation Team, told

us that he had had a full handover from the Consultant Psychiatrist, which included PW's history and said that a MHA (1983) Assessment was needed.

The Duty Psychiatrist told us that he was prepared to go out to see PW but that the social worker decided to go without him. He said he did not know why this was.

It was agreed that two Policemen would attend with the Social Workers but would be unable to remove PW unless he had committed a crime or had been 'sectioned'. The Police and Social Workers attended PW's house, where there was no answer. PW turned up at the house later, he denied and then minimised the incident at Colette's the previous night. He agreed to allow his nephew stay with his brother. The EDT Social Worker telephoned the Duty Psychiatrist to explain the situation and he agreed with the decision to leave PW at home that night.

COMMENT

The Investigation Team interviewed the Operations Manager (Rugby Short Term Team) who brought the following issues that occurred during this incident to our attention.

1) The A&E staff were reluctant to give any information about PW's attendance at the department despite the fact that there was a Child Protection dimension to this case.

2) The lack of response from the Linden Unit to attend the Strategy Meeting was surprising especially as the Child Protection referral was initiated by them.

He had instigated regular meetings with the Locality Manager which had improved the flow of information.

The completed Emergency Duty Service Assessment form was faxed to the Linden Unit at midnight. It stated that the referral had been at 18.00 hours and that the request was for assistance in removing PW's nephew to a safe place, pending PW's assessment under the Mental Health Act 1983.

However, it also stated that the reason for referral was:

> *"request for urgent Mental Health Act Assessment today, further to report of domestic violence at girlfriend Colette 's address last night, allegedly broke in through a window to check on their one year old daughter; threatened to cut Colette's throat as allegedly believed she wanted to kill her. Linden Unit have also been told PW allegedly went to Council Offices the other day and threatened someone with a carving knife. A recent psychiatric assessment*

deemed PW to be psychotic, thinking he is God and can change the weather, is receiving messages from the TV and light bulb and thinks Colette is trying to poison their daughter.

"I arranged to visit PW tonight, together with [Children and Family Team's Social Worker]... and Rugby Police with a view to removing [PW's nephew] and initiating Mental Health Act Assessment tonight, on further advice of the duty Psychiatrist out-of-hours."

The form stated that PW was 'pleasant' and that he agreed to see his GP and the Consultant Psychiatrist the next day - *"did not show any overt signs of mental disorder and further Mental Health Act Assessment was deferred until a planned assessment on 3/2/05."* it also stated: *"…although PW did not appear to be in a mentally disordered state tonight, recent events indicate concern for the potential safety of others and he needs to be followed up by fuller Mental Health Assessment In office hours..*: *There were no grounds to apply a Section 136 and no grounds to obtain a Section 135."*

The risk assessment part of the form was not completed but stated that a full risk assessment was required: *"Further assessment did not appear to be required tonight."*

The final comment was about the arrival of PW's brother, Colette and a female friend. They agreed to ensure that their nephew stayed elsewhere overnight and agreed to look after PW overnight, despite being advised of the potential risks based on recent events. They were given contact phone numbers for the Police and the out-of-hours Social Services contact. The time the assessment was started was given as 21.00 hours and the time of decision, to take no action that night, was given as 22.00 hours.

COMMENT

The Consultant initiated the involvement of the Children and Family Team – which we considered to be good practice.

The Child and Family Team undertook an information gathering exercise before setting up a Strategy Meeting to discuss what to do - this is also an example of good practice.

The Police were present. No-one from the Linden Unit and no GP was present.

The GP telephoned the Strategy Meeting to voice his concerns. There was no mental health input except a telephone discussion with the Locum Consultant Psychiatrist.

The Children and Family Team decided to visit to remove the nephew. They also contacted the Duty Social Worker on the advice of the Crisis Team to arrange a MHA (1983) Assessment under Section 136 which she tried to do but this did not happen.

The intention on the EDT form is not clear. At one point it says that the aim was to support the Children and Families Team, elsewhere it says the aim of her presence was to initiate a MHA (1983) Assessment.

The ASW said that the Duty Psychiatrist was reluctant to come out unless PW was in a place of safety. He said he was happy to come out. It has been impossible to reconcile these two positions.

The result was that the ASW attended with the Children and Family Team. There was no realistic plan of how PW's mental health was to be assessed. The Police were encouraged to use a Section 136 to take him to a place of safety but this relied on him presenting as floridly psychotic. PW did not present this way. The ASW was there by herself and there was no back-up plan available.

The ASW made a brief assessment lasting 5-10 minutes on the road while PW was, in his own words "pissed". She concluded from this that there was no need to proceed to a formal assessment that night, the Duty Psychiatrist later concurred. The form does not indicate the brevity of this assessment and does not state that PW was under the influence of alcohol. The EDT assessment form could give the impression that the assessment lasted one hour.

The ASW knew that a formal assessment was planned for the next day. She had made a short assessment on the street of a man who was drunk and acknowledged that this should not be relied on. The ASW knew the risk involved from the history and the duty Psychiatrist had been given a full account of PW's symptoms.

COMMENT cont …

The Duty Psychiatrist had been told by the Consultant Psychiatrist that a MHA (1983) Assessment was needed. As the patient was under the care of the Linden Unit and the Duty Doctor was on call it could be argued that he had been delegated the responsibility from the Consultant Psychiatrist for PW's care.

It could be argued that the on call Psychiatrist was responsible for PW being properly assessed and a plan made that night irrespective of whether MHA Assessment was undertaken.

The Children and Family Team knew that PW was psychotic, dangerous, carrying knives, violent towards Colette and had threatened to kill her. They knew that he had accused Colette of harming their child. They had been warned by her brother that he thought that someone was going to get hurt. They had been told that his behaviour was changeable.

The Children and Family Team had decided that the situation was so 'risky' that the nephew should not stay at home.

A short curb-side interview had been enough to convince the ASW that nothing else needed to be done that night.

The risk to their nephew was managed by asking responsible adults to make sure that he was not staying with PW. There was no clear risk management plan for the risk to Colette or their child. There was no management plan for the risk to PW.

The impression was that the services agreed to leave the management of PW to his family. No assessment of their capability to understand and manage this risk was undertaken.

At this stage the risks were clear and present and there had not been a competent assessment and consequent plan to decrease them, however it was decided that it was safe to leave the assessment of PW's mental health to the next day.

The options open to the ASW were significantly decreased by the fact that no doctor was present. Even if the on call Psychiatrist was not going to attend, the ASW could have persuaded another doctor, provided that they were registered under Section 12 MHA(1983) as an Approved Doctor to attend, so that, if appropriate an emergency Section such as a Section 4 MHA (1983) could have been entertained.

3RD FEBRUARY 2005

The Crisis Team's documentation starts at 11.25 hours with a discussion between the Duty Nurse and the Psychiatric Nurse who worked closely with the Criminal Justice System. She told the Crisis Team Duty Nurse that there was no Police record of the incident at the Council Offices. She added that Colette had had a previous

boyfriend, the father of her two older children, who had been so violent that Colette had said he was mentally unwell but no charges were brought against him.

COMMENT

The Investigation Team could not ascertain that much weight, if any, was given to this information or indeed whether the Crisis Team knew that Colette's previous partner was visiting the house next door and she was concerned about that. However, in assessing any element of risk they should have taken previous violence to Colette into consideration, when deciding how 'safe' she might be.

The Duty Nurse noted that she discussed this with the Consultant as he was going to speak to the Duty Approved Social Worker that day. She spoke to PW's brother and *"they will try to persuade PW to attend Linden outpatients to see The Staff Grade Psychiatrist."*

She took a call from Colette's brother expressing his concerns and a call from the Children and Family Social Worker asking to be contacted after the Mental Health Act Assessment, due at 12.30 hours, had taken place.

There were two more telephone calls from Colette's brother who said that he had been trying to get Psychiatrists to help for six months, that "serious errors" were being made on every side and now he was concerned for Colette's safety and her own well being as she was not receiving the support she had hoped for from the mental health services.

The nurse discussed all of these conversations with the Consultant. She recorded that he said that PW's brothers were 'not keen' on a MHA (1983) Assessment being carried out. Because PW did not attend outpatients the Consultant requested that the Crisis Team visit PW at home. However, the Crisis Team were reluctant to go because of the identified risks and so they would telephone PW to persuade him to attend for further outpatient appointment on 4th February 2005. The nurse telephoned both PW's mobile and home numbers with no answer. Colette's brother made more telephone calls to the Crisis Team, and was advised to contact PW's GP.

A meeting was convened with the Consultant, the acting Locality Manager, the ASW and the Duty Nurse from the Crisis Team. They agreed the following plan:

"OPA (outpatient appointment) made for PW to see The Staff Grade Psychiatrist at 10.00am. If not attending then Mental Health Act Assessment to be instigated for 4/2/05. Social Worker spoke to PW's brother and informed him of this and that the Mental Health Act Assessment will be instigated at 10.15am. PW's nephew stayed at PW's house last night."

At about 17.25 hours, Colette telephoned the Crisis Team to say that PW had been at her house 30 minutes previously. She was advised to call the Police if she felt threatened. The GP telephoned the Crisis Team at 18.15 hours to make enquiries about the assessment and that and he had been inundated with calls from various people concerned about PW.

Colette told the Duty ASW, who had the process of arranging the MHA Assessment, that she did not want to be involved in the assessment, as a brother of PW had said that she was to blame and it would ruin PW's life if he were to be 'sectioned'. The ASW telephoned the GP who was available between 12.30 hours and 13.00 hours. She read the EDT forms and noted that they recorded that PW did not show any overt signs of mental disorder. She spoke to PW's brother who stated that his brother was *"just depressed"* and that he did not think he was a risk to himself or others.

She then discussed the situation with the Consultant to find out if PW's mental state was stable, whether he had been seen since January and whether there was a bed available.

She noted:

"following further discussion, including the possibility of an informal assessment, it was agreed that he would offer PW and outpatient clinic appointment at either 12.30 or 1.00 pm today to assess his current mental state."

When the ASW found that PW did not attend the appointment she telephoned his brother who said that PW had refused to attend but may be amenable to a domiciliary visit.

The ASW discussed PW again with the Consultant and her view appeared to be that the information, received by the nurse working with the Criminal Justice system, from the Police, provided little evidence to indicate the need for a formal MHA Assessment at that time and that a 'domiciliary visit' may be more appropriate.

Her recollection of this meeting was that:

> *"there seemed to be a need to assess any deterioration in this man's mental health on an informal basis prior to a formal measure."*

The ASW believed that the Consultant wanted to visit at 16.30 hours that day but wanted the Police present. She and her colleague felt that this was unlikely to be practical at 30 minutes notice. The Consultant offered to 'handover' the assessment to the Duty Doctor, but eventually he offered an outpatient appointment and if PW did not attend, then he would undertake a formal MHA (1983) Assessment.

The professionals discussed the conflicting reports and the information from PW's family indicating that they did not want a full MHA (1983) Assessment, if alternative action could be arranged**.**

> *"it was noted within the meeting that information received appeared to be indicative of domestic issues rather than a deterioration in PW's mental state. The acting Locality Manager asked if it was felt that as a multi-disciplinary team we could make a clinical decision to postpone any further action until tomorrow. There was general agreement to this proposal."*

In a later telephone call with PW's brother he stated that his nephew had stayed with PW the night before and he did not know where he would stay that night.

The GP told us that he received a message at lunchtime from the ASW telling him that PW had been persuaded to attend the Linden Unit and he would not need to go out on the assessment. He also said that, following a call from a concerned friend of PW, he contacted the Consultant Psychiatrist to express his concerns and requested an assessment with a view to 'sectioning' PW under the Mental Health Act.

COMMENT

None of the factors that led to PW being considered a risk had changed on the 3rd February 2005.

PW was still a man with a documented psychotic illness who was untreated in the community. There was still a recent history of aggression and threats to harm others. He had a history of drug misuse. It continued to be unclear as to where his nephew was staying. There had been no proper mental health assessment, formal risk assessment or management plan.

However, four main factors led to the services considering that they had previously over-estimated the risk:

COMMENT cont …

1. The ASW was considered to have undertaken an assessment and found that PW was not overtly ill;

2. PW's brothers said that PW was depressed and not a risk - they seemed to corroborate the ASW's assessment;

3. The nurse working with the Criminal Justice System could not corroborate some of the information regarding the Council Offices;

4. It appeared to the Investigation Team that there was an assumption that this was not mental illness but perhaps a 'domestic' issue.

It is not clear that the psychiatric team undertook a formal structured risk assessment. Perhaps if they had they would have further interrogated their new assumptions.

The EDT report indicated that the decision not to act on 2nd February 2005 was based on the fact that she thought a MHA (1983) Assessment was going to happen the next day.

The professional who knew PW best, his GP, **was not** at the meeting on 3rd February 2005. He still believed that a MHA (1983) Assessment should happen that day despite having seen the ASW's assessment.

The ASW documented that PW had admitted that there had been a problem in the Council Offices and that he had broken into Colette's house and there were documented injuries to Colette and PW.

He said he broke in to see his daughter, which did accord with the reported delusion that he was worried about Colette harming their daughter. Both her brother and a neighbour reported their view about the risk to Colette.

PW's irritability and aggressiveness had been witnessed and documented in the Crisis Team notes.

The links between domestic violence, mental health and risk are well known. These should increase rather than decrease the perception of risk.

Had a formal risk assessment been undertaken it would have been possible to monitor the changing levels of risk throughout this case.

Though the services, excluding the GP had reassured themselves that PW may not have been as 'risky' as they had thought, a formal risk assessment would have demonstrated that he would still have scored highly on 3rd February 2005 (see Appendix 7), in fact his risk factors could have been considered to have increased due to:

a) use of alcohol,
b) lack of engagement with services despite family support

COMMENT cont…

c) very changeable mental state,
d) family failure to keep the nephew away from PW

Management Plan

It is not clear why the plan was to offer another outpatient appointment. PW had been offered an appointment for the 2nd February 2005 but did not attend.

He had been offered an appointment for 3rd February 2005, which, his brothers said, they would ensure that he attended but as it turned out they were unable to do so.

There had been attempts to get him to the GP surgery for an assessment and to get him to A&E for an assessment but he had not attended.

It is unclear why the services thought that he would be likely to attend yet another appointment. In addition a number of attempts had been made to engage PW by telephone but he had not taken these up.

If those at the meeting knew all of this, they must have considered it unlikely that PW would attend the outpatient appointment the next day. Therefore, in agreeing to offer a further appointment they took a big risk, which was not supported by any structured risk assessment documentation or procedure.

An assumption was made that it was safe to wait another day for a MHA assessment when they could have chosen to perform an assessment on the night of the 3rd February 2005 but decided not to.

However, it must be noted that even if they had made the decision to undertake an assessment it may not have happened. PW may have been out, or difficult to find or there may have been logistical difficulties which stopped it from happening. Neither do we know what the outcome would have been.

PW's account of events offers a classic description of the development of paranoid schizophrenia. He told us that he had been hearing voices on and off for years before his presentation. He was able to control them by keeping busy and ignoring them. They were made worse by the use of cannabis. Even so he was able to live a normal life.

COMMENT

Many people who hear voices can control them and they do not come into contact with mental health services.

As psychosis evolves occasional hallucinations or delusions become more regular, often due to life events or social stress.

The voices had become louder in 2004 and had given him a number of ideas. These ideas concerning sugar making him ill had come from the voices.

When he had visited doctors he had not told them about the voices. He wanted to find out if he was physically ill and did not want to prejudice the interview. When he was offered tests he took this as vindication that he was possibly physically ill and not mentally ill as some of his family were telling him.

PW thought that the problems with his benefits were something to do with a conspiracy against him which was why he got angry in the Council Offices, according to him.

He also thought that he needed protection and so was carrying a knife some of the time. He had a number of bizarre delusional ideas which came from the auditory hallucinations.

He attended clinic, partly to test out whether his thoughts were real or not. He says he would have taken medication but he was unsure whether he would have agreed to hospital admission.

PW's worries concerning his child were based on his delusional beliefs. The voices had told him that Colette was harming the children. PW acted on this.

CHAPTER 5

USE OF CRIMINAL AND MENTAL HEALTH LEGISLATION

In seeking to interpret and learn from the events of January and February 2005, the Investigation Team repeatedly returned to a simple question: 'Could the law have been used more effectively to prevent Colette's tragic death?' During their interview and in correspondence, Colette's parents were at a loss to understand why, with so much information available, the 'system' did not protect their daughter.

Mental Health Law is carefully drafted to help professionals respond promptly in situations that are often chaotic and fast-moving. It seeks to balance the rights of the individual patient with the rights of others to protection from harm. In the case of PW, the law was not applied in a way that protected Colette and her mother.

Once PW's mental state began to deteriorate rapidly from around 19th January 2005, and particularly during the relatively short period from 1st – 3rd February 2005, there were four principal entry routes into the 'system' open to the Police, Health and Social Services professionals:-

a) Voluntary treatment
b) Criminal arrest
c) Sections 135/136, of the Mental Health Act 1983
d) Section 2, of the Mental Health Act 1983

Any one of these could have resulted in PW receiving the care and treatment that he needed. The Investigation Team was acutely aware of the benefit of hindsight, if any lessons are to be learnt it is important to review each area to see if more could have been done and prevent the crime being committed at the time when PW was acutely ill.

1. Voluntary Treatment at Home, or in Hospital

The primary legislation for treatment of mental disorder is the Mental Health Act (1983), supplemented by guidance in the Code of Practice to the Mental Health Act published in 1999. A fundamental principle of the Act and the Code

is that care or treatment should be the 'least restrictive' commensurate with protection of the patient and other people. In their assessments, professional staff are required to take account of:

'other forms of care or treatment including, where relevant, consideration whether the patient would be willing to accept medical treatment in hospital informally or as an out-patient…..(Code 2.6)

'Where admission to hospital is considered necessary and the patient is willing to be admitted informally this should in general be arranged. Compulsory admission powers should only be exercised in the last resort' (Code 2.7)

'Before making an application for admission of a patient to hospital an approved social worker shall….satisfy himself that detention in hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need'
(Mental Health Act 1983 S13(2))

The mental health legislation gives extensive powers to doctors and ASWs. Patients can be detained for up to six months on the basis of one assessment. ASWs are strongly influenced by the requirement to use voluntary treatment where appropriate, and there was evidence of this tension, frequently, in written statements and interviews.

The concerns expressed by the two ASWs directly involved, that it was premature to opt for a full Mental Health Act Assessment on both 2nd and 3rd February 2005, were shared with the Team Leader. The outcome was that *'more informal measures should be tried prior to full Mental Health Act Assessment'.* All three social work staff wanted to seek the 'least restrictive alternative', and thought that a further out-patient appointment should be offered.

During the rapid escalation phase in late January and early February 2005, PW was not interviewed by a Psychiatrist, and no offer of admission was made. In the earlier stage of his illness, PW was actively seeking support and treatment, and readily accepted medication from his GP. It is not possible to state with any certainty that PW would have co-operated with out-patient or in-patient treatment, as his level of consent and insight was not assessed. However, as he was not assessed or given the opportunity to have treatment on a voluntary basis his symptoms ran out of control.

COMMENT

The Investigation Team noted the wishes of the ASWs to achieve an informal assessment and treatment of PW's mental state if possible, rather than using the Mental Health Act prematurely.

However, there was some evidence of 'muddled' thinking, since PW was considered potentially dangerous on both 2nd and 3rd February 2005, to the point where Police involvement or a more secure location was considered essential before an interview could take place.

Given the rapidly increasing level of concern from various quarters, it appears to the Investigation Team that it would have been appropriate to arrange a formal MHA Assessment on 2nd February 2005, and certainly by 3rd February 2005. Even if a patient is assessed 'formally', this does not preclude the subsequent use of voluntary treatment (as an out-patient or in hospital) if the patient consents and is not considered dangerous.

2. Criminal Law

In practice, there is a close link between potentially criminal acts, and entry to the NHS mental health services. People suffering from a mental disorder can be arrested under the criminal law on suspicion of assault or criminal damage, and taken to a Police Station for questioning. It is often not clear to arresting officers, at this stage, that there is a mental health issue. If, on later investigation of information from family, friends or professional staff, the arrested person appears to have mental health needs, they will be assessed in the Police Station.

This is undertaken initially by a Forensic Medical Examiner (usually a GP) in a Custody Suite, who will then refer on to a Psychiatrist for more in depth assessment. If necessary, a full Mental Health Act(1983) assessment can then be arranged, and the patient can be admitted to hospital on a voluntary basis or subject to detention under the Mental Health Act(1983) 'sectioned' if necessary. This is a fairly common route into formal NHS care for people with disturbed or criminal behaviour who have not accessed psychiatric services via standard referral and out-patient appointments.

In the case of PW, even though there was fairly strong evidence that a criminal act had been committed on 1st February 2005, and that domestic

violence may have occurred, PW was not interviewed or arrested by the Police.

COMMENT
The Investigation Team accepts that it is beyond the scope of this investigation to comment on the acts or omissions of Police Officers. Even, had the Police taken action, there was no guarantee that PW would have been subsequently detained under the Mental Health Act 1983 even if an assessment had taken place.

3. Sections 135/136 (1983 Mental Health Act)

These sections allow Police Officers to enter property by force if necessary (Section 135), or to arrest a person in a public place (Section 136 MHA (1983)) who 'appears to him to be suffering from a mental disorder', and to take that person to a 'Place of Safety' for assessment.

On the evening of 2nd February 2005, a plan had evolved whereby two Police Officers and two social workers would visit PW. This event had been co-ordinated by the Child Protection team, following an earlier referral from the Consultant. The primary reason for the visit was to ensure the safety of PW's nephew, and a second aim appears to have been to attempt to arrest PW under S136, then arrange a full assessment (potentially for Section 2) at the Police Station. An Approved Social Worker from the Emergency Duty Team was called out to accompany the Child Protection Social Worker.

This visit was the only occasion on which PW was to be seen by a 'mental health professional' with experience of working with people with a mental illness, during the critical phase and before the fatal assault on Colette. While there was considerable confusion, among many members of staff we interviewed, about the expected outcome of this visit, it was clear that the ASW did not intend the visit itself to constitute a Mental Health Act Assessment. A standard MHA Assessment requires two doctors to interview the patient, and no doctors were expressly invited to join the visit that evening.

In addition to the significant risk of assessing an unknown patient who may be carrying a knife in his own home, the ASW was concerned about the risk of a long delay in finding a bed.

The potential difficulties in finding a bed were repeated again the next day by another ASW.

COMMENT
The potential problem of finding a secure bed for violent patients is well recognised. However, there was a bed available in the Linden Unit and so this **should not** have been a reason for not carrying out the assessment, or indeed delaying it. It is extremely difficult to control a situation when a patient is being assessed at home and has to wait for many hours until a bed is found, under some form of supervision from Police and ASWs. The strategy of attempting to use a S136 MHA arrest runs the risk (as in PW's case) that there will not be sufficient 'obvious' symptoms to permit the Police to implement S136 MHA and detain the patient, and so the patient is not assessed at all.

The Social Workers held a planning meeting with the Police, which is standard practice for joint working of this kind. Based on second and third hand information, both Police and Social Workers expected PW to present as significantly mentally disordered. In the event, according to the ASW, he was

> *'extremely pleasant and agreeable… did not show any indications whatever of mental disorder. He did not appear deluded or paranoid and spoke normally. There were no grounds for the Police to apply Section 136 and no grounds to obtain an urgent Section 135 Warrant to undertake further assessment tonight'.*

COMMENT

Given the combination of circumstances which led to the home visit on 2nd February 2005, the Investigation Team consider that the Police Officers and ASW acted within normal professional standards in not implementing a S136 arrest. There was insufficient overt evidence of mental disorder at that time to justify either an immediate arrest, or the use of a S135 warrant. We are clear that this was not a 'Mental Health Act Assessment', and that the ASW acted properly when she noted in her report that 'recent events indicate concern for the potential safety of others and he needs to be followed up by fuller mental health assessment in office hours'. At that stage, only about eight hours had elapsed since the first referral for a MHA assessment. We note that PW stated his consent to an assessment next day, and that an assessment had in fact been set up.

4. Section 2 (1983 Mental Health Act)

Section 2 MHA is the usual method of admitting patients for assessment where voluntary treatment at home or in hospital is inappropriate. The grounds are that:

'he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in hospital…. and… he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons'. (S2 (2))

The Investigation Team interviewed a number of witnesses at some length in an attempt to understand why there was no formal interview of PW on 2nd or 3rd February 2005. He failed to attend outpatient appointments on both days. On one level, the Consultant and both daytime ASWs involved were pro-active, initiating the standard process for an assessment under Section 2 MHA 1983. Following the break-in by PW at Colette's home on 1st February 2005, and concern expressed by Colette, a formal referral was made to Social Services for a MHA (1983) Assessment at 14.00 hours. On 2nd and 3rd February 2005 two impromptu meetings were held at the Linden Unit, with a view to setting up either an informal mental health assessment, or a formal Mental Health Act Assessment. The former requires a single Psychiatrist, and the latter requires an 'approved' Psychiatrist (under Section 12 MHA 1983), a second doctor and an ASW.

It was not considered possible in the time available to set up a formal MHA(1983) assessment on 2nd February 2005. However, an EDT Social Worker was later briefed by the daytime ASW, and it was agreed that she would consider using Section 136 MHA(1983) if appropriate when she visited later that evening, as an alternative to the more usual Section 2 MHA (1983) assessment.

COMMENT
There was some confusion about the actual level of risk posed by PW on the afternoon of 2nd February 2005. Information was conflicting, and at that stage he had not been seen by a mental health professional since 20th January 2005.

Following the brief visit by the ASW on the evening of 2nd February 2005, no further attempt was made to assess PW that day. On Thursday 3rd February 2005, PW failed to turn up for his appointment at 13.00 hours, and a further meeting was held during the afternoon to plan an assessment. For part of that afternoon, PW was sitting with his brother, and when the ASW telephoned, he apparently said:

'He's just sitting here, he's just depressed'.

The meeting took place at around 16.00 hours on 3rd February 2005. All, except one of the staff present, were interviewed by the Investigation Team about the discussion that took place. The Consultant told the meeting that he was able to attend an assessment almost immediately that being at 16.30 hours but not any later in the day.

All the staff involved appeared to reach a multi-disciplinary agreement that it was safe to defer an assessment until Friday 4th February 2005, yet, when we interviewed staff, all expressed their frustration that it had not been possible to arrange an assessment on 3rd February 2005.

The Consultant and the ASW expressed their concern to us that the situation was drifting, some 48 hours after the violent domestic incident on 1st February 2005, yet apparently both agreed that a deferred assessment was appropriate.

COMMENT

Once a referral for Mental Health Act Assessment has been made, 'the ASW has overall responsibility for co-ordinating the process of assessment' (Code 2.11). The Consultant retains clinical responsibility for his patient and for the actions of NHS staff under his authority. In practice, decisions about when and how a patient should be assessed (taking known risks into account) are usually taken by the ASW and the Doctors together, as was the case on 3rd February 2005.

The Investigation Team debated at great length whether the decision not to assess with a view to Section 2 MHA 1983 on 3rd February 2005 was reasonable, given the information available to the practitioners at the time. PW had been seen the previous evening by an ASW (although not formally assessed), had been calm and did not display any overt symptoms. Serious assaults or homicides by patients suffering from mental illness are rare. However, the cumulative evidence of risk was strong, and became more critical as time went on and therefore on balance was unreasonable.

We plotted the main risk factors (Appendix 7) to show how various elements contributed to the overall risk of not assessing PW on 3rd February 2005. We accept that the staff were in some doubt about the validity of some of the evidence at the time, and that staff acted in good faith in reaching their joint decision. Nevertheless, it appears to us that the decision reached by the multi-disciplinary team not to assess under MHA (1983) on 3rd February 2005 did not take sufficient account of six critical factors:

- Repeated calls from Colette to various NHS staff expressing concern from 19th January 2005.
- Repeated calls from Colette's family members and friends expressing concern.
- Repeated calls expressing concern over several days from the GP, who knew PW and Colette well. The GP had significant psychiatric experience, and had in fact trained in Rugby.
- The specific call from GP to the Consultant on the afternoon of 3rd February 2005, requesting urgent MHA assessment. This call involved the Consultant

being interrupted during a patient interview, and was unusually forceful in terms of professional relationships.

- 14 days elapsing **without the patient being seen by a Psychiatrist** from first reports being received about significant psychotic features, to the decision not to assess on 3rd February 2005.

- The cumulative risks, as evidenced in Appendix 7.

COMMENT

At both the meetings on 2nd and 3rd February 2005 the available options were pro-actively discussed, and apparently those present made decisions in good faith.

It seemed to the Investigation Team that, all the information received by the Crisis Team was not always used during these meetings with the result that the impact of the factors noted above was diluted.

This was clearly a failure in the communication system of the Crisis Team.

COMMENT

One of the key factors that appeared to influence the decision not to assess under the MHA was the timing of critical discussions, linked to the end of the working day.

If action could not be planned to take place within working hours, there was an apparent reluctance to set up assessments out-of-hours involving 'emergency' procedures, because the case did not seem to be sufficiently high-risk. We noted that there was a culture in Rugby of expecting patients to attend the Linden Unit where possible, and some reluctance to conduct domiciliary visits.

We noted that there appeared to be no system for out-of-hours mental health assessments other than a formal Mental Health Act Assessment.

Mental health problems do not necessarily occur in office hours, and the 'normal' assessment system needs to operate for longer than 9am – 5pm, Monday to Friday so that 'standard' MHA Assessments can be set up to take place in the early evening or at weekends. Many areas now operate shift systems up to 8pm or 10pm, so that 'standard' assessments can be set up to take place in the early evening, rather than be transferred to Emergency Duty Teams, which tend to have a much higher risk threshold for response.

RECOMMENDATION

The Independent Investigation recommends that the Trust :

- ❒ **Provide the necessary arrangements that will enable people to be assessed in their own homes and the community, without there having to be a formal MHA (1983) assessment process.**

RECOMMENDATION

The Independent Investigation recommends that the Trust and Social Services:

- ❒ **Increases the flexibility of out-of-hours Mental Health Act Assessment procedures. This should enable better continuity, so that cases can be assessed routinely during the evening or at weekends if they begin during the working day, without recourse to 'emergency systems'**

CHAPTER 6

MANAGEMENT OF THE CRISIS TEAM IN RUGBY

Crisis Resolution services were one of the 'new style' services headlined within the Mental Health National Service Framework (NSF) published in 1999. The intention was to provide a service meeting the aspirations of service users and their carers by offering speedy access to secondary practitioners without requiring people to agree to in-patient treatment.

Some mental health providers had begun to develop such services before the NSF was published – although it is, probably, fair to say that this was more easily operationalised in urban areas; where an 'economy-of-scale' could be employed.

It was not until 2002 that the Department of Health published 'The Mental Health Policy Implementation Guide' (PIG) which gave an 'evidenced-based' set of criteria for the provision of a variety of the new-style National Service Framework (NSF) services, including Crisis Resolution. The PIG envisaged services for populations of around 150,000 – with a multi-disciplinary team of 14 whole time equivalents (wte), who would work with between 20 & 30 clients at any one time and provide:

- A 24 hour service for seven days a week
- Rapid response following referral
- Intensive intervention & support in the early stages of the crisis
- Active involvement of the service user, family and carers
- Assertive approach to engagement
- Time-limited intervention with sufficient flexibility to respond to differing service user needs
- Learning from the crisis

The PIG was also clear about the styles of engagement and intervention which should be offered: -

'Crisis resolution/home treatment services are best provided by a discrete, specialist team that has:-

- Staff members whose sole (or main) responsibility is the management of people with severe mental health problems in crisis
- Adequate skill mix within the team to provide all the interventions listed [above]
- Strong links with other mental health services and a good general knowledge of local resources'

and that:-

staff training should include:

- Principles of the service, cultural, gender and anti-racist training
- Skills in delivering all of the interventions listed above
- Team building, colleague support and working within a team framework
- Medication – storage, administration, legal issues, concordance training, side effect awareness
- Use of Mental Health Act and alternatives to hospital admission
- Benefits to service user and family/carers of home treatment approach

In addition the guidance was prescriptive about the participation of medical staff in that they were to be active members of the team by providing:

- 24 hour access to senior Psychiatrists and the ability able to carry out home visits
- Involvement from both consultant and middle grade Psychiatrists
- A level of psychiatric input determined by local need and service configuration

and that:

- Service users and their families/carers should be provided with the following information*:*
- Description of the service, range of interventions provided and what to expect
- Name and contact details of Care Co-Ordinator and other relevant members of the team
- Contact detail details for out-of-hours advice and help
- Care plan and comprehensive advice about medication

- Relapse prevention and crisis plan
- Discharge plan
- How to express views on the service.

The Crisis Service, appears to have been established before the guidance was published in 2002. The Investigation Team were told, by a range of practitioners and managers, that advice on setting up the service was provided by an external Consultancy, advocating what was variously described as the 'Shire' or 'Irish' model – neither of which are cited in the implementation guidance evidence-base or on any web-site accessed.

The model appeared to be based on an alignment between In-Patient and Crisis Resolution services. Whilst such a partnership is not unfamiliar to members of the Investigation Team, the use of senior ward staff to provide the basis of the Crisis service, and the apparent instruction to place a first responsibility upon in-patient responsibilities are unfamiliar.

It was not apparent that the Commissioners (Rugby PCT), of the service in Rugby, understood the implications of the service model proposed or 'signed-up' to the model in an informed manner even had they understood these implications.

The Investigation Team were informed that the original Crisis Team was composed of two senior nurses from the ward – who were told that they would provide the Crisis service; but maintaining their responsibility for the management of the ward as well. At a later date an additional three more senior nurses were appointed. At the time of the incident the Crisis service consisted of six or seven practitioners, including an Occupational Therapist - some part-time and mainly nurses, who also provided the senior cover for the ward as well as acting as a Crisis Resolution & Home Treatment Service.

Since the incident, further recruitment, and a Social Care practitioner, has occurred and a Team Leader (a nurse) has been appointed. The Investigation Team believe that the current establishment has only been in place since Spring 2006.

In these circumstances it is difficult to reconcile the 2005 Local Implementation Team (LIT) 'Autumn Assessment' which suggests that the 'traffic light' status for Crisis Resolution for the LIT is 'green'

Additionally, the catchment population of 90,000 means that an 'economy-of-scale' for practitioners would appear to be absent. The current establishment is cited at 8.41 wte plus one wte support worker and 0.9 wte Team Leader. On this basis, two practitioners on duty during the day and one practitioner on duty at night is just mathematically possible. The Team Leader asserted that by 'manipulating' shift-patterns – using bank staff, staff working long days or staff completing overtime - it was possible for more practitioners to be on duty at key times, for example, team discussion and medical liaison discussions.

The Guidance was clear about the requirement for a Care Co-ordination role, and the NWPCT Internal Inquiry was equally clear that the Crisis Team was required to apply the Trust Care Programme Approach (CPA) policy.

The CPA policy presented to the Investigation Team did not accord with the practice described by the Crisis Team practitioners or their managers. The Internal Inquiry recommendation and the subsequent action plan requirement; to apply the CPA policy as it stood, appeared to us to be unhelpful because it was not possible to reconcile this recommendation with the perception of Crisis Team practitioners and managers.

RECOMMENDATION

The Investigation Team recommends that the Trust:

- ❒ **Review the application of the local CPA policy; to ensure that it reflects both the Department of Health (1999) Guidance, and the experience of Best Practice within Crisis services, nationally.**

This must include:

- ❑ **a system which ensures that all information relating to the care and treatment of a person in contact with services is available to all practitioners involved in that care and treatment across all disciplines and equally applicable to Health & Social Care.**

The issue of medical involvement still appears to be problematic. At the time of the incident the Investigation Team were informed that:

a) medical responsibility was based on 'take-days'; not geography;

b) medical practitioners were engaged through 'corridor' and/or office-based discussion rather than through formal processes.

Subsequently the Consultant Psychiatrist teams have 'sectorised' and there is a system for discussion between the Crisis Team and the relevant medical staff, much of which takes place at regular, formal meeting each Monday afternoon, Tuesday and Wednesday mornings with each one of the three Consultant teams. This means that the Crisis Team still does not review all of the people on their caseload with all the practitioners involved, with regard to prioritising their workload and discharging patients as appropriate.

However, the Investigation Team were also informed that:

- At the time of the incident the Crisis Team appeared to rely on verbal hand-overs and the quality of individual practitioners' understanding of those in contact with the service;
- All members of the multi-disciplinary team continue to keep separate Health (and Social Care) records;
- Practitioners still share information informally and verbally; rather than by completing a full written record, although Review Sheets are used. There is no culture of recording the decisions made at meetings,
- There is no 'fail-safe' to ensure all relevant information is shared between all involved practitioners,;
- There continues to be no dedicated 24 hour access to senior Psychiatrists able to do home visits;
- General Practitioners continue to experience a lack of routine feedback, from the Crisis Team, for those people referred, until a conclusion to engagement has been reached.

The Investigation Team were assured that a full range of interventions, including Home Treatment, was now available and that about 24 people were in 'active engagement'.

However, the Investigation Team were also told that the Crisis Team, both at the point of inception, and subsequently, had not had the benefit of dedicated 'Time Out' during which they would be able to explore and understand the very different role which they were being asked to undertake, in accordance with the principles set out in the PIG. In fact we were told that a day had been allocated but cancelled because of the Independent Investigation.

RECOMMENDATIONS

The Investigation Team recommends that the Trust:

- ❒ **Ensures that the Crisis service, across North Warwickshire and Rugby, is consistent with the aspirations and requirements of the Mental Health Policy Implementation Guidance (PIG), 2002 – and is a model that is acceptable and agreed with the Commissioners of the service.**

This will include:

- ❑ **a comprehensive Review of the current establishment of the Crisis Team – including, of critical importance, the medical establishment and medical engagement – with a commitment to act on any Findings and Recommendations including, if necessary, recourse to the Local delivery Plan investment process for 2007/8 if required;**

- ❑ **an undertaking to, as soon as possible, provide those practitioners and Managers charged with the responsibility for delivering the agreed service with dedicated 'Time Out' during which they will be able to explore and understand the very different role which they were being asked to undertake, and confirm their ability to undertake this role.**

CHAPTER 7

SUPERVISION OF MEDICAL STAFF

All doctors who are no longer in formal training should be involved in a scheme of continuing professional development to make sure that their skills and knowledge are up-to-date. In addition to this, doctors require supervision to help them perform to the required standard for their service.

Doctors, working in psychiatry, are organised in teams led by a Consultant Psychiatrist. Under the supervision of the Consultant there may be a number of different grades of doctor. These can be considered in two groups; those in training to become Consultant Psychiatrists and those who are not.

The training grades include Senior House Officers (SHO) and Specialist Registrars (SpR). Doctors stay in the Senior House Officer grade for 3-4 years and will take the Part 1 and Part 2 of the Royal College of Psychiatrists membership examination in that time. They have to pass both parts of this examination before they can progress to the Specialist Registrar Grade. In the 3 years as a SpR, doctors have access to the appropriate training, including clinical as well as management skills, to become a Consultant.

Non-training grades include Staff Grades, Associate Specialists. Doctors in these groups will have had more experience as a Senior House Officer and many will have had more years of experience than a Specialist Registrar. However, their access to Consultant jobs is very limited because they have not undertaken the formal training required or passed the examinations. Though quite experienced Staff Grade doctors are expected to have limited responsibility. The level is that of an experienced SHO or a new Specialist Registrar.

Associate Specialists are at a higher level than a Staff Grade but not at Consultant level. They are expected to work at the level of an experienced Specialist Registrar; however 15% work in roles that are similar to Consultants.

Under the Mental Health Act 1983 doctors can be ‘approved’ as having special knowledge in the diagnosis of mental illness. Such doctors are said to be ‘approved’

under Section 12 of the Mental Health Act 1983. Most Specialist Registrars, Staff Grades and Associate Specialists are approved under this section of the Act

Consultant Psychiatrists have a complex management and clinical role. To take up a substantive Consultant post, an applicant must be on the General Medical Council's (GMC) Specialist Register. They have to demonstrate that they have undergone and passed their specialist training thus proving that they are capable of working as a Consultant. Consultants are expected to supervise the doctors that work in their team. Consultants are not expected to need regular formal supervision but are expected to continue their own professional development through agreed personal development plans, monitored both by their peers and their Royal College.

Senior Consultants take up management posts such as Associate Medical Director and Medical Directors of Trusts and they manage Consultants.

All doctors are expected to undergo annual appraisal of their work. Supervision of medical staff is a key facet of good medical practice.

Staff Grade doctors are expected to have the necessary supervision and support to undertake roles delegated by the Consultant of the team that they work for. Similarly Associate Specialists are expected to have supervision as necessary.

Though the Royal College of Psychiatrists suggests that SHOs and SpRs receive weekly one hour supervision from a registered Consultant, the rules for Staff Grades and Associate Specialists are more fluid. It is left up to the Medical Director, the Associate Medical Director and the Consultant who leads the team to decide on the amount of supervision that is required. The general principles of this would be in line with the responsibilities of Medical Managers of teams set out in the GMC Guidance *Good Medical Practice*.

Among many other duties they are expected to do their best to make sure that:

- Systems are in place to enable high quality medical services to be provided;
- Care is provided and supervised only by staff who have the appropriate skills (including communication skills), experience, training and qualifications;

- The people you manage have appropriate supervision, whether through close personal supervision (for junior doctors, for example) or through a managed system with clear reporting structures.

For those who lead teams they must ensure that:

> *"each patient's care is properly co-coordinated and managed and that patients know who to contact if they have questions or concerns;*
>
> *regular reviews and audit of the standards and performance of the team are undertaken and any deficiencies are addressed"*

One of the responsibilities of successful team management is delegation. Again the GMC gives guidance – *Management in Health Care : The Role of Doctors*.

> *"Delegation involves asking a nurse, doctor, medical student or other health care worker to provide treatment or care on your behalf. When you delegate care or treatment you must be sure that the person to whom you delegate is competent to carry out the procedure or provide the therapy involved. You must always pass on enough information about the patient and the treatment needed. You will still be responsible for the overall management of the patient".*

There were four doctors from mental health services who were involved directly in PW's care. These were:

- The Staff Grade Psychiatrist (A) responsible to the Locum Consultant whose caseload was based in Rugby.
- A second Staff Grade Psychiatrist (B) responsible to another Consultant Psychiatrist in Rugby.
- The Locum Consultant who was 'in-charge' of the care and treatment of PW but in fact he never saw him and,
- The duty Psychiatrist, on the night of 2 February 2005, who was working as an Associate Specialist based in the north sector of the Trust and on the joint 'on call' rota.

The Associate Medical Director for Rugby was the Medical Manager of the Locum Consultant Psychiatrist.

The Staff Grade Psychiatrist (A) and approved under Section 12 MHA 1983, was the first doctor to see PW when he was referred to the services. At the time he had 10 years of experience working in psychiatry and less than three of these were in a training post. He had no post graduate examinations in psychiatry.

PW had been referred by his GP and the Staff Grade Psychiatrist saw him with the Crisis Team in A & E. The interview lasted between 45 minutes and one hour, taking place between 6 and 7 o'clock during which time The Staff Grade Psychiatrist was on call.

He stated that though regular supervision was offered to the SHO by his Consultant, his supervision was more ad hoc:

> *"from time to time I pop in when she does supervision of the SHO, for example, but if I have been through an interesting case, I can discuss it with her always. She is keen to give her opinion."*

The Staff Grade Psychiatrist said that as he saw PW out-of-hours, he did not discuss the patient with the Consultant on call because he did not think that it was an acute problem. Neither did he speak about the case in supervision with his Consultant nor contact the Locum Consultant about the patient.

He did discuss PW with the Crisis Team and arranged some tests and for the patient to see another Staff Grade Psychiatrist in 4-6 weeks time. Because of the *"on take arrangements"* he believed that PW was not the responsibility of his team. He said there was no formal arrangement that all new patients would be reviewed by a Consultant and so it was left to him when he chose to present the case to the Consultant. The Staff Grade Psychiatrist was subject to annual appraisal which was undertaken by the Associate Medical Director with his Consultant.

Another Staff Grade Psychiatrist (B), responsible to the Locum Consultant was the next doctor to see PW. He was also 'approved' under Section 12 MHA 1983. He had at least 12 years experience working in psychiatry at the time he saw PW. Three of these were in a general adult training post and then for eight years, he worked as an old age Psychiatrist. He re-started working in general adult psychiatry in November 2003, twelve months before he saw PW. In the meantime, he had not passed any examination in psychiatry. He saw PW twice in the outpatient clinic, on 11th November 2004 and on 9th December 2004. He decided;

> *"because he did not have any major mental illness after two successive encounters with him I thought there was no need for me to see him again, but I told the GP if he thought it was necessary he could re-refer to us".*

He discharged PW from clinic and therefore from the care of the Locum Consultant without discussing him with either his Consultant, or any other colleague.

When PW was re-referred in January 2005, The Staff Grade Psychiatrist was consulted by the Crisis Team. He referred them to the Consultant because:

> *…."I had seen PW on two successive occasions… I told him (WD) because there are more experienced people I would like him to be seen by the Consultant"…*

The Staff Grade Psychiatrist directed the Crisis Team Duty nurse to the Consultant Psychiatrist on 20th January 2005 and again on 26th January 2005. He saw the Locum Consultant to ensure that an appointment was made for PW but did not discuss PW with his Consultant in any detail:

> *"I discussed it quickly with him and orally, not in detail, about my findings and what they are requesting now…"*

The Staff Grade Psychiatrist told us that there was no formal supervision with the Locum Consultant. He said that if he needed to discuss a patient he was able to do so between seeing patients during their individual outpatient clinics on a Thursday. The Staff Grade Psychiatrist said that there was no specific time for supervision only ad hoc times when they discussed particular patients and his continuing professional development.

There was no system in place whereby new patients were regularly presented to the Locum Consultant or reviewed by him. It was not uncommon for patients to be referred to the Consultant and to be treated under his name by the Staff Grade Psychiatrist without the Consultant knowing anything about them. The Staff Grade Psychiatrist was subject to annual appraisal, undertaken by the Locum Consultant and the Associate Medical Director.

The Associate Specialist was working as a duty Psychiatrist on the intermediate rota as a Senior Clinical Medical Officer (SCMO), when he was asked to see PW. He had 9 years experience in psychiatry at the time, three and a half years of which were in a training post. He had not passed any examinations in psychiatry. He was 'approved' under Section 12 MHA(1983). When he received the referral he acted autonomously. He did not discuss any of his decisions with the available Consultant on call. He did not feed back his decisions the next day to the Consultant in Rugby who had previously called him to tell him about PW. This doctor could not identify any formal arrangement for 'feeding back' decisions whilst 'on call' to another doctor. He was supervised by a Consultant working in the north sector of the Trust.

A Locum Consultant was in charge of PW's care. He had nearly 20 years experience in psychiatry. He had worked in Egypt and Saudi Arabia before coming to the UK in 1995. He was employed in a training position for the first three and half years and passed the first part of his membership of the Royal College of Psychiatrists examination. He then moved into the private sector working as an Associate Specialist in Learning Difficulties, when he sat and passed part two of his membership of the Royal College of Psychiatrists examination.

He was employed as a Locum Consultant in Old Age Psychiatry and Learning Difficulties services while at St. Andrews Hospital, a private hospital in Northampton. He took up a position as a Locum Consultant Psychiatrist in Rugby in March 2003 and worked there for two years. He was not on the GMC's Specialist Register for Psychiatry and was therefore, not eligible to take up a substantive consultant post. He told us that he had had no 'orientation' when he took up the Consultant post in Rugby. When asked about supervision he said:

> *"……What I had was chatting to my fellow Consultant about how the system works and how things are, but I would not say I had a formal supervision…."*

The Locum Consultant also said that there was informal support from other Consultants, who were friends, peer discussions, but no formal support mechanisms.

Though the Locum Consultant never saw PW, he was the 'named' Consultant and the two Staff Grade Psychiatrists, when looking after PW, were doing so under his supervision. The Locum Consultant was responsible for their supervision and should have ensured that PW was properly treated.

The Associate Medical Director was the line manager for the Locum Consultant. As Associate Medical Director, she was expected spend one day a week on the specific duties expected of this post, which sometimes, had to compete with her clinical work. When asked about supervision arrangements she told us that:

> *"The consultants as a group… in adult psychiatry meet once a month under the personal development plan arrangements."*
>
> *"We would pick each others brains if you like. We would come along and say this is a case that I am having difficulty with what do you think about doing this?"*

She stated that she did not think that the Locum Consultant attended the sessions often. She also told us that newly appointed Consultants were usually paired with

established Consultants but as she had not appointed this Locum Consultant, she did not know if that had been the case. She said she suspected that he was not paired with anyone as no information to this effect had come to light in his annual appraisals which she had undertaken.

New Consultants were also encouraged to take advantage of the Royal College of Psychiatrists leadership scheme as well but this did not apply for Locums.

The Associate Medical Director was of the opinion that the Locum Consultant offered the Staff Grade Psychiatrist regular supervision. She stated that it was not the practice in the Trust to expect Staff Grade doctors to discuss every case with their Consultant. It is left to them to decide whether a case was complicated and therefore needed to be discussed. She was of the opinion that all referral letters to the Consultant's team would be read by the Consultant and that they would monitor any re-referrals or problems in that way. In the case of PW, the fact that his pathway to care was out-of-hours through the Crisis Team meant that his referral was not monitored in this way. The Consultant Psychiatrist explained to the Investigation Team that:

> *"If it is a referral from a GP, I will see all the referrals and distribute them between myself and The Staff Grade Psychiatrist according to my assessment and give them appointments. However, if the patient was referred to my team because it was during my on take night, for example, that he appeared in A & E or was seen by the Crisis Team I may not hear about the patient at all."*

The Locum Consultant had specifically taken this up with the Crisis Team:

> *"I went to the meeting and asked can you please tell me what I am supposed to do with these copies (of patient discharges)? Those patients came to A & E, they have been seen by The Staff Grade Psychiatrist or the SHO on call and referred to the Crisis Team. The Crisis Team have done their bit, and they discharged him. Are you letting me know just for information or are you expecting me to take part in the process? I said if you are sending me the copy to make me part of the responsible people that is not fair. "*

He raised his concerns about the way the system worked. At his meetings with the Associate Medical Director, he questioned how he could be held responsible for cases allocated to him, when he had not discussed them in the referral meeting. He did not think he had the power to change anything about the existing system.

….“I thought this was the system in this place, it has been going on for a long time, it has worked alright and the other Consultant was happy for this to continue. To be honest, being a Locum consultant coming from an agency without a contract, I would not be able to change the whole system or ask for a change….”

The Locum Consultant, when asked why he did not closely supervise more junior doctors, explained:

“…When I had an SHO at some point in time, I would discuss every case with him at my request. I did not do the same thing with the Staff Grade Psychiatrist because the Staff Grade Psychiatrist was doing the same thing (seeing patients on his own) and everyone was really happy for that to continue. I have to say that I was not really comfortable about a few things in Rugby but when I put them on the table in a nice polite way I did not really get feedback from my seniors saying that, yes, you are right. They reassured me by saying this is the system we had before and we shall continue for the time being…”.

PW was seen on four occasions by three different professionals; two doctors and a nurse member of the Crisis Team staff, without any discussion or review of his care by the Consultant. When the Staff Grade Psychiatrist did ask his Consultant for his opinion this was done in an informal conversation, without all the facts to hand.

The Consultant said that it was common practice for patients to be assessed under his name. They could be seen by the Crisis Team and/or a doctor and discharged without any discussion or CPA assessment.

Although the Locum Consultant was an experienced clinician he was not eligible to be on the Specialist Register as a Consultant Psychiatrist. For the four years before taking up his consultant role he had not worked regularly in acute adult psychiatry. Despite this he worked autonomously in Rugby for two years. There would have been a responsibility on his medical managers, in this case the Associate Medical Director, to ensure that he had adequate support and supervision of his clinical duties. The practice of pairing new Consultants with more established clinicians for support did not happen in this Locum Consultant’s case. There was annual appraisal based on ‘self-reporting’ from the Locum Consultant but there was no evidence of any system in place properly to monitor his clinical care or management capability. Unstructured group supervision was available but he did not often attend. It is not clear that any remedial action was taken to make sure that the Locum Consultant attended supervision.

COMMENT

Better management and supervision of this Locum Consultant may not have changed the outcome in this case but it is clear that to ensure good clinical practice, proper systems need to be in place and staff need to be in place who can do the job. It could have been argued that if the Trust chose to appoint a doctor as a Locum who would not have been eligible to take up the substantive post then they have a duty to prove that he is able to perform the post through assessment and need to offer adequate supervision.

The Locum Consultant, as the lead of a team, was responsible for the delegation of duties and the supervision of those who saw patients under his name. He was responsible for deciding the level of supervision that the Staff Grade Psychiatrist co-ordinated. Though the Associate Medical Director would be involved in deciding what work the Staff Grades were contracted to do on a day to day basis the Locum Consultant should be responsible for making sure that this was done safely.

No systems were in place to ensure that the Crisis Team and the Staff Grade's work were regularly or properly supervised. Supervision was ad hoc and at the instigation of the Staff Grade. No weekly supervision was set up, and no regular presentation and discussion of new cases were in place. New patients were assessed and discharged without any discussion. It is unclear whether this level of supervision was adequate for the running of a good quality safe service, but neither of the Staff Grades had passed their membership examinations and the majority of the Staff Grade Psychiatrist's experience was in old age psychiatry. He had only returned to general adult psychiatry for a year before he first saw PW.

The clinicians on the Locum Consultant's team were himself, not on the specialist register and with most of his senior UK experience in old age and learning disability and the Staff Grade Psychiatrist who was an Old Age Psychiatrist. Neither had clear, regular structured supervision.

The Associate Medical Director was clear that the onus was on the Staff Grade Doctor to decide when they needed to see the Consultant about a case. However, it was unclear how the service could be sure that this was a safe way to proceed. The responsibility must be for the Consultant and the senior medical managers to decide on what duties are delegated rather than the current situation where the Staff Grade what duties are delegated. One of the few ways that the Trust can ensure that the proper level of work is delegated is for there to be regular, structured supervision and for there to be systems, through which all new cases are properly presented and discussed with a Consultant. These systems were not present when PW was seen.

RECOMMENDATIONS

The Independent Investigation recommends that the Trust:

- ❒ **Support all medical practitioners, at a grade lower than Consultant, to provide optimum quality patient care.**

This will require:

- ❑ **a regular supervision system; to which all practitioners have access;**
- ❑ **explicit understandings of all duties delegated by Consultants to junior-grade doctors, including discharge arrangements - which should always be discussed with the Consultant.**

CHAPTER 8

THE TRUST'S INTERNAL INQUIRY

In the event of a violent incident, the Health Circular, *Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community* HSG(94)27, stated that "*an immediate investigation should be carried out to "identify and rectify possible shortcomings in operational procedures, with particular reference to the Care Programme Approach*".

In 2000 further guidance *An Organisation with a Memory* was issued to encourage NHS organisations to take a more open and transparent approach to investigating. This was followed by guidance on implementation *Building a Safer NHS for Patients,* which set out the principles for clinical governance which can be defined as *"a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."* A First Class Service: Quality in the New NHS Department of Health 1998. Bearing all of this guidance in mind and having an eye to local sensitivities, Trusts are obliged to investigate all serious and adverse incidents and to publish their findings and conclusions as well as making recommendations to improve the service for future patients and boost staff confidence.

In May 2005, shortly after this incident, the subject of this investigation, the Department of Health issued updated more Guidance in relation to paragraphs 33 – 36 of HSG (94) 27

The above Guidance demonstrated that NHS Trusts have a responsibility to firstly, carry out a review and secondly, conduct an Internal Inquiry following any serious incident involving a patient. It is usual practice for the Trust to report the findings and any action taken to their Commissioners and the Strategic Health Authority. In many Independent Investigations such as this, the terms of reference may include a review of the Internal Inquiry previously carried out. In this case we took the decision to ask more questions about the Internal Inquiry as we felt it was in the public interest

as both families concerned were only given an eight page summary, whereas the full document we were given, was over 100 pages, including a timeline of events.

North Warwickshire Primary Care Trust (NWPCT) *(now Coventry & Warwickshire Partnership Trust)* had not had previous experience of such an Inquiry. The Trust was still in the early stages of putting in place, what might be considered complex, governance structures across the organisation, including the Serious Untoward Incident (SUI) sub-committee and the Risk Management Committee. Both Trusts (NWPCT and Rugby PCT) had different focussed Directorate groups, which were only just 'bedding' in.

NWPCT, Rugby PCT and Warwickshire County Council agreed to set up a single Inquiry team and conduct a joint investigation. They anticipated that the review would be complex. Both PCTs had been trained in, and were introducing root cause analysis methodology as recommended for NHS Trusts. A decision was taken to co-opt two further people to strengthen the capacity of the inquiry team, these being two specialist advisers, from the National Patient Safety Agency (NPSA) and the National Institute of Mental Health (England) (NIMHE). In addition, and given the seriousness of the incident, the Strategic Health Authority was invited to nominate an observer.

As the Independent Police Complaints Commission (IPPC) were about to instigate their own inquiry they too, were invited to participate but only as 'observers'. Warwickshire Police agreed to provide information about their involvement as allowed by the Data Protection and the Police and Criminal Evidence Acts. The IPCC Commissioner influenced the decision of the SUI committee and the Mental Health and Learning Disability Directorate Governance Board, not to release the full report, giving reasons of potential criminal proceedings from his findings and not prejudicing PW's trial.

COMMENT
PW's trial took place in March 2005 and the respective families were not given the summary report until sometime in April or May 2006.

The final membership of the Internal Inquiry team was as follows:

- Director of Integrated Governance - Chair
- Director Mental Health & Disability – Inquiry Team
- Acting Service Manager In-patient Care – Inquiry Team
- Consultant Psychiatrist NWPCT – Inquiry Team
- GP Rugby PCT – Inquiry Team
- Non-Executive Director Rugby PCT
- Assistant Service Manager Warwickshire County Council (Social Services) – Inquiry Team
- Head of Service Governance (MH&LD) NWPCT – Inquiry Team
- Service Improvement Manager, NWPCT – Inquiry Team
- Race Equality Lead NIMHE (West Midlands) – Inquiry Team
- National Patient Safety Agency (NPSA)
- Director of Public Health WMSHA
- Regional Commissioner IPCC
- IPCC Commission Officer

The Inquiry Team reviewed of all the records held by the GP practice, the mental health services and those held by the Social Services. The Police gave them access to their records concerning the incident on 3rd February and any previous Police contact.

The IPCC observers briefed the Inquiry Team on any matters that arose from their investigation about health or social care without disclosing their documents and reserving the right to take unilateral action.

The Investigation Team held two facilitated sessions, one with the Crisis Team and one with those managers involved locally with commissioning and/or the implementation of services. The purpose of these sessions was to learn how the Crisis Team worked in practice and its relationship with the wider service and to understand the relationship between the commissioning processes and day-to-day operational service management. The GPs, NHS and Social Services staff made statements shortly after the incident and most of these staff members were interviewed by at least two members of the Inquiry Team.

We were told that the Inquiry Team had wanted contact with family members of both the victim and the alleged perpetrator in order to explore their perceptions of the care and treatment provided to PW. In the event a meeting was held with two members of PW's family and family of Colette declined to meet with them, although her brother did provide a statement via the telephone. The Inquiry was convened on 9th February 2005 and completed its report on 29th July 2005.

It was most unfortunate that only the summary document was given to the families and those members of staff who were invited to our investigation. It is possible that in mitigation the Serious Untoward Incident Policy (due for review in October 2004), which the external Inquiry Team was provided with, stated that only a Summary Report would be provided to *'third parties'* other than the PCT Board and relevant committees. In fact many members of staff told us that following their interview during the Internal Inquiry, they heard nothing more until appointments were given for our external investigation.

OUTCOME OF THE INTERNAL INQUIRY AND OUR OBSERVATIONS

The Internal Inquiry identified concerns and short-comings in relation to communication, leadership care co-ordination and risk management. However, to understand the full extent of these concerns it was necessary to read the full report, which we were privileged to do. We have used the same headings to discuss our observations.

1. Communication

The Investigation Team identified concerns about communication in the care and management of PW and we would agree with them.

The Investigation Team could not discern a **single person** orchestrating the care plan, if indeed there was an effective one. Little notice seems to have been taken of the number of times family members and the GP telephoned with their concerns which does not fit with Mental Health Policy Implementation Guidance requirements referred to earlier. Both brothers of PW expressed concerns about the need for and level of mental health service involvement for PW which do not appear to have been resolved with them.

Colette was one of the main sources of information about PW, described by PW's GP as 'good historian'. The health and social care records show that she contacted all five agencies at different times, sometimes contacting more than one agency on the same day and yet later decisions may have been based on previous history rather than what she was saying now about PW. These records show Colette's brother also contacted three different agencies in the period between 1st and 3rd February 2005.

As noted, in the section regarding the Crisis Team, their notes and those of the medical staff were held in different offices and we were told that even when discussions took place, all the notes were not always available.

2. Leadership

We were told that each nurse took responsibility for a shift on the Crisis Team and assumed the named Consultant was in charge of the case. As a consequence, no one person was taking an overview of the situation. Staff Grade Doctors were, apparently, not considered to require supervision and so little time was given to discussing patients on a formal basis. On 3rd February 2005 the acting Locality Manager called a meeting but, according to her account to the Investigation Team, took no proactive role other than establishing that should a bed be required that there was one available. At times the responsibility for carrying out the MHA (1983) assessment was confused with the GP being asked to do so, the Crisis Team asked to make a home visit, the Consultant not wanting to see PW without Police presence and the ASW seeing him but only for a few minutes. As noted earlier, we understand that there was no one Consultant who was responsible for the medical component of the Crisis Team, which we felt led to fragmentation and poor communication.

The Investigation Team's conclusion was that there was a lack of senior leadership at the point of the crucial multi-disciplinary meeting, which took place on 3rd February 2005. There appeared to us a reluctance to take either managerial or medical responsibility.

3. Care Co-Ordination

As discussed earlier the application of the Care Programme Approach (CPA) was inappropriate and there was no formally identified care co-ordinator and there is no evidence of the identification of the need for a carer's assessment.

The Investigation Team identified that there was a lack of understanding of specific cultural factors that need to be acknowledged and accommodated when planning an effective care package for people from African-Caribbean communities.

We were unable to agree with this view, as we found no evidence to substantiate this point of view. However, we do accept that there is always a need to take account of any factors in relation to culture, ethnicity and class as well as familial preconceived views about mental health. We have already commented on the fact that PW was referred to as 'white British" in one of his encounters with the mental health service. Many people are suspicious of services and drugs used and therefore psychological, 'talking therapies', should always be considered.

4. Risk Management

The Investigation Team identified concern about risk management relevant to the care and management of PW, which again we completely agree with.

There were different views about the need for and assessed urgency of intervention between the professionals involved and as far as we were concerned, these differences did not ever seem to have been resolved.

There was no clear diagnosis of PW's mental health, which we felt, may have influenced the services on offer and as a consequence he did not qualify for Home Treatment when telephone contact failed after his assessment of 20th January 2005.

We could find no documentary evidence of a comprehensive or competent risk assessment at any time there was contact with PW or his family. Neither was there a documented contingency care plan of the action to be taken in the event of 'no answer' to attempts at telephone support.

The risk assessment process was not helped by the fact that the health and social care services received different and conflicting information about PW's behaviour and the nature of the risk that he presented.

There were two parallel plans: re-assessment of PW's mental health in outpatients as well as a formal assessment of PW under the Mental Health Act either in outpatients or at his home. To be fair this could be seen as a service seeking to use all possible means to engage a "reluctant patient"; but, we believe, in the care of PW it was an approach that appears to have caused confusion about what actions needed to take place and who should have taken charge of the situation.

The Internal Inquiry identified that the Crisis Team staff did not appear to be attuned to the cultural evidence about the nature of presentations by men of African-Caribbean origin to mental health services in the UK. The Investigation Team felt that when the Crisis Team was asked about ethnicity, the response was one which related to the 'colour blind' approach. The fact that the Crisis Team did not highlight PWs ethnicity raises some serious concerns about the Team's approach in meeting the cultural needs of PW and any concerns, issues and barriers that PW and the family may have had in accessing culturally appropriate mental health services.

During the Internal Inquiry the NIMHE Adviser was told that there was a lack of confidence in the local mental health services from the local black community. There appeared to be a view that PWs family did not support a formal assessment which could have been due to the perception of the *'big, black and dangerous'* stereotype and assumptions that families often view the mental health system as '*making black people mad'*. PW attended outpatients regularly as requested and was supported by his family until such a time where he became more generally paranoid. There was a reluctance concerning him being assessed for a 'Section' under the Mental Health Act but this is a general concern of families and carers which is not necessarily to do with ethnicity**.**

The ASW recorded that one of PW's brothers voiced strong disagreement to a Mental Health Act Assessment taking place although he agreed to taking PW to the Linden Unit the following day. The ASW found another brother to be supportive of outpatient assessment and informal involvement. There appeared to be a view held by professionals in the mental health services that PW's brothers did not think there was a need for a Mental Health Act Assessment for PW before the incident. When we met with PW's brother he told us he thought PW needed treatment but was fearful of PW being 'sectioned'. It was clear to us that both families had an understanding of the local mental health services and if more time had been spent talking to them then PW might well have been assessed and possibly not required to be detained, having agreed to treatment. However, we shall never know the answer to that possibility.

The behaviour of PW does not appear to have been fully followed through as an incident of domestic violence. The Trust did not have a policy despite guidance being issued by the Home Office *"Tackling Domestic Violence Exploring the Health Service Contribution"*. This was compounded by the Police Officers not following through their own domestic violence procedures. There has been no specific training in domestic violence for the Crisis Team nor did it appear to us that they were familiar with Warwickshire Police's Policy and Procedures in cases of domestic violence.

RECOMMENDATION

The Independent Investigation recommends that the Trust should:

- ❒ **Enable all practitioners to work to an appropriate Domestic Violence Strategy.**

This will entail:

- ❑ **undertaking a multi-agency training programme.**

THE INTERNAL INQUIRY CONCLUSIONS

As an Independent Investigation we have reviewed the conclusions of the Internal Inquiry, particularly as they were presented in the Trust's Summary Report and then made available to the families.

The conclusions of the Trust are written in black type, whilst the conclusions of the Independent Investigation are in red type.

1. PW was not well known to the mental health services and in the time that he was known to them he had a varied presentation. The mental health services received conflicting information about him from those who knew him well. The mental health service also had limited direct contact with PW. The mental health service was clear that PW should be reassessed. These staff did not achieve direct contact with him in order to do this.

THE INDEPENDENT INVESTIGATION VIEW
We concluded that he was seen on four occasions for a period of time which in all amounted to over four hours. This could have been increased if only an appropriate decision was made about the assessment required for his own and his family's safety. However, in January 2005 the appropriate response should have been a longer assessment and for PW to be seen face to face by a Psychiatrist.

2. The Trust concluded that it appeared that PW's mental health was changing and more specifically psychotic symptoms may well have developed particularly in the period 1st – 3rd February 2005. However, taking account of the unclear and fluctuating nature of these symptoms and the assessment on 2nd February, the Internal Inquiry concluded that it was reasonable to believe that PW may not have met the criteria for admission to hospital for assessment (and/or treatment) on either a voluntary or a formal basis between 3rd and 4th February 2005. In this event it would therefore follow that the mental health services would not have had a basis to be able to remove PW from his own home before this tragic incident took place. The information made available to the Internal Inquiry from the Reaside clinic, (currently looking after PW) after the incident, described a continued pattern of variation

and fluctuation in his presentation which would have been difficult to assess and diagnose.

THE INDEPENDENT INVESTIGATION VIEW
We concluded that there was ample documented evidence of psychotic symptoms in the GP and Crisis Team notes from 20th January 2005 onwards. There was evidence that PW had not attended out-patient appointments and was considered a danger to his nephew and to Colette. The Investigation Team were of the view that because of this, it was likely that he may have met the criteria for admission to hospital.

3. The Internal Inquiry Team concluded, that the mental health service received conflicting reports of potentially threatening behaviour and reports that PW carried a knife. PW did not have a history of violence and aggression. The Internal Inquiry Team did not believe, in the period from 1st to 3rd February 2005, that the mental health services could reasonably have foreseen that PW would act in the way that he did.

THE INDEPENDENT INVESTIGATION VIEW
We concluded that although PW did not have a known history of violence at that time, there was **sufficient** concern expressed about his violent behaviour and attitude to have warranted more proactive action.

4. The external Inquiry Team identified significant issues of concern in the care and treatment that was provided to PW. If the local mental health service changes the systems and processes that it uses, this should reduce the risk of the likelihood of a similar incident happening in future.

THE INDEPENDENT INVESTIGATION VIEW
We concluded that given the current state of the Crisis Team without dedicated medical time and more focussed discussions with shared notes, it is not possible to say that this kind of incident will not re-occur.

5. The Internal Inquiry team concluded that focus was not given to PW's and his family's ethnicity and the barriers to engagement that this can present. The fears that BME communities have about mental health services can be assuaged by liaison and information. This means involving the family, nearest relatives and user, to make choices about their own care. The role of the Community Development Worker, is now recommended nationally as someone who, on an on-going basis, can be working both inside (with mental health services) and outside (with the community) to ensure: that access, experiences and outcomes for BME communities are improved, to build mutual trust and confidence with communities and to tackle issues of fear and stigma around mental illness within the community.

THE INDEPENDENT INVESTIGATION VIEW
We concluded that although there may have been elements of this view, the Investigation Team is of the opinion that **all** patients should be assessed in a manner which always takes account of their cultural, ethnic background and their previous knowledge and or experience of mental health services.

6. The previous experience of the PW's family may have created barriers in their minds about engaging with mental health services and in their being able to support PW to do so. The decisions made by the GP and Consultant to seek a Mental Health Act Assessment from 1st February 2005, may have compounded these barriers.

THE INDEPENDENT INVESTIGATION VIEW
We concluded that this may well have been the case but could find no evidence that the decision to seek a Mental Health Act Assessment created barriers between PW's family and the professionals.

7. Had a care co-ordinator been in place responsibility for frequently reviewing the case would have been explicit, together with the process of engagement and working with the family and carers. This might have reduced the fear of engagement expressed by PW's family and ensured more effective engagement by PW with mental health services.

THE INDEPENDENT INVESTIGATION VIEW
We concluded that there is a requirement to reconcile the requirements of the national CPA guidance and local policy with application by the Crisis Team.

8. The mental health services did not engage fully with PW. The care and treatment that was offered to him was determined in part by his presenting needs, which were unclear, and partly by the local criteria for home treatment. This means that the Crisis Team did not offer him intensive follow up. Follow up was offered via outpatients, even though his attendance at outpatients was variable.

THE INDEPENDENT INVESTIGATION VIEW
We agree with this conclusion. From 20th January 2005 PW's needs were not formally assessed neither were the needs of the 'carer' – Colette. The communications about PW's varying presentation were inadequate which led to the lack of an appropriate care plan.

9. The absence of a daily review meeting in the Crisis Team was in part a function of the limited resources in the Crisis Team and the context in which the team had been established. A dedicated Team Leader is a person with clear responsibility to ensure control measures are in place. Such a person also requires easy access to medical advice and leadership. The use of CPA with a validated risk assessment system would have been a further control measure to help manage and reduce potential risk.

THE INDEPENDENT INVESTIGATION VIEW
We urge the Trust to re-consider this in light of the Recommendations from Chapter 6.

10. Risk assessment and the application of the Care Programme Approach were both inadequate. There is limited evidence of risk assessment. Although it is unlikely that PW would have met the criteria for detention in hospital, a formal assessment under the Mental Health Act was not completed in order to ascertain this.

THE INDEPENDENT INVESTIGATION VIEW
We agree with this conclusion.

11. The fact that there was no mechanism to resolve the different views of the professionals involved, there was no daily review meeting in the Crisis Team and the Care Programme Approach was not properly used resulted in an inappropriate decision-making process about the care and management of PW. The local system for medical support and medical leadership also contributed to this ineffective decision making process.

THE INDEPENDENT INVESTIGATION VIEW
We agree with this conclusion – but would suggest that this is still **not** resolved.

12. The Internal Inquiry identified a number of other issues of concern in the day to day operation of services, which undoubtedly led to a less than competent service for the needs of mental health patients. Sadly some of the following are not just pertinent to Rugby.

- ❑ Temporary and/or Acting senior management arrangements over a prolonged period together with a prolonged need to employ Locum Consultant Psychiatrists.
- ❑ The operational policy and the internal structures of the Crisis Team are no longer consistent with national requirements.
- ❑ Difficulties in the recruitment and retention of staff. It is recognised that this is a national problem in mental health services. The national vacancy rate for Psychiatrists in 2005 was 11% and for nurses was 3%.
- ❑ No standards for routine medical administrative functions.
- ❑ The current commissioning arrangements do not work to the best benefit of either Rugby PCT, GP's in Rugby or North Warwickshire PCT as service provider and potentially therefore for users and carers.

THE INDEPENDENT INVESTIGATION VIEW
We agree with all of these points, some of which are subject of further discussion within the report.

Having read and discussed the Internal Inquiry conclusions and recommendations with senior staff members in both the Trust and with the Commissioners, it was not totally clear to us how these where agreed, either internally, for example with the Crisis Team, in respect of CPA and externally with the Commissioners (Rugby PCT) who have the responsibility for on-going monitoring of progress.

SUPPORT FOR FAMILIES

'Safer Services' (National Confidential Inquiry into Homicides and Suicides by people with Mental Illness Department of Health 1999) demonstrated that extreme crimes of violence such as murder or manslaughter were more likely to be committed by a family member than a stranger and this was no different when a person deemed to be mentally ill committed the offence.

Families involved in this kind of tragedy are often left to support each other, although a Police Family Liaison Officer will be appointed to the identified victim's family. Families feel robbed of a loved one and when the victim is also a family member and other family members may be confused and feel guilty that they were unable to do anything or did nothing. They may also feel belittled, emasculated and stripped of their self respect as the public media glare is trained on their private family life and grief. When the victim is a stranger the tabloid press tend to 'point the finger' at the professionals involved in the case, not wanting to hear the truth about staff shortages, excessive workloads and poor management, support and supervision.

For this reason both families and carers need help with dealing with the crisis they find themselves in and reassurance about future action to be taken. The Investigation Team do consider that early contact with, and offers of support to a victim's family in the aftermath of an incident such as this, is very important and should be documented.

THE INTERNAL INQUIRY PROCESS

It is the view of the Investigation Team that the Internal Inquiry could be perceived as 'cumbersome' in that processes were run in parallel and the interviewing was conducted by pairs of interviewers rather than the same people - perhaps a team of three. Even by their own admission, the Trust struggled with this process of collecting evidence and holding interviews. Concurrently explanations were given to staff about the process as they, too, were not familiar with the techniques and inquiry

process tools and at the same time interviews were conducted. We were also told that few senior members of staff had sound experience of conducting this kind of interview resulting in staff being interviewed by teams of two people who of necessity were not always the same.

COMMENT

The Investigation Team was concerned that, although, the Trust produced a Serious Untoward Incident Policy it was out-of-date and we received no subsequent assurance that this has been addressed, despite the Chief Executive being alerted to this shortfall. It is possible that, as the policy had been accredited by the NHS Litigation Authority, it was felt that it could be left to the new mental health organisation due to come into being in October 2006.

The Internal Inquiry was, unnecessarily, complex both from the perspective of participation and through to a final report written using the taxonomy of Root Cause Analysis which, we feel, most readers would find difficult to navigate. It seemed to us that this complexity, in many senses, mirrored the Trust's governance structures, where a multiplicity of committees appeared responsible for both this Internal Inquiry and the monitoring of the action plan to address the recommendations from the Internal Inquiry. Although a Board Director chaired the Internal Inquiry, she did not take part in any of the interviews nor take any responsibility for the implementation of the recommendations.

When we met with the Director of Governance, the Chair of the Internal Inquiry and Board member, she was unclear as to what progress had been made with regard to the Internal Inquiry recommendations. The complex arrangements for the management of serious untoward incidents made it difficult for us to understand who should provide this information. In the circumstances we were no clarity as to how the Trust Board was kept informed of progress nor could we be assured that they actually understood what the contemporary position was.

Practitioners told us, that when interviewed as part of the Internal Inquiry they felt less-than-fully supported. For example, prior to our Independent Investigation, many staff members had no idea of the content of the Internal Inquiry report or the subsequent action plan. We were pleased to see that on attending our interviews, members of staff were given a copy of the summary report and accompanying action plan.

The Director of Mental Health Services, who joined the Trust some six months prior to the incident, told us that her recommendation to the then Board was that if in the short term such an incident happened again they should use an external organisation to carry out the Internal Inquiry as this might provide greater assurance for the Board. This was because there was only one Director with this kind of experience who also happened to manage the service in question.

However, in light of the emerging Trust we consider that much would be lost to the organisation in terms of the culture, the learning and processes. Whilst no one person or organisation wants to be faced with having to investigate serious incidents, even in the best managed services there are times when things go wrong. The outcomes of any investigation need to be firm, with a clear expectation of who should do what, by when it should be completed, include checks to ensure that it has been done, and finally an evaluation of its effectiveness needs to be in place. This can only occur with appropriate training to provide competence and instil an appropriate level of confidence.

Having had the benefit of reading the full report, the Investigation Team concur with most of their findings but we found it most unfortunate that the Trust felt unable to share more of the report with the respective families although, we understand, that this might have been dictated by the Trust's *Serious Untoward Incident* Policy. We have since learnt that the IPCC did not want to risk the integrity of their own inquiry and outcome should there be subsequent criminal proceedings. The Independent Investigation is of the view that the full report could have been shared with both families in such a way that the integrity of the IPPC investigation was not interfered with. As a consequence we were unable to meet with some family members, the reason given as their annoyance at not being able to see the whole report. We do accept, however, that the format of the final report would need to be different for easy reading and understanding of the issues.

RECOMMENDATION

The Independent Investigation recommends that the Trust:

- ❑ **Comprehensively reviews its SUI processes to take account of a more open approach to help staff and families.**

This will ensure that:

- ❑ **a senior person makes contact with families who are the victims of serious incidents;**
- ❑ **staff take account of the sensitive nature of support required, seeking guidance from and including the various voluntary agencies such as Victim Support in the preparation of the training programme;**
- ❑ **the level of competence and confidence of staff, when dealing with serious untoward incidents is enhanced;**
- ❑ **A supportive framework is provided - which includes counselling if necessary, adequate time for briefing and the opportunity to receive feedback as well as full discussion about any action plan which has to be implemented;**
- ❑ **the internal processes must be aware of other parallel investigations of other organisations such Coroner's office and or Police. However, these should not stop the internal processes from being progressed.**

RECOMMENDATION

The Independent Investigation recommends that the Trust should:

- ❒ **Consider all the comments made in this Report; regarding aspects of the interactions between PW, Colette and their respective families with all statutory agencies - particularly during the critical period of 1st to 3rd February 2005 and to amend their practices and processes accordingly.**

CHAPTER 9

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

From all the evidence we heard, we cannot say with surety that the outcome for Colette would have been any different if a Psychiatrist had assessed PW in early February. However, we did find serious lapses in critical thinking and decision making by the senior professionals involved in the period of time from 20th January 2005 until 3rd February 2005.

We were at a total loss to understand why a mental health assessment, either informally or under the auspices of the Mental Health Act, **was not undertaken** before the 3rd February 2005. The level of concern from both families was rising given the number of telephone calls to the GP, the Police, the Children and Family Team and the mental health services and should warranted action by the mental health services. The Consultant should have led by example as he made the initial referral with concerns as to the safety of PW's nephew, Colette and her children.

Our GP member said it was almost unprecedented in his experience that a fellow GP insisted on disturbing a Consultant during a consultation clinic. The professionals allowed 14 days to elapse without PW being seen by a Psychiatrist despite reports being received about significant psychotic features. The cumulative risks are documented in Appendix 7.

In these few weeks there was a great deal of information available, perhaps locked in separate 'compartments', which, had a full multi-disciplinary meeting taken place with all practitioners and agencies contributing, then a more complete picture would have been available and the quality of the decision making improved. On more than one occasion Colette raised the alarm herself, to be left on her own only with the support of her family, who, too, were unable to influence the decision making of the professionals. Protecting people in the community as well as the patient should be paramount in any community based mental health service. When properly managed in a multi-agency approach it should also mean that the public too are protected. This aspect of public protection was sadly lacking in Rugby in February 2005.

In addition, these are the Investigation Team's major findings which support this conclusion

The Investigation Team spent a lot of time in discussing whether the Crisis Team was 'fit for purpose' and whether we should recommend that it be closed and, as we could not come up with an alternative service, we felt that the people in Rugby would not have been well served. We **implore** the Commissioners and the new specialist mental health Trust to take note of this comment when drawing up their action plan in response to our findings, conclusions and recommendations.

1) The GP responded to the physical symptoms reported by PW when he came to the surgery and requested appropriate (and extensive) tests. He never deviated from the view that PW may well have a mental illness and continued to refer PW for assessment by the Crisis Team. He is to be commended for his persistence.

2) The GP practice was also proactive in advising the Staff Grade Psychiatrist that PW had reported to them the use of cannabis and ecstasy.

3) Whilst not a major aspect of our investigation, we were dismayed to learn that having failed to attend one outpatient appointment to see the Consultant Neurologist, PW was removed from the 'follow-up' list and therefore not sent another appointment. Patients who have a mental illness do not always remember or appreciate the relevance of attending appointments and whilst we do not expect that these patients require different treatment, many other patients may well miss out on their follow-up appointments as a result of this policy.

4) The Consultant Psychiatrist informed his on-call colleagues of the situation on 2nd February. However, the Investigation Team were uncertain as to why the on-call Psychiatrist and a second Doctor did not go out with the ASW to assess PW. At that time there appeared to be a reluctance on the part of the doctors to carry out assessments in the community, especially without the Police being present.

5) The Children and Family Team Social Worker was right to respond to the concerns about the welfare of PW's nephew. It was therefore unfortunate that although the referral came from the Consultant Psychiatrist in the morning of 2nd February 2005, no one from the mental health services attended the Strategy Meeting later that afternoon.

6) Whilst we fully appreciate that the referral to the Children and Family Team was primarily about PW's nephew, more consideration should have been given to the safety of Colette and her children, as PW was in regular contact with them and Colette was the subject of one of his delusions. Child protection is not about individual children but must take account of all children in a family relationship.

7) Although there were good communications between the Children's Social Worker and the Approved Social Worker (ASW), it appeared to us that there was an unclear agenda for the home visit on 2nd February 2005, particularly on behalf of the mental health services. The interview with PW by the ASW in accompanying the Children's Social Worker gave subsequent professionals the impression that an assessment of PW's mental health had been completed.

8) The concept of 'partnership' working arrangements has been integral to the principles of effective child protection policies for some time. This was borne out, in this case, by the calling of the Strategy Meeting within only a few hours of receiving the referral from the Consultant Psychiatrist. The focus of all the information gathered was the safety of the nephew, with a decisive outcome to visit that day. It was in sharp contrast to the changing decisions and lack of focus in the discussions by the mental health service about PW and his mental health and whether he was a danger to either himself or others. The result of their indecision about conflicting evidence was that PW remained unassessed.

9) Despite a Care Programme Approach (CPA) being in place for many years no care co-ordinator for PW was identified. No one person was assigned to communicate with either other professional or indeed family members, which might have built up a more comprehensive picture of PW's mental state.

Despite most of PW's care being arranged by either Colette or PW's brother, no Carer's Assessment was ever undertaken.

10) The Crisis Team reported that the current CPA documentation did not address their needs because of their usually short term involvement.

11) There was, and is still, not a routine daily meeting in the Crisis Team to review all their current cases. This would have given the opportunity for all staff to discuss what they had in turn learnt about PW and family concerns for his mental health. The Crisis Team should have taken on the role of 'entry point' to the mental health services and responsibility for liaising with the other organisations involved with PW. In addition they could have called a 'case conference' for all to share their information about PW as there appeared to differing views. In fact the meeting held on the afternoon of 3rd February 2005 only seemed to dissipate the risk and anxiety previously expressed.

12) The response of the Crisis Team to Colette's telephone calls about her feelings of being 'unsafe' with PW was naïve to say the least, especially as they had been given information about her previous relationship, which had an element of violence in it. From their notes it appeared that they made detailed records of what was said to them but little written down about their response and critical thinking

13) There was no effective leadership in the Crisis Team and as a result was not performing as an effective service as it appeared to be a 'telephone' service, not being able to intervene either through lack of experience or lack of staff.

14) Although PW was seen by the mental health services on four occasions in response to the GP referrals, he never saw a Consultant. Neither was PW's care reviewed by a Consultant until 2nd February 2005.

15) There was a difference of opinion between the GP's, Crisis Team and Consultant and Social Work Services about the threshold for initiating a Mental Health Act Assessment. The Consultant and ASW had different views about whether a formal or informal approach to an assessment of PW's mental health was the most appropriate. During 2nd February 2005, the

Consultant was concerned about both the danger/risk that PW represented and the viability/urgency of a formal assessment. He referred what information he had to the Children and Family Team Social Worker and reported his concern for the safety of PW's nephew, Colette and her children following alleged reports of dangerous behaviour. On 3rd February 2005, he concluded that an outpatient assessment of PW's mental health should be pursued despite a view that PW might not attend. Later that day the Consultant confirmed that he did not now consider immediate action was required to protect PW's nephew although the young man was still with PW. The information provided to the mental health services about PW's mental health and dangerousness was inconsistent throughout. A member of the public contacted PW's GP about his concerns about PW's aggressive behaviour. He reported this to the Consultant Psychiatrist. He did not contact the Police because he believed that the mental health team was in control of the situation. Surely this telephone call from the GP should have been more seriously? The Consultant did not take and leadership role, but played a waiting game with tragic consequences.

16) The Police and the Crisis Team never had a conversation to discuss whether mental health or criminal matters (domestic violence) was the key issue in this case and, if so, what their respective responsibilities would be. The Crisis Team and Police did discuss the fact that PW may be mentally unwell and that he was reported to be carrying a knife. The Police and the Forensic Nurse told the Crisis Team about Colette making similar allegations about a previous partner. There was no record of formal assessment of the relative weighting given to these different pieces of information by the mental health services and how they were used.

17) The Internal Inquiry process was unnecessarily complex – perhaps because the Trust, by their own admission, was new to this form of review. The Trust's Serious Untoward Incident (SUI) policy (the version of which the Trust provided to the Independent Investigation was out-of-date) prescribed the arrangements for sharing the outcome of the Internal Inquiry - meaning that neither the families of those involved, nor the practitioners, were privy to the full document. Although this, detailed, report contained many comments that

were critical of the mental health services, these were not obvious because they were lost in the detail of the text and 'third parties' (including the families and the practitioners) only received a Summary; which did not make those criticisms clear. Had the families been able to see this transparency much of the distress expressed by members might have been alleviated.

18) The junior staff who saw PW did not have regular supervision and not all cases were considered by a Consultant before discharge. The Locum Consultant was not qualified for autonomous work but did not receive any supervision. There were no processes in place to ensure that the medical staff were providing clinical care of a sufficient quality.

19) The Investigation Team came to the conclusion that there appeared to something of an 'office hours' culture within the mental health service. The result was that outside office hours patients were seen by medical staff who did not know them and possibly did not have access to their records which was not good practice. This rigid cut-off at 17.00 hours also applied to Mental Health Act assessments, instead of a more flexible 'shift' system operating across North Warwickshire.

RECOMMENDATIONS

The recommendations of the Internal Inquiry can be found in Appendix 2 and we have taken each one into account when formulating our own. Many are about the same aspect of mental health care but where necessary, we have been more forceful and expanded the recommendation.

The Independent Investigation recommends that:

The Mental Health service, currently provided by Coventry & Warwickshire Partnership Trust *(formerly North Warwickshire Primary Care Trust)*, has to provide better outcomes for people using its services, their carers and those who provide services; by working with Commissioners and other partners to:

- Ensure that the Crisis Service, across North Warwickshire and Rugby, is consistent with the aspirations and requirements of the Mental Health Policy Implementation Guidance (PIG), 2002 – and is a model that is agreed with the Commissioners of the service - (Chapter Six).

- Provide the necessary arrangements that will enable people to be assessed in their own homes and the community, including out-of-hours, if necessary, without there having to be a formal Mental Health Act (1983) Assessment process - (Chapter Five).

- Increase the flexibility of out-of-hours Mental Health Act Assessment procedures. This should enable better continuity, so that cases can be assessed routinely during the evening or at weekends if they begin during the working day, without recourse to 'emergency systems'

- Support all medical practitioners, at a grade lower than Consultant, to provide optimum quality patient care - (Chapter Seven).

- Review the application of the local CPA policy; to ensure that it reflects both the Department of Health (1999) Guidance, and the experience of Best Practice within Crisis services, nationally - (Chapter Six).

- Enable all practitioners to work to an appropriate Domestic Violence Strategy - (Chapter Eight).

- Comprehensively review its SUI processes to take account of a more open approach to help staff and families - (Chapter Eight).

- Consider all the comments made in this Report; regarding aspects of the interactions between PW, Colette and their respective families with all statutory agencies - particularly during the critical period of 1st to 3rd February 2005 and to amend their practices and processes accordingly - (Chapter Eight).

APPENDIX 1 - PW'S CRIMINAL RECORD

DATE OF CONVICTION	CHARGE	SENTENCE
12.12.1995	Handling stolen goods. Rugby Magistrates Court	Conditional discharge 2 years
4.10.1996	Driving a motor vehicle with excess alcohol. Driving whilst disqualified and no insurance	2 months imprisonment and disqualified from driving for 5 years
11.11.1996	Rugby magistrates Court making a false statement or representation in order to obtain benefits	Fine £100
1.10.1999	Warwick Crown Court Obtaining services by deception	15 months imprisonment
12.10.2001	Rugby Magistrates Court Using disorderly behaviour or threatening/ abusive likely to cause harassment.	Conditional discharge 12 months
27.8.03	Making a false statement or representation in order to obtain benefits	Conditional discharge

APPENDIX 2 - INTERNAL INQUIRY RECOMMENDATIONS

NORTH WARWICKSHIRE PRIMARY CARE TRUST (*now the Coventry & Warwickshire Partnership NHS Trust)*

RECOMMENDATION 1

This recommendation concerns the Care Programme Approach:

a) The Crisis Team must use the Care Programme Approach (CPA), this includes the care co-ordinator function. The local CPA policy and procedure needs to be streamlined to support this. Urgent attention is required locally to agree an interim arrangement so that CPA is used.

b) North Warwickshire PCT should undertake an audit of care plans produced for people from Black and Minority Ethnic (BME) communities to assess if the care offered takes account of cultural needs and act on the results of this audit.

c) North Warwickshire PCT needs to design and implement a validated risk assessment and risk management process within CPA for use in all teams. It must take account of mental health needs, violence and aggression. It must be used and understood by all professionals within the service.

RECOMMENDATION 2

The local procedure to initiate a Mental Health Act Assessment in the integrated mental health service should be reviewed to ensure that the threshold to request an assessment is clearly specified together with the roles and responsibilities set out in the Code of Practice for the key professionals involved in this process.

RECOMMENDATION 3

The procedures used by the Crisis Team need to be updated to ensure that they are consistent with the functions set out in the Policy Implementation Guidance. The procedures should emphasise face-to-face contact as well as guidance on the action to be taken in response to people who do not attend, people who do not respond to telephone support and how to respond to people flagged as potentially risky non-attendees.

RECOMMENDATION 4

The Crisis Team when working with service users from BME communities should consider whether the care co-ordinator should work in partnership with the Community Development Worker to help to address any concerns and negative experiences around Black African-Caribbean communities accessing mental health services. This could help to begin to improve access, experience and outcomes for people from BME communities.

RECOMMENDATION 5

North Warwickshire PCT should review the current arrangements for medical leadership within the Crisis Team in order to have a higher level of dedicated medical cover and put in place a dedicated Team Leader for the Crisis Team with agreed funding.

RECOMMENDATION 6

North Warwickshire PCT needs to urgently review the risk assessment training provided to its staff. Staff should have the opportunity to train together as team(s) in the use of a validated risk assessment and risk management process that can be used as part of CPA. This training needs to explicitly address individual roles and responsibilities as well as the role of the care co-ordinator and the role of the team.

RECOMMENDATION 7

Immediate briefing is required for all staff in the mental health services on the threshold for requesting an Assessment under the Mental Health Act. Once the local policy has been reviewed consideration should be given on how best to provide training to staff and to monitor its implementation (including Primary Care).

RECOMMENDATION 8

The overall management and medical leadership structure for the mental health service in Rugby must be confirmed as soon as possible.

RECOMMENDATION 9

This recommendation concerns cultural competence.

a) National workforce directives around developing a culturally competent workforce need to be implemented within the mental health services.

b) Staff should be trained regardless of ethnicity, to ensure that all practitioners at all levels are trained to be culturally competent in the services they provide to all communities, not just for the BME communities. National Policy further recommends that work on cultural competency is driven from the top of the organisation, starting with the Board and the Chief executive.

c) North Warwickshire PCT should conduct a baseline audit of their cultural competency training to date.

d) North Warwickshire PCT should review its compliance with the Race Relations (Amendment) Act 2000. This should ensure that services Polices and procedures of the organisation begin to tackle issues around the approaches to race, especially around tackling the colour-blind approach to services for BME communities. The Race Impact Assessments, as part of the Race Equality Scheme would ensure appropriate models of training around cultural competency to ensure that this approach to practice is mainstreamed within the organisation.

RECOMMENDATION 10

The Local Implementation Team should:

a) Promote increased partnership with BME community organisations, including increased partnership in mental health promotion to help to support effective community engagement, with clear targets to measure progress.

b) Develop and agree a clear strategy and action plan that can be recommended to commissioners in order to develop appropriate and culturally responsive services in the LDP from 2006/7.

WARWICKSHIRE POLICE, WARWICKSHIRE COUNTY COUNCIL, WARWICKSHIRE PCTS

RECOMMENDATION 11

Warwickshire Police together with Warwickshire County Council and the three PCTs in Warwickshire should meet to review the joint information sharing protocol between them. New guidance is required for information sharing that takes account of the Freedom of Information Act. It also needs to specify the action required when both mental health needs and potentially criminal behaviour are present or suspected.

RECOMMENDATION 12

North Warwickshire PCT, Warwickshire County Council and Warwickshire Police need to meet to agree more flexible formalised process for joint working this should include the response times for urgent and non-urgent Mental Health Act Assessments.

RUGBY PRIMARY CARE TRUST

RECOMMENDATION 13

Rugby PCT has a target allocation for one Community Development Worker. The Local Delivery Plan (LDP) did not prioritise this role in 2005/6. Rugby PCT should review the prioritisation of funding in the LDP order to create a community development worker post.

RECOMMENDATION 14

Rugby PCT should have a commissioning forum with North Warwickshire PCT that generates a Service Level Agreement (SLA). This SLA needs to include a Crisis Team consistent with the Policy Implementation Guidance.

RECOMMENDATION 15

Rugby PCT should conduct a baseline audit of their cultural competency training.

THE WARWICKSHIRE PRIMARY CARE TRUSTS & WARWICKSHIRE COUNTY COUNCIL

RECOMMENDATION 16

North Warwickshire PCT and Rugby PCT and Warwickshire County Council, should commission specific training for primary care and mental health services staff on the somatisation of mental health problems, particularly in relation to the evidence about the presentation of people from BME communities. This training is intended to educate and raise awareness so that services are more culturally sensitive to the needs of Black African-Caribbean communities, especially in relation to being offered talking therapies and the links between how different communities view mental distress, through mind-body symptoms.

APPENDIX 3 - INVESTIGATION DOCUMENTATION PERTAINING TO PW

- ❑ Trust Documentation
- ❑ GP Records
- ❑ Raeside Medium Secure Clinic Records
- ❑ HMP Blakenhurst Records
- ❑ Social Services Records
- ❑ Trust Policies and Procedures
- ❑ Police Records

APPENDIX 4 - PUBLICATIONS

A National Service Framework for Mental Health – Dept of Health1999

An Organisation with a Memory – Report of an Expert Group on Learning from Adverse Events in the NHS – 2000

Breaking the Circles of Fear : A Review of the Relationship between Mental Health Services and African Caribbean Communities – Sainsbury Centre for Mental Health 2002

Building a Safer NHS for Patients – Implementing an Organisation with a Memory -2001

Building Bridges – A Guide to Arrangements for Inter-Agency working for the Care and Protection of Severely Mentally Ill People – 1995

Code of Practice Mental Health Act 1983

Code of Practice Mental Health Act 1999

David Bennett Inquiry Report Norfolk Suffolk and Cambridge Strategic Health Authority 2003

Delivering Race Equality – A Framework for Action : Mental Health Service Consultation Document

Domestic Violence – A National Report (March 2005)

Effective Care Co-ordination in Mental Health Services – A Policy Booklet

Engaging and Changing – Developing Effective Policy for the Care and Treatment of Black and Minority Ethnic Detained Patients – NIHME 2003

From Values to Action: The CNO's Review of Mental Health Nursing (DoH – April 2006)

Guidance – "Independent Investigation of Adverse Events in Mental Health Services" – an amendment to paragraphs 33-36 (pages 10-11) of HSG(94)27

Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community – HSG(94)27 Dept of Health

Inside Outside – Improving Mental Health Services for Black and Minority Ethnic Communities in England – NIMHE 2003

IPCC Summary Report of the Murder of Hayley Jane Richards (inc Wiltshire Police Response) - (IPCC – April 2006)

Journey to Recovery (The) – The Government's Vision for Mental Health Care – 2002

Mental Health Act (1983) Section 136 Policy

Mental Health Policy Implementation Guide – Adult Acute Inpatient Care Provision – 2002

Mental Health Policy Implementation Guide – Dual Diagnosis Good Practice Guide – 2002

Safeguarding Children – A Joint Chief Inspectors Report on Arrangements to Safeguard Children (Department of Health – October 2002)

Safety First - 5-year Report of the National Confidential Inquiry into Homicides and Suicides by people with Mental Illness – 2001

Standards for Better Health Care – Department of Health, July 2004

Still Building Bridges – The Report of a National Inspection of Arrangements for the Integration of Care Programme Approach into Care Management

Tackling Domestic Violence: Exploring the Health Service Contribution - (Home Office 2004)

Domestic Violence A National Report Delivering Services for Survivors of Domestic violence: the Government's Progress and further action 2005

Warwickshire Safeguarding Children Board – Child Protection Procedures

Warwickshire Sharing of Information Protocol

APPENDIX 5 - GLOSSARY OF ACRONYMS

A&E	Accident and Emergency
ASW	Approved Social Worker
BME	Black Minority Ethnic
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CSWT	Children's Social Work Team
ECPA	Electronic Care Programme Approach
EDT	Emergency Duty Team
EEG	Electro Encephalogram
HMP	Her Majesty's Prison
IDT	Incident Decision Tree
IPCC	Independent Police Complaints Commission
LDP	Local Delivery Plan
LIT	Local Implementation Team
MH & LD	Mental Health and Learning Disability
NHS	National Health Service
NIMHE	National Institute of Mental Health England
NPSA	National Patient Safety Agency
NWPCT	North Warwickshire Primary Care Trust
PACE	Police and Criminal Evidence Act
PCT	Primary Care Trust
PIG	Mental Health Policy Implementation Guide
RCA	Root Cause Analysis
SLA	Service Level Agreement
SUI	Serious Untoward Incident
WTE	Whole time equivalent

APPENDIX 6 – LIST OF WITNESSES

- ❑ Approved Social Workers
- ❑ Associate Medical Director
- ❑ Associate Specialist in Psychiatry
- ❑ Chief Executive
- ❑ Child Protection Referrals and Assessment Team manager
- ❑ Colette's Parents
- ❑ Consultant Neurologist
- ❑ Consultant Psychiatrist
- ❑ Director of Integrated Governance
- ❑ Director of Mental Health & Learning Disabilities
- ❑ Emergency Duty Officer
- ❑ 'F' Grade Nurses
- ❑ General Practitioners
- ❑ Locality Manager
- ❑ Locum Psychiatrist
- ❑ Manager – Inpatient & Crisis Service
- ❑ Operations Manager
- ❑ PW
- ❑ PW's brother
- ❑ Social Workers
- ❑ Staff Grade Psychiatrists

APPENDIX 7 - RISK FACTORS

RISK MATRIX – PW INVESTIGATION														
	KNOWN RISK AREA	**Jul-04**	**Nov-04**	**19-Jan**	**20-Jan**	**21-Jan**	**26-Jan**	**1-Feb AM**	**1-Feb PM**	**2-Feb AM**	**2-Feb PM**	**3-Feb AM**	**3-Feb PM**	**3-Feb EVE**	**Post Incident**
1	Fluctuating mental state	1	1	4	4	4	5	4	6	3	3	3	3	3	
2	Deteriorating mental state	1	1	4	4	4	4	4	5	5	3	3	3	3	
3	Unassessed mental state	1	1	1	1	1	1	4	4	4	3	4	5	5	
4	Command Hallucinations	1	1	1	1	1	1	1	1	1	1	1	1	1	5
5	Suicide and self-harm	1	1	1	1	1	1	1	1	1	1	1	1	1	
6	Alcohol	1	1	1	1	1	1	1	1	1	3	1	1	1	
7	Drugs	2	2	2	2	2	2	2	2	2	2	2	2	2	
8	Forensic history	2	2	2	2	2	2	2	2	2	2	2	2	2	
9	Weapons carried/used	1	1	1	1	1	1	5	6	5	5	5	5	5	
10	Direct harm to children	1	1	1	2	2	2	2	3	3	2	2	2	2	
11	Indirect harm to children	1	2	3	3	3	3	3	5	5	3	5	5	5	
12	Co-operation with treatment	1	1	1	1	1	1	1	1	3	3	4	4	4	
13	Insight	1	1	4	4	4	4	4	4	4	4	4	4	4	
14	Isolation/Support	1	1	1	1	1	1	1	1	1	1	1	1	1	
15	Relationship with Carers	1	1	1	1	1	1	1	1	1	1	1	1	1	
16	Potential victims frightened	1	1	4	4	2	3	4	6	2	2	4	4	4	
17	Stable location/access	1	1	1	1	1	1	1	1	1	3	3	3	3	
18	Violence to others	1	1	1	1	1	1	1	1	1	3	3	3	6	
19	Aggressive behaviour	1	1	4	2	2	2	2	6	3	2	2	2	2	
20	Property/fire	1	1	1	1	1	1	1	6	4	4	3	3	3	
	TOTAL	**22**	**23**	**39**	**38**	**36**	**38**	**45**	**63**	**52**	**51**	**54**	**55**	**58**	

Risk Score: 1: Low 2: Low/Medium 3: Medium 4: Medium/High 5: High 6: Imminent Danger **[High=bad]**

	PROTECTIVE/MITIGATING FACTORS													
1	Direct supervision by Carer	3	3	3	3	3	3	3	2	1	2	4	3	1
2	Co-operation with support	3	3	3	4	3	3	2	2	1	3	2	1	1
3	Seen by mental health practitioner	5	5	1	5	1	1	1	1	1	3	1	1	1
4	Seen by Psychiatrist	5	5	1	1	1	1	1	1	1	1	1	1	1
5	Seen by GP	5	5	1	5	1	1	1	1	1	1	1	1	1
	TOTAL	**21**	**21**	**9**	**18**	**9**	**9**	**8**	**7**	**5**	**10**	**9**	**7**	**5**

Mitigation score: 1: Low 2: Low/Medium 3: Medium 4: Medium/High 5: High **[High = good]**