REPORT OF THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF ANDREW ACKROYD

A report commissioned by

North Derbyshire Health Authority
and
Derbyshire County Council Social Services

Under HSG(94)27

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The North Derbyshire Health Authority, in compliance with the Health Service Guidance (94)27, appointed the following persons to the Panel to undertake the Independent Inquiry into the care and treatment of Andrew Ackroyd, a person who had been in receipt of care and treatment from mental health services in Chesterfield, North Derbyshire prior to the commission of a homicide committed by Andrew Ackroyd. This is the Report of the Independent Inquiry.

Chair

Professor Michael Gunn	Associate Dean, Nottingham Law School, The Nottingham Trent University and Professor of Law

Members

Dr. Eric Birchall	Consultant Psychiatrist
Ms Janice Lowe	Service Development Consultant and Social Worker
Mr Colin Vines	Lead Nurse, Worcestershire

SUMMARY OF RECOMMENDATIONS

The broad conclusion drawn by the Panel is that the standard of psychiatric care in Chesterfield is good with many health professionals striving hard to provide a high quality service. There appears to be good communication and cooperation between individuals in different disciplines (para. 4.3). Many factors contributed to this tragedy. Although there are areas of concern in the care of Andrew Ackroyd, the Panel considers that no individuals can be held responsible for his deteriorating mental health which led to Mr. Ackroyd's death (para. 4.4). The Panel wishes to underline the importance of the critical combination of three factors in Andrew Ackroyd's case. These are:

- the absence of some relevant information from the notes and files;
- the decision, by the Mental Health Review Tribunal, to grant an absolute discharge;
- and the decision to change Andrew's medication from a depot injection to oral medication.

These two decisions were made with careful consideration of the facts available at the time. They were reasonable decisions. With hindsight, it can be seen that these three factors meant that Andrew was in control of his medication and so was in control of the progress of his illness even if he denied that he was ill. It is in desiring to avoid a repetition of such a case, and so to facilitate learning from this incident, that the recommendations in this Report are made (para. 5.2.4).

The recommendations that the Panel makes are as follows. The Panel takes the view that the first eight are the most important recommendations.

1. Because of the importance of the information in question, **we recommend** that, when a patient is being transferred from one unit to another (in this

case from a regional secure unit to the community), all relevant clinical notes, reports and documents are transferred with the patient to the new team in charge of the patient's care and treatment (para. 5.2.3).

2. In view of the particular difficulties presented by patients with a forensic history, **we recommend** that North Derbyshire Health Authority in collaboration with the Confederation (whereby Social Services and Health work together) review the forensic psychiatry needs in North Derbyshire. This might be achieved by having a community forensic psychiatry team (para. 5.3.2).

3. **We recommend** that it is essential for an assertive outreach team or any team working in the community to have forensic experience amongst its members in view of the number of patients with a forensic history that will be its clients. But this is not intended to mean that such teams must become community forensic teams. Rather such community teams must be able to identify the different issues that arise in relation to patients who have been through the criminal justice system and, therefore, how they care for and treat these patients in the community, whilst also having the ability to seek specialist advice when appropriate (para. 5.3.2).

4. **We recommend** that the Royal College of Psychiatrists should be asked to consider making it mandatory for psychiatrists applying to join the Specialist Register for General Psychiatry to have received training in forensic psychiatry either at Senior House Officer level or at Specialist Registrar level (para. 5.3.2).

5. **We recommend** that, with regard to enhanced CPA, the documentation should include a contingency plan that deals with what should occur if the care plan is not followed and/or where the condition of the patient deteriorates (para. 5.6.8).

6. **We recommend** that the Confederation review its processes for enabling staff to make sound, up-to-date risk assessments. One part of achieving this will be by accessing the expertise of the forensic services both in terms of process and in terms of training and clinical supervision (para. 5.6.8).

7. **We recommend** that the Confederation review the interaction between its psychiatrists and the approved social workers (para. 5.7).

8. **We recommend** that, in establishing and operating assertive outreach services, workers making the transition to a new way of working require considerable, comprehensive initial and on-going training. If they are to deliver a good service, this must be provided (para. 5.10.1).

9. **We recommend** that, in order to maintain sufficient currency of forensic skills and to validate approaches in relation to clients with a forensic history, clinical supervision sessions should be provided to the assertive outreach team and other community teams. Such supervision may be provided by a Forensic Psychiatrist, but can also come from other forensic professionals (para. 5.3.2).

10. **We recommend** that Health Authorities, together with forensic psychiatry services, should ensure that all general adult psychiatry services have ready access to advice and support, in particular from a named consultant in

forensic psychiatry. This advice should be available both for in-patients and for patients in the community. It is only by considering these recommendations that forensic support for local services can be provided on an effective, easily accessible and easily deliverable basis (para. 5.3.2).

11. **We recommend** that there be a review of what accommodation for service users, particularly supported accommodation, can be made available in the Chesterfield area, taking fully into account assessed needs (para. 5.4.2).

12. **We recommend** that all staff should be conversant with the use of the Care Programme Approach. Training in its use and application should be available to all staff in both hospital and community settings (para. 5.6.8).

13. **We recommend** that, for patients subject to the enhanced level of CPA, reviews should be documented in the patient's notes and counter signed by the patient's responsible medical officer or consultant. Where a care plan is rolled over, written confirmation should be placed within the patient's record (para. 5.6.8).

14. **We recommend** that, with regard to enhanced CPA, the documentation should be forwarded to the hospital ward on admission of a patient (subject to CPA) to hospital (para. 5.6.8).

15. **We recommend** that, with regard to enhanced CPA, the documentation in itself is not likely to be sufficient where the patient is on the case list of an assertive outreach team. What is additionally required is a comprehensive care plan that addresses the hopes, plans and needs of the whole person (see the Appendix A) (para. 5.6.8).

16. **We recommend** that, with regard to enhanced CPA, the carer's assessments should be available to all carers of patients subject to CPA (para. 5.6.8).

17. **We recommend** that the assertive outreach teams review the documentation that they are using and decide whether to continue to use the CPA documentation or devise their own to provide the necessary level of information, etc (para. 5.6.9).

18. **We recommend** that the assertive outreach teams comply with the normal review and other requirements of CPA (para. 5.6.9).

19. **We recommend** that the assertive outreach services review what policies and procedures they have and develop and add to them in accordance with current guidance and best practice (para. 5.8.1).

20. **We recommend** that nursing policy manuals (to include, for example, policies on observation, patients taking their own discharge, patients absent without leave, patient property, admissions procedures, discharge planning, risk management, untoward incidents, accident reporting, illicit substances, alcohol, child visiting, vulnerable patients, and harassment) should be available on each ward, department and community team and updated on an annual basis (para. 5.8.2)

21. **We recommend** that Mental Health Act policies (including a policy on the use of section 5(4)) should be available on each ward, department and community team and updated on an annual basis (para. 5.8.2).

22. **We recommend** that a clear structure for clinical supervision should be developed for all nurses in both a hospital and a community setting (para. 5.9).

23. **We recommend** that a system of individual performance review is put in place for all nursing staff (para. 5.9).

24. **We recommend** that assertive outreach services be provided with the necessary clinical supervision as a team to consider such problems as the engagement of clients who are resisting services and the use of compulsory treatment where there is a risk of alienating the client (para. 5.10.1).

25. **We recommend** that on-going training needs of the assertive outreach services be identified, and that an appropriate programme be planned and delivered (para. 5.10.1).

26. **We recommend** a Confederation-wide review of the commitment to, provision of and take-up of training (para. 5.10.2).

27. **We recommend** that a formal training plan is developed for all staff preparing to move to work in a new style of service (para. 5.10.2).

28. **We recommend** that Mental Health Act training be made available to all staff (para. 5.10.2).

29. **We recommend** that a regular programme of Mental Health Act update training be established (para. 5.10.2).

30. **We recommend** that specific training be provided to qualified nurses working within an inpatient setting on the use of section 5(4) of the Mental Health Act (para. 5.10.2).

CHAPTER 1

1. Introduction

1.1 Andrew Ackroyd was tried for the death of his father at Nottingham Crown Court in October 2000. He pleaded guilty to manslaughter by reason of diminished responsibility. His sentence was the imposition of a Hospital Order with restrictions under the Mental Health Act 1983, sections 37 and 41.

1.2 Andrew Ackroyd was a user of mental health services in Chesterfield. He was a patient on the list of Dr Gayle Jackson (Consultant Psychiatrist) and of the Chesterfield Assertive Community Team (ACT). As he was in receipt of care and treatment from mental health services, it was necessary for the North Derbyshire Health Authority to establish an independent inquiry into the care and treatment of Andrew Ackroyd prior to the assault on his father that caused his father's death.

1.3 For reasons of clarity, this Report will refer to the perpetrator of the homicide and the recipient of relevant mental health services as Andrew Ackroyd. The victim, Andrew's father, will be referred to as Mr. Ackroyd.

1.4 The recommendations in this Report are directed to organisations and staff within North Derbyshire, except where explicitly directed otherwise. However, all Reports such as this provide organisations and staff working with people with mental health problems with the opportunity to learn from the experience of others.

CHAPTER 2

2. Organisational, management and planning issues

2.1 Mental health services in North Derbyshire are, on the health side, commissioned by the North Derbyshire Health Authority. The health services are provided by the North Derbyshire Community Health Care Service NHS Trust. Social services are provided by Derbyshire County Council Social Services Department. As an innovative partnership, it was decided that mental health services should be provided, for both health and social care, by the North Derbyshire Confederation of Adult Mental Health Services. The Confederation commenced work in November 1999. One of the first tasks of its first Director was to undertake the internal inquiry into this case. It was appropriate to ask the Director to undertake this task. The Report was very helpful to the Panel in its work. The Director left the Confederation in 2001. The establishment of the Confederation was an important innovation in the delivery of co-ordinated care and treatment. This approach is to be applauded.

2.2 There were clear planning weaknesses associated with the establishment of the ACT. Whilst the planners followed the lead offered by the Government for the establishment of assertive outreach services, the newness of this approach was not fully appreciated. The incremental approach to development was adopted. For assertive outreach, or any service development as new as this, such an approach is not appropriate. Not all the current guidance on assertive outreach services (see Appendix A) was available at the time, 1998, that the Chesterfield service was being planned. Nevertheless, it is clear that a Team which was too small, with no

Team leader, was established (see also paras. 5.5.3 & 5.11.1). It was established without sufficient commitment to induction and initial and on-going training to enable it to deliver a proper assertive outreach service (see also paras. 5.5 & 5.10.1). It was established without sufficient resources in terms of staff membership. For example, not only was the Team small, but also it relied for medical input on the consultants retaining responsibility for their patients who were transferred to ACT, even though this demanded a much greater time commitment on their part (see also para. 3.19). Subsequently, the Confederation has provided dedicated Consultant psychiatrist input to the team, which the Panel welcomes.

CHAPTER 3

3. Case history

3.1 The information provided about Andrew Ackroyd's history is that determined by the Panel to be necessary to an understanding of this Report. Care has been taken not to provide more information than is strictly necessary.

3.2 Andrew was born in 1963 and moved to Essex with his family at seven years of age. His early life seems to have been happy and uneventful. His work at primary school was satisfactory. At secondary school his work deteriorated and Andrew believes this was due to memory problems. He occasionally truanted. His sisters said to the Panel that, from the age of about 13 years, his behaviour became increasingly difficult. They informed the Panel that they felt that he often had a menacing presence and that he occasionally hit his sisters for no apparent reason. They became frightened of him and tended to avoid him.

3.3 After leaving school, Andrew had various unskilled jobs which only lasted for a short time. He was unemployed for long periods.

3.4 It is unclear when he began to experience psychotic symptoms, but in one psychiatrist's report, from January 1987, it is recorded that Andrew stated that he had been 'paranoid' since schooldays but without knowing what was going on. It is recorded that in early 1985 he had begun to feel that people were interfering with his thoughts. He believed that his thoughts were being controlled from the outside and that thoughts were being put into his

head. He believed that he could read other people's thoughts and sometimes other people could read his. He also believed that cameras were observing his behaviour and he heard messages about himself on the radio concerning what he was going to do and felt that items in newspapers had a particular significance for him.

3.5 In a different psychiatrist's report from February 1987, it is recorded that he heard voices telling him to go to the Isle of Wight and that, in February 1986, Andrew had left home to live there. It is recorded that, whilst on the Isle of Wight, Andrew smoked cannabis about three times a week and his psychotic symptoms became worse. He believed that he had been hypnotised and had been through an occult ceremony. At the end of November 1986, he telephoned his father and asked him to take him home as he was convinced that he was going to be killed or would die of a brain tumour or a heart attack. His parents noticed that he appeared depressed and lethargic and was unable to sleep. He complained that he had "the mark of the devil on his lip." His parents took him to the GP who offered to get a psychiatric opinion but Andrew refused this.

3.6 Shortly after his return from the Isle of Wight, on 28 December 1986, Andrew Ackroyd committed his first offence. He stabbed a theology student who was trying to help him and who he already knew. Andrew thought that the student was practising black magic on him and that he was going to be killed. It is recorded that Andrew, therefore, felt justified in trying to kill the student. Andrew was prosecuted for attempted murder and was found not guilty by reason of insanity.

As a result he had imposed upon him the equivalent of a hospital order with restrictions under the Criminal Procedure (Insanity) Act 1964.

3.7 If these accounts are accurate, it is noteworthy that Andrew was experiencing clear psychiatric symptoms for two years before it became obvious to others that he was unwell. Also, although the GP correctly made a provisional diagnosis of schizophrenia, nothing Andrew said made him think that Andrew might have been dangerous and needed emergency treatment.

3.8 After the initial offence, Andrew was arrested and remanded to Brixton Prison. There he was diagnosed as suffering from Paranoid Schizophrenia and was treated with Clopixol Depot injections. There was a good response to this medication. By the time of his transfer to Ashworth Hospital in December 1987, Andrew was free from symptoms. In December 1987, it is recorded that his father visited and stated that "Andrew has not appeared as well as at present for 5 years."

3.9 At Ashworth Hospital, it was decided that Andrew should be taken off medication for observation.

3.10 In a written statement, in September 1988 made for a hearing before a Mental Health Review Tribunal, Andrew said, "I would question whether I still suffer from mental illness". However, in December 1988, changes in his behaviour were noted and he was described as "becoming more bizarre and withdrawn." By February 1989, he had become preoccupied with religion and in that month he stood up at a meeting and said he was Jesus. He also asked nursing staff if his interviews were being recorded.

3.11 In consequence, treatment with Clopixol was recommenced and the symptoms gradually disappeared. However, Andrew never accepted that he had had a relapse of his illness or that he needed medication.

3.12 Andrew responded well to medication. Thus, the process of moving him on from Ashworth was commenced and he was seen by Dr Shapero. Andrew Ackroyd was transferred under the care of Dr Shapero to the Regional Secure Unit at Leicester in February 1991. His rehabilitation there was uneventful and the only concern was his reluctance to take medication (as made clear during a multi-disciplinary team meeting in June 1991). He was eventually given a conditional discharge in September 1993 by a Mental Health Review Tribunal, with the support of Dr Shapero. However, Dr Shapero commented that Andrew "should never be made subject to a full discharge from a conditional discharge, as he will take the opportunity to stop taking medication." This comment was made in two letters from Dr Shapero to C3 Division in the Home Office in July 1991 and in September 1992. These were both formal reports to the Home Office and would have assisted it in formulating its reports for presentation to subsequent Tribunal hearings. Dr Shapero's opinion does not appear as a part of the record of the Tribunal hearing and does not appear otherwise in the notes of Andrew's case.

3.13 Following his conditional discharge, Andrew Ackroyd was discharged under the care of Dr Gwilym Hayes, then a Psychiatrist in Chesterfield, and to live in the Carr-Gomm hostel at Chesterfield. In August 1994, the care of Andrew Ackroyd was taken over by Dr Gayle Jackson who had replaced Dr. Hayes.

3.14 Andrew remained well, but began to complain of side-effects from the depot injection Piportil which he was then receiving. The dosage was first reduced, but, as he continued to complain, this medication was stopped in September 1995 and replaced by oral Sulpiride. He appeared to be symptom-free.

3.15 Andrew Ackroyd applied for an absolute discharge by a Mental Health Review Tribunal in 1996. It is important to record that neither Dr Jackson nor Dr. Hayes were aware of Dr. Shapero's strongly expressed opinion (see paragraph 3.12, above) that Andrew should never be granted an absolute discharge. Both Dr Jackson and Dr Hayes supported Andrew's absolute discharge. He was absolutely discharged by the Tribunal in October 1996. The reasons given make clear that the Tribunal accepted that Andrew was symptom free whilst on his medication and was entirely satisfied that he was completely trustworthy and that any fear that he might abandon his medication and suffer a relapse was entirely groundless.

3.16 However, subsequent to his absolute discharge by the Tribunal, matters took a turn for the worse. In August 1997, Andrew Ackroyd missed an outpatient appointment with Dr. Jackson. He began to move accommodation on a fairly frequent basis. In October 1997, Dr Jackson spoke to Mr Ackroyd by telephone and was informed that Andrew had lost weight and appeared physically unwell. Mr Ackroyd also said that Andrew had been angry with him and he had been concerned for both his and his wife's safety because of the intensity of Andrew's anger. It seems clear that Andrew had not been taking his medication, but when seen by Dr Jackson he denied this and denied experiencing psychotic symptoms. Dr Jackson has subsequently informed us that Andrew's statement that he was taking his

medication was double checked by her ringing up and discussing the matter with his G.P. who confirmed that Andrew was picking up his medication on time.

3.17 The situation then settled though Andrew continued to move around and missed a number of outpatient appointments.

3.18 In August 1998, Andrew admitted to Dr Jackson that he had some paranoid feelings and occasional auditory hallucinations. She advised him to increase the dose of Sulpiride, but he refused to do so on the grounds that this would cause side-effects. Dr Jackson has subsequently informed us that he was offered and agreed to change to Olanzapine, which he wished to defer until his next appointment with her. Until that appointment, Dr Jackson arranged for increased input from the CMHT. Andrew did not attend the appointment in September. With hindsight, it is unlikely that Andrew was taking medication on a regular basis. He then went missing for three months and went to live in Sheffield. While there he was involved in a fight in a pub but the cause of the fight is unclear.

3.19 Andrew returned to Chesterfield in November 1998. He was referred to the newly established assertive outreach service, called the Assertive Community Team (ACT). The Team consisted of three professional members (two CPNs and one occupational therapist) with provision for a fourth (a social worker). Psychiatrist support was provided by the existing consultants retaining their patients and continuing to work with them, in conjunction with the ACT.

3.20 Dr Jackson saw Andrew at her outpatient clinic on 11 November 1998, 1 December 1998 and at an ACT review on 4 December 1998. It was from the review on 4th December that the ACT commenced its work with Andrew. Dr. Jackson noted that he was experiencing auditory hallucinations and thought alienation. The family have reported to the Panel that Andrew was very unwell during the Christmas period. One sister returned to her own home early and his parents barricaded themselves into their bedroom at night. His father reported to the ACT that Andrew had been agitated, muttering and staring angrily and that his parents had been afraid that he would harm them. However, when seen by Dr Jackson, as an emergency, on 8 January 1999, Andrew was pleasant and appropriate in mood, with good eye contact and rapport. He denied delusions. Andrew refused admission to hospital but agreed to take an increase in his medication (Olanzapine) and to cooperate with the outreach team. Dr Jackson did not consider that there were sufficient grounds for detention under the Mental Health Act and thought that, if she had recommended compulsory admission, this would have alienated Andrew and the ASW would have refused to make the application.

3.21 Having read the psychiatric reports written in 1987, it seems likely to the Panel that Andrew's mental state in December 1998 was similar to his mental state shortly before the first offence. If this assumption is correct, it follows that there was a possibility of a serious violent incident any time after December 1998. On the basis of the evidence the Panel had before it, the clinical team (that is the ACT and Dr Jackson) does not appear to have considered this possibility. The last available Care Plan, dated 15 February 1999, makes no mention that compulsory treatment in hospital might become necessary.

3.22 During the next few months Andrew's mental state fluctuated, presumably depending on how much of his medication he was taking. At times, he described psychotic symptoms to Kay Willett, a member of the ACT with whom he met more frequently than with other team members. However, he then denied these symptoms when interviewed by Dr Jackson. Andrew moved about a great deal and, though, for example, a council flat was obtained for him, it was unfurnished and he had to sleep on the floor. In May 1999, he talked about people being able to read his thoughts.

3.23 Andrew was admitted to hospital at his own request on 15 June 1999 because he thought he had a tapeworm, which was keeping him awake at night. Investigations established, unsurprisingly, that he had no tapeworm. Concerns are recorded in his notes as to whether this was a delusional belief and whether it was evidence of a relapse in his illness. At the time, it was noted that he showed animosity towards his father and said that he was moving around the country to get away from his father. In spite of this, he took his own discharge on 23 June 1999, and went to live in his parents' caravan at their home in Hope.

3.24 On 28 June 1999, he was re-admitted to hospital at his own request having taken too many of his tablets in order to get to sleep. In hospital he said that people might be damaged by telepathy and the nursing staff noted that he seemed reluctant to eat the hospital food as though he thought it might be poisoned. He was discharged on 6 July 1999, and went to live at the Carr-Gomm Hostel. There was friction with other residents and he soon left. When visited by the ACT at his parents' house on 10 August 1999, Andrew remarked that his father might be poisoning him to get rid of him; but then turned it into a joke.

3.25 When seen by Kay Willett on 16 August 1999, Andrew talked about hearing the voice of a man in Chesterfield and said that the voice was giving him violent thoughts. He requested admission to hospital, and this was arranged. He also requested to go back onto a depot injection and he was given an injection of Piportil which was due to be repeated in one month. In hospital he was quiet and pleasant and his behaviour was appropriate. Thus, when he asked to leave the hospital at midnight, the nurse in charge saw no reason to detain him. He was visited by two members of the ACT the following day. These were Kay Willett, an occupational therapist, and Simon Smith, an Approved Social Worker. It was decided that they would not be joined by Dr Milner, Specialist Registrar to Dr Jackson, as it was known that Andrew did not like meeting with him. As Andrew seemed more settled and had had his medication by depot, they decided that he could not be detained under the Mental Health Act.

3.26 At this point, Andrew disappeared. The ACT did not know where he was living and he was not at his parent's home when they visited. He failed to keep his outpatient appointment with Dr Jackson in September 1999, and he did not return for his second Depot injection. The ACT made repeated attempts at this time to ascertain Andrew's whereabouts and to re-establish contact with him.

3.27 The notes indicate that Andrew had come to regard Kay Willett as a friend rather than as a health professional, which she raised as a matter of concern. He was, therefore, upset when she left. He was told on 10 August 1999 that she was leaving on 17 August 1999. This appears to have been the

reason for his avoidance of the ACT in September 1999, but, as a result, he was without support at a time when he was particularly vulnerable.

3.28 Andrew reappeared at the ACT base at St Mary's Gate on 18 October 1999. He requested medication. He refused to see a doctor and refused to give his address, but showed no psychotic symptoms and was pleasant and polite. The Team believed there were no grounds or means for detaining him. He was given a prescription for medication and an out-patient appointment for the following week.

3.29 Tragically, a few days later Andrew Ackroyd killed his father.

3.30 There seems no doubt that Andrew is suffering from paranoid schizophrenia and that, at the time of both offences, his mental state was severely disturbed.

3.31 It seems likely to the Panel that aspects of his personality contributed to the two violent attacks. His sisters have described to the Panel how from the age of 12-13 years his behaviour became difficult and odd. He was occasionally violent towards them for no reason and they found him frightening. His school work deteriorated and he did not conform. After school, he could not hold down a job and he became rather socially isolated. He frequently told convincing lies. Several psychiatrists have remarked that he shows emotional blunting. When the Inquiry Panel interviewed him, Andrew's expressions of regret at killing his father, though genuine, lacked any real emotional depth. This picture suggests that his personality may have been damaged by the onset of the schizophrenia process at an early age, possibly at 12 years of age. This appears to have led

to a failure on Andrew's part fully to appreciate the enormity of his actions in committing the two offences.

3.32 Andrew is different from many of the typical clients seen by the services with which he had contact as he is particularly articulate, socially aware, middle class and, despite his difficult schooling, intelligent. He appears to be able to mask many of the symptoms of his illness.

CHAPTER 4

4. Comment

4.1 The Inquiry Panel has striven to remind itself at all times that it has the benefit of hindsight in reviewing the care and treatment provided to Andrew Ackroyd. Events may appear more obviously causally related or connected with the benefit of hindsight than was possible to recognise at the time events were unfolding.

4.2 The primary focus for the Inquiry Panel has been on the care and treatment provided by Dr Jackson and the ACT.

4.3 The broad conclusion drawn by the Panel is that the standard of psychiatric care in Chesterfield is good with many health professionals striving hard to provide a high quality service. There appears to be good communication and cooperation between individuals in different disciplines.

4.4 Many factors contributed to this tragedy. Although there are areas of concern in the care of Andrew Ackroyd, the Panel considers that no individuals can be held responsible for his deteriorating mental health which led to his, Mr. Ackroyd's death.

4.5 The Panel notes that, in the proposals made by the Government for reform of the Mental Health Act 1983, certain aspects might have an impact on how cases such as that of Andrew Ackroyd are handled in the future. The proposals, contained in the White Paper, *Reforming The Mental Health Act*,[i] emphasise the importance to the care and treatment of service users of the care

programme approach. Care and treatment could be provided compulsorily in a number of venues, including the community. No treatment would be provided compulsorily in the community where the patient was actively resisting it. It is possible that this change in the law might have helped the ACT handle Andrew Ackroyd.

CHAPTER 5

5. Areas of concern in relation to the care and treatment of Andrew Ackroyd

5.1 *Contact with the family*

5.1.1 There is no evidence that any of the clinical teams at Ashworth, Leicester or Chesterfield ever tried to see all four members of the family (Mr. Ackroyd, Mrs Ackroyd and the two daughters - one older and one younger than Andrew). Evidence from the whole family would have provided valuable additional context to an assessment of Andrew, particularly potentially in terms of identifying deterioration in his health and in recognising his dangerousness. This is because the sisters had identified their own indicators for noting when Andrew was ill. He evidently became physically ill, he lost a huge amount of weight, his eyes became intensely insane and he smoked extremely heavily. The sisters also had a different view of Andrew from that presented by the professionals. The sisters said that they had felt an air of menace about him. He had occasionally hit them for no apparent reason.

5.1.2 However, there is little in Andrew's contacts with the Chesterfield team to indicate a rationale for being in contact with his sisters. They lived away from the area and it was clear that they had little contact with Andrew. Contact with the sisters would have been possible when Andrew was an in-patient. For example, while Andrew was in Leicester, a social work report of August 1991, commented that his sisters "visit him in hospital but have made it clear that they want little contact when he leaves hospital." If this observation had led to an interview with his sisters, it might have revealed features of Andrew's personality which might have made the health

professionals more cautious in their dealings with him. Had that contact been made and information gleaned, it might have been available to the Chesterfield team and it might have assisted in determining what care and treatment to provide Andrew.

5.1.3 Because of Mrs Ackroyd's poor physical health, communication by the professionals was mainly with Mr Ackroyd. Thus, it was only his views on Andrew that were received. There is evidence to the Panel that, from a mixture of parental love and feelings of responsibility for his son, Mr Ackroyd, at times, had difficulty engaging with services. The team could have engaged better with Mr Ackroyd and that might have produced more relevant information both about Andrew's past and present condition and behaviour. Whilst not a part of the Care Programme Approach at the time, a Carer's Assessment might now be called for in Andrew's case, though the team would have to assess whether Mr Ackroyd was indeed a carer. Such an assessment might have provided some of the additional information indicated in this and the preceding paragraph.

5.2 *Information*

5.2.1 When Andrew was transferred from Leicester to Chesterfield, only limited information was transferred with him. Although Dr Jackson later borrowed case files from Ashworth High Security Hospital, she seems to have remained unaware that, in the Regional Secure Unit at Leicester, Andrew expressed the belief that he was not suffering from a mental illness and therefore did not require medication. She was also unaware of Dr Shapero's strongly expressed opinion that Andrew should never be given an absolute discharge. In 1995, Andrew Ackroyd was able to persuade his consultant to

change his medication from a Depot injection to oral medication on the grounds that he was having side effects from the injection. Dr Jackson has given a logical explanation for this decision and the decision was a reasonable one. However, Andrew's continuation of his medication was then dependent on him having sufficient insight into the need for it. In view of the opinions expressed by him when he was in the RSU, it seems likely that he would eventually stop his tablets. Once he began to move around restlessly, it is probable that he became too disorganised to take his tablets regularly. Had full information from the RSU been available, it is possible that Dr Jackson and the other professionals working with Andrew at the time would not have so completely supported his application to the Mental Health Review Tribunal for absolute discharge.

5.2.2 After the Tribunal decision, Andrew's mental health steadily deteriorated. It is clear to the Panel that the absolute discharge allowed Andrew to become non-compliant with his medication and removed the ability of the health professionals to insist on his co-operation. The Panel considers that this case illustrates how vital it is to ensure that all relevant information and professional opinions are recorded and made available to the teams currently offering care to patients. The Panel recognises that it may have been an error not to have sought evidence from the Home Office, but the Panel was not intending to go back beyond the decision of the Tribunal to order absolute discharge, a decision that was clearly reasonable. In any case, the information to the Panel makes clear that the Home Office presented evidence to the Tribunal opposing Mr. Ackroyd's discharge on the basis of a deep concern that he would not continue to take his medication.

5.2.3 Of course, it is possible that the people working with him at the time might have continued to support Andrew's application for absolute discharge, but if more information had been available, it would then have been on the basis of a carefully considered rejection of views expressed earlier at Leicester. Because of the importance of the information in question, we **recommend** that, when a patient is being transferred from one unit to another (in this case from a regional secure unit to the community), all relevant clinical notes, reports and documents are transferred with the patient to the new team in charge of the patient's care and treatment.

5.2.4 The preceding paragraph emphasises the importance of the accurate handing on and assessment of relevant information. The Panel wishes to underline the importance of the critical combination of three factors in Andrew Ackroyd's case. These are: the absence of some relevant information from the notes and files; the decision, by the Mental Health Review Tribunal, to grant an absolute discharge; and the decision to change Andrew's medication from a depot injection to oral medication. These two decisions were made with careful consideration of the facts available at the time. They were reasonable decisions. With hindsight, it can be seen that these three factors meant that Andrew was in control of his medication and so was in control of the progress of his illness even if he denied that he was ill. It is in desiring to avoid a repetition of such a case, and so to facilitate learning from this incident, that the recommendations in this Report are made.

5.3 *Forensic services*

5.3.1 After his transfer to Chesterfield, there was no further involvement with the Forensic Services. The Panel was informed that advice from a Forensic

Psychiatrist, if requested, would have been difficult to obtain. Within a year of transfer he was put under the care of a newly appointed General Psychiatrist who had no experience of Forensic Psychiatry and who had a heavy workload. It is clear, from this case, that how a forensic psychiatrist and other professionals with forensic training approach a case is often different from that of professionals with general psychiatry training and experience. In particular, forensic training and experience will result in considerable emphasis being placed upon the initial offence as a predictor for future behaviour. In the circumstances, it is hardly surprising that this emphasis was not apparent to the professionals working with Andrew Ackroyd in Chesterfield. For example, Andrew was clearly psychotic in December 1998. He had been out of touch with the services for at least three months and it is unlikely that he had been taking any medication during this time. Over the following months he continued to show psychotic symptoms. The lack of experience of forensic psychiatry within the team and the absence of any forensic advice or support, led the team seriously to under-estimate the dangers posed by Andrew's mental state. Further, it is the view, therefore, of the Panel that, had a Forensic Psychiatrist been involved in some way in Andrew's care, it is unlikely that he would have gained an absolute discharge in 1996, Dr Jackson would almost certainly have sought the advice of a forensic psychiatrist in late 1998 when she was very concerned about Andrew and the outcome might have been different.

5.3.2 In view of the particular difficulties presented by patients with a forensic history, **we recommend** that North Derbyshire Health Authority in collaboration with the Confederation (whereby Social Services and Health work together) review the forensic psychiatry needs in North Derbyshire. This might be achieved by having a community forensic psychiatry team.

Further, **we recommend** that it is essential for an assertive outreach team or any team working in the community to have forensic experience amongst its members in view of the number of patients with a forensic history that will be its clients. But this is not intended to mean that such teams must become community forensic teams. Rather such community teams must be able to identify the different issues that arise in relation to patients who have been through the criminal justice system and, therefore, how they care and treat these patients in the community, whilst also having the ability to seek specialist advice when appropriate. **We also recommend** that, in order to maintain sufficient currency of forensic skills and to validate approaches in relation to clients with a forensic history, clinical supervision sessions should be provided to the assertive outreach team and other community teams. Such supervision may be provided by a Forensic Psychiatrist, but can also come from other forensic professionals. **We also recommend** that Health Authorities, together with forensic psychiatry services, should ensure that all general adult psychiatry services have ready access to advice and support, in particular from a named consultant in forensic psychiatry. This advice should be available both for in-patients and for patients in the community. It is only by considering these recommendations that forensic support for local services can be provided on an effective, easily accessible and easily deliverable basis. Further, **we recommend** that the Royal College of Psychiatrists should be asked to consider making it mandatory for psychiatrists applying to join the Specialist Register for General Psychiatry to have received training in forensic psychiatry either at Senior House Officer level or at Specialist Registrar level.

5.4 *Accommodation*

5.4.1 After leaving the Carr-Gomm flat in 1997, Andrew Ackroyd had at least 16 changes of accommodation. This is highly relevant information as it may speak to his mental state. An assertive outreach team has the capacity to assess the importance of such information. It can achieve this through its relatively small caseload (but of particularly challenging clients) and the team approach allowing a more careful and considered assessment of any relevant evidence and information. It is essential that outreach services have the ability to amass, synthesise and evaluate considerable amounts of information from many different sources. It is this that enables them to deliver an improved service in handling difficult to engage service users.

5.4.2 The shortage of supported accommodation in Chesterfield made it impossible for the team to do anything about Andrew's frequent changes of accommodation. **We recommend** that there be a review of what accommodation for service users, particularly supported accommodation, can be made available in the Chesterfield area, taking fully into account assessed needs. The Panel was concerned that it appeared that the only supported accommodation available was the Carr-Gomm Hostel, thus providing no flexibility in provision. When staff succeeded in obtaining a council flat for him, Andrew had no money for furniture and the team was unable to provide any. As a result, Andrew had little choice but to return to live with his parents even though it was clearly documented that there was considerable friction with his parents at times.

5.5 *Assertive Community Team*

5.5.1 The Assertive Community Team was newly established and was therefore inexperienced in Assertive Outreach work. We have raised some concerns about the planning process in relation to the establishment of this, and of other new and different services (see para. 2.2, above).

5.5.2 It is the Panel's opinion that the small Team struggled to take fully on board the implications of the whole team approach that is demanded by assertive outreach. It did have shared discussions about clients and it did make use of individual's expertise (for example the forensic experience of one member). But, despite there being more than one worker involved in his case, Andrew Ackroyd encouraged and developed a one-to-one relationship with one Team member. This, it seems to the Panel, resulted in Andrew having a strong attachment to, even attraction for, her. This is contrary to the rationale for a whole team approach.

5.5.3 However, not only was the team inexperienced in assertive outreach work, but also it lacked a Team leader and, therefore, there was no-one to take an overall view of cases or the work of the team. This may have been the reason why the possibility of Andrew developing a transference for the Team member was not recognised and why there was not more effective planning for his care when she left the team. Contrary to this view, it has subsequently been stated to the Panel that the issue of transference was recognised and that attempts were made to involve other team members in Andrew's care.

5.5.4 Andrew Ackroyd was clearly a very difficult person to engage. However, there appear to be indications that the ACT was not properly equipped,

through training and support, to develop a proper understanding of their task so as to be able to move on to the next stage. The next stage involves identifying what is to be the work of the team once the service user is engaged. In doing so, there must be a consideration as to how the full range of skills and expertise within the team can be used to the benefit of the service user. Further, it is necessary for such a team to determine how it is to keep hold of its service users. This last question needed an answer when Andrew turned up at the ACT base after a two month absence, when he had been without medication (to the team's knowledge) since the depot injection at his last hospital admission. The creative work of an assertive outreach team is partly to think on its feet and use all the means at its disposal to find and keep its service users. Clearly, part of the answer is better risk assessment and contingency planning (see para. 5.6.2 below), but also there is a clear need for proper induction and initial training and for on-going training and clinical supervision (see para 5.10.1 below and para 2.2 above).

5.6 *Care Programme Approach*

5.6.1 Administratively, the Care Programme Approach process appears to be sound. The range of documentation includes adequate systems for risk assessment, care planning, user involvement, care plan reviews and contingency planning. However, at a grassroots level, the documentation did not appear to be fully utilised in Andrew Ackroyd's case. The essence of the CPA process is that it assists the individual in identifying their full range of needs and describes a course of action to meet those needs. These plans need to be reviewed with the team, the patients and, where appropriate, her/his family on a regular basis.

5.6.2 There is little evidence in the case notes of Andrew Ackroyd that the care planning approach was central to his care. This is highlighted by the fact that there were few care plans and only one CPA risk assessment (dated 24th December 1998 shortly after he was accepted as a client for the ACT) available in the casenotes. There were no contingency plans in his notes. A contingency plan should be written or, in exceptional circumstances, it can be oral. It should contain information on early warning signs of relapse, a treatment plan and a crisis plan. The existence of a contingency plan would have meant that there would have been an understanding amongst all staff as to what level Andrew could be allowed to deteriorate and what course of action there would be were he to reach that level. Such a plan and a regularly up-dated risk assessment are essential tools particularly when a team is working with difficult service users such as Andrew Ackroyd. In the absence of a contingency plan, each member of staff had to make their own decisions as situations arose. A contingency plan would have given clear direction to staff as to the action to take should Andrew have expressed his intention to discharge himself and the subsequent action to be taken following discharge.

5.6.3 Information available to the Panel made it clear that hospital staff were involved fully in the process of discharge planning, but rarely, if ever, did they receive a patient into their care with CPA documentation. Members of the ACT involved in admitting Andrew, particularly Ms. Willett, did give verbal accounts of the circumstances leading to admission, which were recorded in the notes. Despite training on CPA and from the ACT, the ward staff were unaware of Andrew's CPA records or his plan of care in the community during his numerous short-term admissions. This was particularly

telling at the time of Andrew's third admission to hospital on 16th August 1999. At paragraph 3.25, we state the reasons recorded in the notes for this informal admission. After admission, Andrew did receive his medication, by way of a depot injection of Piportil. He then sought to discharge himself at midnight.

5.6.4 The Panel is clear that there can be no criticism of the decision of the nurse on duty not to exercise her power, under section 5(4) of the Mental Health Act 1983, to detain Andrew for up to six hours or until Andrew's responsible medical officer or nominated deputy came to decide whether Andrew should be detained under the Act or not. If there had been full and appropriate CPA documentation on the ward, it is possible that any contingency plan contained therein would have enabled the nurse, in the light of the reasons for admission that afternoon, to have felt confident in the exercise of her powers to have prevented Andrew from leaving the hospital. It is also important to state that the fact that Andrew was not prevented from leaving hospital was not causative of the tragedy both because it was Andrew that killed his father and because the following morning the ACT members who visited him at his parent's home decided that it was not proper to detain him under the Mental Health Act 1983.

5.6.5 Multidisciplinary reviews were held and were recorded in the in-patient records and in the community records, but were not recorded on the formal review sheet in the CPA documentation.

5.6.6 The Panel understands that Andrew was considered for the supervision register and rejected, though he clearly satisfied the criteria.

5.6.7 Although Andrew spent some time living with his parents or in a caravan in his parents' garden, there is no evidence of a carer's needs being assessed. In short, the system that is promoted by the Trust and the Confederation did not seem to be in place or working for Andrew.

5.6.8 Therefore, **we recommend** that all staff should be conversant with the use of the Care Programme Approach. Training in its use and application should be available to all staff in both hospital and community settings. **We also recommend** that, for patients subject to the enhanced level of CPA, reviews should be documented in the patient's notes and counter signed by the patient's responsible medical officer or consultant. Where a care plan is rolled over, written confirmation should be placed within the patient's record. **We also recommend** that, with regard to enhanced CPA, the documentation should be forwarded to the hospital ward on admission of a patient (subject to CPA) to hospital. **We also recommend** that, with regard to enhanced CPA, the documentation should include a contingency plan that deals with what should occur if the care plan is not followed and/or where the condition of the patient deteriorates. **We also recommend** that, with regard to enhanced CPA, the documentation in itself is not likely to be sufficient where the patient is on the case list of an assertive outreach team. What is additionally required is a comprehensive care plan that addresses the hopes, plans and needs of the whole person (see Appendix A). **We also recommend** that, with regard to enhanced CPA, the carer's assessments should be available to all carers of patients subject to CPA. **We also recommend** that the Confederation review its processes for enabling staff to make sound, up-to-date risk assessments. One part of achieving this will be by accessing the expertise of the forensic services both in terms of process and in terms of training and clinical supervision (see also para. 5.3).

5.6.9 There is an important question about the adequacy of the CPA documentation in detailing and following the care of an Assertive Outreach service user. CPA Form A, the Assessment Summary, does give sub headings, particularly under "current circumstances". Had this been completed, it would have created a good, holistic profile of Andrew Ackroyd. However, there is no record of this form having been completed for him. The level of detail indicated by this part of the CPA documentation (or indeed using another form devised for assertive outreach) is essential and possible for Assertive Outreach service users who have very complex needs and will remain users of the service for a very long time. The detail of this or a similar form requires regular reviewing if the team is to continue to think and plan their work in a complex and sophisticated way. A very small team caseload at the time gave the opportunity for this thinking, writing and planning. **We recommend** that the assertive outreach team reviews the documentation that they are using and decide whether to continue to use the CPA documentation or devise their own to provide the necessary level of information, etc. **We also recommend** that the assertive outreach teams comply with the normal review and other requirements of CPA.

5.7 *ASW/Psychiatrist Interaction*

The Panel received some contradictory evidence as to the ASW service in Chesterfield. Dr Jackson reported that there was a serious shortage of Approved Social Workers in Chesterfield and that several of the ASWs on the rota do not work in mental health services. Therefore, she said, they have to make their assessments under the Mental Health Act based on a single interview. It was her opinion that, for patients who are able to mask their symptoms such as Andrew, the ASW would be unwilling to make an

application under the Act. Dr Jackson indicated that there had been times when she had been sufficiently concerned about Andrew's mental health to make a recommendation for his detention under the Act, but did not do so because she believed that the ASW would refuse to make the application. Social Services staff reported that there was no shortage of Approved Social Workers in Chesterfield. They were surprised to hear that some psychiatrists reported working difficulties with approved social workers as they expected that such difficulties would have come to their attention through one of a variety of routes. **We recommend** that the Confederation review the interaction between its psychiatrists and the approved social workers.

5.8 ***Policies and Procedures***

5.8.1 On talking to a range of staff, it appeared to the Panel that team members felt clear and confident in the roles they undertook, but they seemed to be disadvantaged by the level of information and guidance available to them. **We recommend** that the assertive outreach services review what policies and procedures they have and develop and add to them in accordance with current guidance and best practice.

5.8.2 Within a hospital setting, nurses were left without procedural guidance in many areas, including the procedure on dealing with patients wishing to take their own discharge. A policy on the use of the nurses holding power under section 5(4) was not available on the wards. Therefore, **we recommend** that nursing policy manuals (to include, for example, policies on observation, patients taking their own discharge, patients absent without leave, patient property, admissions procedures, discharge planning, risk management, untoward incidents, accident reporting, illicit substances, alcohol, child visiting, vulnerable patients, and harassment) should be

available on each ward, department and community team and updated on an annual basis. **We also recommend** that Mental Health Act policies (including a policy on the use of section 5(4)) should be available on each ward, department and community team and updated on an annual basis.

5.9 *Nursing Issues*

When we were taking evidence, we identified, within both a hospital and community setting, no clear policy statements on the models or availability of clinical supervision. The majority of staff said that they did not have access to regular clinical supervision. Staff within the in-patient unit stated that clinical supervision had not been available for many years. All nurses, however, stated that they received regular support and guidance from their respective ward managers. Staffing at night-time within the hospital was an issue. Regularly only three staff per ward were available and often these staff would be very junior. Whilst this is not unusual, across many in-patient units across the country, it was noted that the whole hospital often depended upon very junior grades of staff. The most senior nurse at night-time would be an E grade nurse and these staff could at times be only recently qualified. Individual performance review was not in place and consequently individual training needs were often not identified. **We recommend** that a clear structure for clinical supervision should be developed for all nurses in both a hospital and a community setting. **We also recommend** that a system of individual performance review is put in place for all nursing staff. However, we have subsequently been informed that clear polices for Clinical Supervision and Individual Performance Review did exist.

5.10 *Training*

5.10.1 Upon formation of the Assertive Community Treatment team a formal training plan was not devised. Staff were moved from traditional community roles without adequate preparation to meet the challenges they would face in this new style of working. Training should be a continuum commencing with the induction process. Assertive outreach workers making the transition to a new way of working require considerable, comprehensive and on-going training if they are to deliver a good service. In the creation of such services, **we so recommend.** In addition, staff in such a service require regular individual and group clinical supervision in order to explore the therapeutic task and to develop an understanding of, and relationship with, service users. Through clinical supervision, the team also develops an understanding of how to work as a whole team, so thereby applying the whole team approach essential to assertive outreach. **We recommend** that assertive outreach services be provided with the necessary clinical supervision as a team to consider such problems as the engagement of clients who are resisting services and the use of compulsory treatment where there is a risk of alienating the client. **We recommend** that on-going training needs of the assertive outreach services be identified, and that an appropriate programme be planned and delivered.

5.10.2 Within the in-patient unit there was little evidence of any training activity. Of the nurses consulted, none had been offered basic Mental Health Act training. In addition there had not been training for using the nurses holding power under section 5(4) of the Mental Health Act. It was noted that none of the nurses spoken to had received recent training or guidance in the use of this power and felt uncomfortable about using their discretion in applying this section. **We recommend** a Confederation-wide review of the

commitment to, provision of and take-up of training. **We also recommend** that a formal training plan is developed for all staff preparing to move to work in a new style of service. **We also recommend** that Mental Health Act training be made available to all staff. **We also recommend** that a regular programme of Mental Health Act update training be established. **We also recommend** that specific training be provided to qualified nurses working within an inpatient setting on the use of section 5(4).

5.11 ***Leadership***

5.11.1 The lack of clarity around leadership appeared to be a common feature in those teams dealing with Andrew Ackroyd. The newly appointed ACT team originally ran as a component of the CMHT and lacked direction and the intensive support it deserved. Had a team leader not already have been appointed, we would have so recommended.

APPENDIX A

Appendix: Assertive Outreach Services

1. This appendix gives a brief outline of the components and the development of assertive outreach services. These services are also known as assertive community treatment services. The differences between them are both minor and in debate and are not necessary to define for the purposes of this Report.

2. Assertive outreach services form an essential part of modern community mental health services. The model lends itself to being as strong and predictable as the bricks and mortar of the hospital used to be. In other words, it can contain and be reliable both for users and for the workers who deliver the care and treatment.

3. Assertive community treatment originated in the Mendota Mental Health Institute, Madison, Wisconsin in the early 1970's. Dr Leonard Stein and Dr Mary Ann Test were its instigators. Through ACT, they and others successfully enabled many of their most profoundly mentally ill patients to achieve improved stability and quality of life in the community.

4. ACT was adopted and adapted throughout the USA and in other parts of the world. During the 1990's assertive outreach and ACT services were developed in the UK, most notably the North Birmingham Trust teams which were developed in the mid 1990's as part of a staged approach to reducing hospital use through the development of services in the community.

5. The white paper *Modernising Mental Health Services: Safe, Sound and Supportive*[ii] was published in 1998 and noted assertive outreach as an important model to meet future needs.

6. Also in 1998 the Sainsbury Centre for Mental Health published *Keys to Engagement - Review of care for people with severe mental illness who are hard to engage with services*[iii]. This became an essential reference for anyone developing assertive outreach services. In 2001, the Department of Health[iv] has published an implementation guide to support the delivery of adult mental health policy in local areas. This gives details about assertive outreach and other community services which all mental health service providers are expected to develop according to the National Service Framework 1999[v] and the National Plan 2000[vi].

7. The core components of assertive outreach

- A self-contained team responsible for providing the full range of interventions
- A single RMO (responsible medical officer) who is an active member of the team
- Treatment provided on a long-term basis with an emphasis on continuity of care
- Majority of services delivered in the community
- Emphasis on maintaining contact with service users and building relationships
- Care co-ordination provided by the assertive outreach team
- Small caseload - no more than 1:12 ratio

8. These core components are taken from the Department of Health guidelines which are based on a range of evidence, in particular the work of Teague et al who, in April 1998, published the Programme Criteria for Fidelity to ACT otherwise known as the Dartmouth ACT Scale.[vii] Teague et al based this on the work of Stein & Test[viii] and also the work of McGrew & Bond and Santos and others.

9. Assertive outreach services are tailored to, and work well for, men and women who are resistant to using traditional statutory services; may move from place to place; have frequent psychiatric hospital admissions and experience themselves as socially isolated and excluded. They often have other associated problems such as homelessness, drug or alcohol dependency and may be vulnerable to self-harm or self-neglect. Many will have experience of the Criminal Justice System and are known to forensic services.

10. Therefore, there is the need for assertive outreach teams to be able to develop expertise in working with this defined group using the following and other interventions

- Engagement
- Regular & reliable service
- Psychosocial interventions
- Therapeutic techniques eg. CBT & counselling
- Practical and hands on work
- Promoting use of social care - benefits, housing etc.
- Promoting access to education and employment

11. In other words assertive outreach teams care for the whole person, recognise and work with strengths as well as problems, and go to great lengths to keep in touch with the user. The user has access to the expertise of the whole team through the rotating of visits between workers, and the team thinking together about their users and their users needs and mental health, that is, a Team Approach.

12. This is a complex matter, and the development of trust and relationship with the user needs to be considered together with the possible use of the law when the client is not able to take responsibility for themselves and the safety of self or others is at risk. This containment by the team of the user requires good leadership and good team collaboration.

13. In conclusion, it may be said that within each local area there is a small number of people who require assertive outreach services. The intensity of care and support can achieve

- Improved engagement
- Reduction of hospital admissions and lengths of stay
- Increased stability in the lives of users and their carers
- Improved social functioning
- Cost effectiveness.

APPENDIX B

NORTH DERBYSHIRE HEALTH AUTHORITY
DERBYSHIRE COUNTY COUNCIL

Independent Inquiry in accordance with HSG (94) 27 into the Care and Treatment of Andrew G Ackroyd

Remit for Inquiry

1. To examine the care and treatment of Andrew G Ackroyd at the time of the incident leading to the death of his father Mr George Ackroyd in or around October 1999. In particular:

   a. the suitability of his care in view of the patient's

      (i) history
      (ii) assessed health and social care needs
      (iii) assessed risk of potential harm to himself and others.

      Taking account of any relevant drug and alcohol abuse and the number and nature of any previous court convictions as may be relevant to the Inquiry,

   b. to examine the extent to which Mr Ackroyd's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC(90)23, LASSL(90)11, Supervision Registers HSG(94)5 and Discharge Guidance HSG(94)27 and local operational policies,

   c. the adequacy of the care plan and its monitoring by the key worker,

   d. the exercise of professional judgement.

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

   a. the agencies involved in the care of Mr Ackroyd or in the provision of services to him and

   b. the statutory agencies and Mr Ackroyd's family, taking particular cognisance of the need for sensitivity in regard to any dealings with his family.

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

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

5. To prepare a report with recommendations to North Derbyshire Health Authority and Derbyshire County Council including identification of good practice within the existing services.

APPENDIX C

NORTH DERBYSHIRE HEALTH AUTHORITY
DERBYSHIRE COUNTY COUNCIL

PROCEDURE FOR INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF ANDREW G ACKROYD

1. All sittings of the Inquiry will be held in private. The press and other media will not be allowed to attend.

2. Every witness of fact will receive a letter in advance of appearing to give evidence informing them:
   (i) Of the terms of reference and the procedure adopted by the Inquiry;
   (ii) Of the areas and matters to be covered by them;
   (iii) Requesting them to provide a written statement to form the basis of their evidence to the Inquiry;
   (iv) That when they give oral evidence they may raise any matter they wish which they feel may be relevant to the Inquiry;
   (v) That they may bring with them a friend, relative, member of a defence organisation, member of a trade union, solicitor or anyone else they wish to accompany them with the exception of another witness to the Inquiry;
   (vi) That it is the witness who will be asked questions and who will be expected to answer.
   (vii) That their evidence will be recorded and a copy sent to them afterwards for them to sign as an accurate record.

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

4. Representations written or oral may be invited form relevant professional bodies, agencies and other interested parties who may have a contribution to the matter under consideration by the Inquiry.

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

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

7. The findings and any recommendations of the Inquiry will be presented in a report to and made public by North Derbyshire Health Authority and Derbyshire County Council.

APPENDIX D

INTERVIEWEES

Mr A Ackroyd	Perpetrator of the homicide
Mrs G Ackroyd	Andrew Ackroyd's mother
Ms S Ackroyd	Andrew Ackroyd's sister
Ms E Ackroyd	Andrew Ackroyd's sister
Mr C Allsopp	Community Psychiatric Nurse
Mr T Armitage	Community Psychiatric Nurse
Mr A Bevan	Manager Hartington Wing CNDRH
Dr M Cork	CHCS Chief Executive (until September 2001)
Ms D Elliott	RMN Hartington Wing CNDRH
Dr Geelan	Consultant Forensic Psychiatrist (Arnold Lodge)
Ms M Hague	Community Psychiatric Nurse - ACT
Dr G Hayes	Consultant Psychiatrist (Wathwood Hospital)
Ms J Holt	RMN Hartington Wing CNDRH
Dr G Jackson	Consultant Psychiatrist
Dr G Mayers	SHO Hartington Wing CNDRH (until August 1994)
Dr E Milner	Consultant Psychiatrist
Ms S Mitchell	Confederation of Mental Health Director (until June 2001)
Mr G Oxley	Community Mental Health Team Manager - Chesterfield
Dr P Rowlands	Consultant Psychiatrist
Ms W Slater	CPA Co-ordinator
Mr S Smith	Social Worker
Ms A Sweeney	Community Psychiatric Nurse
Dr J Sykes	CHCS Medical Director
Mr M Taylor	CHCS Chief Executive at the time of the incident (until December 1999)

APPENDIX D

Ms K Willett	Occupational Therapist/Former AOT member (until August 1999)
Dr N Zaki	Consultant Psychiatrist (Rampton Secure Unit)
Dr N Zurman	Consultant Psychiatrist and Clinical Director

GLOSSARY OF TERMS

ACT	Assertive Community Team
ASW	Approved Social Worker
CHCS	Community Health Care Services
CMHT	Community Mental Health Team
CNDRH	Chesterfield and North Derbyshire Royal Hospital
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
RMN	Registered Mental Health Nurse
RSU	Regional Secure Unit
SHO	Senior House Officer

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