CONFIDENTIAL

Sunderland Health Authority

Report of the Independent Inquiry into the management of

Andrew John Douglas

November 1999

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1 PANEL MEMBERSHIP

Chairman	Mr Neil Robinson MBE, JP former Health Service Chief Executive Mental Health Act Commissioner
Member	Mr Bill Morgan University Lecturer Mental Health Act Commissioner
Member	Dr Angela Walsh Consultant Psychiatrist Northumberland Mental Health NHS Trust

2 APPOINTMENT AND TERMS OF REFERENCE

The Independent Inquiry was set up under the statutory provision of the Department of Health's, Health Service Guidance note HSG(1994)27 (Section 34 – Guidance on the discharge of mentally disordered people and their continuing care in the community).

It confirms that where the offender is known to the mental health services, and in the case of homicide, "it will always be necessary to hold an Inquiry which is independent of the providers involved".

The terms of reference for this Inquiry are as follows:-

- To examine the arrangements made for the care and treatment of Andrew Douglas, in particular his follow-up by statutory agencies and his discharge from care.
- To examine the suitability of that care in view of his history and assessed social and health care needs.
- To consider the exercise of professional judgement.
- To consider the extent to which his care has corresponded to statutory obligations and local operational policies.
- To consider the adequacy of the care plan and its monitoring by the key worker.
- To examine whether appropriate conclusions were drawn from the internal investigation.
- To prepare a report with recommended actions and their timescales and recommendations for review for Sunderland Health Authority.

3 BACKGROUND TO THE INDEPENDENT INQUIRY

In December 1998 Andrew John Douglas (born 6 July 1973) was found guilty of the murder of Wearside publican Mr James Byrne of the Bridge Hotel in High Street West, Sunderland. Mr Douglas was known to the mental health services in

Sunderland at the time of the murder and, as such, had identifiable links to the National Health Service.

Mr Douglas was arrested by Police on the afternoon of Friday 20 March 1998, the murder having taken place on the 19 March 1998. Mr Douglas is currently detained in HMP Durham following his conviction for murder.

4 MODUS OPERANDI

The Independent Inquiry Panel met on several occasions during August 1999 in order to interview persons who had been most closely involved with Mr Douglas in respect of his involvement with health and social services during the 1990s.

A list of primary witnesses was compiled and these persons were specifically invited to meet the panel in order to give evidence. A list of such witnesses is given in Appendix I.

Interviews were conducted in private and evidence was recorded as an aide memoire to the Panel in compiling this report.

Persons who had not been specifically invited to address the Panel were also encouraged to contribute to the panel's accumulation of knowledge via contact with invitees, although no additional persons came forward.

The Panel is grateful to the witnesses for the time and care they gave in presenting their evidence and was mindful of the potentially stressful nature of the procedure.

The Panel considered a number of specific documents, a selected list of which is given in Appendix II.

Grateful thanks are due to Mr Bill Hackett and Mrs Julie Danby from Sunderland Health Authority who facilitated the Inquiry and provided secretarial support.

5 THE INTERNAL INVESTIGATION CONDUCTED BY PRIORITY HEALTHCARE WEARSIDE NHS TRUST

The incident was originally reported on 23 March 1998 as an 'Untoward Incident' by the Acting Chief Executive of Priority Healthcare Wearside NHS Trust to the NHS Executive (Northern and Yorkshire), in accordance with agreed protocol.

Sunderland Health Authority (the statutory 'commissioning body') was notified at the same time.

An Internal Investigation of the Untoward Incident was conducted by the NHS Trust and a report was published in May 1998. The report was submitted to the NHS Executive (Northern and Yorkshire) on 18 June 1998.

It was commendable that the Trust acted promptly in dealing with this 'untoward incident' and in the establishment of the internal investigation.

The Panel, whilst recognising that some documents were not available at the Internal Investigation, in particular the forensic reports, consider that the Internal Investigation did not address some important issues, namely:-

- despite comments made by witnesses that Mr Douglas expressed no violent feelings towards others, the documentary evidence compiled by the Panel indicates otherwise;
- neither a formal nor informal risk assessment of the danger posed to others was undertaken;
- the Internal Investigation appeared to accept at face value some statements made by witnesses which were not always supported by reference to the case notes and other documents;
- the issues around the discharge of Mr Douglas within the Care Programme Approach.

6 FINDINGS

Discharge Arrangements

a) Mr Douglas was discharged from care on the basis of simple failure to attend which appeared to be rather hasty. The Panel feels that further enquiries should have been made to establish the reasons for his non-attendance.

b) The designation of 'minimal' Care Programme Approach was not apparently made until the point of discharge from care.

c) The low risk designation of Mr Douglas' Care Programme Approach level (minimal) may have prevented a more robust discharge assessment being undertaken.

Care Programme Approach

d) The Panel would have expected a more detailed care plan for Mr Douglas and a more integrated team approach involving medical, nursing and social services staff within the Care Programme Approach guidance.

e) Although, on a number of occasions, Social Services staff were involved by arranging specific assistance for Mr Douglas, the case would have benefited by their greater involvement in that Social Services would have had a greater understanding of Mr Douglas's problems.

Risk Assessment

f) The case notes demonstrated in November 1995 and January 1996 that Mr Douglas had expressed thoughts of killing others. The Panel found no evidence that appropriate assessment of this risk had been undertaken, either formally or informally.

g) The Panel found no integrated risk assessment procedure/protocol, which involved both medical and nursing staff, in place during the period of his care and this still pertains.

General Issues

h) Mr Douglas had an alcohol problem and this does not appear to have been addressed and he was not offered any specialist help for this problem although a specialist team existed at the time. The Panel found from examination of his case notes that most of his threats of violence to himself and others occurred while intoxicated with alcohol and it was recorded that the index offence was committed under the influence of alcohol.

i) Several documents inspected by the Panel were undated, in particular the CPA policy, and they did not show an implementation date or review date. This led to difficulties in establishing when documents were implemented and revised, and whether or not they were in place at the relevant time.

j) Although all of the persons interviewed by the Panel were surprised that Mr Douglas had committed the murder, he had expressed violent feelings towards others several times and these were recorded in the case notes.

k) The Panel was impressed by good professional relationships which were developed between Mr Douglas and the nursing staff, especially with his CPN and staff at the Grange Park Clinic. It was also commendable that the nursing notes were full and legible.

7 CONCLUSION

The Panel has criticised certain aspects of Mr. Douglas's assessment and care and the lack of formal procedures present. However, the impulsive nature of the offence, whilst intoxicated with alcohol, would have been difficult to prevent.

It is therefore the Panel's view that the identified deficiencies in the service provision are unlikely to have had a significant effect on the outcome in this case.

8 RECOMMENDATIONS

The Panel recommends:

- **Care Programme Approach**

  The introduction of a formal Care Programme Approach system which integrates the statutory care management system operated by the Social Services Department.

- **Risk Assessment**

  The introduction of a formal protocol for assessing risk management for those who have threatened violence, including a multi-professional approach to its development and application.

- **Drug/Alcohol Abuse**

  A specialised service for those clients displaying substance misuse is already in existence at the Trust and consideration should be given to the referral of all clients with Mental Health problems associated with alcohol abuse.

These three recommendations to be introduced as soon as possible and certainly within a short timescale of 3-6 months.

- **Documentation**

  Specific attention should be given by all health and social service professionals to the dating of documents and to their implementation and revision dates.

  This recommendation to be implemented immediately.

Neil Robinson | Bill Morgan | Dr Angela Walsh