Wakefield NHS
Health Authority

COMPLEX NEEDS

Report of an Independent Inquiry into the care and treatment of Daniel Williams for Wakefield Health Authority

June 2001

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ANONYMITY

Apart from naming Daniel Williams and the deceased, Adrian Pawson, the report has been kept anonymous. The consultant psychiatrist who was Daniel Williams' responsible medical officer is referred to as "the Consultant".

ACKNOWLEDGEMENTS

Giving evidence to an Inquiry can be stressful for those concerned. We wish to place on record our appreciation of the frankness and co-operation of all those who provided evidence, both written and oral. We are particularly grateful to the relatives of Adrian Pawson and Daniel Williams who came to talk to us – we know how difficult this was for them.

A list of those who contributed, together with people who gave evidence, can be found on pages 64 and 65.

We would also like to thank all those at Wakefield Health Authority who gave us assistance.

We take this opportunity to put on record our debt to Jane Crosby who organised the Inquiry with commendable efficiency and made a valued contribution.

MEMBERSHIP OF THE PANEL

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PREFACE

This report was commissioned by Wakefield Health Authority into the circumstances surrounding the care and treatment of Daniel Williams by the Wakefield and Pontefract Community Health NHS Trust. The Inquiry's terms of reference are set out in Appendix 1.

Daniel Williams was also receiving services from the Housing and Social Care Department of the Local Authority. His care was coordinated by a Social Worker and he lived in Warren Court, a Social Services-run hostel.

We have approached our task throughout with the aim of being constructive as we appreciate it is easy to be wise after the event. Since the killing we know that the Trust and the Social Services have embarked on a programme to redress some of the issues which have arisen from this tragedy.

Two features stand out.

The first is that Daniel Williams was admitted to hospital not because of clinical reasons, but because he was to become homeless. Our view is that he was in fact suffering from a mental illness which was not adequately assessed. Warren Court could no longer cope with his behaviour due to his drug use and his mental state. This raised questions in respect of inter-agency working. There was no alternative residential accommodation suitable for him which had the level of support required to cope with the challenges he presented. As a result Daniel Williams was reluctantly admitted to hospital whilst a more suitable home could be found. It was while he was an inpatient that he killed a fellow patient with a knife from a set in his possession.

The second is how he was allowed to have such dangerous items in his possession in what should have been the safe environment of a hospital. Understandably this has caused public concern.

The lack of a suitable home and treatment for someone with Daniel Williams' complex needs lay at the core of the events which led to this tragedy.

THE KILLING

Daniel Williams killed Adrian Pawson on 19 December 1998. Both were patients on the Priory Unit*, Aberford Centre of the Fieldhead Hospital, Wakefield, which specializes in the assessment and treatment of adults with a mental illness.

At the trial on 18 February 2000 the prosecution barrister stated that 22 wounds had been inflicted on Adrian Pawson, amongst them being wounds to the chest, back, left lung, left neck, left leg and body. Two of the wounds penetrated his heart. In the opinion of the pathologist there had been at least moderate force as many of the wounds to the chest and abdomen had been inflicted when the victim was on the floor.

Daniel Williams pleaded guilty to manslaughter with diminished responsibility. Reports available to the Court indicate that he was suffering from paranoid schizophrenia and a severe personality disorder.

Daniel Williams was given a life sentence. The trial judge said the report indicated that the condition was not treatable in a mental hospital and that he had no alternative sentence other than that of life imprisonment.

The Judge commented: -

"It is one of the most appalling tragedies that you were permitted to enter a hospital, where there are other mentally ill people, in possession of these potentially hideous and lethal weapons, albeit that they are described...., and indeed they are, kitchen knives. How it comes about that you were allowed to be there with them uncontrolled I do not know..."

ADRIAN PAWSON

At the time of his death, Adrian Pawson was 24 years old. He had been admitted informally to the Priory Unit at Fieldhead Hospital on 15 July 1998. His last Care Programme Review had focused on a proposed discharge plan and, as part of this, the need to find suitable residential accommodation.

* an acute mental health unit at Fieldhead Hospital Wakefield providing care for men and women aged from 16 to 65. In 1998 the Priory was a 48 bedded unit, all comprising single rooms

The Panel met Adrian's mother and stepfather. They said that they had assumed that the hospital would look after their son. We extend our sincere sympathies to Adrian's family on their tragic loss.

DANIEL WILLIAMS' FAMILY

Daniel Williams' parents separated when he was approximately five years old. He has a sister, stepsisters and a stepbrother.

DANIEL WILLIAMS – EARLY YEARS UP TO 1995

Daniel Williams was born on 21 October 1972. As stated above his parents separated when he was approximately five years old. When he was nine years of age he was admitted to hospital with recurring headaches. It was thought that they were migrainous in nature.

When he was nine years of age it was discovered that he had been "sniffing" gas and, at about fourteen, he was known to be inhaling glue. From the age of fifteen he is said to have become a regular, virtually daily, user of amphetamines. He started to use cannabis over the same period. Later he also used ecstasy and heroin.

Daniel Williams left school at fifteen with no qualifications. He worked on a youth training scheme for six months and then held various manual jobs for short periods.

Daniel Williams' General Practitioner (GP) notes show that when he was seventeen he complained of lethargy and it was noted that he had been "head-banging" for some years. Referral was made to the psychiatric clinic at Stanley Royd Hospital in Wakefield. An appointment was made for him but he failed to attend.

When he was 18 he was allocated a Council owned flat and his family helped him to move and make it comfortable. They said he was enjoying it but he was not able to live independently. He was unable to budget and would spend all his money as soon as he got it.

When Daniel Williams moved into the flat, his mother moved to another house a mile away. She told him that she was moving but did not give him her new address. Daniel found out where she was living and would walk there three times a day for his meals.

At this time Daniel began to dress unconventionally. We were told by his family:

> *"He would have... an orange coloured shell-suit on with white cream all over his face and neck, thick white cream, a hat on and a pack on his back.....and shorts over his shell-suit bottoms"*

"Another time he had got Army boots on, track suit bottoms with, like, satin shorts over the top of them,[and] a shell suit top"

"Sometimes... like a German military soldier .... Sometimes a Canadian soldier"

and on occasion

"...with a big staff and dress like a shepherd".

On 21 August 1992 Daniel Williams was convicted of trespassing with an offensive weapon and was given a 12 months' conditional discharge.

On 7 September 1993 he was convicted of possessing an offensive weapon in a public place and also trespassing on premises with an offensive weapon. He was given an 80 hour Community Service Order.

His GP notes for this time included the following: -

3.12.92 Withdrawal symptoms after stopping cannabis. Told by boss to get Doctor's note...

24.2.93 Over sensitive, panic attacks, anxious, not very happy with [?life]. Poor appetite, unemployed...

Daniel Williams was then referred to community psychiatric nursing services at Fieldhead Hospital. The Community Psychiatric Nurse (CPN) went to see Daniel Williams on 12 March 1993 but he was not available. A letter was sent asking Daniel Williams to make contact but he failed to do so.

On 14 April 1993 the CPN called to see Daniel Williams' mother at her request. In his letter to the GP the CPN states:

"She has become increasingly frightened of her son who has abused many illicit substances, and sniffed glue. She says he has mood swings, and can become violent.

[She] says he gets depressed and threatens to kill himself, but [intends] to take his mother with him."

The CPN recommended an urgent referral to a psychiatrist. This was Daniel Williams' first involvement with mental health services.

The same day Daniel Williams went to his GP accompanied by his mother. The GP notes record:

14.4.93 Attended with mother, can be violent, "head full of wild thoughts". Not seen [CPN] yet, advised to make contact... Patient has paranoid delusions, auditory hallucinations, distorted self-image.

An urgent referral was made to the Consultant.

He was seen at his mother's home on 29 April 1993. The Consultant reported that Daniel Williams was preoccupied at this time with disputes occurring between his mother, his sister and himself and with fears of becoming homeless. His mother described him going into rages when his mood would change very quickly. This had been a problem for many years although recently had been worse. There were details of his taking amphetamines, LSD and cannabis.

By this time, Daniel Williams had convictions for "joy-riding", trespass and possession of cannabis and these were recorded. The Consultant's assessment was **"an abnormal personality, predominantly anti-social type. In addition... non-dependent misuse of drugs".** He was unable to find any evidence of serious mental illness. There is no record of a formal risk assessment, but his mother was advised that if she could not cope with his behaviour she should obtain a Court Order to stop him coming to her house.

Daniel Williams was prescribed an anti-psychotic medication and a follow up appointment was arranged. He failed to attend. The Consultant accurately predicted that Daniel Williams was unlikely to comply with medication. There was no further contact with the mental health services until May 1995.

FINDINGS -

1. Daniel Williams was, even at this early stage, very socially disabled. During this period it was noted that he was unable to budget for himself. He was not capable of living independently. He was dressing strangely which was alienating him socially. He was abusing substances.

2. His conviction for trespassing with an offensive weapon showed his propensity for carrying dangerous items.

3. He was showing signs of aggression towards his mother and his first contact with the mental health services indicated that he would not comply with medication long term.

DANIEL WILLIAMS - MAY 1995 TO JULY 1996

On 6 May 1995 Daniel Williams' mother went to the GP and said she was very worried about her son. A visit by the CPN was requested.

The CPN saw Daniel's family on 11 May. He reported:

> **"[the mother] is a very frightened lady, who lives in fear that Daniel is going to harm her. [The family] all describe various facets of his behaviour which included grimacing, constantly pacing, mood swings, talking to himself and aggressive behaviour... he is always clean (to the point of obsession) on occasions his dress is bizarre...He is also dangerous as he leaves gas appliances on unlit and pans unattended... he says he can read his mother's thoughts."**

The Consultant called twice to see Daniel Williams. The CPN called several times. Both were unable to make contact as Daniel Williams was never at home. Messages were left for him but he did not respond.

On 18 September 1995 Daniel Williams was arrested for failure to attend Court for adding extra medicines to a prescription. He had apparently added anabolic steroids and E45 cream to the original. He was seen by a member of the "diversion from custody" scheme. On enquiry it was found that his mother had concerns about his behaviour. It was also noted that, on the day prior to his arrest, he had struck his mother causing minor injuries to her head. A mental state assessment was requested and as a result of this he was seen in police custody and admitted for assessment that day as a psychiatric in-patient under Section 2 of the Mental Health Act. Daniel Williams was taken to his home to collect his belongings and it was found he had various weapons in the flat including two large pieces of wood, an ice pick and what was described as a large metal hook.

A urine drug screening taken on admission tested weakly positive for cannabis but no other illicit drug was found.

An assessment was carried out by a consultant forensic psychiatrist on 4 October 1995 and it was his opinion that:

- **Daniel Williams suffered from schizophrenic mental illness, characterised by paranoid and grandiose delusions.**

- **That his taking of illegal drugs might well have brought on or worsened a pre-existing condition.**

- **That there was a clear risk of violence towards his mother.**

It was concluded that Daniel Williams represented a danger to his mother. A panic alarm was fitted to her home by the local police.

As Daniel Williams was also considered by the Probation Service to represent a high risk to other members of the community a Potentially Dangerous Offenders meeting was arranged involving the agencies that had, or might in the future have, significant contact with him. The meeting on 20 October 1995 was attended by the Police, Probation Service and the CPN from the "diversion from custody" scheme. The hospital medical team and the community-based psychiatric service were also invited but did not attend. It was concluded that Daniel Williams had manipulative fantasies of killing people and represented a real threat to nursing staff – especially females – and would be a high risk to the community. It was decided that:

- he would be registered as a potentially dangerous offender.

- The Consultant was to be informed of the concerns regarding the risk he posed.

- The police and Daniel Williams' mother were to be informed if he went "off-ward".

- A case review was to be held where appropriate and also before discharge from hospital.

- Copies of the recommendations were to be given to the Consultant and to the ward manager.

On 17 November 1995, following a meeting between his Social Worker and medical staff, Daniel Williams was placed on the Supervision Register. Its purpose is to identify individuals who are considered to be at significant risk, or at potentially significant risk, of committing serious violence or of suicide or of causing serious self-neglect as a result of severe and enduring mental illness and to ensure they receive adequate care, support and supervision in the community. An approved Social Worker was appointed to take the lead in planning and coordinating his care.

After several successful periods of leave, Daniel Williams was discharged on 18 December 1995. The prognosis given was poor in that he was likely to abuse illicit drugs and not comply with his medication. He continued to threaten his mother and to use illicit drugs. She was advised to call the police if he tried to gain admission to her home.

Daniel Williams was followed-up through outpatients and it became clear that he did not accept the diagnosis of schizophrenia.

On 7 March 1996, Daniel Williams' mother contacted the GP to say she was very worried by her son's threatening behaviour. Daniel Williams was visited by the CPN and his Social Worker was contacted. The GP was advised not to visit Daniel Williams and to be very cautious if he visited the surgery. Daniel Williams' mother was advised by the GP, CPN and the Social Worker to contact the police if he came to her home. This she did on 8 March and Daniel Williams was admitted from the Police Station to hospital under Section 2 of the Mental Health Act.

On admission Daniel Williams was dressed in Army clothes, and was clean and tidy. He was said to be preoccupied with joining the RAF and he expressed the view that people were able to read his thoughts. During his admission he admitted to non-compliance with medication. He was treated with an intra-muscular long acting medication (commonly known as 'depot') and this was later changed to an alternative preparation. His mental state appeared to improve. A urine drug screen tested negative.

On 9 April 1996 he discharged himself against medical advice. The discharge letter stated that Daniel Williams appeared to suffer from paranoid schizophrenia with premorbidly [ie preceding the onset of the illness] anti-social personality traits, which would suggest a poor prognosis unless he remained compliant with medication.

On 12 April 1996 the Probation Service convened a Potentially Dangerous Offenders' meeting in respect of Daniel Williams. Present were representatives from the Probation Service, the Police and Social Services. The action agreed included:

- the involvement of Daniel Williams in a new day centre service at the hospital which was starting.
- The offer of continued support to his mother.
- Police to visit his mother to assess risk and, if appropriate, re-install a panic alarm.
- Police to make a note on the police computer so there would be a quick response if an incident occurred at his mother's home.

- If Daniel Williams committed violence against his mother then he should be charged with an offence rather than be diverted from prosecution.

His name was removed from the Potentially Dangerous Offenders' Register on 12 April 1996 as it was considered the risk he posed could be managed without his continued registration.

On 15 May 1996 Daniel Williams was admitted informally to hospital as a respite admission because of anxiety following a fight with two neighbours who he said were members of a well known family in Wakefield. He was preoccupied with his personal safety and had asked his Social Worker to provide him with a safe haven. This was agreed in an attempt to improve future compliance. It was noted that he was wearing combat gear. He said he needed to speak German to understand German politics. Daniel Williams continued to deny any psychiatric illness but accepted medication. He discharged himself the next day. Follow up was to be made by the CPN and the Social Worker and Daniel Williams was to remain on the Supervision Register.

FINDINGS -

1. Daniel Williams' mother was able to make a contribution to his management. She was also seen as the main person at risk. Daniel Williams had items which were seen as dangerous and had struck his mother.

2. The decision to place him on the diversion from custody scheme led to measures to provide protection. The placing of Daniel Williams on the Supervision Register did not bring any additional resources but served to indicate a significant level of risk both at the time and for the future.

3. Important predictors of future risk were identified by the multi-agency risk panel in placing him on the Dangerous Offenders' Register on 20 October 1995, including the fact that he had fantasies about killing people. The panel de-registered him on 12 April 1996 but made recommendations about offering his mother protection.

4. Daniel Williams continued to dispute the diagnosis of mental illness and this indicated that he would be unlikely to comply with medication.

DANIEL WILLIAMS - JULY 1996 TO MAY 1998

On 3 July 1996 Daniel Williams moved to Warren Court* following an emergency referral from the mental health team. He had been vulnerable to exploitation and aggression from other residents in the area.

After three months an assessment was carried out to decide whether Daniel Williams should remain at Warren Court. It was decided he would remain there only whilst looking at other housing options. The assessment also noted the following:

- **He did not accept the diagnosis of schizophrenia.**
- **He had been interviewed by the police about the disappearance of three bikes from Warren Court.**
- **His finances were in chaos. He said he had £650 arrears in rent on his previous property. He would spend relatively large amounts on clothing, which would leave him without food and then rely on his family to feed him. He would not accept help with budgeting.**

On 7 October 1996 Daniel Williams went to his GP and "confessed" that, for the last three years, he had been smoking 1 gram of heroin per day, every day. He also said he took amphetamines, ecstasy and magic mushrooms. He wanted a prescription for methadone: the GP refused this request. Daniel Williams was advised to stop taking all drugs. This information was passed to the Consultant who was still seeing Daniel Williams as an outpatient.

The Warren Court records note that, on 14 January 1997, Daniel Williams made a decision to leave Warren Court, purchase a large dog and live in Horbury Park. No amount of persuasion or rational discussion could change his mind. He returned later that day. There was concern that his mental health was a factor in this as he had made similar decisions in the past.

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* a Social Services run rehabilitation hostel for tenants with severe mental problems. All residents have their own room but share other facilities. There was a team of 7.5 staff, a cleaner, and 2 non-care night staff responsible for the building's security. A keyworker is identified for each resident but care coordination remains the responsibility of the care programme coordinator

In view of his wish to live independently, it was agreed that a tenancy should be sought from the Housing Authority. There were still substantial arrears from his previous tenancy and also arrears of rent for Warren Court.

There was concern at Warren Court that Daniel Williams was introducing illegal drugs onto the premises. On 15 May, a contract was signed between Warren Court and Daniel Williams whereby, whilst not accepting that he was using illegal substances, Daniel Williams agreed not to use them in Warren Court and not to provide them to other residents. Any breach of this contract would jeopardise his residential agreement.

A review meeting was held on 3 July 1997 at Warren Court with Daniel Williams present. He still challenged the diagnosis and felt he should not have this "label". Daniel Williams said he was keen to move from Warren Court.

On 9 July 1997, the Consultant saw him as an outpatient. He recorded that Daniel Williams had been refusing medication for the previous six months and that he was guarded and uncooperative.

In mid September 1997 Daniel Williams attended a Housing Panel meeting where, it appears, he stated his satisfaction at living in Warren Court. Concerns were raised regarding his mental well-being since the last review had taken place. There were recorded concerns, by the staff on 17 September 1997, at Daniel Williams' consumption of caffeine substances and also of his consumption of plants from the gardens of Warren Court. His GP visited at the request of the staff on 22 September. She noted that he had been eating rosebuds and weeds and accusing other people at Warren Court of poisoning him. He was admitted to hospital under Section 3 of the Mental Health Act. At this point it was noted that he had not taken his medication for some time prior to his admission.

During this admission Daniel Williams was allowed to have overnight stays at Warren Court. His keyworker at Warren Court contacted his Social Services Manager to express his concerns regarding Daniel Williams' admission and working relations with the ward. This was followed up by a detailed letter dated 21 December 1997. The letter listed concerns that had arisen from Daniel Williams' behaviour during his stays at Warren Court including the following:

- **On 22 November Warren Court had contacted the ward regarding, what they considered to be, his threatening manner. The ward staff nurse was said to have responded that Daniel Williams was fine on the ward and that female staff did not feel threatened by him.**

- **On 1 December 1997 the care coordinator and Daniel Williams' Social Worker attended the CPA review and relayed the concerns from Warren Court's point of view, particularly regarding Daniel Williams' hostility [to staff]. Two days leave per week was agreed.**

- **Daniel Williams was recorded as stating: "there were a few murderers at Warren Court and a few people he could kill and that he could get a gun easily"**

- **On the day of discharge Warren Court was contacted. No prior discussions had taken place. The CPA coordinator was not aware of the position at this stage. Warren Court suggested a meeting to explore the discharge plan but the ward did not feel it necessary following the CPA and Section 117 meeting on 1 December.**

It was said by Warren Court that the CPA/Section 117 meeting had not considered Daniel Williams' discharge. The final paragraph from the keyworker's letter states:

> **" my overall perception... is that [the Ward] seemed to believe we were blocking the discharge for ulterior motives, rather than attempting to ensure good practice"**

The hospital records refer to a ward round by the Consultant on 18 December 1997. It states that Warren Court be consulted regarding the possibility of discharge. The Social Worker's notes for the meeting on 1 December 1997 record that Daniel Williams was now ready for discharge. He was discharged on 19 December 1997.

The discharge letter dated 9 January 1998 stated:

> **"Whilst on the ward he spent his time pacing up and down in a military fashion and changed his clothes frequently. He tended to wear military outfits with large Army boots... He complied well with time allowed out and medication. He gradually became more sociable and pleasant and less intimidating in manner... He was eventually discharged to Warren Court and agreed to continue taking his medication at this time. He was immaculately dressed with very short smoothed-down hair.... He felt optimistic about the future and felt he was able to cope. He accepted his diagnosis and agreed to continue his depot".**

On 29 January 1998 a CPA review was held and concerns were raised over a number of issues: -

- **Daniel Williams was not paying rent and had arrears and debts.**

- **He had often missed appointments with his Social Worker.**

- **Daniel Williams said he was spending money on amphetamines while being aware that this contravened his tenancy agreement.**

The Social Worker agreed to contact SUMIT*. SUMIT accepted the referral and agreed to visit Daniel Williams in the near future.

To redress the arrears, the Social Worker contacted the Benefits Agency to request weekly payments and Daniel Williams was to consider applying for a disability living allowance. Two weeks later it is recorded that **"the situation regarding finance is not improving and Daniel seems intent on sabotaging any care plans designed to help".**

Daniel Williams was admitted to the Priory Unit on 16 February 1998. He had gone to the Accident and Emergency Unit as he felt paranoid and frightened that he might harm himself or others. On admission he was dressed in Army clothing. He gave a coherent account of himself and was not obviously anxious or agitated. He confirmed that he was regularly using amphetamines and he was observed to be drinking when off the ward. There was no formal review of the risk assessment.

He was discharged on 10 March 1998 with follow-up as an outpatient and the CPN to continue to administer his medication.

The discharge letter to his GP contained the following: -

> **"He told us he had threatened to kill someone in Warren Court who had taken five eggs from him, he said if he had attacked him he would not have worried at the consequences... Although his manner was slightly threatening at times he socialised appropriately with fellow patients... Prior to discharge he felt he was able to process his own thoughts before acting on them... He denied hearing voices or thoughts of harming others..."**

He was discharged to Warren Court where his Social Worker saw him fortnightly.

On 27 April 1998 Daniel Williams told his key worker at Warren Court that he had injected air into his veins. He was taken to the Accident and Emergency Department where he said he was feeling suicidal. He was admitted to the Priory Unit that day. During his stay it was recorded that he immediately settled on the ward. His mood did not appear particularly depressed. He was given a week's leave but did not return for further assessment. He telephoned the ward on 5 May 1998 to say he felt better and was discharging himself. The discharge letter states that Warren Court had been contacted and they were happy for him to be discharged.

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* a service for those with substance misuse problems involving drugs, illicit substances and alcohol covering the entire Wakefield Health area. It sees itself as providing a specialist service which tends to take clients who have more complex drugs and substance misuse problems. It has an open referrals system and applicants are subject to a thorough assessment

FINDINGS –

1. By November 1997 the views of Warren Court and of the mental health team* were beginning to diverge. A member of the Warren Court staff saw Daniel Williams as threatening and posing a safety risk, concerns which were not shared by hospital staff.

2. The letter of 9 January 1998 did not amount to coordinated discharge planning. Warren Court's request for a meeting to discuss the discharge plan was appropriate. As Warren Court staff were not represented at the 1 December meeting, the appropriate professionals to plan to discharge in accordance with Section 117 planning were not involved There was no mention of relatives being informed or involved and that meeting was therefore flawed.

3. Daniel Williams had a reasonable therapeutic relationship with the hospital which he had begun to regard as a safe haven.

4. Daniel Williams told the mental health team he had threatened to kill someone at Warren Court. The references to killing other people should have been taken more seriously later on.

5. Daniel Williams' inability to budget is a feature throughout. He had substantial rent arrears. He was not able to manage money. The option of making arrangements with the DSS to use appointeeship was not pursued to a conclusion .

* medical and nursing professionals

DANIEL WILLIAMS - MAY 1998 TO 7 DECEMBER 1998

On 15 May 1998, Daniel Williams told his Social Worker that he had fallen out with his mother over his use of amphetamines. He asked him to contact her and let her know how sorry he was. On 11 June 1998 the Social Worker visited Daniel Williams' mother and sister at their home and discussed Daniel Williams' history and the risks he posed in some detail. His family expressed their continued care and support for Daniel Williams but his mother was genuinely frightened of him when he became aggressive.

The Social Worker visited Daniel Williams on 3 July 1998. Daniel Williams was recorded as being agitated and angry towards his Consultant. Daniel Williams denied he had any mental health problems. He said he would not accept his medication and would not see the worker from SUMIT (drug abuse project).

On 9 July 1998 Daniel Williams was apparently seriously assaulted. He told the police that a stereo had been stolen from him. There was doubt whether the equipment was his or was already stolen.

On 27 July 1998, Daniel Williams approached Warren Court staff and discussed his medication which he now agreed to take. The next day, 28 July, Daniel Williams was noted to be carrying a knife by the night staff. When approached the next day he said it was a penknife and agreed to restrict its use to his own room.

The CPN attended on 30 July but Daniel Williams refused medication as he said he felt well. The same day a worker from SUMIT visited him but Daniel Williams refused to see him.

On 31 July 1998, Warren Court contacted Social Services management about Daniel Williams' mental health. He had fallen out with his father and had been threatening his mother. On 3 August the Social Worker was contacted. Main discussion points were the risk to others in view of his carrying the knife and apparent hostility and paranoia. The same day it was noted that he was abusive and hostile to a fellow resident.

On 4 August Daniel Williams was attacked by an acquaintance and he sustained an open wound to his skull. He was taken to the Accident and Emergency Unit and the assault was reported to the police. Warren Court became concerned at his behaviour. They felt he was the most disturbed they had seen him throughout his residence with them. On 5 August he arrived at his grandmother's house in a distressed state. He was admitted to the Calder Ward of Fieldhead Hospital after intervention by the crisis team. Warren Court was concerned about his safety, as there were fears of a repeated assault.

On admission he admitted that he had been using amphetamines. His deterioration was put down to his refusal to take his medication.

On 13 August Daniel Williams was moved to the Priory Unit and seemed more settled. He did not want to return to Warren Court. His Social Worker agreed to explore the options available.

On 7 September 1998 a CPA meeting was held with the Consultant and the Social Worker present. There is no record of Daniel Williams being present. The main issue was accommodation. Daniel Williams would not return to Warren Court but there was difficulty in obtaining an alternative because he had rent arrears of approximately £1200 and was failing to co-operate with Warren Court. Supported accommodation was to be preferred but his continued drug use would be an obstacle. It was also recognized that the safety of his mother would need to be a factor in reaching a decision about where Daniel Williams should live.

He was given agreed periods of leave to visit Warren Court. His reluctance to return began to ease. On 8 October 1998 Daniel Williams put in a complaint about his diagnosis of "paranoia". On that day, a drug screening test proved positive for amphetamines. Daniel Williams was unable or unwilling to explain why this was positive.

On 9 October 1998 a CPA review was held. Present were medical staff, his Social Worker and his key worker at Warren Court. The main issue, again, was accommodation. Daniel Williams did not want to go back to Warren Court. The Priory Unit agreed that he could visit every day and the Social Worker agreed to visit weekly.

The following conditions were attached to his return to Warren Court:

- To have drug screenings.
- Not to bring "drug contact" friends to Warren Court.
- To work with staff at Warren Court.
- To stop taking drugs.
- To stop encouraging others to take drugs.
- To be compliant with regard to prescribed medication.
- To pay rent.
- To clear his room of needles and other drug equipment.

The hospital notes state that Daniel Williams had agreed to a forensic opinion. Warren Court differs in that they note that **"a forensic assessment to be completed around risk".**

Daniel Williams was discharged to Warren Court on 12 October 1998. A discharge letter to his GP was not written until 24 November 1998. The letter did not reach the GP as it was wrongly addressed to Daniel Williams' previous GP. On 16 October his mother visited Daniel Williams. She was advised not to assist in cleaning his room because of the risk from needles.

On 20 October Daniel Williams attended an appointment with his GP. He had previously complained to the Chief Executive of the Trust about his Consultant and his diagnosis. It was noted that Daniel Williams was now having doubts about this.

On 27 October 1998 there was an increase in concern regarding Daniel Williams' behaviour. Apparently he had sold another resident some amphetamines and had stolen tobacco from the resident claiming he owed him money. Daniel Williams was said to be verbally and physically threatening over a long period and the two had to be separated by staff. The police had to be called in view of the open references to illegal drug transactions. Daniel Williams denied all drug allegations and agreed to return the tobacco.

On 28 October 1998 Warren Court staff, Daniel Williams' Social Worker and the mental health team manager met in response to reports of escalating incidents of aggression and threatened violence (by Daniel Williams) and to consider alleged illegal drug trading. Staff continued to be concerned for the safety of the other residents and themselves. It was also reported that Daniel Williams was regularly approaching other residents for money despite repeated requests not to do so. It was agreed that the police would be called if:

- Daniel Williams threatened staff or residents.
- Daniel Williams was under the influence of any substance, which would increase the likelihood of an incident.
- There was reasonable suspicion that Daniel Williams had illegal substances in his room.
- On release from the Police Station he should continue to act in an aggressive or threatening manner or be under the influence of substances.

This plan was discussed with Daniel Williams and he expressed a wish to move from Warren Court as soon as possible.

On 1 November 1998 Daniel Williams purchased a cheap set of chef's knives which he said he wanted to use for cooking. Warren Court staff saw the knives and a note was made in his records about the concern that he had potentially dangerous items in view of his recent behaviour.

On 3 November 1998 he showed the set of knives to the night staff and was said to be pleased with his purchase.

On 4 November 1998, the Social Services operations manager for mental health services authorised increased staffing levels for Daniel Williams at a staff meeting at Warren Court so that staff would only work with him in pairs. The police were to be contacted about safety. A CPA meeting was to be urgently convened and as soon as suitable alternative accommodation was found, Daniel Williams was to be given notice to leave Warren Court.

Also on 4 November Daniel Williams contacted the Chief Executive of the Trust seeking an apology for his diagnosis of paranoid schizophrenia. He also returned his medications saying he no longer required them.

On 5 November the mental health team manager advised the Consultant by letter that Warren Court was no longer suitable for Daniel Williams and a joint action plan was required. A Care Planning meeting would be arranged by his Social Worker on return from holiday.

On 6 November Daniel Williams was told about the meeting but not about the discussions about giving him notice to quit as soon as an alternative was in place. The police were contacted and three officers from the Safe Team came to Warren Court, including one who had dealt with Daniel Williams' recent assault case. They agreed one of them would attend the next CPA meeting.

The night staff were told that if Daniel Williams was awake during the night he was not to be approached or engaged in conversation. They were not to remain in the same room as Daniel Williams on their own.

On 7 November 1998 Daniel Williams had a meeting with his Social Worker and wanted to re-start his contact with SUMIT.

On 12 November 1998 Daniel Williams went to see his GP accompanied by two staff from Warren Court. The GP noted that he was wearing **"increasingly more bizarre clothing"** and that he was seeking an alternative place to live. There was difficulty in prescribing his medication as the discharge letter had not been received following his last admission to hospital.

On the same day, Daniel Williams approached a Warren Court staff member wanting to know if it was legal to carry a knife. He was told it was not acceptable in Warren Court and that he could take further advice from the police who were, as it happened, in the building at that time.

On Friday, 13 November, Daniel Williams said he had found somewhere else to live and would pick up the key on the following Monday. He also added that he was attracted to the landlord's daughter. On Monday 16 November he was visited by his Social Worker. Daniel Williams was upset. He had changed his mind and was now not ready to leave Warren Court. The Social Worker was of the view that he could not live independently at this stage, but he was being encouraged to do so by Warren Court staff. The Social Worker said he never felt that Daniel Williams was emotionally stable or mature enough to live independently. The Social Worker said he would continue his search to find a place in more suitable accommodation for Daniel Williams.

On 16 November 1998, a staff member at Warren Court wrote to the managers at Warren Court about his concerns over Daniel Williams being at Warren Court. The letter mentioned:

- **The recent threat made to kill a resident.**
- **The use of amphetamines and alleged supply to others.**
- **His "explosive" behaviour, which was said to be intimidating to others.**
- **The preoccupation with Nazi imagery and combat items.**
- **The recently stated intention to carry an offensive weapon.**
- **The presence of used needles and their danger to others.**

The reply mentioned that suitable alternative accommodation was being sought. In terms of the health and safety issues, a risk assessment was carried out and placed on his file. A copy of the letter and reply were sent to the mental health operations manager of the Local Authority. It was indicated that funding would be made available if a placement could be found for Daniel Williams in another project.

On 18 November staff at Warren Court noticed that knives were going missing from the kitchen. This was also the planned date of a CPA review for Daniel Williams, which was cancelled due to poor attendance. The meeting was re-arranged for 7 December 1998.

On 23 November his Social Worker and a staff member from Warren Court took Daniel Williams to his appointment with SUMIT. A drugs worker, who was a qualified CPN, saw him alone. At this interview it was said that Daniel Williams talked about his Consultant and said that tablets provided by the

Consultant were making him ill. Daniel Williams was asking to be prescribed amphetamines. He was told that SUMIT no longer prescribed amphetamines. The worker said that Daniel Williams was not interested in any medication designed to help him. After discussion with the medical director of the project no further appointment was made for Daniel Williams as SUMIT was not going to prescribe amphetamines and had nothing further to offer him.

Warren Court advised Daniel Williams' Social Worker on 30 November 1998 of additional problems which he was presenting. He was pestering the other residents for money. It was claimed that Daniel Williams had stolen the residents' Christmas turkey and was generally behaving in an intimidatory manner. On the same day, residents told staff that the missing kitchen knives were in Daniel Williams' room.

On 1 December 1998 a letter signed by eight residents at Warren Court was sent to the Social Services department stating that, due to his behaviour, they felt Daniel Williams should not be living at Warren Court. They wanted an immediate end to the situation. The Social Worker's view was that Daniel Williams was complying with his medication and as far as his behaviour and "menacing" was concerned, that was just his manner.

On Wednesday, 2 December, Daniel Williams attended an outpatient appointment escorted by the manager and his keyworker from Warren Court. His Social Worker was also in attendance. The Consultant said he first spoke with the Social Worker and was told that Daniel Williams felt well and did not require hospitalisation. He was told of the issues of non-payment of rent, continued drug misuse, the belief that Daniel Williams was stealing from other residents and of the missing knives from the kitchen. The Consultant considered that the CPA meeting due to be held in five days' time would be the appropriate forum for full discussion. For that reason he did not see the manager from Warren Court. The Consultant saw Daniel Williams and was of the opinion he was not "thought-disordered" and nothing in his behaviour indicated he was mentally ill.

On the same evening police received a call from Warren Court about an alleged burglary. The allegation was that Daniel Williams was responsible for stealing a turkey (which had been purchased for a communal Christmas Dinner) and a CD player and disc from another resident's room. Daniel Williams was arrested and taken to the Police Station. The police returned to Warren Court with authority to search Daniel Williams' room. During the search a number of knives were found. These included the set of chef's knives he had purchased earlier and the knives which were missing from the Warren Court kitchen. The set of chef's knives were left in the room as Daniel Williams had purchased them and the staff were aware of this. Other items, believed to be controlled drugs were also seized. At that stage the police were investigating offences of theft and possible unlawful possession of drugs. There was no CD player or disc found.

Daniel Williams was interviewed in the presence of his solicitor and a social worker acting as an appropriate adult. He denied stealing the CD player and disc. Daniel Williams said he had taken the turkey as a joke and he had merely "borrowed" the knives to prepare food and was going to return them as he now had a set of his own. He was released on police bail to return to the Police Station on 22 December 1998.

The following day, Thursday 3 December, Daniel Williams visited Turning Point*. He was told that an appointment would be arranged and he would be notified by post. The same day, the manager and deputy manager (who was also Daniel Williams' keyworker) decided, after discussions, that Daniel Williams had to leave Warren Court. The Inquiry was advised that this had also been discussed with the managers in the Social Services department. The deputy manager told the Inquiry that the situation had become intolerable. The Social Services managers agreed to the notice requiring Daniel Williams to leave but on the express condition that it was not implemented.

The police were asked to attend Warren Court and waited outside Daniel Williams' room while the manager and deputy manager saw him. He was told he would have to leave Warren Court by 3 pm on Monday 7 December 1998. His Social Worker was not involved in these discussions and did not find out about them until the following day. The Social Worker's view was that the situation had gained a momentum of its own, like a steam train out of control. He said that no one in Wakefield was offering any help for Daniel Williams, and that a specialist housing provider would not offer him accommodation as he had failed to comply with its referral system. The Housing Department would not assist as he had substantial rent arrears. He did not think that Daniel Williams was capable of independent living. He was having difficulty managing money, was still very immature, had a serious mental health problem and was on medication; also, there was no guarantee that once out in the community he would maintain contact with the support services.

The Social Worker contacted Housing Department staff to make them aware of the situation. He also contacted the Consultant to keep him informed. The Social Worker was unable to attend the CPA meeting arranged for Monday 7 December 1998.

* a non-statutory agency offering advice and support for current and former drug users, their families and friends

At 4pm on 4 December Daniel Williams was taken to the Accident and Emergency Unit after he told Warren Court staff that he had taken an overdose of anti-psychotic medicine. The following morning, Saturday 5 December, Daniel Williams discharged himself from hospital before a psychiatrist could see him. About this time the records indicate that Daniel Williams stated that he had stopped taking illegal drugs.

FINDINGS -

1. Warren Court was correct to seek a forensic assessment but it was never actioned. The last forensic assessment was undertaken on 4.10.95 and there was sufficient evidence available for Daniel Williams' risk assessment to be reviewed to take into account violence targeted at others and the threat from weapons.

2. Warren Court was aware that Daniel Williams had the set of chef's knives in his room. This was noted in its records for Daniel Williams. It is not clear whether Warren Court raised its concerns about the knives with him. It would not have been unreasonable for them to check that he was in fact using the knives for cooking.

3. The other residents, like Daniel Williams, were dependent on benefits. His requests to borrow money would have been disruptive and caused concerns to them.

4. The letter from the Social Services Mental Health Manager to the Consultant of 5 November made it clear that the placement had broken down and that Warren Court was unable to care for him. Those concerns should have been acknowledged and a timely review of his placement organised urgently.

5. Daniel Williams was not suitable for SUMIT as he lacked the necessary motivation. There was no facility in which mentally ill people could be detained to limit their use of drugs. SUMIT saw Daniel Williams on a number of occasions and attempted to support him. SUMIT's decision to end its involvement was appropriate in the light of Daniel Williams' continued requests to be prescribed amphetamines, which was against SUMIT's policy.

6. Daniel Williams' Social Worker did not share Warren Court's views about the risks posed by Daniel Williams and the residential staff did not have an opportunity on 2 December to contribute their view. The Consultant deferred a decision until the care planning meeting on 7 December.

7. The notice to quit was not an appropriate method to resolve the deadlock, but in the circumstances it was understandable. Exclusion of the Social Worker who was also the care coordinator from the decision to evict Daniel Williams was unhelpful. There was also a failure to involve Daniel Williams' family in the decision to evict, even though his mother was the person seen as being at risk, and his family would have had to cope with his homelessness.

DANIEL WILLIAMS - 7 TO 18 DECEMBER 1998

The CPA meeting was held on the morning of 7 December 1998. It was described by a number of the participants as exceedingly difficult. The meeting was attended by:

- The Social Services manager who was responsible for Warren Court and was in the chair at the beginning of the meeting.
- The manager of Warren Court.
- The deputy manager of Warren Court who was also Daniel Williams' keyworker.
- Daniel Williams' CPN.
- The Consultant.
- Member of the Trust's rehabilitation services.
- Member of the Trust's Mental Health Act and CPA manager.
- Two nursing staff from the Priory Unit.
- Another Social Services manager, who arrived during the course of the meeting and took over the chair for the latter part of the meeting.

The Social Worker, who was not present at the meeting, was also the CPA care coordinator.

Daniel Williams arrived with an advocacy worker from the Richmond Fellowship and was asked to wait outside. The meeting became polarized between Warren Court staff and the health team. The health team members were of the view that Daniel Williams was as well as they had seen him for some time: he was complying with his medication and appeared to be mentally well. This was also the view held by Daniel Williams' Social Worker. The Warren Court staff, on the other hand, were saying that they did not consider him well and his behaviour was such that he was a significant risk within Warren Court and that he could not stay there. There were also the issues of rent arrears, use of illicit drugs, intimidation, theft from fellow residents and knives found in his room. Warren Court considered that Daniel Williams should be admitted to hospital.

The Consultant's view was that Daniel Williams did not need to be in hospital and should not be admitted for social reasons. Warren Court staff were adamant that Daniel Williams would have to leave that day at 3 pm. It was accepted that

Daniel Williams was not capable of independent living. Other suggestions of living in a bed & breakfast or family hostel were discussed but thought not to be suitable. In the absence of any other alternative, the Consultant agreed that he would admit Daniel Williams into hospital whilst more suitable accommodation could be found, as he could not see such a vulnerable person out on the streets. While this discussion was taking place, Daniel Williams and the advocacy worker were waiting outside. They were then invited into the meeting. The advocacy worker reported that the atmosphere at the meeting was very strained. Daniel Williams was told that he would be admitted to hospital and due to lack of bed space at the Priory Unit, he would initially go to the Farndale Ward in Pontefract. He was also told that he had to stay on the ward unless under staff supervision. Daniel Williams agreed to this.

The Consultant arranged for Daniel Williams to be admitted, informally, to the Farndale Ward, Pontefract General Infirmary, that day. The Consultant said he spoke to the ward and passed on the information regarding the concerns of Warren Court, Daniel Williams' past history, including that he was on the Supervision Register, and also the issue of drug abuse. He also discussed the level of observation required and that Daniel Williams was not to leave the ward unescorted. The Warren Court manager and his keyworker escorted Daniel Williams to the hospital. His keyworker said she drew the attention of the nursing staff to the fact that he might have knives in his possession and also to the risk of his having hypodermic needles on his person.

On admission to Farndale Ward, Daniel Williams' belongings were searched by nursing staff for prohibited items. A record of his property was made. He told the admitting nurse that he had not used drugs for the last five days. The urine drug screening was negative. The admitting junior doctor clerked him in thoroughly and identified abnormalities in his mental state. The doctor agreed levels of observation and investigations with nursing staff.

Two days later, on 9 December, Daniel Williams was transferred to the Priory Unit in Wakefield. The doctor on the ward did not see him until two days later. By that time, the level of nursing observation specified had lapsed and the condition of no unescorted leave off the ward was not being implemented.

On 10 December, the police visited Warren Court to return the knives taken from Daniel Williams' room, one of which was identified as belonging to Daniel Williams. The police officer then took the knife to the Priory Unit. He gave it to a nurse (who he mistakenly believed to be a doctor). He informed the staff present that a large collection of knives had been found in Daniel Williams' room and that he might try to bring such knives onto the ward.

On 14 December 1998 Daniel Williams had a meeting with his Social Worker and a member of the Housing Department's homeless section. A formal assessment of his housing needs was completed and both the Social Worker and Daniel Williams were assured that the situation would be considered as urgent.

During his stay at Priory Unit, Daniel Williams visited Warren Court three times. The first visit was on 11 December. Daniel Williams visited to collect some belongings. The second visit was on 13 December when he said he had come with a friend and left after a short while. The third and last visit was on 18 December when he came to collect the last of his belongings. The manager and his keyworker drove Daniel Williams back to the Priory Unit. There he was told not to return to Warren Court as he had been evicted. He was said to have accepted this but was sad. He was dropped off at the entrance to the hospital with his belongings.

While on the Priory Unit, Daniel Williams was permitted regular unescorted leave. It was noted that he came back, at times, smelling of alcohol. On 19 December it was reported that Daniel Williams had consumed alcohol.

On the afternoon of 19 December, Adrian Pawson was permitted to go to the shop with another patient. On his return, he was chatting and joking with the staff and Daniel Williams. Later that afternoon, Daniel Williams had an argument with another patient who had taken offence at the Army type clothing he was wearing – which was noted as *"Army attire", "German uniform", "Nazi clothing".*

Adrian Pawson had intervened on Daniel Williams' behalf saying that Daniel Williams was entitled to wear what he wanted.

Daniel Williams was upset by the argument and told the staff at approximately 4 pm. The staff brought the two men together and mutual apologies were exchanged and accepted. At about 7.30 pm, Adrian Pawson was in the smoking room. Daniel Williams was alone in his own room.

At 7.55pm, Daniel Williams walked into the ward office. He was described by some members of staff as being calm, others variously described him as pale, shaken, upset and agitated. Without preamble, he said that he had killed Adrian Pawson. Noticing he had blood on his arm, two members of staff went to his room. On reaching his room, they could hear that repetitive "techno" music was playing. On pushing open the door, they found Adrian Pawson lying on the floor. It was immediately obvious to them that he was gravely injured. Attempts to resuscitate him failed. Twenty-two wounds had been inflicted, including wounds to the chest, abdomen, back, left lung, left-side neck and left leg.

At the trial it was stated that the stabbing was connected to the incident that afternoon which was referred to earlier. Daniel Williams told someone else he had done it because Adrian Pawson had come to his room. The knife was found outside below his room window. It was identified as one of the set of chef's knives he had purchased while at Warren Court.

A nurse had returned to the office where Daniel Williams had been waiting alone and called the police. Daniel Williams waited quietly until the police arrived and took control. The police said that the staff had dealt with the situation fairly well. They had closed off the room and Daniel Williams was kept separate from other patients. Daniel Williams was arrested and taken into custody.

FINDINGS -

1. The change in the chair of the meeting on 7 December was unhelpful but probably did not affect the outcome of the meeting.

2. The advocacy service was useful in providing support to Daniel Williams.

3. The lack of suitable facilities for a person with dual diagnosis meant that there was no alternative to hospital admission.

4. Although there was a patient's agreement about drugs on admission at the Farndale Ward it did not include dangerous items such as sharp objects.

5. There was uncertainty in the Priory Unit about the circumstances in which patients and their belongings could be searched leaving a vacuum where there should have been a clear policy.

6. No record was made in the medical notes about when and how the observation levels and the restriction of leave from the ward without an escort were allowed to lapse. The Consultant was unaware that this had happened following the transfer to Priory Unit.

7. Assessment of risk at the hospital concentrated on the here and now, did not take account of Daniel Williams' previous history and was not undertaken systematically.

8. The police are to be commended for returning the knife in their possession belonging to Daniel Williams to nursing staff for safe-keeping and not to him.

9. The nursing levels at the time of the killing were inadequate, taking into account the design and layout of the ward and the needs of the client group. Whether this would have affected the outcome is not clear.

10. The Trust offered counselling services for staff involved in the incident.

11. There is no evidence in Daniel Williams' case of a policy to guide the management of inpatients who misuse substances during their period of inpatient care.

DANIEL WILLIAMS – 19 DECEMBER 1998 TO 18 FEBRUARY 2000

Daniel Williams was charged with murder and was remanded in prison pending trial. On 8 January 1999 he was seen by a consultant psychiatrist. At the time of this examination the consultant psychiatrist suspected that Daniel Williams might be suffering from a mental illness namely paranoid schizophrenia in a setting of a long-standing history of amphetamine abuse. Further, there was a possibility that he was a danger to himself. It was recommended that he be transferred to a secure hospital.

Daniel Williams was transferred to Rampton Hospital under section 48/49 of the Mental Health Act 1983 on 2 February 1999. During his stay at Rampton Hospital it was reported that he did not show evidence of a psychotic illness. The medical and nursing assessments at Rampton Hospital were that he suffered from a personality disorder and that he had a history of psychotic symptoms related to his use of amphetamines. A multi-disciplinary team review confirmed the diagnosis of personality disorder within six weeks of his admission.

Daniel Williams was returned to prison on 4 May 1999.

On 18 February 2000 Daniel Williams pleaded guilty to manslaughter on the grounds of diminished responsibility. The medical reports available to the court agreed that Daniel Williams suffered from paranoid schizophrenia and a severe psychopathic personality disorder which was likely to have impaired his responsibility for his actions.

The Judge stated that the reports indicated that the condition was not susceptible to treatment in a mental hospital and therefore he could not make an order that Daniel Williams be detained in hospital. The only sentence available was one of life imprisonment which was the sentence passed.

COMMENTARY -

Daniel Williams was admitted to Rampton Hospital for assessment and stayed there for approximately eight weeks. During this time his depot medication was withdrawn and his diagnosis was reformulated as psychopathic disorder. The relatively short stay was insufficient to assess reliably the impact of withdrawing long-term maintenance medication for schizophrenia. Daniel Williams has reported the return of auditory hallucinations to his family when they visited him in prison since the trial. He did not appear well when the Panel visited him. Although not within the remit of this Inquiry we would request that on-going psychiatric assessment should be provided whilst Daniel Williams is in prison.

TABLE OF KEY EVENTS

DANIEL WILLIAMS (DW) – TABLE OF KEY EVENTS 22.9.97-19.12.98

DATE	EVENTS	SOCIAL SERVICES	MENTAL HEALTH SERVICES
22.9.97			DW admitted to Priory Unit under MHA Section 3 following non-compliance with medication
22.11.97		Warren Court staff raised concerns with ward regarding DW's threatening manner. Told DW fine on ward	
1.12.97		DW's social worker noted DW ready for discharge	CPA review. CPA care coordinator and social worker relayed concerns of Warren Court staff about DW's hostility. Leave agreed
18.12.97			Consultant ward round – Warren Court to be consulted about possibility of DW discharge
19.12.97		Warren Court staff requested Section 117 meeting. DW discharged – no prior discussion with CPA care coordinator	
21.12.97		Warren Court staff wrote to management about joint working with health and inter-agency communication. Reference made to threats by DW	
29.1.98		Review meeting. DW not paying rent, had arrears and debts. DW said he was spending money on drugs. DW often missing appointments with social worker. Suggest applying to specialist housing provider	
16.2.98			DW attended A & E unit – getting regular messages to brain to kill people. Admitted to hospital. DW confirmed he was regularly using drugs
10.3.98			Discharged to Warren Court with follow up as outpatient and CPN to administer medication
27.4.98			Taken to A & E-had attempted to inject air into vein. Admitted Priory Unit
5.5.98			Discharged in his absence to Warren Court
11.6.98	Social worker made home visit to DW's mother. Family expressed continued care and support as well as fears when DW aggressive		
3.7.98	DW visited by social worker. DW agitated and angry towards consultant. Denied any mental health problems. Refused medication and visit by SUMIT		
9.7.98	DW assaulted. Told police a stereo stolen from him		
27.7.98		DW discussed medication with Warren Court staff – agreed to have it	
28.7.98	DW noted to be carrying a knife		

DATE	EVENTS	SOCIAL SERVICES	MENTAL HEALTH SERVICES
30.7.98	CPN attended. DW refused medication. Refused to see SUMIT worker		
31.7.98		Warren Court staff contacted social services department concerning DW's mental health	
3.8.98		Social worker contacted by Warren Court staff regarding risk to others of DW carrying knife, and his hostility and paranoia. DW noted to be abusive and hostile to another resident	
4.8.98	DW attacked by an acquaintance - taken to A & E –open wound to skull		
5.8.98			Admitted to Calder unit – non compliance with medication. Had been abusing amphetamines and trouble with local youths. Did not want to return to Warren Court
13.8.98			DW transferred to Priory. More settled
7.9.98			CPA meeting – main issue: accommodation; rent arrears. Difficulty obtaining alternative to Warren Court. DW did not wish to return there. Leave agreed
8.10.98	DW put in complaint about his diagnosis of paranoia		
9.10.98			CPA discharge meeting at Priory. Risk assessment to be sought from forensic service. Accommodation discussed. DW did not wish to return to Warren Court. Priory agreed he could visit the unit every day
12.10.98			Discharged to Warren Court
16.10.98	DW's mother visited – advised not to assist DW in cleaning his room because of risk of needlestick injury		
27.10.98	Incident at Warren Court involving another resident and alleged sale of drugs. Police called	Warren Court staff concerned re DW's hostility and threats of aggression	
28.10.98		Strategy meeting. Agreed if DW threatening or under influence of substances police to be called. Social worker received several calls in preceding 2 weeks from staff concerned about DW's behaviour. Management request CPA review urgently	
1.11.98	DW purchased set of chef's knives		
3.11.98		DW showed knives to night staff	
4.11.98	DW spoke to Trust wishing to pursue complaint about diagnosis. DW returned prescribed medicine to Warren Court staff saying he did not require it.	Warren Court meeting – increased staff levels agreed. Police safe team to be consulted. CPA meeting to be convened urgently – management urged need for joint approach to DW's needs. Once suitable alternative placement found management agreed that 4 weeks' notice to quit Warren Court could be given to DW	

DATE	EVENTS	SOCIAL SERVICES	MENTAL HEALTH SERVICES
5.11.98		Letter sent from mental health team manager to consultant reiterating need for joint approach and urgent CPA. No acknowledgement on file	
6.11.98		DW informed of staff meeting outcomes (but not that he would be given notice when suitable placement found). Police Safe team visited Warren Court – a representative to attend next CPA. Policy for waking night staff agreed	
7.11.98	DW met social worker – wanted to restart contact with SUMIT		
12.11.98		DW asked Warren Court management about legality of carrying a knife. Advised not acceptable in Warren Court/seek advice from police who were coincidentally in the building	
13.11.98	DW informed Warren Court staff he had found private rented flat		
16.11.98	DW low in mood – no longer felt able to take up tenancy	Letter to Warren Court managers from a Warren Court staff member expressing concerns at situation and risks inherent for DW, other residents and staff	
Mid to late Nov		Senior management indicated funding would be available for external placement for DW in event of suitable placement being found within context of DW's care plan	
18.11.98	Knives noted to be missing from Warren Court kitchen		Abortive CPA meeting due to unavailability of key staff. To be rearranged as soon as possible
23.11.98	DW kept appointment with SUMIT. Seen by CPN		
30.11.98	DW noted to be cooking turkey purchased for Warren Court residents' Christmas lunch	Social worker informed of problems with DW. Residents told Warren Court staff that missing kitchen knives were in DW's room. Letter sent to GP inviting her to CPA meeting and referring to deterioration in DW's mental health	
1.12.98	Complaint received from 8 Warren Court residents re DW's behaviour		
2.12.98			DW attended outpatient appointment – found to be mentally stable. Consultant saw social worker – thought issues could wait until CPA on 7.12.98 therefore did not speak with Warren Court manager
Later 2.12.98	DW arrested at Warren Court in connection with alleged thefts. His room searched, items removed including assorted knives. Bailed to return to police station on 22.12.98		

DATE	EVENTS	SOCIAL SERVICES	MENTAL HEALTH SERVICES
3.12.98	DW visited Turning Point (drug misuse service)	DW given verbal notice to quit Warren Court on 7.12.98 at 3.00pm. (Supervisor had agreed that DW would not be evicted in the event of no suitable alternative being identified and secured for DW)	
4.12.98	DW reported he had taken overdose. Admitted via A & E department to ward 3 at Pinderfields General Hospital.	Social worker contacted Housing Aid Homeless Section to assist DW. Informed consultant of current situation. Social worker unable to attend CPA on 7.12.98	
5.12.98	DW discharged himself from hospital		
7.12.98			CPA meeting at Priory. DW admitted to Farndale Ward Pontefract until more appropriate accommodation found. Mental health team considered decision to make DW homeless inappropriate. Consultant indicated nursing observation level to be used and no unescorted leave. DW rent arrrears £800
7.12.98 later	Keyworker and social worker took DW to Farndale ward for admission. Gave full history including warning that DW might have knives and/or needles with him		Full examination and risk assessment done by admitting doctor. Reiteration of nursing observation levels and no unescorted leave
9.12.98			DW transferred to Priory. No record of examination on transfer or agreement to change nursing observation levels and unescorted leave
10.12.98	Police visited Warren Court to return kitchen knives from DW's room. Police return one knife belonging to DW to Priory and give to ward staff for safe keeping	Formal letter to DW asking him to collect belongings by 18.12.98 and explaining he would not be allowed to return to Warren Court thereafter	
11.12.98	DW returned to Warren Court for belongings on foot and unaccompanied		DW seen by junior doctor at Priory – no reference to risk
13.12.98	DW returned to Warren Court on foot with friend		
14.12.98		Social worker and Homeless Department representative meeting with DW at Priory to complete formal assessment of his homeless circumstances	
15.12.98			First ward round since admission. Consultant called away and did not see DW, round completed by colleague
18.12.98	DW collected last belongings from Warren Court	DW assisted by Warren Court management and keyworker to take his belongings to Priory. Manager explained to DW that he could not return to Warren Court	Seen again on ward round. Medical notes state "remains well, not psychotic, compliant with treatment"
19.12.98 later	DW had argument with fellow patient at Priory. Mutual apologies exchanged. DW killed AP		

ASSESSMENTS

FAMILY/CARER ISSUES

Daniel Williams first came in contact with the mental health services in Wakefield in April 1993, when the Consultant visited him at his mother's home. This was the first and last time that Daniel Williams' mother met the Consultant in person. At this stage Daniel Williams had a diagnosis of personality disorder and the Consultant informed his mother of this. Although the diagnosis was subsequently changed, it was not until his court appearance after the incident that the family learned that Daniel Williams was suffering from schizophrenia.

Although she and other members of his family evidently cared deeply for Daniel Williams, visiting him regularly both at Warren Court and in hospital, they made it clear to the Panel that they felt that they were not kept appropriately informed about, or involved with, his care. For example, when his family visited him at Warren Court, Daniel Williams would sometimes become disturbed and agitated, but when they asked for advice about how they should try to maintain the relationship they were simply advised to stay away. Although it was felt by the clinical team that it was best for both Daniel Williams and his mother that they should be kept apart, the rationale for this was not made clear to the family.

It is a requirement of the Care Programme Approach and of the Supervision Register, which was then in use, that a proper assessment of the needs of families and carers be carried out. There is no evidence that this in fact took place, nor that the family was invited to CPA meetings prior to discharge.

After the incident, the family had contact only with the police. They stated that they had received no offers of support from the mental health service whose responsibility it had been to care for Daniel Williams.

These themes of lack of information, involvement and support were largely re-iterated in the evidence provided by the family of Adrian Pawson, although the support of the keyworker was warmly appreciated by them.

CARE PLANNING

The Care Programme Approach (CPA) was introduced in 1990 to ensure that people with severe and enduring mental illness, and/or with complex needs, would receive systematically planned and coordinated packages of care which would integrate the views and contributions of different professionals and agencies, families, carers and the patients themselves. Clearly, Daniel Williams,

with a diagnosis of schizophrenia and a complex range of needs requiring input from a range of services, was the kind of person for whom the CPA was intended.

From Daniel Williams' first admission to in-patient care in 1995 his care coordinator was a Social Worker. After he began his stay at Warren Court the task of the CPA care coordinator was a complex one, requiring attention to Daniel Williams' mental state and therefore liaison with health staff such as the Consultant and the CPN, to his substance misuse, to his social care needs and to the challenges arising from his residence at Warren Court.

Problems occurred with the effective functioning of the CPA; for example, after the CPA review meeting on 1 December 1997, Daniel Williams was discharged from hospital to Warren Court without the care coordinator being aware, and although a discharge letter was written, no coordinated discharge planning took place. It became evident to the Panel that by late 1998 the CPA care coordinator was caught between the continuing pressure from Warren Court for Daniel Williams to be re-located, the perception by the health staff (and himself) that Daniel Williams' mental state did not indicate admission, and the lack of any other alternative service to which he could be moved.

Unfortunately, the care coordinator was unable to be present at the final CPA meeting on December 7 1998, although he arranged for his views to be represented. Aware that Warren Court were planning to evict Daniel Williams, he believed that this CPA meeting would be an opportunity for all the issues to be explored and an agreement reached between the different professionals and agencies involved. As it turned out, the CPA meeting did not function in this way. All witnesses who were present agree that the meeting was very difficult and that it was in effect a confrontation between health staff and staff from Warren Court. Matters were not helped by an unfortunate change of chair part way through what was a tense meeting. Vital information from Social Services management that Daniel Williams would not in fact be evicted regardless of the views of Warren Court staff was not communicated to the meeting.

Faced with what he believed to be a fait accompli, and under the impression that Daniel Williams was to be evicted from the hostel, the Consultant arranged for his admission to a bed in Farndale Ward, Pontefract General Infirmary. The fact that neither he, the keyworker nor the other health service staff considered this admission to be necessary on mental health grounds was to influence subsequent events, since the ward staff both at Farndale Ward and then the Priory Unit treated his stay as a social admission due to his lack of accommodation, and care planning from then until the incident took no real account of any potential risk which Daniel Williams might present.

The nursing care plan formulated when Daniel Williams was admitted to Farndale Ward reflected the Consultant's instructions that he was to be observed every thirty minutes and was not to leave the ward unescorted. After his transfer to the

Priory Unit two days later this observational regime had lapsed, there was no reference in the nursing records to the need to maintain any but general observations, and Daniel Williams was coming and going from the ward as he chose. On several occasions he was noted to have returned to the ward showing signs that he had been drinking, and on three occasions he returned to Warren Court for his belongings unaccompanied.

There were some failings in the way in which the care of Daniel Williams was planned. However, care planning can only operate effectively where a spirit of co-operation exists between professionals and agencies, and we conclude that intransigent attitudes as much as human error underlay the events which led to the final admission of Daniel Williams to hospital and to the incident.

SUBSTANCE MISUSE

Daniel Williams was an habitual user of illicit substances from an early age. While in his teens he was said to have inhaled glue. When he was aged twenty his medical records showed that he used cannabis and in 1996 he admitted long term heroin use and use of other drugs. There were numerous references in the records to him taking amphetamines right up to his last admission to hospital on 7 December 1998.

In 1998 Daniel Williams had contact with SUMIT. This project provides a service to people with substance misuse problems involving drugs, illicit substances and alcohol. He was seen by SUMIT four times during the summer of 1998. Daniel Williams wanted SUMIT to prescribe amphetamines and did not want to change his drug habits.

In November 1998 Daniel Williams decided to resume his contact with SUMIT. He was seen on 23 November. Again the assessment was that he wanted to be prescribed amphetamines and was not interested in medication designed to help him. As he lacked the motivation to change his behaviour SUMIT ended its involvement with him.

On 3 December 1998 Daniel Williams contacted Turning Point which is a non-statutory agency which operates Druglink and offers counselling, advice, information and support to current or former drug users, their families and friends. They agreed to accept this self referral and an appointment was to be sent to him.

We are of the view that SUMIT provided a reasonable service within the limits of its resources. The medical consultant who heads the project has a very high workload which in our view is unsustainable in the long term.

SUMIT's protocols and procedures were adequate. SUMIT followed its protocols with Daniel Williams but he did not fit its criteria. He lacked the will to change his behaviour. He was also receiving treatment for a mental illness, and SUMIT was not set up to deal with dually diagnosed persons. Despite this he was seen by SUMIT at least five times.

Our discussions with SUMIT revealed a gap in services offered. There are no services for dually diagnosed persons, by which we mean those with the presence of a mental disorder co-existing with another mental health diagnosis, including substance misuse. Although the drug workers identified the need for this client group they had no sense that there was any long term planning to provide it.

The plans drawn up jointly by Social Services and the Trust to provide a package of services for people who challenge services are, in general, very comprehensive. However we were not clear whether there were firm plans to meet the needs of those people with dual diagnosis.

Our discussions with the mental health team responsible for Daniel Williams indicated that they were uncertain as to the extent of the contact he had with SUMIT. His Consultant did not know of it. It would be good practice, in cases where SUMIT sees a dually diagnosed person who they are unable to help, for SUMIT to inform that patient's consultant.

Both Turning Point and SUMIT cover the same geographical area. Daniel Williams twice, when refused by one service, went to the other. This shows the ease with which people can move from one service to the other. It also indicates the need to share information between different agencies so that this can be used in the planning process to develop a strategy to respond to local needs.

THE PRIORY UNIT

During his last periods of stay as an in-patient Daniel Williams was mainly in the Priory Unit at the Fieldhead Hospital at Wakefield. This is an acute mental health unit which cares for men and women aged from 16 to 65. In December 1998 this was a 48 bed unit all comprising single rooms. It opened in 1997 following a refurbishment. It had previously been used by a hospital trust for elderly patients' rehabilitation.

The unit was split into two areas each with 24 single bedrooms. The two areas were connected and there was no distinction between Priory 1 and Priory 2.

The Wakefield Community Health Council visited Priory Unit in October 1997 and again in November 1998. In each case a report was prepared for the Trust.

They identified a number of issues which they took up with the Trust. Two issues are particularly relevant to our inquiry.

The first issue was the ease of access into and out of the unit without being observed. The CHC said that carers explained that people could walk in and out of the unit freely. They also stated that they could walk around the unit without being challenged by staff. The carers were concerned that anyone could walk on to the unit and their relative could be at risk. The staff offices were not at the entrance to the unit and were said to be difficult to locate. Both Adrian Pawson's and Daniel Williams' relatives commented about this. Daniel Williams' relatives said that the unit was like a youth club with people walking in and out, and that it was difficult to tell who were staff, patients or doctors. Adrian Pawson's relatives said that it was like a hotel with patients coming and going as they wished.

The second issue concerned patients' safety. The unit comprised single bedrooms which made nursing observation of patients difficult. It was hard to keep track of patients as the two units were connected and there was more than one entrance. We were told that concerns about the layout had been expressed by medical and nursing staff to management; that those concerns were acknowledged prior to moving into the accommodation, and that the solution was to be increased nurse staffing levels. Staffing levels had not been increased; the impression of staff was that the reverse had occurred.

Since December 1998 a number of measures have been taken by the Trust. Originally there had been no distinction between the two wards within the Priory Unit. Now they have been separated and there is no open access between them. The reception has been changed. The reception is manned during the week during office hours. A small office has been created behind new reception desks which is occupied by administrative and research staff.

In 1999 the ward was fitted with a Pinpoint alarm system. This requires each member of staff to have a personal alarm activator attached to them. Once activated an audible alarm is sounded and the location is given to pagers carried by staff. The staff also have ID tags as well as wearing belts on which they have keys and their personal alarm.

The Trust also states that the following further measures have been taken:

- A policy for the issue and care and control of keys has been introduced
- Training in control and restraint techniques
- A policy has been developed governing the searching of in-patients and their belongings.

- A policy has been developed governing escorting patients away from the unit.

- Procedures have been implemented for handling and storage of suspected illegal substances.

- A banned and controlled items policy has been implemented for the High Dependency unit with a view to it being extended into the remainder of the in-patient areas.

As already stated the nursing levels in the Unit at the time of the killing were inadequate taking into account the design, layout and client group although it is uncertain that this would have affected the tragic outcome.

CLINICAL AND RELATED ISSUES

It was evident from our review of the notes that Daniel Williams was a very ill young man. He was admitted to hospital from Warren Court four times in the year before the killing. There is no record of any functional assessment despite the difficulties he had in managing money and the social impact of his disordered behaviour and odd dressing style. The severity of his illness and the associated social disability were underestimated. Following the breakdown of his placement at Warren Court, he needed admission for intensive rehabilitation, not a social admission.

He also had severe substance use disorder; the impact of continuing alcohol and drug misuse on his mental state was not recognised; and no steps were taken to reduce it whilst he was an in-patient after the move to Priory Unit. He needed skilled intervention to manage his substance use safely, as one part of the treatment for his chronic schizophrenia. This was not available.

Daniel Williams' Consultant was called away to court during the ward round where Daniel Williams' risk assessment and leave from the ward could have been discussed.

Daniel Williams was not seen by a junior doctor for two days after he was transferred from Farndale. During this period, the level of observation and leave arrangements agreed by the consultant on admission lapsed. There was no opportunity to review these management decisions, and Daniel Williams was allowed to leave the ward. This gave him the opportunity to drink alcohol and

collect his knives. There is a need for robust inter-ward transfer procedures and for training of medical staff in addressing risk management on a regular basis.

The killing of one young man by another in hospital is an horrific event. Both men had families who were understandably traumatised and needed support. We were told by Daniel Williams' family that this did not happen with them. Staff were also traumatised, and support particularly to senior staff appeared haphazard. Management should ensure that there is sensitive staff support and that support is offered to families of both victim and perpetrator.

TRUST MANAGEMENT

Both Daniel Williams and Adrian Pawson were, at the date of the killing, patients in the Priory Unit of the Fieldhead Hospital Wakefield. The hospital is part of the Wakefield & Pontefract Community Health NHS Trust.

The Trust serves a population of 320,000 people spanning the Wakefield Metropolitan District. The Trust has about 2000 employees based in a total of more than 50 locations. Services are provided from hospital sites in Hemsworth, Castleford and Wakefield as well as clinics and health centres, group homes for people with mental illness or learning disabilities, community homes for elderly people with dementia and respite care units for children with learning disability.

The Trust has to work in demanding circumstances and there is pressure caused by lack of resources. The inpatient units were said to have occupancy levels of between 107% and 120%. The workload of the medical and nursing staff is considerably higher than the levels recommended by their professional bodies. The Chief Executive of the Trust said that the Trust had to meet a demanding cost improvement programme. It had released nearly six million pounds in costs to help balance the books in the district as a whole.

In the course of the Inquiry we met and took evidence from local Members of Parliament, local GPs, Wakefield Community Health Council and the Social Services Department of the Local Authority as well as the relatives of both Daniel Williams and Adrian Pawson.

We also met and took evidence from employees of the Trust. This included medical and nursing staff as well as Trust management, including the Chief Executive.

An issue that arose repeatedly was poor communication with the Trust management. The Trust was seen as being defensive and unwilling to engage in a constructive dialogue.

During the period between August 1997 and October 1997 there were four deaths of patients whilst in the care of the Trust. An internal review was set up under the leadership of the Chief Executive. Recommendations were made but the conclusion was that there was no evidence to indicate any link between the four deaths and that appropriate action had been taken to provide adequate care to all four patients.

An external review was also undertaken. The report of that team was said to be confidential because it contained personal details of patients. Its recommendations were included in a paper which went to a public Trust meeting. A request by the Community Health Council to see the external review team's report was met by a robust refusal. A local Member of Parliament with a constituency interest and who had also raised issues with the Trust spoke of his difficulty in obtaining relevant extracts of the report. The Consultant said that the report had not been officially disclosed to him. We were told that medical staff often found themselves having to respond to, rather than being involved in, planning. Their perception was that rather than being involved in a process, solutions were imposed upon them and they had to try to work within them. (A copy of the recommendations and actions following the external review of mental health services is attached at Appendix 2).

The Community Health Council said the view of carers was that whatever people complained about the Trust seemed to be able to justify it. This perception is strengthened by the conclusion of the internal inquiry into the killing of Adrian Pawson which was that the attack could not have been predicted or prevented, a view clearly articulated to us by the Consultant and other senior professional staff in the hospital. This is not our view.

To categorise the killing as an entirely unpredictable event removes the need to invest energy in reducing the risk of similar incidents in the future. Minds are closed to the professional learning which should come out of the tragic events.

The lessons that need to be learned will require the Trust management to create an environment where criticism can be used positively as a tool to improve the service it provides to the people of Wakefield.

SOCIAL SERVICES

Although a number of Social Services staff made substantial contributions to Daniel Williams' day to day care and pertinent contributions to risk assessment, the overall coordination of care management by the Social Services Department in the period prior to his last admission to hospital in December 1998 was ineffective, and there were significant gaps in liaison between the department and Daniel Williams' family.

A care coordinator, a mental health Social Worker with case management responsibility, had overall responsibility for Daniel Williams' care within the department, involving liaison with residential care staff, Daniel Williams' consultant psychiatrist, other health professionals and voluntary sector agencies. Senior managers with responsibility for residential care functions had parallel responsibility for day to day care issues concerning Daniel Williams. The care coordinator took insufficient account of the concerns of residential staff about the risks posed by Daniel Williams to other residents and to staff in the months preceding his final admission to hospital. The care coordinator disagreed with residential staff about the seriousness of Daniel Williams' mental state and the risks he posed at this period. This divergence of view contributed to the turmoil at the final care planning meeting on 7 December 1998. The absence of the care coordinator at the final care planning meeting compounded the difficulties faced by those involved.

Although the care coordinator had some significant contact with Daniel Williams' family, this was not consistently sustained and the Social Services Department did not integrate the family in planning for Daniel Williams' social care over the period of their involvement with him. Not involving Daniel Williams' family prior to his admission to hospital in December 1998 was a significant omission, and too little regard was paid to the risks to which members of Daniel Williams' family were exposed from his threatening behaviour. This contrasts with the high standard of support provided by the same care coordinator to the family of Adrian Pawson.

Daniel Williams was quite unable to manage his own finances. His accumulated rent arrears became a significant problem and Daniel Williams declined help from Social Services to deal with this. There is no record that Social Services considered taking further powers, for example appointeeship.

Warren Court was resourced to provide supportive care to people with moderate mental health problems who were capable of living with a degree of independence in a hostel setting. Warren Court was not resourced to look after a person with such complex needs as Daniel Williams. The contribution made by staff at the unit to Daniel Williams' care over extended periods is to be commended. Staff at the unit monitored Daniel Williams' behaviour carefully,

liaised with other professionals including the general practitioner, and made significant and positive contributions to risk assessment throughout the period leading up to Daniel Williams' admission to hospital in December 1998. These risk assessments took account of the needs of other residents and were well documented. Too little heed was paid to these views by other professionals involved. Residential managers recognised the determined efforts by Warren Court staff to support Daniel Williams. Residential staff were influenced by the fears of other residents in setting in train notice to quit procedures. These steps were understandable but inappropriate and contributed significantly to the tensions experienced at the December care planning meeting.

Warren Court staff were aware that Daniel Williams had obtained a set of chef's knives at the beginning of November 1998. It would have been appropriate for the staff to have checked whether he was simply using these for cooking or with more dangerous intent. Warren Court staff could have done more to involve the care coordinator when they were considering evicting Daniel Williams at the end of November/early December.

We agree with the conclusions of the Social Services management review that record keeping fell below required standards although the day to day record of Daniel Williams' progress at Warren Court was thorough during his periods of residence there.

INTERNAL INQUIRIES

The Trust and the Social Services have conducted separate internal inquiries and a joint inquiry into the events leading to the killing on 19 December 1998.

The Social Services reviewed their involvement with Daniel Williams up to their last contact with him on 18 December. The Trust inquiry's remit was to review the care provided to Adrian Pawson and to Daniel Williams, including the death and its immediate aftermath.

The Social Services undertook a thorough review. Its report contained a detailed analysis of the history, with clear recommendations and conclusions. The recommendations included:

- The need to improve communications between the Trust and Social Services
- The planning of care for those with very complex mental health needs
- The inclusion of service users in care assessment and management

- Appropriate procedures on the issuing of a "notice to quit"
- Agreements on risk assessment between the Trust and Social Services
- An integrated approach with drug agencies
- Arrangements for "checking in" belongings of service users from Warren Court on admission to hospital.

The Trust review focused mainly on the killing and the immediate aftermath. The earlier history, events and issues up to the last admission were, as a result, not given the scrutiny required. The recommendations were largely concerned with the issues around the incident and its management. The recommendations were:

- Review of the general training needs of medical and nursing staff
- Review of the training of staff in managing emergencies
- Review of policies for mental health services including development of policy on " property checks" on admission and on inter-ward transfers.

The report reached the conclusion that the violent attack on Adrian Pawson could not have been predicted or prevented. This conclusion is not accepted by the panel. The attack on Adrian Pawson could not have been predicted but there were sufficient factors present to indicate that the assessment of Daniel Williams presenting a low risk was wrong.

There followed a joint health and social services review by two senior officers each from the Trust and from the Social Services. They were of the view that the single most significant issue was the absence of appropriate accommodation for Daniel Williams to meet his needs; that staff at Warren Court clearly believed Daniel Williams was misplaced there, and that he represented a risk to other residents; and that health staff agreed to his admission to the Priory Unit in the belief that there was no alternative.

SUBSEQUENT DEVELOPMENTS

The Trust jointly with the Social Services has taken a number of steps since the killing on 19 December 1998 which we broadly welcome, including:

- The commissioning of a project to identify individuals who present a challenge to the services and examine their needs.
- The appointment of a Mental Health Development Manager with responsibility to review policies and develop joint working.
- Roles of Community Mental Health Team (CMHT) coordinators have been reviewed and agreement reached about joint appointment of team managers.
- The holding of a major clinical risk assessment conference and the Trust has subsequently implemented recognised risk assessment formats into inpatient care.
- Agreement that the number and boundaries of CMHT teams match Primary Care Groups and that Consultant Psychiatrists will be closely aligned to CMHTs
- Agreement to the joint appointment of a National Service Framework Project Coordinator to develop and implement the local action plan.
- Agreement on a joint investment plan for mental health services. This includes the use of assertive outreach as a means to meet the needs of people who challenge services.
- The Trust's out of hours Crisis Service has been extended.
- The Trust has now appointed a consultant in rehabilitation psychiatry.

The Trust and the Social Services recognize that twenty four hour staffed accommodation providing medium to long term care for individuals like Daniel Williams does not exist in Wakefield. This situation is not unique to Wakefield.
This gap in service is to be covered by use of assertive outreach teams as agreed in their joint plan.

FAMILIES AND CARERS

There was little evidence of involving the family in the care planning for Daniel Williams. Although it is accepted that Daniel Williams was seen as a risk to his mother, his family, including his mother, maintained contact and gave support throughout.

The notice requiring Daniel Williams to leave Warren Court was given without any consultation with his family. This was a serious omission as Daniel Williams was seen as a particular threat to his mother. She and other family members would have had to deal with his behaviour and provide support, including shelter, if he were allowed to become homeless.

1. **We recommend that:**

i. **the Trust and the Social Services re-emphasise the need to actively involve families and carers in planning the care of patients. A full review meeting, including carers, should be held before major decisions are made in accordance with existing care planning guidance;**

ii. **vulnerable patients should only be discharged (or evicted) into independent accommodation if consistent back-up support is made available.**

PROHIBITED ITEMS

One of the striking features was the lack of a clear policy about the items which could not be brought on to the ward. This ambiguity was present in the evidence of senior management.

It appears that different practices were being implemented within the Trust. On Daniel Williams' admission to the Farndale Ward in Pontefract on 7 December 1998 a search was made of his belongings. On his transfer to the Priory Ward in Wakefield no such precautions were taken.

2. **We recommend that:**

i. **Trust staff be made aware of, and be trained to implement, a clear policy which identifies dangerous and prohibited items which must not be in the possession of patients, whether their admission is a formal or an informal one;**

ii. **all patients and visitors be made aware of this policy and how it is to be implemented.**

EXTERNAL COMMUNICATIONS

There is a need to improve the quality of communications between the Trust and external agencies. We heard from a number of different quarters of the poor communications which exist between them and the Trust.

3. **We recommend that:**

i. **the Trust be more open to sharing information, and that to this end it reviews its communications policies about sharing information with other agencies who have a legitimate interest, subject to having due regard to confidentiality;**

ii. **the Trust takes steps to improve its relations with other agencies involved in the provision of an individual's care and treatment, including independent agencies such as General Practitioners, Community Health Councils and other representatives of local people;**

DEVELOPMENT AND TRAINING

The view was expressed by a number of the medical and nursing staff that the killing of Adrian Pawson was not predictable, that it was a total surprise, and that the assessment of Daniel Williams was that he presented a low risk.

This view was also stated in the major incident review by the Trust which said that Daniel Williams' "violent attack on Adrian Pawson could not have been predicted or prevented".

We do not accept this view. There was a risk of a violent attack. There were sufficient factors present to indicate that the assessment of low risk was wrong. There was no current risk assessment. His GP

was of the view that Daniel Williams presented a very high risk to other people and to himself. Daniel Williams had expressed homicidal ideas, he had been diagnosed as suffering from paranoid schizophrenia, he was known to possess dangerous weapons, was known to abuse drugs and had a history of homicidal thoughts and violence.

If the Trust and its staff persist in their view that the killing could not be prevented or predicted, their minds will be closed to the professional learning that must come out of the killing. The need to invest energy to reduce the risks of future incidents will be lacking.

We were told that the external report commissioned by the Trust, following a number of inpatient suicides, was not officially disclosed to the clinical staff involved; and that medical staff feel that rather than having an input into planning, they have solutions imposed upon them and have to try to accommodate them.

4. We recommend that:

i. the Trust develops a strategy for risk assessment and management which includes:

- **reviewing risk factors**
- **training for caring for patients with dual or multi-diagnosis**
- **staff development**
- **inter-agency working**

ii. the Trust develops protocols to improve the involvement of clinical and nursing staff in formulating policy

iii. the Trust develops policies which facilitate professional learning from untoward incidents

INTERNAL TRANSFER OF PATIENTS

Daniel Williams was transferred from the Farndale Ward in Pontefract to the Priory Unit at Wakefield on 9 December 1998. On Farndale Ward he was not allowed to leave the ward unescorted and was on a specified observation level. On the Priory Unit he was allowed to leave the ward as he wished and the level of nursing observation was allowed to lapse. There is no record of how or when these restrictions were altered.

5.We recommend that:

i. **there be a full multi-disciplinary exchange of information and discussion when patients transfer from one ward to another;**

ii. **receiving wards only amend the advice and management plan from the referring ward after careful consideration and discussion**

SERVICES FOR PATIENTS WITH DUAL DIAGNOSIS

Neither Warren Court nor SUMIT were able to provide the kind of service needed by someone like Daniel Williams, who had both a severe mental illness and an illicit drug habit. Dual diagnosis has become increasingly prevalent in recent years, and it is important that this issue is addressed.

6. **We recommend that a service be developed to meet the needs of people who require mental health care and treatment and who have a dual diagnosis**

SOCIAL CARE

Daniel Williams' social care was shared between the Trust and the Social Services. His Social Worker was also his care coordinator. Although several Social Services staff members knew Daniel Williams well, accountability for his social care was, at times, confused, and the contributions of staff members to decision making regarding Daniel Williams late on in 1998 were not well coordinated. Social Services should have taken a more pro-active approach to helping Daniel Williams to manage his financial affairs and also to investigating the knives which came into his possession in the second half of 1998.

7. **We recommend that the Social Services, in conjunction with the Trust as appropriate, reassess its policies with the following objectives:**

- **to ensure that all involved are clear about where lead responsibility for service users with mental health problems is located, and to ensure that other staff can make a full contribution to coordinated decision making;**

- **to provide maximum protection to all service users, members of the public and staff;**

- **to develop a proactive policy to use methods such as appointeeship to manage the financial affairs of service users who are unable to manage this aspect of their lives independently.**

APPENDICES

APPENDIX 1

TERMS OF REFERENCE

1. To examine all the circumstances surrounding the care and treatment of Daniel Williams, by the Mental Health Services of Wakefield and Pontefract Community Trust, until 19 December 1998 which include:-

   - the quality and scope of mental health and social care

   - the assessment and management of risk

   - the appropriateness of the treatment, care and supervision in relation to:

     - assessed health and social care needs
     - risk assessment in terms of harm to self and others
     - previous psychiatric history including drug, or alcohol abuse

   - the appropriateness of professional and in-service training of those involved in the care of Daniel Williams or the provision of services to him including the training of mental health staff to manage or access care for medical emergencies

   - the extent to which an effective care plan was drawn up, delivered and complied with by the patient.

2. The extent to which Daniel Williams' care complied with statutory obligations, local operational policies and relevant guidelines from the Department of Health, at the relevant times.

3. To examine the adequacy of collaboration and communication between the agencies involved in the care and treatment of Daniel Williams.

4. To prepare a report and make recommendations to Wakefield Health Authority.

5. To publish a summary of the findings and recommendations

APPENDIX 2

TRUST RESPONSE TO RECOMMENDATIONS OF EXTERNAL REVIEW OF MENTAL HEALTH SERVICES COMMISSIONED IN 1997

Recommendation 1

Risk assessment and management policy, incorporating clinical risk management to be devised and implemented. Policy to clearly articulate where responsibility lies within the Trust.

The review team had been issued with the Trust's risk assessment policy and copies of the Clinical Governance Strategy, which addressed these issues and defined lines of accountability and responsibility.

Further evidence presented at the Trust Board meeting of 4 November 1999 to demonstrate action in this area included:

- The comprehensive application of a standard risk assessment tool.
- Integrated nursing and medical records.
- Monitoring of application and compliance with CPA.

A clinical risk working group has also been developed to focus on risk issues in mental health services.

Recommendation 2

The above strategy should be accompanied by an action plan identifying responsible officers and timetables, to be monitored by the Trust Board.

The Clinical Governance Sub-Committee receives reports on risk management issues.

The Trust had to demonstrate effective management of risk to achieve Level I for the Clinical Negligence Scheme for Trusts. Level II has now been achieved.

Recommendation 3

A risk profiling exercise to be carried out.

A tool for identifying environmental risk factors in patient areas has been developed and is being piloted in Newton Lodge, St John's Flats and the adult acute wards.

Recommendation 4

A rigorous approach to reviewing serious untoward incidents to be adopted, including a framework for review, action plans and monitoring process.

The Trust already had an established procedure for recording all risk incidents, including mechanisms for reporting serious incidents which was fully compliant with Regional Office requirements.

The procedure was reviewed in December 1999. This included development of a proforma for managers to aid analysis of incidents and identification of actions and review process. A training programme was carried out with senior staff, including scenario planning and case reviews.

Recommendation 5

Robust framework to be developed for management reports following incidents.

See actions on recommendation 4.

Recommendation 6

Management reports following incidents to be supported by clear action plans.

See actions on recommendation 4.

Recommendation 7

The Trust must adopt a plan to ensure an improvement in the involvement of clinical staff in decision making processes. These processes must be open and transparent. The new joint medical director should play a key role in the development of this plan. A review of the adult clinical management team would be timely.

At the time of the visit, clinical management teams incorporating doctors, nurses and other clinicians were an integral part of the management structure.

Programme Directors had regular individual meetings with the Chief Executive and with Programme Managers.

Further work carried out since includes:

- Establishment of Management Boards to focus on clinical issues, including representation of all CMTs
- Clarification of the role of CMTs

- Development of the role of Programme Directors and Managers linked to a development programme/training/mentorship arrangements

- Appointment of a Programme Director to adult mental health services.

Recommendation 8

The Trust Board must address the culture which tolerates managers being openly dismissive of clinicians and clinicians being openly dismissive of managers.

The review team were challenged to provide evidence to substantiate this recommendation to enable the Trust to address this issue. The view was particularly challenged by the Medical Directors and Director of Medical Education and Training. The Chairman of the review team refused to provide any evidence to explain how this view had been reached.

Recommendation 9

Development of clinical leadership skills should be a priority for the Trust, linked to the development of a strategy for medical staffing. This should be a priority for the consultant forensic psychiatrist who is to become joint Medical Director.

There was nothing in the report to link this recommendation to evidence. It is understood that it may have related to issues around the size of caseload of individual consultants, which the Trust has been unable to address because of difficulties in gaining approval for additional consultant posts.

A strategy for supporting Programme Directors was already in place, as was job planning for individual consultants. All consultants have individual review meetings.

This issue of the number of consultants required to meet the population size and need is being addressed through the NSF.

Recommendation 10

Development of multi-disciplinary training eg: training in psycho-social interventions would help improve clinical skills and develop a culture of mutual respect.

The development and implementation of a training programme was recommended in the paper presented to the Trust Board on 4 November 1999.

There is already a comprehensive regional approach to developing skills in psycho-social intervention, in which the Trust plays an active part: the Regional Office has commissioned providers of training through universities.

A number of staff have already gone through training programmes.

Recommendation 11

The Trust's nursing strategy should be given a higher profile in mental health services

This recommendation failed to recognise that the nursing strategy already applied across all services. This includes:

- Specialist advisors on a range of issues.
- Professional development nurses to provide clinical leadership across all services.
- Lecturer/practitioner posts
- Development of nurse consultant posts (the first such post has now been developed in older people's services)

The new structure of management boards draws nursing issues into all service planning through the Chief Nurses, who are members of Management Boards.

Recommendation 12

The Trust should work with the Health Authority and Social Services to articulate a clear vision for the future of community based psychiatric services which has the support of all stakeholders.

This is being addressed through the NSF steering group which includes representatives of statutory agencies and service users.

The implementation plan for the NSF has been classed by the Regional Office as "amber".

CMHTs moved to integrated management arrangements from July.

RU/SH/10392

APPENDIX 3

BIBLIOGRAPHY/DOCUMENTS USED

HC(90)23/LASSL(90)11 – *The care programme approach for people with a mental illness referred to the specialist psychiatric services*

HSG(94)5 – *Introduction of supervision registers for mentally ill people from 1st April 1994*

HSG(94)27 – *Guidance on the discharge of mentally disordered people and their continuing care in the community*

Department of Health. *Mental illness – key area handbook.*
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The Dixon Team Inquiry Report – report of the independent inquiry team to Kensington and Chelsea and Westminster Health Authority, Westminster City Council, Newham Council and East London and the 'City Health Authority'. April 1999

Sheppard D. *Learning the Lessons – Mental Health Inquiry Reports published in England and Wales between 1969 and 1996 and their recommendations for improving practice.*
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'Sharing the Burden' – an independent inquiry into the care and treatment of Desmond Ledgester. Report commissioned by Calderdale and Kirklees Health Authority 1997.

'Bridging the Gaps' – independent inquiry into the care and treatment of Naseer Aslam. Report commissioned by Bradford Health Authority 1999

Effective care co-ordination in mental health services. Modernising the Care Programme Approach. A Policy Booklet. SSI/NHS Executive

A guide to the Mental Health Act 1988. Robert Bluglass

Community care tragedies: a practice guide to mental health inquiries. Margaret Reith

Regina –v- Daniel Joseph Williams 18.2.2000 - transcript of Leeds Crown Court proceedings

LOCAL DOCUMENTS

Wakefield Metropolitan District Council (WMDC) Community and Social Services Department – Review of care management in respect of Daniel Williams. 17.3.99

Final report – major incident review April 1999 – report of the major incident review team into an incident which occurred on the Priory Unit, Aberford Centre in Wakefield on 19th December 1998 involving Daniel Williams and Adrian Pawson – report commissioned by Wakefield and Pontefract Community Health NHS Trust (WPCHT) for the Trust Board

WPCHT/WMDC Joint health and social services review of major incident 14.1.2000

WMDC/WPCHT Health and Safety Circular No 28 – risk assessment, in service provision

WPCHT/WMDC Community and Social Services Department joint policy – community mental health teams

National Service Framework for Mental Health – Wakefield District local implementation plan 2000-2001 28.3.2000

WMDC Community and Social Services Department – policy, procedure and guidelines on assessment and care management October 1996

WPCHT/WMDC Care programme approach/Supervision Register policy 1997

Wakefield Health Authority/City of Wakefield Metropolitan District Council – Wakefield District integrated policy and procedures – assessment and care management/care programme approach

Wakefield IHealth Authority factfile.

Turning Point – Druglink Wakefield and District project guide

Correspondence between the Mental Health Act Commission and WPCHT in February/April 2000

WPCHT Documents –

Guidelines for the completion of core risk assessment November 1999

Nursing guidelines – staff dealing with individuals exhibiting aggressive or violent behaviour or resistance to care October 1996

Nursing policy – handover of duties between staff at change of shifts and accounting for patients November 1996 and September 1999

Nursing guidelines – property of patients admitted to hospital care, items handed to hospital staff for safe custody October 1996

Admission procedure (adult mental health services) March 1999

Procedure for use of Pinpoint June 1999

Procedure for the use of physical responses to aggression September 1999

Policy on searching of patients' belongings on in-patient areas July 1999

Adult mental health nursing policy – responsibilities of named nurse, shift leader and allocated nurse August 1999

Adult mental health nursing policy, the use of escorts and access August 1999

Care pathways through health and social services

Discharge policy mental health inpatient services May 1996

Discharge policy Pinderfields General Hospital

Discharge policy Pontefract General Infirmary

Discharge policy mental health in-patient services 2 May 1996, 1st review May 1998, 2nd review March 2001

Observation policy Review date – December 1999

Supportive observation policy May 2000

Universal infection control precautions October 1998

Sharps policy October 1998

Hepatitis Information October 1998

Information on resuscitation equipment review

Nurse staffing structure on Priory 2 ward – December 1998

CPA documentation for Daniel Williams

Arrangements for staff security on Priory Unit December 1998 and subsequently

Issue and control of keys (Priory I and II, Trinity and High Dependency Unit) September 1999

Procedure for the handling and storage of a suspected illegal substance January 2000

Adult mental health nursing policy – the use of escorts and access August 1999

Procedure for banned and controlled items (High Dependency Unit) Review date – December 1999

Procedure for management of serious untoward incidents Revised January 1997

Incident management procedures: serious untoward incidents Revised December 1999

Confidential report – Review of inpatient psychiatric services for adults

Risk incident reporting form

Plan of Priory Unit at time of incident

Confidential psychiatric reports on victim and perpetrator

Protocol for admission to special care unit

Information about relationships between CMHT and Warren Court

Annual report 1998-99

Report to Trust Board 5 February 1998 – Internal review on adult mental health services

Working together to make a difference – a strategy for nursing and specialist clinical professions 2000-2003 – draft

Senior management structures at time of incident and in December 2000

Communication arrangements between the Trust and General Practitioners

WRITTEN EVIDENCE

Correspondence from Mr David Hinchliffe MP involving the Trust, the Health Authority and constituents;

written statements from those invited to give evidence about their qualifications, training and involvement with Mr Daniel Williams;

information about substance misuse and the work of SUMIT;

a statement and appendices submitted by Wakefield Community Health Council including a chronological list of events, visits to Priory Unit, correspondence with Trust management and with Health Authority management, extracts from CHC minutes and other correspondence considered to be relevant;

information relating to the psychiatric care of both victim and perpetrator;

submissions and related documents from Social Services and Trust management regarding the progress of actions taken since the incident and future mental health developments;

information from West Yorkshire police concerning the incident and related matters;

documentary information from West Yorkshire Probation Service;

information provided by the family of the victim relating to his care.

APPENDIX 4

PERSONS INTERVIEWED AND OTHER CONTRIBUTORS

Mr D Williams	Subject of the Inquiry
Mr D Williams' mother	
Mr D Williams' step-sister	
Mr A Pawson's mother	
Mr A Pawson's stepfather	
Dr A E Ahmed	then Senior House Officer, Wakefield & Pontefract Community Health Trust
Ms L Brentnall	then Deputy Manager, Warren Court Hostel, Wakefield
Dr C A Cruickshank	Consultant Psychiatrist, Wakefield & Pontefract Community Health Trust
Mr S Davis	then Community Psychiatric Nurse, Wakefield Community Mental Health Team
Dr N Dissanayaka	then Senior House Officer, Wakefield & Pontefract Community Health Trust
Ms K Dunwoodie	Chief Officer, Wakefield Community Health Council
Dr J Gaunt	then General Medical Practitioner, Wakefield
Mr M Grant	then Social Worker, Wakefield Community Mental Health Team
Ms K Hayes	Community Psychiatric Nurse, SUMIT, Wakefield
Mr D Hinchliffe MP	Member of Parliament for Wakefield
Ms A Hopkins	Director of Nursing and Primary Care, Wakefield & Pontefract Community Health Trust
Dr M Y Jardine	Consultant Psychiatrist, Wakefield & Pontefract Community Health Trust
Mrs S Jarvis	Operations Manager, Housing and Social Care, City of Wakefield Metropolitan District Council
D Lister	Acting Detective Inspector, West Yorkshire Police, Wakefield CID
Mr S McDaid	Clinical Nurse Manager, SUMIT, Wakefield
Mr S Michael	Director of Mental Health, Wakefield & Pontefract Community Health Trust
Mr Milburn Muir	Manager, Airedale Community Mental Health Team
Mr B O'Brien JP MP	Member of Parliament for Normanton

Mr D Pickersgill	then Acting Ward Manager, Wakefield & Pontefract Community Health Trust
Inspector I Ramsay	West Yorkshire Police, Wakefield
Dr G Roney	Joint Medical Director, Wakefield & Pontefract Community Health Trust
Dr G D Slater	General Medical Practitioner, Wakefield
Mr I Smith	Community Care Service Manager, Housing and Social Care, City of Wakefield Metropolitan District Council
Ms J Smith	Wakefield Community Health Council, Vice Chair, Special Interest Group on mental health and related issues
Mr K Swift	Wakefield Community Health Council Vice Chair
Mr S Taylor	Mental Health Advocate, Richmond Fellowship Advocacy Service
Ms H Walshaw	Director of Nursing and Corporate Development, Wakefield & Pontefract Community Health Trust
Mr J Whittle	Senior Social Worker, SUMIT, Wakefield
Mr R Wilk	Chief Executive, Wakefield & Pontefract Community Health Trust

OTHER CONTRIBUTORS

Associated Verbatim Reporters	Bolton
Mrs L Brereton	West Yorkshire Probation Service, Wakefield
Mr J Ford	former Wakefield Health Authority Deputy Director of Strategic Development
Ms A Hargate	Project Manager, Wakefield & Pontefract Community Health Trust
Mr R Logush	Current Warren Court Manager
Mrs A Moss	Wakefield Health Authority Assistant Director of Strategic Development
Rampton Hospital Authority	